United States Department of Labor
Employees' Compensation Appeals Board

T.S., Appellant	)	
and	)	**Docket No. 15-1597**
	)	**Issued: January 5, 2016**
U.S. POSTAL SERVICE, CAROL STREAM PROCESSING & DISTRIBUTION CENTER, Carol Stream, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On July 20, 2015 appellant filed a timely appeal from a June 15, 2015 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 has met her burden of proof to establish more than 19 percent impairment of the right upper extremity and 1 percent impairment of the left upper extremity, for which she received schedule awards.

On appeal, appellant contends that OWCP improperly relied on the opinions of its medical advisers whose reports were not based on an accurate medical background. She states that Dr. Michael D. Hellman, an orthopedic surgeon and OWCP medical adviser, incorrectly

[1] 5 U.S.C. § 8101 *et seq.*

stated that a normal April 23, 2014 electromyogram (EMG) related to her right arm when it only addressed her left arm. Appellant states that Dr. Hellman's medical opinion is not entitled to greater weight than the medical opinion of Dr. Samuel J. Chmell, an attending Board-certified specialist, because Dr. Hellman is only a resident in training. She further states that Dr. Sanjai K. Shukla, a Board-certified orthopedic surgeon and OWCP medical adviser, incorrectly opined that she had a temporary symptom exacerbation due to crutch use for her right ankle surgery. Appellant denies using a crutch.

FACTUAL HISTORY

On December 28, 2005 appellant, then a 49-year-old flat sorter machine clerk, filed an occupational disease claim (Form CA-2) alleging that her tendinitis in her right hand, wrist, arm, and fingers was due to employment factors. On January 25, 2006 OWCP accepted her claim for right wrist tendinitis.

On July 2, 2009 appellant filed a claim for a schedule award (Form CA-7). She submitted an August 14, 2009 impairment evaluation from Dr. Chmell who found that she had 37 percent impairment of the right arm under the sixth edition of American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. Chmell completed an upper extremity impairment worksheet excerpted from the sixth edition of the A.M.A., *Guides*, based on the rating methodology of Table 15-32. He obtained the following ranges of motion for the right wrist: 0 to 20 degrees of flexion equaling 7 percent impairment; 0 to 20 degrees of extension equaling 7 percent impairment; 0 to 5 degrees of ulnar deviation equaling 4 percent impairment; 0 to 5 degrees of radial deviation equaling 4 percent impairment. Dr. Chmell determined that the right wrist had grade 4 strength equaling 10 percent impairment and moderate crepitus equaling 5 percent impairment. He added these impairment percentages to equal 37 percent impairment of the right upper extremity. Dr. Chmell diagnosed right wrist tendinitis and opined that appellant had reached maximum medical improvement on July 2, 2009. In a September 30, 2009 medical report, he found that appellant had multiple tendinitis of the left wrist which developed in 2005 as a result of her repetitive work duties.

By letter dated September 18, 2009, OWCP accepted appellant's claim for left wrist tendinitis.

On September 19, 2009 Dr. Neil S. Ghodadra, a Board-certified orthopedic surgeon and an OWCP medical adviser, reviewed the medical record, including Dr. Chmell's August 14, 2009 findings. He determined that appellant had 19 percent impairment of the right upper extremity under the sixth edition of the A.M.A., *Guides*. Dr. Ghodadra utilized Table 15-32, page 473, to find seven percent impairment each for 0 to 20 degrees of flexion and 0 to 20 degrees of extension, four percent impairment for 0 to 5 degrees of ulnar deviation, and one percent impairment for 0 to 5 degrees of radial deviation. He added the range of motion impairment ratings to find that appellant had 19 percent impairment of the right upper extremity. Dr. Ghodadra concluded that she reached maximum medical improvement on July 2, 2009, as found by Dr. Chmell.

In a November 17, 2009 decision, OWCP granted appellant a schedule award for 19 percent impairment of the right upper extremity using the range of motion method.

In a March 8, 2010 report, Dr. Chmell opined that appellant had right carpal tunnel syndrome due to her repetitive work duties based on his examination findings and a nerve conduction velocity (NCV) test dated March 21, 2008. He recommended right carpal tunnel release.

By letter dated December 17, 2010, OWCP accepted right carpal tunnel syndrome. On March 4, 2011 it authorized right carpal tunnel surgery.[2]

On November 18, 2011 appellant filed a claim for an additional schedule award (Form CA-7) for her right upper extremity. In a December 28, 2011 report, Dr. Chmell again opined that appellant had 37 percent impairment of the right upper extremity. He completed an upper extremity impairment worksheet excerpted from the sixth edition of the A.M.A., *Guides*, based on the rating methodology of Table 15-32. Dr. Chmell obtained the following ranges of motion for the right wrist: 0 to 45 degrees of flexion equaling three percent impairment; 0 to 40 degrees of extension equaling three percent impairment; 0 to 10 degrees of radial deviation equaling two percent impairment; and 0 to 5 degrees of ulnar deviation equaling four percent impairment. Utilizing Table 15-23 to rate impairment due to appellant's accepted right carpal tunnel syndrome, he reported that she had a significant history, decreased grip sensation on examination, and moderate impairment based on EMG and nerve conduction results equaling 25 percent impairment. Dr. Chmell added the range of motion and diagnosis-based impairment percentages to equal 37 percent impairment of the right upper extremity. He diagnosed tenosynovitis of the right hand and wrist, and right carpal tunnel syndrome. Dr. Chmell opined that appellant had reached maximum medical improvement on September 1, 2011.

On May 27, 2012 Dr. Shukla reviewed the medical record, including Dr. Chmell's December 28, 2011 report. He found that appellant had no more than 19 percent impairment of the right upper extremity under the sixth edition of the A.M.A, *Guides*. Dr. Shukla found no evidence to support an increase in her previous impairment rating. He reasoned that appellant appeared to have a temporary exacerbation of symptoms secondary to her use of a crutch related to her right ankle surgery.[3] Dr. Shukla compared Dr. Ghodadra's findings to Dr. Chmell's December 28, 2011 notes which showed that range of motion of her right wrist had improved. Dr. Ghodadra's note reported 0 to 20 degrees of flexion and 0 to 20 degrees of extension whereas Dr. Chmell's note reported 0 to 45 degrees of flexion and 0 to 40 degrees of extension. Dr. Shukla related that, if any change were made to appellant's rating, it would be a decrease in impairment. He recommended referral of appellant to an independent medical examiner if a dispute continued regarding her current impairment.

By decision dated February 27, 2013, OWCP denied appellant's claim for an increased schedule award for the right upper extremity based on Dr. Shukla's opinion.

On March 14, 2013 appellant requested an oral hearing before an OWCP hearing representative.

[2] The record does not indicate that appellant underwent the authorized right carpal tunnel release.

[3] On April 18, 2012 appellant underwent right tarsal tunnel release and posterior tibial tendon repair performed by Dr. Chmell.

In a May 8, 2013 decision, an OWCP hearing representative set aside the February 27, 2013 decision and remanded the case to OWCP for further medical development. He found that neither Dr. Chmell nor Dr. Shukla provided an impairment rating in accordance with the A.M.A., *Guides*. The hearing representative found that Dr. Chmell had combined diagnosis-based impairment ratings with range of motion ratings to find 37 percent right arm impairment. He further found that Dr. Shukla had not considered whether appellant had greater impairment due to her accepted right carpal tunnel syndrome.

On remand, Dr. David H. Garelick, a Board-certified orthopedic surgeon and an OWCP medical adviser, reviewed appellant's medical record. In a December 16, 2013 report, he determined that appellant had no more than 19 percent impairment of the right upper extremity and one percent impairment of the left upper extremity under the sixth edition of the A.M.A., *Guides*. Dr. Garelick diagnosed right carpal tunnel syndrome and reported that appellant had subjective complaints of numbness and tingling in the right arm which represented a grade 2 modifier for significant intermittent symptoms under Table 15-23, page 449. The alleged atrophy in the thenar musculature described in the physical examination represented a grade 3 modifier under the same table. The March 21, 2008 EMG/NCV test described normal motor latencies, but a sensory conduction delay represented a grade 1 modifier for test findings. Dr. Garelick determined that the average of the grade modifiers was 2 which represented five percent impairment of the right upper extremity for appellant's accepted right carpal tunnel syndrome. He noted that, as this impairment rating was significantly less than the 19 percent previously awarded, there was no change in the percentage of permanent impairment. Dr. Garelick noted that appellant had subjective complaints of radial sided left wrist pain consistent with de Quervain's tenosynovitis. According to Table 15-3, page 395, he determined that she had one percent impairment of the left arm for wrist pain without consistent objective findings. Dr. Garelick concluded that appellant had reached maximum medical improvement on July 2, 2009.

By decision dated December 17, 2013, OWCP granted appellant a schedule award for one percent impairment of the left upper extremity. It found that she had no more than 19 percent impairment of the right upper extremity, which had been previously awarded.

On January 3, 2014 appellant requested an oral hearing before an OWCP hearing representative.

On April 17, 2014 appellant filed a claim for an increased schedule award (Form CA-7) for her left upper extremity. On April 18, 2014 Dr. Chmell disagreed with OWCP's schedule award for one percent impairment of appellant's left arm. He noted that, she never had an appropriate physical examination to determine the extent of impairment to her left upper extremity and the diagnoses upon which such impairment was established did not include her work-related left carpal tunnel syndrome. In an April 28, 2014 report, Dr. Chmell reiterated that appellant had 37 percent right arm impairment.

In a July 25, 2014 decision, an OWCP hearing representative affirmed in part the December 17, 2013 decision finding that appellant had one percent left arm impairment and set aside and remanded the case to OWCP for further medical development regarding the extent of her right arm impairment. He determined that Dr. Garelick did not provide a rationalized

opinion on whether appellant's impairment due to her accepted right carpal tunnel syndrome duplicated her impairment due to the accepted right wrist tendinitis for which she previously received a schedule award.

On remand Dr. Hellman, an OWCP medical adviser, reviewed the medical record including, Dr. Chmell's reports. In an October 29, 2014 report, he determined that appellant had no more than 19 percent impairment of the right arm and one percent impairment of the left arm. For the right arm, Dr. Hellman noted that section 15.4f, page 432 of the A.M.A., *Guides* could not be used for her accepted right carpal tunnel syndrome since the April 23, 2014 EMG was normal (Appendix 15-B, page 487).[4] Instead, he used section 15.2, page 387, and the diagnosis of nonspecific wrist pain. Based on section 15.3f, page 419, Dr. Hellman only used the most impairing diagnosis within this region, which was de Quervain's tenosynovitis. Utilizing Table 15-3, page 395, he determined that this diagnosis yielded a class 1, grade C impairment with a default value of one percent. Dr. Hellman used section 15.3, page 405, for grade adjustment calculations. He determined that appellant's functional history, based on Dr. Chmell's December 28, 2011 note which found that she had significant intermittent symptoms, yielded a grade modifier 2 under Table 15-7, page 406. Appellant's physical examination, based on the same note from Dr. Chmell which revealed mild loss of motion in the wrist, was consistent with a grade modifier 1 under Table 15-8, page 408. Her clinical studies showed normal conduction of the median nerve based on the April 23, 2014 EMG and a normal wrist based on a March 21, 2008 magnetic resonance imaging (MRI) scan. Utilizing Table 15-9, page 410, appellant's clinical studies were consistent with a grade modifier 0. The net adjustment was (2-1) + (1-1) + (0-1) = 0. Dr. Hellman determined that appellant had a grade C default impairment which yielded one percent impairment.

For the left arm, Dr. Hellman used Table 15-3 to determine that her de Quervain's tenosynovitis yielded a class 1, grade C impairment with a default value of one percent. He used section 15.3, page 405, for the grade adjustment calculations. Dr. Hellman agreed with the prior OWCP medical adviser's finding that appellant's functional history yielded a grade modifier 1 under Table 15-7, page 406. He also agreed with his finding that her physical examination was consistent with a grade 1 modifier under Table 15-8, page 408. Dr. Hellman found that appellant's clinical studies showed normal median nerve conduction based on the April 23, 2014 EMG and a normal wrist based on a May 2, 2014 MRI scan. Using Table 15-9, page 410, he found that she had clinical studies consistent with a grade modifier 0. The net adjustment was (1-1) + (1-1) + (0-1) = -1 and Dr. Hellman moved appellant's grade to a grade B based on page 411. Under Table 15-3, this yielded one percent impairment. Dr. Hellman agreed with the previous medical adviser's assessment that appellant reached maximum medical improvement on July 2, 2009. He was uncertain as to how Dr. Chmell reached his 37 percent right arm impairment rating. Dr. Hellman noted that Dr. Chmell had recently obtained bilateral upper extremity EMGs which showed that appellant did not meet the diagnostic criteria for carpal tunnel syndrome under Appendix 15-B. Since appellant had multiple diagnoses within the wrist region, her tenosynovitis was used as the most impairing diagnosis based on page 419. Dr. Hellman related that Dr. Chmell may have been unbundling wrist region diagnoses. Further,

[4] The record contains an April 23, 2014, motor nerve conduction study indicating that the right median and ulnar nerves were normal. This study also contains findings for the left arm.

he noted that the most impairment that could be awarded was two percent for de Quervain's tenosynovitis and one percent for nonspecific wrist pain.

In a December 5, 2014 decision, OWCP found that appellant had no more than 19 percent impairment of the right upper extremity and one percent impairment of the left upper extremity based on Dr. Hellman's opinion.

On December 27, 2014 appellant requested an oral hearing before an OWCP hearing representative.

In a June 15, 2015 decision, an OWCP hearing representative affirmed the December 5, 2014 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[6] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[7] For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.[8] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[9]

The sixth edition of 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).[10] Under the sixth edition, the evaluator identifies the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional

[5] *Supra* note 1.

[6] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[7] *Id.*

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

[9] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a.3 (January 2010). This portion of OWCP procedures provide that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

[10] A.M.A., *Guides* (6th ed. 2008), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12]

Although the diagnosis-based approach is the preferred method of evaluating permanent impairment under the sixth edition of the A.M.A., *Guides*,[13] Table 15-2 through Table 15-5 provide that, if loss of motion is present, the impairment may alternatively be assessed under section 17-7, range of motion impairment.[14] A range of motion impairment stands alone and is not combined with a diagnosis-based impairment.[15]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[16] In Table 15-23, grade modifiers 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.[17]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a 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.[18]

ANALYSIS

OWCP accepted appellant's claim for bilateral wrist tendinitis and right carpal tunnel syndrome. The Board finds that appellant has not met her burden of proof to establish more than 19 percent permanent impairment of the right upper extremity and one percent of the left upper extremity.

The December 28, 2011 report from Dr. Chmell, appellant's attending physician, is of diminished probative value on the issue presented. Dr. Chmell found 37 percent impairment of the right arm, based on loss of range of motion (12 percent), and diagnosis-based impairment of 25 percent to the right wrist. The Board notes that the A.M.A., *Guides* clearly state that a range

[11] *Id.* at 383-419.

[12] *Id.* at 411.

[13] *Id.* at 461, section 15.7.

[14] *Id.* at 391-05.

[15] *Id.* at 405.

[16] *Id.* at 449.

[17] *Id.* at 448-50.

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

of motion impairment is not to be combined with the diagnosis-based impairment. A range of motion impairment stands alone.[19] Therefore, a finding based on the addition or combination of a range of motion impairment rating with a diagnosis-based impairment rating cannot be accepted as valid.

Regarding appellant's left arm impairment, Dr. Chmell, in the April 18, 2014 report, disagreed with OWCP's issuance of a schedule award for one percent impairment. He related that appellant had not undergone an appropriate examination to rate impairment for her work-related left carpal tunnel syndrome. The Board notes that OWCP has not accepted left carpal tunnel syndrome. For conditions not accepted by OWCP as being employment related, it is the employee's burden to provide rationalized medical evidence sufficient to establish causal relation, not OWCP's burden to disprove such relationship.[20] Dr. Chmell did not provide any medical rationale explaining how the diagnosed left wrist condition was causally related to the accepted employment injuries. The Board has long held that a medical opinion not fortified by medical rationale is of little probative value.[21] Dr. Chmell also did not explain how appellant's accepted left wrist tendinitis caused more than one percent left arm impairment pursuant to the A.M.A., *Guides*. Thus, Dr. Chmell's report is of diminished probative value and is insufficient to establish an increased left arm impairment.

In accordance with its procedures,[22] OWCP properly referred the evidence of record to Dr. Hellman, a medical adviser, who reviewed the clinical findings of Dr. Chmell on October 29, 2014 and determined that appellant had no more than 19 percent permanent impairment of the right arm and one percent impairment of the left arm, for which she received schedule awards.[23]

Regarding her right upper extremity, Dr. Hellman used the diagnosis-based impairments set forth in section 15.2, page 387 and identified the diagnosis as nonspecific wrist pain rather than section 15.4f, page 432, to rate her accepted right carpal tunnel syndrome because an April 23, 2014 EMG was normal.[24] Based on section 15.3f, page 419, he used the most impairing diagnosis of de Quervain's tenosynovitis which represented a class 1, grade C impairment which yielded a default value of one percent under Table 15-3, page 395. Dr. Hellman applied grade modifiers for functional history of 2, physical examination of 1, and clinical studies of 0. Applying the net adjustment formula, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (2-1) + (1-1) + (0-1) = 0, yielded grade C default impairment of one percent.

[19] A.M.A., *Guides* 500.

[20] *G.A.*, Docket No. 09-2153 (issued June 10, 2010); *Jaja K. Asaramo*, 55 ECAB 200 (2004); *Alice J. Tysinger*, 51 ECAB 638 (2000).

[21] *Brenda L. Dubuque*, 55 ECAB 212, 217 (2004); *Donald W. Long*, 41 ECAB 142 (1989).

[22] *See supra* note 18.

[23] *W.M.*, Docket No. 11-1156 (issued January 27, 2012).

[24] A.M.A., *Guides* 445-46. The A.M.A., *Guides* provides that if conduction testing does not meet the diagnostic criteria or have not been performed, there is no ratable impairment due to entrapment neuropathy; however, an impairment may be rated using the diagnosis-based impairments set forth in section 15.2.

Regarding appellant's left upper extremity impairment, Dr. Hellman found that her de Quervain's tenosynovitis yielded a class 1, grade C impairment which had a default value of one percent under Table 15-3, page 395. He applied grade modifiers for functional history of 1, physical examination of 1, and clinical studies of 0. Applying the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (1-1) + (1-1) + (0-1) = -1. Dr. Hellman found this resulted in grade B impairment which resulted in one percent impairment of the left arm under Table 15-3.

The Board finds that Dr. Hellman's opinion represents the weight of the evidence and establishes that appellant has no more than 19 percent impairment of the right upper extremity and one percent impairment of the left upper extremity. He properly applied the appropriate provisions of the A.M.A., *Guides* to the clinical findings of record.[25]

On appeal, appellant contends that she is entitled to a greater percentage of permanent impairment because OWCP improperly relied on the medical reports of its medical advisers which were not based on an accurate medical background. She states that Dr. Hellman incorrectly read the April 23, 2014 EMG related to her right upper extremity. Appellant asserts that this diagnostic test only addressed her left upper extremity. The Board notes, however, that the EMG in question specifically stated that a motor nerve conduction study found that the right medium ulnar nerve was normal and that a sensory nerve conduction study found that the right palmar nerve was normal. Appellant further states that Dr. Hellman's medical opinion is not entitled to the weight of the medical opinion evidence because he is a resident in training while Dr. Chmell is a Board-certified specialist. As noted herein, Dr. Hellman is a physician in the relevant field of orthopedic injuries. Moreover, Dr. Chmell's opinion is of diminished probative value as he failed to properly utilize the A.M.A., *Guides* in determining that appellant had 37 percent right arm impairment and he failed to provide a rationalized opinion to establish that she sustained left carpal tunnel syndrome and any resultant impairment due to her accepted employment-related injuries. The Board finds, therefore, that appellant's contentions have not been established.

Appellant further contends on appeal that Dr. Shukla incorrectly believed that she had a temporary exacerbation of her symptoms due to crutch use for her right ankle surgery. She denies using a crutch. The Board notes, however, that OWCP did not rely on Dr. Shukla's opinion in its final decision regarding the extent of appellant's bilateral upper extremity impairment. Consequently, appellant has not demonstrated that OWCP erred in denying her request for an increased schedule award.

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.

[25] *See W.M.*, Docket No. 11-1706 (issued March 20, 2012).

CONCLUSION

The Board finds that appellant has failed to meet her burden of proof to establish more than 19 percent impairment of the right upper extremity and one percent impairment of the left upper extremity, for which she received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the June 15, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 5, 2016
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board