United States Department of Labor
Employees' Compensation Appeals Board

D.D., Appellant	)	
and	)	**Docket No. 14-1930**
	)	**Issued: January 14, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Palatine, IL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 3, 2014 appellant filed a timely appeal from the July 29, 2014 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 merits of this case.

ISSUE

The issue is whether appellant met her burden of proof to establish more than an eight percent permanent impairment of her left arm, for which she received schedule awards.

FACTUAL HISTORY

In May 2011 OWCP accepted that appellant, then a 53-year-old mail clerk, sustained left cubital tunnel syndrome and left de Quervains's tenosynovitis due to performing her repetitive work duties. It later expanded the accepted conditions to include left radial styloid tenosynovitis,

[1] 5 U.S.C. §§ 8101-8193.

left ulnar nerve lesion, left-sided rheumatism, nontraumatic compartment syndrome of the left arm, and rupture of extensor tendons of the left hand and wrist. On September 2, 2011 appellant underwent OWCP-authorized left ulnar nerve transposition surgery.

OWCP had previously accepted, under a separate claim file, that appellant sustained injuries due to a lifting incident on September 24, 2001 including neck, shoulder, and upper arm sprains, displacement of cervical intervertebral disc and cervical spondylosis without myelopathy, and brachial neuritis/radiculitis. In connection with these injuries, it granted her a schedule award on March 14, 2006 for a five percent permanent impairment in each arm.

In a December 20, 2011 report, Dr. Howard Freedberg, an attending Board-certified orthopedic surgeon, indicated that appellant had reached maximum medical improvement with respect to her left arm condition. Appellant reported that her left elbow was fine, that the range of motion for her left arm was good, and that she had no pain or issues with her left arm. Dr. Freedberg reported his physical examination findings, noting full and painless range of motion in her left arm at the shoulder, elbow, and wrist. He noted that appellant had 5/5 grip strength in her left hand.

On March 22, 2012 appellant filed a claim for an additional schedule award due to her accepted work injuries.

In a September 17, 2012 decision, OWCP denied appellant's claim as she had not submitted medical evidence establishing additional impairment.

In an October 22, 2012 report, Dr. Neil Allen, an attending Board-certified internist and neurologist, described appellant's work-related conditions and history of medical treatment. He reported appellant's current symptoms and his physical examination findings. Dr. Allen applied a range of motion rating method for appellant's left arm by applying Table 15-30 (thumb motion), Table 15-31 (digit motion), Table 15-32 (wrist motion), and Table 15-33 (elbow motion) of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009). He indicated that, under Table 15-2 through Table 15-5 pertaining to the upper extremities, certain diagnosis-based conditions contain an asterisk (*) which indicate that the range of motion method may be used as an alternative stand-alone rating method. Dr. Allen concluded that appellant had 46 percent permanent impairment of her left arm based on the range of motion rating method.

On February 4, 2013 an OWCP hearing representative set aside OWCP's September 17, 2012 decision and remanded the case for further development and a new decision after proper consideration of the October 22, 2012 impairment evaluation by Dr. Allen.

On remand, OWCP further developed the evidence of record. In a June 3, 2013 report, Dr. David Garelick, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, discussed Dr. Freedberg's physical examination findings and Dr. Allen's impairment rating. He posited that Dr. Allen's evaluation was improperly based on the range of motion rating method. Dr. Garelick concluded that, under the sixth edition of the A.M.A., *Guides*, appellant had three

percent left arm impairment rating based on a diagnosis-based rating method for cubital tunnel syndrome. He stated:

> "According to Dr. Freedberg's note dated December 20, 2011, [appellant] has done well following her left elbow and wrist surgery. In fact, as of that date, she denied numbness, tingling, or pain and had "no issues" in the elbow. However, she did have some residual numbness in the ulnar innervated digits. Physical examination demonstrated full LUE [left upper extremity] ROM [range of motion]. The elbow flexion test no longer reproduced her symptoms. Sensation was intact to light touch. There was no mention of any residual symptoms related to the left wrist.
>
> "According to [T]able 15-23, p. 449 of the A.M.A., *Guides*, a [g]rade 1 modifier is awarded for the test findings which demonstrated a mild ulnar neuropathy at the level of the elbow. The mild intermittent symptoms and the normal physical examination would also qualify for a [g]rade 1 modifier. Given these average a [g]rade 1 modifier, 2 percent LUE PPI [permanent partial impairment] is awarded for the residual cubital tunnel syndrome. As it relates to the radial styloid tenosynovitis, 1 percent LUE PPI is awarded for a history of painful injury without consistent objective symptoms as noted in Table 15-3, p. 395 of the A.M.A., *Guides*. Use of the combined values table on p. 604 of the A.M.A., *Guides*, 3 percent LUE PPI is awarded. The date of MMI [maximum medical improvement] occurred on December 20, 2011 per Dr. Freedberg's recommendation."

On August 25, 2013 Dr. Christopher Gross, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, concurred with Dr. Garelick's impairment rating and explained that Dr. Garelick's three percent impairment rating was in addition to the five percent left arm impairment previously awarded. He stated that Dr. Garelick's impairment rating "is additional to the five percent already assigned since that impairment rating accounted for cervical pathology and not pathology at the wrist and elbow."

By decision dated December 13, 2013, OWCP granted appellant a schedule award for eight percent permanent impairment of her left arm less the five percent impairment previously awarded. The award ran for 9.36 weeks from December 20, 2011 to February 23, 2012.

Appellant requested a telephonic hearing with an OWCP hearing representative. During the June 10, 2014 hearing, counsel argued that appellant's schedule award should have been based on the range of motion rating method.

In a July 29, 2014 decision, OWCP hearing representative affirmed OWCP's December 13, 2013 decision. She found that Dr. Garelick's report properly evaluated appellant's left arm impairment under the sixth edition of the A.M.A., *Guides*.

LEGAL PRECEDENT

The schedule award provision of FECA[2] and its implementing regulations[3] 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. 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.[4] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[5]

Peripheral nerve impairment is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[6] In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[7]

While Section 15.2 of the sixth edition of the A.M.A., *Guides* provides that "[d]iagnosis-based impairment is the primary method of evaluation for the upper limb," Table 15-2 through Table 15-5 also provide that, if motion loss is present for a claimant who has certain upper extremity conditions, impairment may alternatively be assessed using section 15.7 (range of motion impairment). Such a range of motion impairment stands alone and is not combined with a diagnosis-based impairment.[8]

Section 15.7 of the sixth edition of the A.M.A., *Guides* provides:

> "Range of motion should be measured after a "warm up," in which the individual moves the joint through its maximum range of motion at least [three] times. The range of motion examination is then performed by recording the active measurements from [three] separate range of motion efforts. Measurements

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] *Id*.

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Disability*, Chapter 2.808.5(a) (February 2013).

[6] *See* A.M.A., *Guides* 449, Table 15-23.

[7] A survey completed by a given claimant, known by the name *Quick*DASH, may be used to determine the functional scale score. *Id.* at 448-49.

[8] *Id.* at 387, 391-405, 475-78.

should be rounded up or down to the nearest number ending in 0…. All measurements should fall within 10 [degrees] of the mean of these three measurements. The maximum observed measurement is used to determine the range of motion impairment."[9]

ANALYSIS

OWCP granted appellant schedule awards for eight percent permanent impairment of her left arm. A portion of the award was based on the June 3, 2013 report of Dr. Garelick, a Board-certified orthopedic surgeon serving as an OWCP medical adviser. In this report, he found that appellant had three percent permanent impairment of her left arm based on entrapment neuropathy caused by cubital tunnel syndrome and radial styloid tenosynovitis.[10] Dr. Gross, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, indicated that appellant had previously been granted a five percent rating for left arm impairment which was based on peripheral nerve impairment stemming from her neck and noted that combining this five percent impairment with the three percent impairment based on appellant's entrapment neuropathy, as calculated by Dr. Garelick, meant that appellant had a total left arm impairment of eight percent.

In his June 3, 2013 report, Dr. Garelick discussed his review of the medical records and provided an opinion that appellant had three percent impairment for cubital tunnel syndrome and radial styloid tenosynovitis under the standards of the sixth edition of the A.M.A., *Guides.*[11] He properly applied these standards to reach his conclusion about appellant's permanent left arm impairment.

Dr. Garelick properly made reference to Table 15-23 (Entrapment/Compression Neuropathy Impairment) on page 449 of the sixth edition of the A.M.A., *Guides*.[12] He correctly chose grade modifiers from the table for the various categories, including test findings, history, physical findings and functional scale, based on Dr. Freedberg's findings. Dr. Garelick concluded that appellant had three percent impairment, comprised of two percent impairment due to cubital tunnel syndrome combined with one percent impairment due to radial styloid tenosynovitis.[13] This three percent impairment rating was properly added to the previously awarded five percent impairment rating to equal a total left arm impairment of eight percent.

The Board notes that there is no medical evidence of record showing that appellant has more than eight percent permanent impairment of her left arm, for which she already received

[9] *Id.* at 464.

[10] Dr. Garelick derived his impairment rating after reviewing the medical evidence of record, including the December 20, 2011 examination findings of Dr. Freedberg, an attending Board-certified orthopedic surgeon.

[11] OWCP's decision regarding impairment was not issued until after May 1, 2009 and therefore evaluation of appellant's impairment under the sixth edition of the A.M.A., *Guides* was appropriate. *See supra* note 5.

[12] A.M.A., *Guides* 449, Table 15-23 (6th ed. 2009).

[13] *Id.*

schedule awards. In an October 22, 2012 report, Dr. Allen, attending Board-certified internist and neurologist, determined that appellant had 46 percent permanent impairment of her left arm. However, this impairment rating was not carried out in accordance with the standards of the sixth edition of the A.M.A., *Guides.* Although the sixth edition of the A.M.A., *Guides* specifies that the range of motion rating method may be used as an alternative to rating some diagnosis-based conditions of the upper extremities, Dr. Allen did not specify for which diagnosis-based condition he was using the range of motion method as an alternative nor provide a rationalized basis for departing from the preferred diagnosis-based impairment method of evaluation.[14] In addition, Dr. Allen did not indicate that his range of motion measurements were obtained after a warm up, provide active measurements from three separate range of motion efforts, or provide passive range of motion measurements as required when evaluating motion under the sixth edition of the A.M.A., *Guides*.[15]

For these reasons, OWCP properly declined to award appellant additional schedule award compensation. 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 meet her burden of proof to establish more than an eight percent permanent impairment of her left arm, for which she received schedule awards.

[14] In Table 15-2 through Table 15-5 pertaining to the upper extremities, certain diagnosis-based conditions contain an asterisk (*) which indicate that the range of motion method may be used as an alternative stand-alone rating method. *See* A.M.A., *Guides* 391-405, Table 15-2 through Table 15-5.

[15] *See supra* note 9.

ORDER

IT IS HEREBY ORDERED THAT the July 29, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 14, 2015
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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