United States Department of Labor
Employees' Compensation Appeals Board

V.L., Appellant	)	
and	)	**Docket No. 12-1453**
	)	**Issued: January 4, 2013**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Chicago, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On June 27, 2012 appellant filed a timely appeal of a January 12, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award issue.

ISSUE

The issue is whether appellant sustained more than two percent permanent impairment of the left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On October 31, 2007 appellant, then a 51-year-old facilities management consultant, filed a Form CA-2 alleging that she sustained hand, arm, shoulder and neck pain as a result of

[1] 5 U.S.C. § 8101 *et seq.*

extensive typing on the job. OWCP accepted her occupational disease claim for bilateral carpal tunnel syndrome. On January 17, 2008 appellant filed a separate Form CA-2 alleging that she experienced neck, shoulder and upper back symptoms due to repetitive computer use. OWCP accepted this claim for bilateral brachial plexus lesions.[2] Appellant received disability compensation accordingly.

Appellant underwent left and right endoscopic carpal tunnel releases on March 8 and May 2, 2008, respectively. Both surgeries were authorized by OWCP. A November 10, 2008 functional capacity evaluation conducted by Kathleen Raven, a licensed occupational therapist, revealed normal prehension strength, range of motion (ROM), coordination and two-point discrimination.

A January 12, 2009 magnetic resonance imaging (MRI) scan obtained by Dr. Linda L. Dew, a Board-certified radiologist, exhibited right radiocarpal joint effusion and flexor tenosynovitis with recurrent carpal tunnel syndrome. A January 30, 2009 electromyogram (EMG) obtained by Dr. Anatoly M. Rozman, a Board-certified physiatrist, showed bilateral cubital tunnel syndrome.

In an April 9, 2009 report, Dr. James D. Schlenker, a Board-certified plastic surgeon, examined appellant and observed well-healed bilateral wrist and palm scars, discomfort and tenderness to palpation. He opined that the bilateral carpal tunnel syndrome reached maximum medical improvement while the neurogenic thoracic outlet syndrome remained stable. Dr. Schlenker estimated that appellant sustained 10 percent permanent impairment of the left hand and 10 percent permanent impairment of the right hand due to carpal tunnel syndrome.

Appellant filed a claim for a schedule award on June 10, 2009. Dr. Schlenker noted in a June 24, 2009 report, that she experienced postoperative symptoms in the right hand, which he attributed to an inflamed synovium. He also found signs of neurogenic thoracic outlet syndrome. Dr. Schlenker recommended open carpal tunnel release and tenosynovectomy.

OWCP advised appellant in a June 29, 2009 letter that additional evidence was needed to establish her claim. It gave her 30 days to submit an impairment rating report from a qualified physician that utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[3]

In a July 21, 2009 report, Dr. Schlenker remarked, "I am not prepared to use the 6th edition (of the A.M.A., *Guides*) and would find it very difficult to show how I arrived at the percentage impairment using the applicable tables...." He reiterated that appellant sustained 10 percent permanent impairment of the left hand but withdrew his original rating for the right hand based on continuing symptomatology.

Dr. Roy L. Adair, a Board-certified physiatrist, related in a December 1, 2009 report that appellant's left hand pain worsened. On examination, he observed left upper shoulder tenderness

[2] OWCP combined these claims under File No. xxxxxx116.

[3] A.M.A., *Guides* (6th ed. 2008).

and myofascial trigger points. Dr. Adair diagnosed recurrent left carpal tunnel syndrome and myofascial pain syndrome.

In a December 5, 2009 letter, appellant informed OWCP that she was unable to obtain an impairment rating report from a qualified physician that utilized the A.M.A., *Guides*. In a January 27, 2010 letter, OWCP replied:

> "[OWCP] will refer you for an independent medical examination to determine the amount of permanent partial impairment. The referral will be made at our earliest convenience. You will be notified by letter when the date and time of examination is determined."

In a July 29, 2010 report, Dr. Schlenker examined appellant and observed positive Tinel's signs and Phalen's tests over the bilateral median nerve and positive Tinel's signs over the bilateral ulnar nerve. He diagnosed bilateral carpal tunnel syndrome and cubital tunnel syndrome.[4]

Dr. Manisha S. Khanna, a Board-certified physiatrist, performed an August 5, 2010 EMG and nerve conduction study and showed evidence of bilateral elbow neuropathy and right median neuropathy. A neurological examination also demonstrated diminished left hand sensation to pinprick and positive Tinel's signs at the wrists and elbows.

In a December 16, 2010 report, Dr. Schlenker estimated that appellant sustained 10 percent permanent impairment of the left hand and 15 percent permanent impairment of the right hand due to carpal tunnel syndrome.

On March 14, 2011 Dr. David H. Garelick, OWCP's medical adviser and Board-certified orthopedic surgeon, reviewed the medical file, in particular Ms. Raven's November 10, 2008 functional capacity evaluation report and Dr. Khanna's August 5, 2010 EMG and nerve conduction study. He pointed out that the record did not contain objective evidence of ongoing brachial plexopathy. Applying Table 15-23 (Entrapment/Compression Neuropathy Impairment) on page 449 of the A.M.A., *Guides*, Dr. Garelick assigned grade modifier values of 0 for normal test findings, 2 for history of significant intermittent symptoms and 0 for normal physical findings. After he added these values (0 + 2 + 0), divided the sum by 3 to obtain the average (0.66) and rounded to the nearest integer (1), he found that appellant had two percent permanent impairment of the left upper extremity for residual carpal tunnel syndrome. Dr. Garelick listed November 10, 2008 as the date of maximum medical improvement.

By decision dated June 20, 2011, OWCP granted a schedule award for two percent permanent impairment of the left upper extremity for the period April 9 to May 24, 2009.

[4] Dr. Schlenker restated these findings in an August 26, 2010 follow-up report.

Appellant requested reconsideration on November 3, 2011.[5] She contested the duration of the schedule award and argued that her permanent disability rendered her incapable of performing activities of daily living.[6] Appellant further asserted that OWCP failed to refer her for a medical examination as stated in its January 27, 2010 letter.

On January 12, 2012 OWCP denied modification of the June 20, 2011 decision.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss of or loss of use of scheduled members or functions of the body.[7] However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8]

The A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF). For upper extremity impairments, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[10]

ANALYSIS

The Board finds that the case is not in posture for decision.

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome and brachial plexus lesions while in the performance of duty and authorized left and right endoscopic carpal

[5] On July 15, 2011 appellant requested a telephonic hearing. By decision dated August 8, 2011, OWCP denied the request on the grounds that is was not made within 30 days after issuance of the June 20, 2011 decision. After considering whether to grant a discretionary hearing, it determined that the issue could be further addressed by requesting reconsideration and submitting additional evidence.

[6] Appellant also mentioned a bilateral knee injury. This condition is not presently before the Board.

[7] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[8] *K.H.*, Docket No. 09-341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

[9] *R.Z.*, Docket No. 10-1915 (issued May 19, 2011).

[10] *J.W.*, Docket No. 11-289 (issued September 12, 2011).

tunnel releases on March 8 and May 2, 2008. Dr. Schlenker, her attending physician, presented an impairment rating of 10 percent for the left hand in multiple reports for the period April 9, 2009 to December 16, 2010 report. After appellant filed a claim for a schedule award on June 10, 2009, OWCP advised her in a June 29, 2009 letter that she needed to submit an impairment rating report from her physician that utilized the appropriate A.M.A., *Guides*. She later informed OWCP in a December 5, 2009 letter that she was unable to obtain such a report. The case record shows, in fact, that Dr. Schlenker expressed an unwillingness to apply the sixth edition of the A.M.A., *Guides*. In response, OWCP stated in a January 27, 2010 letter that it would refer appellant for an independent medical examination to determine the amount of permanent partial impairment. The case record indicates, however, that no referral was made before or after OWCP issued its June 20, 2011 decision granting a schedule award for two percent permanent impairment of the left upper extremity.

OWCP is not a disinterested arbiter. In addition to the role of adjudicator, it gathers relevant facts and protects the compensation fund, functions which impose on OWCP the obligation to see that its administrative processes are impartial and fairly conducted. Although the claimant has the burden of establishing entitlement to compensation, OWCP shares responsibility in the development of the evidence. Once it starts to procure medical opinion, it must do a complete job.[11] In this case, OWCP assured appellant in a December 5, 2009 letter that she would be referred for a medical examination to determine the appropriate amount of permanent partial impairment. Because it did not follow through with this referral, it failed to properly discharge its fact-gathering responsibilities. On remand OWCP shall refer the matter to an appropriate Board-certified specialist to determine the extent of appellant's upper extremity impairment in accordance with the A.M.A., *Guides* and, after conducting such further development as deemed necessary, issue an appropriate merit decision.[12]

CONCLUSION

The Board finds that the case is not in posture for decision.

[11] *Richard F. Williams*, 55 ECAB 343, 346 (2004).

[12] The Board notes that appellant submitted new evidence after issuance of the January 12, 2012 decision. The Board lacks jurisdiction to review evidence for the first time on appeal. 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the January 12, 2012 decision of the Office of Workers' Compensation Programs be set aside and the case remanded for further action consistent with this decision of the Board.

Issued: January 4, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board