United States Department of Labor
Employees' Compensation Appeals Board

B.F., Appellant	)	
and	)	**Docket No. 17-0347**
	)	**Issued: May 1, 2017**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Kansas City, MO, 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 December 5, 2016 appellant filed a timely appeal from a June 20, 2016 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.[2]

ISSUE

The issue is whether appellant has established greater than two percent permanent impairment of each upper extremity, for which she previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence to the Board on appeal. The Board s jurisdiction is limited to reviewing the evidence that was before OWCP at the time of its final decision. Therefore, this additional evidence cannot be considered by the Board for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

OWCP accepted that on or before February 1, 2013 appellant, then a 48-year-old tax examining clerk, sustained bilateral carpal tunnel syndrome and bilateral trigger thumb due to repetitive keyboarding, folding documents, and pulling or pushing carts of documents.

Dr. Valerie Deardoff, an attending Board-certified orthopedic surgeon, noted in a December 5, 2014 report that November 21, 2014 nerve conduction velocity (NCV) and electromyogram (EMG) studies showed severe bilateral carpal tunnel syndrome and mild right ulnar nerve compression at the elbow. Appellant underwent a series of steroid injections for bilateral trigger thumb.

On March 2, 2015 Dr. Deardoff performed a right endoscopic carpal tunnel release and right trigger thumb release, approved by OWCP. Appellant returned to full-time restricted duty on March 26, 2015. She participated in occupational therapy in June and July 2015.

On July 30, 2015 Dr. Deardoff performed a left carpal tunnel release and left trigger thumb release, approved by OWCP. She provided periodic progress reports through October 29, 2015 noting scar thickening in the left hand and wrist. Appellant continued to participate in occupational therapy through January 2016.

On February 22, 2016 appellant filed a claim for a schedule award (Form CA-7). In a March 8, 2016 letter, OWCP notified appellant of the evidence needed to establish her schedule award claim, including a report from her attending physician supporting that she had attained maximum medical improvement (MMI), the impairing diagnosis, a detailed description of the permanent impairment, and an impairment rating calculated according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*). Appellant was afforded 30 days to submit such evidence.

In response, appellant submitted a March 31, 2016 report from Dr. Deardoff, finding that appellant had attained MMI. On a March 23, 2016 examination, appellant complained of scar tenderness and difficulty with pinching and gripping. Monofilament testing in both hands showed normal sensation. Dr. Deardoff diagnosed bilateral carpal tunnel syndrome and bilateral stenosing synovitis of the thumbs. She opined that, according to Table 15-23[3] of the A.M.A., *Guides*, appellant had three percent permanent impairment of each upper extremity due to carpal tunnel syndrome. Dr. Deardoff explained that as appellant had no objective clinical findings of stenosing synovitis, she had no permanent impairment rating for the accepted trigger thumbs according to Table 15-2.[4]

An OWCP medical adviser reviewed Dr. Deardoff's report on April 16, 2016, noting that she did not provide an impairment calculation to support the percentages of permanent impairment offered. He found that appellant reached MMI by March 31, 2016. The medical adviser performed an impairment rating using Table 15-23. For both upper extremities, he rated

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

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

carpal tunnel syndrome. The medical adviser found a history grade modifier of 1 due to postoperative scar tissue without median nerve deficit, a grade modifier for physical findings of zero due to a normal sensory examination, and a grade modifier for test findings of 3 due to conduction delay on preoperative EMG and NCV testing. Averaging these modifiers, he calculated a grade modifier of 1.33, rounded downward to a grade modifier of 1.0. The medical adviser noted that, although Dr. Deardoff did not perform or score a *Quick*DASH or other functional questionnaire, she described mild functional deficits from carpal tunnel syndrome that did not require an adjustment of the default grade of two. He therefore found two percent permanent impairment of each upper extremity.

By decision dated June 20, 2016, OWCP granted appellant a schedule award for two percent permanent impairment of each upper extremity due to carpal tunnel syndrome, based on Dr. Deardoff's opinion as reviewed by OWCP's medical adviser.

LEGAL PRECEDENT

A claimant seeking compensation under FECA has the burden of proof to establish the essential elements of his or her claim.[5] With respect to a schedule award, it is appellant's burden of proof to establish permanent impairment.[6] A claimant may seek an increased schedule award if the evidence establishes that he or she sustained an increased impairment causally related to an employment injury.[7] The medical evidence must include a detailed description of the permanent impairment.[8]

The schedule award provision of FECA[9] and its implementing regulations[10] 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.[11] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides.*[12]

[5] *John W. Montoya*, 54 ECAB 306 (2003).

[6] *Edward W. Spohr*, 54 ECAB 806, 810 (2003).

[7] *See Rose V. Ford*, 55 ECAB 449 (2004).

[8] *See Vanessa Young*, 55 ECAB 575 (2004).

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404 (1999).

[11] *K.H.*, Docket No. 09-341 (issued December 30, 2009). For OWCP decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

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

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[13] In Table 15-23, grade modifier levels (ranging from zero to four) 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.[14]

ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome and bilateral trigger thumbs. Dr. Deardoff, an attending Board-certified orthopedic surgeon, performed right endoscopic tunnel release and trigger thumb release on March 2, 2015, and left carpal tunnel release and trigger thumb release on July 30, 2015.

On February 22, 2016 appellant claimed a schedule award. Dr. Deardoff provided a March 31, 2016 report, finding that appellant had attained MMI. She found three percent permanent impairment of each arm due to carpal tunnel syndrome according to Table 15-23 of the A.M.A., *Guides*.[15] However, Dr. Deardoff's impairment rating is of limited probative value as she did not explain how she applied the rating process for Table 15-23 to arrive at her impairment rating.[16]

An OWCP medical adviser (OMA) reviewed Dr. Deardoff's report on April 16, 2016. Based on Dr. Deardoff's findings, the OMA rated appellant's diagnosed carpal tunnel syndrome using Table 15-23. He noted that appellant had a clinical history modifier of 1 for postoperative scar tissue, a modifier of zero for physical findings due to a normal sensory examination, and a modifier of 3 for test findings based on preoperative electrodiagnostic testing. The OMA averaged these to calculate a grade modifier of 1.33, rounded downward to a grade modifier of 1.0. He explained that as Dr. Deardoff did not describe a functional deficit sufficient to warrant adjusting the default grade of two, appellant had two percent permanent impairment of each upper extremity due to carpal tunnel syndrome.

The Board finds that the OMA properly applied the A.M.A., *Guides*, to Dr. Deardoff's findings to determine that appellant had two percent permanent impairment of each arm. The OMA accurately applied the appropriate portions of the A.M.A., *Guides* to Dr. Deardoff's clinical findings and provided detailed rationale explaining his application of the A.M.A.,

[13] A.M.A., *Guides* 449, Table 15-3 (6th ed 2009).

[14] 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.

[15] *Supra* note 13. The rating process for Table 15-23 is set forth at pages 448-50.

[16] *See Richard A. Neidert*, 57 ECAB 474 (2006) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

Guides.[17] The Board finds that appellant has not met her burden of proof to establish more than two percent permanent impairment of each upper extremity.

On appeal, appellant contends that new medical evidence established more than two percent permanent impairment of each upper extremity. However, the Board may not review evidence that was not before OWCP at the time it issued the last decision in the case.[18]

Appellant may request a schedule award or an increased schedule award at any time 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 not established greater than two percent permanent impairment of each upper extremity, for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 20, 2016 is affirmed.

Issued: May 1, 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

[17] *See Linda Beale*, 57 ECAB 429 (2006) (it is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, her opinion is of diminished probative value in establishing the degree of permanent impairment and OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides*, to the findings reported by the attending physician).

[18] *Supra* note 2.