

repetitive work duties. The record does not indicate that she stopped work in 1995, but there is evidence of intermittent wage-loss benefits.

Appellant underwent authorized bilateral cubital and carpal tunnel release surgeries conducted by Dr. John J. O’Keefe, a Board-certified orthopedic surgeon on May 2, 2003, March 3 and (June 19, 2006) April 14, 2005, and June 29, 2006. Following the last surgery of June 2006, she returned to modified work on August 12, 2006.

On June 25, 2007 appellant requested a schedule award.

In a report dated August 14, 2007, Dr. O’Keefe opined that appellant had 20 percent permanent impairment of her bilateral upper extremities, but failed to explain the rating pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*² (hereinafter A.M.A., *Guides*). On December 10, 2007 an OWCP medical adviser reviewed the evidence of record and recommended that appellant undergo a functional capacity evaluation (FCE).

In a January 31, 2008 FCE, appellant demonstrated mild musculoskeletal deficits, but retained the ability to perform light-duty work activities.

Dr. Amon Ferry, a Board-certified orthopedic surgeon, acting as an OWCP medical adviser, reported on April 29, 2009 that appellant had bilateral upper extremity permanent impairments of three percent for each extremity. He explained that for each of the extremities appellant had mild symptoms, but normal physical examination findings. Therefore, using the diagnosis-based method of evaluation, appellant had two percent permanent impairment for carpal tunnel syndrome, (Table 15-23, page 449) and two percent permanent impairment for cubital tunnel syndrome, (Table 15-23, page 449). These two conditions would be combined for each upper extremity, resulting in a finding of three percent permanent impairment of each extremity.

By decision dated August 13, 2009, OWCP issued a schedule award for three percent impairment of the right upper extremity and three percent impairment of the left upper extremity. The award ran for 18.72 weeks for the period January 28 to June 8, 2009.

Appellant thereafter on March 16, 2012 submitted a request for an increased schedule award (Form CA-7).

In an August 12, 2011 report, Dr. William N. Grant, a Board-certified internist, opined that appellant had 43 percent permanent impairment of each upper extremity based on diagnoses of carpal tunnel syndrome and complex regional pain syndrome (CRPS). He made reference in his report to a patient named “Mrs. Beier.” Dr. Grant cited to tables within the sixth edition of the A.M.A., *Guides*.

On January 15, 2012 an OWCP medical adviser reviewed appellant’s medical file along with Dr. Grant’s August 12, 2011 report. He noted the history of carpal and cubital tunnel

² A.M.A., *Guides* (6th ed. 2009).

releases. The medical adviser also noted that the claim had not been accepted for CRPS and that Dr. Grant's report appeared to pertain to a patient other than appellant. He noted that Dr. O'Keefe, in his most recent report of December 16, 2010, noted findings of strong grip and negative Tinel's and Phalen's test. Based on review of Dr. O'Keefe's reports, as well as operative and FCE reports, the medical adviser concluded that there was no additional impairment beyond the three percent right upper extremity and three percent left upper extremity impairment previously awarded. Appellant was noted to be at maximum medical improvement as of April 29, 2009, unchanged since the prior schedule award.

By decision dated April 23, 2013, OWCP denied appellant's claim for an increased schedule award. Special weight was accorded to the opinion of the medical adviser.

Appellant requested a telephone hearing before the Branch of Hearings and Review, which was held on September 23, 2013. She testified about her work duties and history of her upper extremity surgeries. Counsel advised that a new medical report with regard to upper extremity impairment would be provided post hearing.

In an October 11, 2013 report, Dr. Neil Allen, a Board-certified neurologist, noted the history of injury, appellant's accepted conditions, and examination findings of August 8, 2013. For the right elbow, he noted lateral joint line tenderness to palpation, 5/5 strength flexion and extension, restricted range of motion, and negative Tinel's sign. For the left elbow, Dr. Allen found no tenderness to palpation, 5/5 strength, restricted range of motion, and negative Tinel's sign. For the cervical spine, he noted 5/5 muscle strength and negative compression test.

For the right wrist, Dr. Allen stated findings of nontender to palpation, 5/5 muscle and grip strength, normal range of motion, and negative Tinel's and Phalen's signs. For the left wrist, he noted nontender to palpation, diminished two-point touch, 5/5 muscle and grip strength, normal range of motion, and negative Tinel's and Phalen's signs. Dr. Allen opined that appellant had total bilateral upper extremity impairment of two percent. This was comprised of one percent impairment to each wrist, zero percent impairment to the elbows, and zero percent impairment for motor/sensory aspects of the cervical spine pertaining to the upper extremities.

By decision dated November 20, 2013, an OWCP hearing representative affirmed OWCP's April 23, 2013 decision finding that the medical evidence failed to establish an additional impairment.

On June 19, 2014 OWCP received appellant's June 16, 2014 letter requesting reconsideration. Evidence submitted in support of the reconsideration request included a November 22, 2013 report from Dr. Allen which opined that appellant had two percent total bilateral upper extremity impairment based on examination findings of August 8, 2013. Dr. Allen noted that under the A.M.A., *Guides* at page 406, "functional history grade modifier should be applied only to the single, highest spine related diagnostic-based impairment if multiple regions are being rated." He indicated that it was for this reason that functional history was not considered in the calculation of appellant's bilateral elbow impairment as it was used in the calculation of the bilateral wrist impairment. Dr. Allen also explained how the sensory and motor impairments of the elbows were calculated and rated at zero percent.

On August 8, 2014 an OWCP medical adviser used Dr. Allen's August 8, 2013 examination findings and provided the following calculations. As Dr. Allen noted appellant had no sensory deficits between C5-T1, he used Table 15-4, page 425 and graded sensory severity as "normal." Under Proposed Table 1, page 4 of *The Guides Newsletter*, sensory cervical spine impairment was class 0 with a value of 0 percent. Dr. Allen's notes also related that appellant had no motor deficits (5/5) between C5-T1. Therefore appellant also had no impairment for motor deficit, due to her accepted cervical spine condition.

For bilateral elbow regional impairment, an OWCP medical adviser noted section 15.4f, page 432 of the A.M.A., *Guides* for ulnar neuropathy could not be used since no electromyogram (EMG) study showed a conduction delay. Instead section 15.2, page 387 A.M.A., *Guides* was used for the diagnosis of nonspecific elbow pain. Dr. Allen noted appellant had mild symptoms on strenuous activity about the elbow. Under Table 15-4, page 398, A.M.A., *Guides*, the nonspecific elbow impairment was rated as zero percent impairment. For bilateral wrist regional impairment, section 15.4f, page 432 could not be used as no EMG study provided showed a conduction delay. Under section 15.2, page 387 of the A.M.A., *Guides*, a diagnosis of nonspecific wrist pain was provided. Under Table 15-3, page 395, the nonspecific wrist pain impairment was adjusted to zero percent permanent impairment.

In an August 6, 2014 report, Dr. Joseph R. Mejia, Board-certified in physical medicine and rehabilitation, noted the history of injury and set forth examination findings. Using the A.M.A., *Guides*, he opined that appellant had two percent upper extremity impairment. Dr. Mejia indicated that the rating was based on Table 15-23, Entrapment/compression Neuropathy.

By decision dated September 17, 2014, OWCP denied modification of the November 20, 2013 decision as the medical evidence failed to establish increased impairment beyond that previously awarded.

On January 12, 2015 OWCP received appellant's request for reconsideration of the same date.

In a January 1, 2015 addendum, Dr. Allen indicated that OWCP's decision appeared accurate with the exception of the application of functional history regarding appellant's wrist impairment. He noted that under A.M.A., *Guides* page 406, "functional history grade modifier should be applied only to the single, highest diagnosis[-]based impairment." For this reason, the functional history was not considered in the calculation of appellant's bilateral elbow impairment but was used in the bilateral wrist impairment. Appellant denied any/all symptoms and objectively failed to demonstrate any objective deficits of the bilateral elbows, therefore her diagnosis-based impairment was a class 0 impairment. She reported bilateral hand/wrist pain and demonstrated mild objective findings on examination for a class 1 diagnosis-based impairment of the wrists. Dr. Allen concluded that the final bilateral upper extremity impairment was two percent.

In a March 6, 2015 report, an OWCP medical adviser discussed Dr. Allen's January 1, 2015 addendum report. He noted that Dr. Allen awarded the functional history modifier to appellant's wrist region instead of the elbow region and updated his impairment rating to reflect

this fact. The medical adviser set forth his calculations for the cervical spine and bilateral elbow and wrist regional impairments. He again found that appellant's cervical spine impairment resulted in zero percent permanent impairment of the upper extremities. For bilateral elbow regional impairment, under section 15.2, page 387 A.M.A., *Guides*, the medical adviser used the diagnosis of nonspecific elbow pain. Under Table 15-4, page 398, appellant's nonspecific elbow pain was class 1, grade C impairment with a default value of one percent. However with grade modifiers of 0 for clinical studies and physical examination, under Table 15-4, page 398, the nonspecific wrist pain impairment was adjusted to zero percent.

For the bilateral wrist regional impairment, the medical adviser noted that under section 15.2, page 387 of A.M.A., *Guides*, the diagnosis of nonspecific wrist pain was used. As Dr. Allen noted appellant had mild symptoms on strenuous activity about the wrist under Table 15-3, page 395, her nonspecific wrist pain was class 1, grade C with default value of one percent. Under Table 15-3, page 395, the nonspecific wrist pain was rated as zero percent. Thus, Dr. Allen opined that the right upper extremity had zero percent and the left upper extremity had zero percent, which amounted to no increased impairment. The date of maximum medical improvement remained the same at April 29, 2009.

By decision dated April 2, 2015, OWCP denied modification of its prior decision.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA³ and its implementing federal regulations⁴ 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.⁵ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to rate permanent impairment.⁶

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 and lower extremity impairments, the evaluator identifies the impairment class for the Class of Diagnosis (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).⁷ Evaluators are

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404.

⁵ *Id.* at § 10.404(a).

⁶ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); see also Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

⁷ *R.Z.*, Docket No. 10-1915 (issued May 19, 2011).

directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.⁸

Impairment due to carpal tunnel syndrome is evaluated under the process found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text in section 15.4f of the A.M.A., *Guides*.⁹ In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories of 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.¹⁰

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.¹¹

OWCP procedures state that any previous impairment to the member under consideration is included in calculating the percentage of loss, except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.¹²

ANALYSIS -- ISSUE 1

The Board finds that appellant has not established that she has more than three percent impairment to her right upper extremity and more than three percent impairment to her left upper extremity, for which she previously received a schedule award.

There is no medical evidence of record that appellant has more than three percent permanent impairment of the left or right upper extremity, and she has previously received schedule awards for these permanent impairments. The subsequent medical reports do not establish increased permanent impairment of either upper extremity. Appellant is therefore has not proven an increased schedule award.

Dr. Grant's August 12, 2011 report, in which he opined that appellant had 43 percent impairment to each upper extremity, is of diminished probative value. He based his impairment rating on diagnoses of carpal tunnel syndrome and CRPS. However, CRPS is not an accepted condition in this case. Additionally, Dr. Grant made reference in his report as the patient being "Mrs. Beier." Thus, doubt is cast on Dr. Grant's report.

⁸ J.W., Docket No. 11-289 (issued September 12, 2011).

⁹ A.M.A., *Guides* 433-50.

¹⁰ *Id.* at 448-50.

¹¹ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

¹² *Id.* at Chapter 2.808.7.a(2) (February 2013).

Dr. Mejia opined in his August 6, 2014 report that appellant had two percent upper extremity impairment based on Table 15-23, Entrapment/compression Neuropathy. While he provided impairment calculations, he did not identify whether the rating was for the left or right upper extremity or a total upper extremity rating. Furthermore, on its face, the two percent impairment rating is less than the three percent impairment rating previously awarded to each upper extremity. Therefore, this report is of limited probative value to establish an increase in permanent impairment.

Dr. Allen submitted several reports in which he opined that appellant had one percent impairment to left upper extremity and one percent impairment to right upper extremity. This impairment rating is insufficient to support an increased schedule award as it is less than the three percent impairment previously awarded to each upper extremity.

The Board notes that Dr. Allen consistently noted in his October 11 and November 22, 2013 and January 1, 2015 reports that the functional history modifier should be used in the wrist impairment calculation. Under section 15.3a, page 406 of A.M.A., *Guides*, functional history grade modifier should be applied only to the single, highest diagnosis-based impairment. The medical adviser properly utilized the functional history modifier in the wrist impairment calculations in his March 6, 2015 report, in which he reviewed Dr. Allen's January 1, 2015 addendum and concluded that appellant had zero percent impairment to the bilateral upper extremities. The Board notes that, while a discrepancy in the impairment ratings exist between Dr. Allen and OWCP's medical adviser, the impairment calculations result in one percent impairment to the left upper extremity and one percent impairment to the right upper extremity. This impairment rating is insufficient to support an increased schedule award as it is less than the three percent impairment previously awarded to each upper extremity.

On appeal, counsel contends that the medical adviser usurped the power of OWCP and ruled to the detriment of appellant. He further contended that the medical adviser became an advocate in the case and was not objective. Counsel's assertions have no merit. The medical adviser applied the appropriate sections of the A.M.A., *Guides* to the clinical findings of record, in particular Dr. Allen's August 8, 2013 examination findings.¹³ Furthermore, Dr. Allen's impairment calculation was insufficient on its face established additional impairment.

Appellant may request an 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 has failed to establish more than three percent permanent impairment of the bilateral upper extremities for which she had previously received a schedule award.

¹³ See *H.I.*, Docket No. 15-405 (issued May 6, 2015); *W.M.*, Docket No. 11-1706 (issued March 20, 2012).

ORDER

IT IS HEREBY ORDERED THAT the April 2, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 21, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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