United States Department of Labor
Employees' Compensation Appeals Board

S.F., Appellant	)	
and	)	**Docket No. 15-43**
	)	**Issued: March 23, 2015**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, New York City, NY, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 7, 2014 appellant, through counsel, filed a timely appeal from a September 30, 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 to review the merits of this case.

ISSUE

The issue is whether appellant has more than nine percent impairment of his right upper extremity.

FACTUAL HISTORY

On August 11, 2011 appellant, a 61-year-old revenue officer, filed an occupational disease claim alleging that his cubital tunnel syndrome was the result of his federal employment. His orthopedic surgeon had informed him that this was a cumulative work-related injury.

[1] 5 U.S.C. § 8101 *et seq.*

Appellant underwent a neurolysis and anterior transposition of the right ulnar nerve in May 2011, but he felt his symptoms had only grown worse. Dr. Victor E. Ylagan, a Board-certified neurologist, examined him in June 2011 and found clawing of the last two fingers of his right hand, wasting of the interosseous muscles, and a worsening of weakness in the ulnar nerve distribution, all of which were new findings. A repeat electromyogram revealed severely reduced amplitudes on the right ulnar nerve, worse than the previous study. There was evidence of significant denervation in all three ulnar nerve innervated muscles, more noticeable than the previous study. Dr. Ylagan diagnosed recurrent severe ulnar nerve compression of the elbow with axonal loss.

Appellant underwent a repeat neurolysis in July 2011. In March 2012, he underwent a right carpal tunnel release and right revision cubital tunnel release.

Dr. Balazs B. Somogyi, a Board-certified orthopedic surgeon, evaluated appellant in January 2013 and concluded that the findings at the time of evaluation supported the diagnosis of chronic ulnar neuropathy with residual findings.

OWCP accepted appellant's occupational disease claim for right cubital tunnel syndrome.

Appellant filed a schedule award claim. Dr. Isaac J. Kreizman, the attending Board-certified physiatrist, found 21 percent impairment of the right upper extremity as a result of a peripheral nerve injury to the ulnar nerve below the midforearm. He cited Table 15-21, page 443, of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009). Given appellant's moderate motor deficit, Dr. Kreizman found that the default impairment value was 13 percent. He adjusted this to 21 percent using grade modifiers.

An OWCP medical adviser noted that appellant's ulnar nerve compression should be rated as an entrapment or compression neuropathy under Table 15-23, page 449, and not as a peripheral nerve injury. He calculated nine percent impairment of the right upper extremity.

Dr. Kreizman disagreed. He noted that appellant underwent surgery on "January 22, 2013" [sic], and postsurgery findings revealed evidence of motor deficit in the right ulnar nerve. Dr. Kreizman determined that Table 15-21 should be used, which gave appellant a higher rating.

The medical adviser explained that appellant underwent decompression surgery for the slowing of the right ulnar nerve across the elbow. As such, ulnar nerve compressions were rated under Table 15-23. He added that not only did Dr. Kreizman use the wrong table, but he improperly adjusted the default impairment value. Applying Table 15-23, the medical adviser assigned a grade modifier 3 under history, a grade modifier 2 under physical findings, and a grade modifier 3 for test findings. He found that the average of the three grade modifiers was 3 and the default upper extremity impairment was eight percent. The medical adviser noted a functional history score 3 due to the 93.1 percent severity of the *Quick*DASH score. Following the adjustment to the right by 1 value, he concluded that appellant had nine percent right upper extremity impairment.

On September 30, 2014 OWCP issued a schedule award for nine percent impairment of appellant's right upper extremity. It found that the medical adviser had correctly applied the A.M.A., *Guides*.

Appellant's representative asks the Board to modify the schedule award to reflect Dr. Kreizman's analysis.

LEGAL PRECEDENT

The schedule award provision of FECA[2] and the 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. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[4]

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. OWCP has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[5] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[6]

ANALYSIS

Diagnosis-based impairment is the primary method of evaluation for the upper extremities. The first step is to choose the diagnosis that is most applicable for the region being assessed. Selection of the optimal diagnosis requires judgment and experience. If more than one diagnosis can be used, the highest causally related impairment rating should be used; this will generally be the more specific diagnosis. Typically, one diagnosis will adequately characterize the impairment and its impact on activities of daily living.[7]

Specific criteria for that diagnosis determine which class is appropriate: no objective problem, mild problem, moderate problem, severe problem, very severe problem approaching total function loss. The A.M.A., *Guides* assigns a default impairment rating for each diagnosis by class. This may be adjusted slightly using such grade modifiers as functional history, physical examination, and clinical studies.[8]

Dr. Kreizman, the attending physiatrist, applied Table 15-21, Peripheral Nerve Impairment. As appellant had a moderate motor deficit of the ulnar nerve below the midforearm

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[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[5] 20 C.F.R. § 10.404; *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.0808.6.6a (January 2010).

[7] A.M.A., *Guides* 387, 389 (6th ed. 2009).

[8] *Id*. at 497.

(entire nerve), he located the default impairment value of 13 percent on page 443. He then adjusted this to 21 percent using grade modifiers.

There are two problems with this rating. The A.M.A., *Guides* explains that this table is to be used only for impairment from traumatic injury. "This section is not to be used for nerve entrapments since nerve entrapments are not isolated traumatic events; nerve entrapments are rated in [s]ection 15.4f."[9] Appellant did not file a traumatic injury claim. He filed an occupational disease claim for a cumulative injury over time. Appellant was diagnosed with an ulnar nerve compression, and OWCP accepted his claim for right cubital tunnel syndrome. Under the circumstances, his impairment should not be rated as a peripheral nerve injury arising from a traumatic event.

Dr. Kreizman reported that postsurgery findings revealed evidence of a right ulnar motor deficit. He did not explain how this warranted the use of Table 15-21, but if he meant to suggest that appellant suffered a traumatic injury to his right ulnar nerve as a result of surgery, the Board would point out that OWCP has not accepted such injury. OWCP has accepted his occupational disease claim for right cubital tunnel syndrome. If one were to turn to Table 15-21, page 443, one would find the following parenthetical guidance: "See Table 15-23 for cubital tunnel syndrome." The Board finds that Table 15-23 is the appropriate table to rate appellant's impairment.

The other problem with Dr. Kreizman's rating is that the highest rating anyone may receive for a moderate motor deficit of the ulnar nerve below the midforearm is 13 percent. Grade modifiers permit modification of the default value up or down within a given class.[10] They do not permit a change in class.[11] It is therefore apparent that he misapplied the grade modifiers.

The method used to calculate impairment in entrapment neuropathies deviates slightly from the diagnosis-based impairment method. The diagnosis has already been established; therefore, only grade modifiers need be determined for the purposes of calculating the impairment rating.[12]

Table 15-23, page 449, is used to rate the impairment for focal nerve compromise.[13] The medical adviser determined that appellant had a grade modifier 3 or severe compression neuropathy, which has a default impairment value of eight percent. As appellant's functional history was very severe,[14] he properly adjusted the default value to nine percent. Nine percent, incidentally, is the highest upper extremity rating anyone may receive for a compression

[9] *Id*. at 429.

[10] *Id*. at 405.

[11] *Id*. at 409.

[12] *Id*. at 433.

[13] *Id*. at 448.

[14] *See id*. at 406 (Table 15-7, *Quick*DASH Score).

neuropathy such as appellant's. Dr. Kreizman correctly pointed out that the table he used gave a higher rating, but he did not follow the protocols of the A.M.A., *Guides*.

Accordingly, the Board finds that appellant has no more than nine percent impairment of his right upper extremity due to the accepted right cubital tunnel syndrome. The Board will therefore affirm the September 30, 2014 schedule award.

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

CONCLUSION

The Board finds that appellant has no more than nine percent impairment of his right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the September 30, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 23, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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