United States Department of Labor
Employees' Compensation Appeals Board

V.L., Appellant	)	
and	)	**Docket No. 14-573**
	)	**Issued: June 9, 2014**
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:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 23, 2014 appellant filed a timely appeal from a September 27, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) pertaining to a schedule award. 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 merits of this case.

ISSUE

The issue is whether appellant has established that she sustained more than two percent impairment of both the left and right upper extremities, for which she received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board. By decision dated January 4, 2013, the Board set aside a January 12, 2012 OWCP decision, which denied modification of a June 20,

[1] 5 U.S.C. § 8101 *et seq.*

2011 schedule award.[2] While OWCP had advised that it would refer appellant for an independent medical examination to determine the amount of permanent partial impairment, no referral was made prior to the June 20, 2011 decision granting a schedule award for two percent permanent impairment of the left upper extremity. The facts as set forth in the Board's prior decision are herein incorporated by reference. The facts relevant to the appeal are set forth.

Appellant has accepted occupational disease claims for bilateral carpal tunnel syndrome and bilateral brachial plexus lesions.[3] She received disability compensation.

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 an ability to perform work at a light to medium level with a 25-pound maximum lifting restriction. Grip strength was normal, range of motion (ROM) was normal bilaterally and coordination and two-point discrimination were within normal limits.

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. Appellant underwent functional capacity evaluations on October 22 and November 11, 2008 and February 27, 2013. The February 27, 2013 test found that at a minimum appellant demonstrated the ability to function in the light physical demand level for an eight-hour day. It explained that her performance was not an accurate assessment of her current functional status and was invalid secondary to numerous inconsistencies and the inability to put forth maximum effort.

Following a second surgery, appellant returned to work in a restricted duty capacity effective March 2, 2009. She was released to full duty effective April 10, 2009.

Appellant filed a claim for a schedule award for permanent partial impairment to her upper extremities. By decision dated June 20, 2011, OWCP granted a schedule award compensation for a two percent permanent partial impairment to the left upper extremity.

Following the Board's January 14, 2013 decision, OWCP scheduled appellant for a second opinion evaluation by Dr. Allan Brecher, a Board-certified orthopedic surgeon. In an April 10, 2013 report, Dr. Brecher reviewed the statement of accepted facts and the medical record. On examination, he found a full range of motion of her shoulders, elbows, wrists and hands with no triggering. Dr. Brecher stated that two-point discrimination was five millimeters (mm) in all fingers except the left little finger, which was five to six mm. Tinel's sign was noted over the ulnar nerve bilaterally at the elbow, but showed mild tenderness with pseudo Tinel's sign when the lateral epicondyle was tapped. Dr. Brecher advised that there was positive Tinel's and compression tests, but a negative Phalen's test of both wrists. He stated that the brachial

[2] Docket No. 12-1453 (issued January 4, 2013).

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

plexus injury appeared to manifest itself as cubital tunnel compression and ulnar nerve compression. Appellant complained of pain, but had relatively mild limitations. She had pain over the carpometacarpal (CMC) joint to compression and axial loading, suggestive of CMC arthritis; but this could not be confirmed as no x-rays were provided. Dr. Brecher stated that appellant had residual entrapment symptoms that were mild intermittent, which limited heavy lifting but still enabled her to function. Under Table 15-23, page 449 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), he provided grade modifier 1 for testing, grade modifier 2 for history and grade modifier 1 for physical examination. Dr. Brecher added the grade modifiers and divided it by three to arrive at an average grade of 1 (1+2+1 = 4/3 = 1.33). He excluded her *Quick*DASH score of 100, which he stated was misleading and not accurate and would combine her arthritic condition, which was not part of her disability. Dr. Brecher found that appellant had two percent impairment for the median and ulnar nerve of each hand. He combined the two and used half of the second to arrive at three percent final upper extremity impairment to each side. Dr. Brecher opined that maximum medical improvement was reached in April 2009. He provided a completed a permanent impairment worksheet for upper extremity for both the left and right side.

Additional medical documentation from Dr. James D. Schlenker, a Board-certified plastic surgeon, was submitted.

In a May 13, 2013 report, Dr. David H. Garelick, an OWCP medical adviser, reviewed the medical records. He noted that appellant underwent an endoscopic release of the left carpel tunnel on March 8, 2008 and had a similar operation of the right side on May 2, 2008. He noted that OWCP had not accepted cubital tunnel syndrome as work related. Since the February 27, 2013 functional capacity evaluation was deemed invalid, many of the physical examination findings as well as appellant's subjective complaints should be considered inflated and not representative of her true abilities. He agreed with Dr. Brecher's award of two percent permanent impairment for bilateral residual carpal tunnel syndrome. Dr. Garelick disagreed, however, with the additional award of one percent for cubital tunnel syndrome. Although Dr. Brecher related the cubital tunnel syndrome to the brachial plexus lesion, he stated that there was no lesion to the brachial plexus which anatomically traveled in the axilla.[4] He stated that the February 9, 2012 bilateral upper extremity EMG made no mention of any brachial plexus lesion and, thus, it appeared that her symptoms came from the elbow and not the brachial plexus. Accordingly, Dr. Garelick recommended that no additional permanent impairment be awarded for the cubital tunnel syndrome as it had not been accepted as work related and there was no objective EMG evidence to support any bracial plexus lesion. He opined the date of maximum medical improvement was November 10, 2008.

By decision dated May 22, 2013, OWCP granted appellant schedule awards for two percent impairment to the right and left upper extremities. As appellant previously received a June 20, 2011 schedule award for two percent impairment of the left upper extremity, no further compensation was payable.

[4] OWCP's medical adviser indicated that appellant had symptoms consistent with cubital tunnel syndrome, but noted it was not accepted as work related.

On July 10, 2013 appellant requested reconsideration. She advised that she had residuals from her injuries and wanted to be fairly compensated for the lifelong pain and suffering she endured.[5]

In a June 13, 2013 letter, Dr. Schlenker stated that, based on his June 13, 2013 examination, appellant had from 15 to 20 percent permanent impairment of her right and left hands due to the carpel tunnel syndrome. His report indicated that there was no triggering of the left index, middle, ring or little fingers. Carpal tunnel syndrome and ganglion, tendon sheath were assessed.

In a second June 13, 2013 letter, Dr. Schlenker noted the history of appellant's bilateral carpal tunnel syndrome. He noted that she had well-healed scars from endoscopic carpal tunnel release in the wrists and palms bilaterally and presented grip strength testing results. On the basis of his examination, Dr. Schlenker found that appellant had a satisfactory result following release of carpal tunnel compression. He noted a possibility that the triggering in the left middle finger could recur and might require surgery. Dr. Schlenker opined that the triggering of the left middle finger was related to the repetitive activities appellant carried out at work over a long period of time. Although appellant had retired, if work were available, he would release her to the job she previously performed. Dr. Schlenker noted that appellant had paresthesias in both hands and the February 9, 2012 EMG showed bilateral ulnar neuropathies. He opined that her condition was not severe enough to recommend surgery for cubital tunnel syndrome and appellant did not want surgery.

In a September 23, 2013 report, Dr. Garelick reviewed the medical evidence from Dr. Schlenker. While Dr. Schlenker recommended 15 to 20 percent permanent impairment of both upper extremities due to carpal tunnel syndrome, Table 16-23, page 449 of the A.M.A., *Guides* provided that the maximum impairment for carpal tunnel syndrome was 9 percent. Therefore, Dr. Schlenker's rating was not in line with the A.M.A., *Guides*. Dr. Garelick reiterated that appellant had two percent impairment of each upper extremity and that maximum medical improvement was reached on November 10, 2008.

By decision dated September 27, 2013, OWCP denied modification of its May 22, 2013 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 or loss of use of scheduled members or functions of the body.[6] 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

[5] Appellant also mentioned a knee injury, which was denied under claim number xxxxxx907. This condition is not presently before the Board.

[6] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[7]

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).[8] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[9]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.[10]

ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome and brachial plexus lesions while in the performance of duty. It authorized left and right endoscopic carpal tunnel releases on March 8 and May 2, 2008. By decision dated May 22, 2013, OWCP granted appellant schedule awards for two percent impairment of the left and right upper extremity.

Dr. Brecher rated impairment of two percent to both upper extremities for residual carpal tunnel syndrome. He rated an additional one percent impairment to each arm for cubital tunnel syndrome, which he related to a brachial plexus lesion. Dr. Garelick reviewed Dr. Brecher's report and agreed with the two percent bilateral upper impairment rating for residual carpal tunnel syndrome. Dr. Brecher explained that, under Table 15-23, page 449 of the A.M.A., *Guides*, appellant's grade modifiers for test findings (1), history (2) and physical examination (1) total 4, which represented an average grade modifier of 1. He excluded the *Quick*DASH score as being misleading and inaccurate and thus there was no further basis for further adjustment under Table 15-23. The default rating of two percent represented appellant's left and right upper extremity impairment for a grade modifier of 1. Dr. Garelick advised that the impairment rating for residual carpal tunnel syndrome conformed to the A.M.A., *Guides*. He disagreed with Dr. Brecher's rating of an additional one percent bilateral upper extremity impairment for the cubital tunnel syndrome. While Dr. Brecher related the cubital tunnel syndrome to a brachial plexus lesion, Dr. Garelick reviewed the medical record and found that objective testing did not support any brachial plexus lesion. The February 9, 2012 bilateral

[7] *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).

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

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

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

upper extremity EMG did not identify any brachial plexus lesion.[11] He further noted that OWCP had not accepted cubital tunnel syndrome as work related. The Board finds that Dr. Garelick's rating conforms to the A.M.A., *Guides* and represents the weight of the medical evidence regarding the extent of impairment to appellant's arms.

Dr. Schlenker recommended in a June 13, 2013 report that appellant had 15 to 20 percent bilateral upper extremity impairment due to a carpal tunnel syndrome. Dr. Garelick properly noted that this impairment rating was not in line with Table 15-23, page 449 of the A.M.A., *Guides*, which provides a maximum award of nine percent for carpal tunnel syndrome. Further, Dr. Schlenker offered no explanation as to how he calculated the impairment. There is no probative medical evidence to support a greater impairment than that awarded.

On appeal, appellant contested the extent of impairment noting she had residual symptoms. She did not submit any probative medical evidence rating greater impairment conforming to the sixth edition of the A.M.A., *Guides*.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant did not sustain greater than two percent left upper extremity impairment and two percent right upper extremity impairment.

[11] The Board notes that cubital tunnel syndrome is not an accepted condition under the current claim. Based on the January 30, 2009 EMG which showed bilateral cubital tunnel syndrome, it did not preexisted appellant's employment injuries in 2007 or 2008.

ORDER

IT IS HEREBY ORDERED THAT the September 27, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 9, 2014
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board