United States Department of Labor
Employees' Compensation Appeals Board

D.D., Appellant	)	
and	)	**Docket No. 17-1317**
	)	**Issued: December 6, 2017**
DEPARTMENT OF THE NAVY, PUGET SOUND NAVAL SHIPYARD, Bremerton, WA, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 30, 2017 appellant filed a timely appeal from an April 25, 2017 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 the claim.[2]

ISSUE

The issue is whether appellant has established greater than one percent permanent impairment of each upper extremity due to accepted bilateral carpal tunnel syndrome, for which he previously received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

[2] Appellant submitted new evidence accompanying his request for appeal. The Board's review is limited to the evidence that was before OWCP at the time of its final decision. Therefore, the Board lacks jurisdiction to review this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

OWCP accepted that on or before February 21, 2002 appellant, then a 47-year-old shipwright, sustained mild bilateral carpal tunnel syndrome due to heavy lifting, using heavy power tools, repetitive grasping, and repetitive gripping in the performance of duty beginning in 1981.[3]

In September 2004 appellant changed jobs at the employing establishment to work as a rigger. He sought treatment periodically for bilateral hand and wrist symptoms. In a September 14, 2007 report, Dr. Brian K. Miller, an attending Board-certified family practitioner, noted that appellant experienced increasing numbness and paresthesias in both hands beginning in 2005.

On October 17, 2014 appellant filed an incomplete notice of recurrence of disability (Form CA-2a). In an October 28, 2014 letter, OWCP notified him of the evidence needed to establish his claim for a recurrence of disability, including his physician's report documenting a change or worsening in the accepted bilateral carpal tunnel syndrome. It afforded appellant 30 days to submit such evidence.

In response, appellant filed a second notice of recurrence of disability (Form CA-2a) on November 3, 2014, alleging that his condition worsened in September 2014.[4] He explained that symptoms of bilateral carpal tunnel syndrome had been present continuously since his diagnosis in 2002. Appellant requested that OWCP reopen his claim for medical treatment.

In December 2, 2014 reports, Dr. Michael S. McManus, an attending physician Board-certified in occupational medicine, diagnosed carpal tunnel syndrome with bilaterally positive Phalen's signs, and bilateral grasp/thumb abduction and opposition weakness. He prescribed wrist splints and released appellant to full duty.

Dr. Donna E. Moore, an attending Board-certified physiatrist, performed December 10, 2014 electromyography (EMG) and NCV testing demonstrating "very mild bilateral carpal tunnel syndrome," and "bilateral ulnar nerve slowing across the elbows at the cubital tunnel." She provided wave form diagrams of the median and ulnar motor and sensory nerve potentials obtained. Dr. Moore also provided anti-sensory and motor summary tables identifying conduction delays in the left ulnar sensory and motor nerves, and right ulnar motor nerve.[5]

[3] February 27, 2002 nerve conduction velocity (NCV) testing showed mild bilateral carpal tunnel syndrome, with mild prolongation of median motor and sensory distal latencies, and mild median sensory slowing at the cross wrist, bilaterally.

[4] Appellant provided a November 3, 2014 letter from supervisor A.L., which described appellant as a "dedicated, hard-working and dependable rigger." A.L. observed appellant's inability to solidly grip items spontaneously appear without an intervening incident or event. A.L. urged OWCP to evaluate his carpal tunnel syndrome "before a[n] unrepairable accident occurs."

[5] Appellant participated in physical therapy in January 2015.

Dr. McManus maintained appellant at full duty on March 6, 2015. He submitted periodic progress reports. On April 17, 2015 Dr. McManus diagnosed cervical spondylosis, facet arthritis of the cervical region, and right-sided double crush syndrome in the C6-7 distribution.[6]

In an April 28, 2015 report, Dr. Christopher L. Olch, an attending physician Board-certified in orthopedic surgery and hand surgery, diagnosed bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. On May 15, 2015 he performed a right open carpal tunnel release. On May 29, 2015 Dr. Olch performed a left open carpal tunnel release. OWCP authorized both procedures.

Dr. Olch held appellant off work through June 9, 2015. OWCP paid appellant wage-loss compensation during his surgical recuperation. Appellant returned to limited duty on June 10, 2015 and to full duty on June 29, 2015. Dr. McManus maintained appellant on full duty through September 24, 2015.

On September 24, 2015 appellant presented to Dr. McManus with symptoms of intermittent aching in the right wrist, pain in the right wrist when gripping, pinching, or holding objects, decreasing grip strength bilaterally, and increased fatigability of both hands. Right wrist x-rays obtained on September 24, 2015 showed degenerative and long-standing post-traumatic findings involving the distal radius, ulna, and radiocarpal joint. Dr. McManus diagnosed bilateral cubital tunnel syndrome and status post bilateral carpal tunnel releases. A November 16, 2015 left wrist x-rays demonstrated osteoarthritis of the first carpometacarpal joint and distal radial ulnar joint, and widening between the scaphoid and lunate indicating a possible ligamentous injury. Dr. McManus found appellant able to continue working full duty with restrictions.

Appellant retired from the employing establishment, effective January 1, 2016.

On December 9, 2016 appellant claimed a schedule award (Form CA-7). He provided a detailed chronology of repetitive upper extremity tasks during his employment as a shipwright from 1981 through September 2004, and as a rigger from September 2004 through October 2014.

In a December 23, 2016 letter, OWCP notified appellant of the evidence needed to establish his schedule award claim, including a report from his attending physician providing an impairment rating calculated under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[7] Appellant was afforded 30 days to submit such evidence.

In response, appellant submitted reports from Dr. McManus dated from January 20 to December 29, 2016 noting continued bilateral hand and wrist symptoms, greatest in the C7

[6] In a May 13, 2015 letter, appellant requested that OWCP expand his claim to accept a cervical spine condition due to working in confined spaces aboard ships for 34 years, with multiple head impacts. February 13, 2015 cervical spine x-rays demonstrated degenerative anterolisthesis at C3-4, left greater than right cervical facet arthropathy and mild-to-moderate spondylosis at C5-6 and C6-7. A March 21, 2015 cervical magnetic resonance imaging scan showed C-34 left-sided facet arthropathy, C4-5 mild bilateral facet arthropathy, effacement of the anterior subarachnoid space at C5-6, and a left-sided osteophyte at C6-7.

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

dermatome. Dr. McManus provided an impairment rating in the December 29, 2016 report, finding that appellant had attained maximum medical improvement (MMI). On examination of the right hand and wrist, he found a well-healed surgical scar from the carpal tunnel release, tenderness over the radial carpal joint and first carpometacarpal joint, a positive thumb compression test at 20 seconds, decreased pinprick sensation in the median distribution, two-point discrimination at 6 millimeter or less in all fingertips, diminished grip strength, and full range of motion of the wrist, hand, and fingers. Dr. McManus observed the same findings in the left hand and wrist, with the addition of a positive Tinel's sign and a thumb compression test positive at 10 seconds, a tender nodule on the flexor tendon of the middle finger, and intermittent left triggering middle finger. He diagnosed bilateral carpal tunnel syndrome, and status post bilateral open carpal tunnel releases.

Referring to the sixth edition of the A.M.A., *Guides*, he performed a diagnosis-based impairment rating using Table 15-23.[8] For both upper extremities, he found Class of Diagnosis (CDX) of 1 for carpal tunnel syndrome, a grade modifier for Functional History (GMFH) of 1 due to mild intermittent symptoms, a grade modifier for Physical Examination (GMPE) of 3 for grip weakness, and a grade modifier for Clinical Studies (GMCS) of 1 for conduction delay. Applying the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or (1-1) + (3-1) + (1-1), he calculated a grade modifier of "approximately 2," resulting in 5 percent permanent impairment of each upper extremity. Dr. McManus noted that there was no additional modifier for a *Quick*DASH symptom score of 41.

An OWCP medical adviser reviewed the medical evidence of record and a statement of accepted facts on April 18, 2017. He calculated one percent impairment of each arm using Table 15-2,[9] with a class 1 diagnosis-based impairment CDX of nonspecific wrist pain with a default midrange level of one percent. The medical adviser explained that Dr. McManus erred by assigning a grade modifier of 1 for GMCS, even though electrodiagnostic testing did not reveal ratable impairment. He noted, however, that if he could review Dr. Moore's December 10, 2014 electrodiagnostic study, he would consider modifying the rating.

By decision dated April 25, 2017, OWCP issued appellant a schedule award for one percent permanent impairment of the right upper extremity and one percent permanent impairment of the left upper extremity. The period of the award, equivalent to 6.24 weeks, ran from December 29, 2016 to February 10, 2017.

LEGAL PRECEDENT

The schedule award provisions of FECA[10] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the

[8] Table 15-23, page 449 of the sixth edition of the A.M.A., *Guides* is titled "Entrapment/Compression Neuropathy Impairment."

[9] Table 15-2, page 392 of the sixth edition of the A.M.A., *Guides* is titled "Digit Regional Grid: Digit Impairments."

[10] 5 U.S.C. § 8107.

OWCP. For consistent results and to ensure equal justice, the Board has authorized 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 OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[11] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*.[12]

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).[13] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[14] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

ANALYSIS

OWCP accepted that appellant sustained mild bilateral carpal tunnel syndrome in the performance of duty on or before February 21, 2002. It authorized a right open carpal tunnel release on May 15, 2015 and a left open carpal tunnel release on May 29, 2015.

Appellant claimed a schedule award on December 9, 2016. Dr. McManus, an attending physician Board-certified in occupational medicine, found that appellant attained MMI as of December 29, 2016. Referring to Table 15-23 of the sixth edition of the A.M.A., *Guides*, he assessed a CDX of 1 for carpal tunnel syndrome, a GMFH of 1 due to mild intermittent symptoms, a GMPE of 3 for grip weakness, and a GMCS of 1 for conduction delay. Applying the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or (1-1) + (3-1) + (1-1), Dr. McManus calculated a grade modifier of approximately 2, resulting in 5 percent permanent impairment of each upper extremity.

An OWCP medical adviser reviewed the medical evidence of record on April 18, 2017. He disagreed with Dr. McManus' assignment of a GMCS of 1 for electrodiagnostic test results as there was no ratable conduction delay based on Dr. Moore's December 10, 2014 studies. The medical adviser qualified this opinion, however, by noting that he had not actually reviewed Dr. Moore's report. He noted that if he was able to review the studies, that he may change his impairment rating. The Board notes that Dr. Moore's December 10, 2014 electrodiagnostic study, including wave form diagrams and detailed summary tables, was imaged into the electronic case record on January 9, 2015. It is therefore unclear as to why OWCP's medical adviser failed to review this report.

[11] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[12] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[13] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[14] *Id*. at 494-531.

Since the Board's jurisdiction of a case is limited to reviewing the evidence which is before OWCP at the time of its final decision,[15] it is necessary that OWCP review all evidence submitted by a claimant and received by OWCP prior to issuance of its final decision. As the Board's decisions are final as to the subject matter appealed,[16] it is crucial that all evidence relevant to that subject matter which was properly submitted to OWCP prior to the time of issuance of its final decision be addressed.[17]

The Board finds that the opinion of OWCP's medical adviser was based on an incomplete review of the record and therefore requires clarification. The case will be remanded to OWCP to obtain a supplemental report from the medical adviser, based on a review of the complete medical evidence of record. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision in the case.

CONCLUSION

The Board finds that the case is not in posture for a decision.

[15] *See* 20 C.F.R. § 501.2(c).

[16] *Id.* at § 501.6(d).

[17] *See William A. Couch*, 41 ECAB 548, 553 (1990).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 25, 2017 is set aside, and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: December 6, 2017
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board