United States Department of Labor
Employees' Compensation Appeals Board

R.P., Appellant	)	
and	)	**Docket No. 18-0333**
	)	**Issued: August 10, 2018**
DEPARTMENT OF AGRICULTURE, INSPECTIONS OPERATIONS PROGRAM, Minneapolis, MN, 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, 2017 appellant filed a timely appeal from an October 26, 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 this case.

ISSUE

The issue is whether appellant has more than three percent permanent impairment of his bilateral upper extremities, for which he had previously received schedule award compensation.

FACTUAL HISTORY

On May 21, 2014 appellant, then a 57-year-old food inspector, filed an occupational disease claim (Form CA-2) alleging that he developed trigger finger and carpal tunnel syndrome

[1] 5 U.S.C. § 8101 *et seq.*

(CTS) as a result of his repetitive employment duties. By decision dated August 15, 2014, OWCP accepted the claim for bilateral CTS and left ring finger stenosing tenosynovitis.[2] OWCP paid appellant intermittent wage-loss compensation on the supplemental rolls commencing April 29, 2014, and on the periodic rolls commencing April 5, 2015.

On September 26, 2014 appellant underwent surgery to his left ring finger for tendon sheath nodule excision. On December 29, 2014 he underwent left ring finger trigger release with left median nerve decompression. On April 22, 2015 appellant underwent right wrist flexor tendon tenosynovectomy with median nerve decompression.

In a July 21, 2015 medical report, Dr. David M. Rhodes, a Board-certified orthopedic surgeon, discussed appellant's status post right median nerve decompression at the wrist, left median nerve decompression at the wrist, and left ring finger flexor tendon sheath module excision. He reported that appellant had reached maximum medical improvement (MMI) with zero percent permanent impairment.

On January 18, 2016 OWCP referred appellant to Dr. Thomas Rooney, a Board-certified orthopedic surgeon, for a second opinion examination regarding the status of his work-related conditions. In a February 10, 2016 report, Dr. Rooney reported that appellant continued to experience residuals of his occupational injuries and could return to work in a limited-duty capacity.

On April 29, 2016 appellant filed a claim for a schedule award (Form CA-7).

By letter dated May 2, 2016, OWCP requested that appellant submit an impairment evaluation from his attending physician in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] It afforded him 30 days to submit the requested impairment evaluation.

In a May 19, 2016 medical report, Dr. Rhodes reported that an impairment rating of the bilateral extremities would be obtained. No such impairment rating was submitted.

On November 16, 2017 OWCP requested that Dr. David Slutsky, a Board-certified hand surgeon serving as an OWCP district medical adviser (DMA), review the case for a determination on whether appellant sustained a permanent impairment of the upper extremities and date of MMI. It informed Dr. Slutsky that appellant had previously been awarded schedule award compensation for three percent permanent impairment of each upper extremity.

[2] The Board notes that appellant has a prior December 16, 2012 occupational disease claim (Form CA-2) for injury to his hands and left and right index fingers as a result of his repetitive employment duties under OWCP File No. xxxxxx387. OWCP accepted the claim for bilateral CTS and trigger finger of the left and right index fingers. Appellant underwent left hand surgery on January 26, 2011 and right hand surgery on April 25, 2011. On January 5, 2013 OWCP granted appellant a schedule award for three percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity. It administratively combined the current claim, OWCP File No. xxxxxx506, with OWCP File No. xxxxxx387, with the latter serving as the master file.

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

In a December 3, 2016 report, Dr. Slutsky reported that he could not perform a rating for bilateral CTS and triggering of bilateral index fingers due to a lack of information. He reported that in order to provide the date of MMI and an applicable rating, he required the most recent electromyography (EMG) studies, grading of manual motor testing, x-ray reports, sensory testing data, and recent examination findings.

On July 5, 2017 OWCP referred appellant, the case file, a SOAF, and a series of questions to Dr. Robert Holladay, IV, a Board-certified orthopedic surgeon, for a second opinion medical examination and determination as to whether appellant sustained a permanent impairment and to assign a date of MMI.

In a July 11, 2017 report, Dr. Holladay summarized appellant's past medical records, reviewed diagnostic testing, and provided findings on physical examination. He reported that appellant's January 5, 2011 EMG and nerve conduction velocity (NCV) study of the upper extremities revealed bilateral carpal tunnel syndrome. Following bilateral hand surgeries, a January 24, 2012 EMG/NCV study revealed improvement in the median nerve function bilaterally with mild-to-moderate residual abnormality. Dr. Holladay discussed appellant's various surgeries as well as his pre and postoperative diagnoses following the September 26, and December 19, 2014, and April 22, 2015 surgeries. He further discussed Dr. Rhodes' May 19, 2016 x-ray findings pertaining to the right and left hand postsurgery. Dr. Holladay provided findings on physical examination and determined that appellant reached MMI on May 19, 2016.

With respect to appellant's bilateral CTS, Dr. Holladay utilized Table 15-23, Entrapment/ Compression Neuropathy Impairment, of the sixth edition of the A.M.A., *Guides*.[4] He determined that test findings resulted in a grade 1 modifier based on January 5, 2011 EMG/NCV testing which showed bilateral conduction delay in the sensory and motor aspects of the study. Dr. Holladay assigned a grade modifier of 1 for history due to intermittent symptoms and numbness/tingling in the median nerve distribution. He further assigned a grade modifier of 2 for physical findings due to decreased sensation. The grade modifiers averaged 1.33 for a grade 1 modifier at the default two percent. Appellant's *Quick*DASH score of 63 warranted movement one place to the right of the default value, resulting in three percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity.

With respect to appellant's trigger finger, Dr. Holladay utilized Table 15-2, Digital Regional Grid, under the diagnostic criteria for trigger finger or digital stenosing tenosynovitis.[5] He reported that appellant qualified as class 0 because he had no residual symptoms of popping, clicking, triggering, or locking in any digit in either hand. As such, he found no permanent impairment of the left trigger finger based on Table 15-2 for digital stenosing tenosynovitis.[6]

On September 7, 2017 OWCP routed Dr. Holladay's report, the SOAF, and the case file to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP DMA, for review

[4] *Id.* at 449, Table 15-23

[5] *Id.* at 391.

[6] *Id.* at 392.

and determination regarding whether appellant sustained a permanent impairment in accordance with the sixth edition of the A.M.A., *Guides* and to assign a date of MMI.

In a September 11, 2017 medical report, Dr. Harris reported that appellant reached MMI on July 5, 2017, the date of Dr. Holladay's evaluation. He agreed with Dr. Holladay's impairment rating for three percent of the right upper extremity impairment and three percent of the left upper extremity impairment due to residual problems with mild CTS.[7] Dr. Harris reported that because appellant had previously been awarded three percent for each upper extremity, there was no additional permanent impairment.

By decision dated October 26, 2017, OWCP found that the medical evidence of record failed to establish permanent impairment of the right upper extremity and left upper extremity greater than the three percent previously awarded for each extremity. It found that the current medical evidence established that he was entitled to three percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity. As appellant had previously received three percent impairment for each upper extremity, the medical evidence did not support an increase in the permanent impairment already compensated.

LEGAL PRECEDENT

The schedule award provisions of FECA and its implementing regulations 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.[8] 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. Through its implementing regulations, OWCP adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate standard for evaluating schedule losses.[9]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment*." The document included various changes to the original text, intended to serve as an *erratum*/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

[7] The Board notes that Dr. Harris explained that the range of motion (ROM) methodology was not applicable for this diagnosis per the A.M.A., *Guides* and as such, the diagnosis-based impairment method was used.

[8] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[9] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[10] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[11]

The sixth edition requires identifying 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).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13]

It is the claimant's burden to establish that he or she has sustained a permanent impairment of the scheduled member or function as a result of any employment injury.[14]

ANALYSIS

The Board finds that appellant has not submitted sufficient evidence to establish that, as a result of his employment injury, he sustained more than the three percent permanent impairment of the bilateral upper extremities, for which he previously received schedule award compensation.[15]

The Board notes that on January 5, 2013, OWCP granted appellant schedule award compensation for three percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity for his bilateral CTS under OWCP File No. xxxxxx387.

On April 29, 2016 appellant filed a Form CA-7 requesting a schedule award under this claim, OWCP File No. xxxxxx506. In support of his claim, appellant submitted Dr. Rhodes' May 19, 2015 medical report which indicated that he had reached MMI. It is well established that a treating physician's opinion should include a description of impairment, ROM of affected members, any atrophy or deformity, decreases in strength or disturbance of sensation in sufficient detail so as those reviewing the file would be able to clearly visualize the impairment with all its

[10] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

[11] *Isidoro Rivera*, 12 ECAB 348 (1961).

[12] A.M.A., *Guides* 494-531.

[13] *Id.* at 521.

[14] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[15] *W.R.*, Docket No. 13-0492 (issued June 26, 2013).

limitations.[16] Thus, Dr. Rhodes' report is of limited probative value and insufficient to determine the extent of permanent impairment.[17]

On July 5, 2017 OWCP referred appellant and the case file to Dr. Holladay for a second opinion evaluation and determination regarding permanent impairment. The Board notes that Dr. Holladay properly utilized the sixth edition of the A.M.A., *Guides* in determining that appellant had three percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity due to residual problems with mild CTS and neuropathy impairment. Dr. Holladay further properly determined that appellant had no ratable impairment of the left upper extremity due to his left trigger finger.

Having undergone bilateral carpal tunnel releases in 2011/2012 and 2014/2015, appellant's impairment rating under Table 15-23 must be premised on positive preoperative electrodiagnostic evidence of CTS.[18] In this regard, Dr. Holladay and Dr. Harris, the DMA, properly used appellant's January 5, 2011 upper extremity EMG/NCV for purposes of rating compression neuropathy under Table 15-23. He described his findings, explaining that appellant had an average grade modifier of 1 based on test findings, history, and physical findings, which corresponded to a default upper extremity impairment of two percent under Table 15-23.[19] The final step in the rating process was to factor in the functional scale based on appellant's *Quick*DASH score of 63 (moderate), which represented a grade modifier of 2 and adjusted his impairment upward to three percent.[20] Dr. Holladay further explained that appellant had no ratable impairment of the left trigger finger based on Table 15-2 for digital stenosing tenosynovitis as he qualified under class 0 for no residual symptoms of popping, clicking, triggering, or locking.[21]

Dr. Harris, serving as the DMA, agreed with Dr. Holladay's findings, establishing that appellant was entitled to no more than the three percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity previously

[16] *See Peter C. Belkind*, 56 ECAB 580 (2005).

[17] *T.E.*, Docket No. 11-1805 (issued August 2, 2012).

[18] *See* Section 15.4f, Entrapment Neuropathy, A.M.A., *Guides* 445-46, 448-49. Test findings are the key factor for determining impairment in this section. *Id*. at 446.

[19] *Id.* at 449, Table 15-23.

[20] If the grade modifier assigned to the functional scale score is equal to the grade assigned for the condition -- in this case grade 1 -- the default value (two percent) within that grade is the appropriate final rating. However, if the functional scale score is 1 grade higher or lower than the grade assigned the condition, the lower or higher value, respectively, is the appropriate impairment rating. A.M.A., *Guides* 449, section 15.4f.

[21] *Id.* at 392.

awarded.[22] Thus, OWCP properly determined that appellant was not entitled to an increased schedule award than that which he was previously awarded under File No. xxxxxx387.[23]

On appeal, appellant argues that OWCP failed to provide him the necessary testing required to determine his permanent partial impairment. In support of his argument he references Dr. Slutsky's December 3, 2016 report, serving as an OWCP DMA, who reported that he could not provide an impairment rating due to lack of information without the most recent EMG studies, grading of manual motor testing, x-ray reports, sensory testing data, and examination findings. OWCP subsequently referred appellant to Dr. Holladay who provided a detailed summary of appellant's prior medical and diagnostic reports, as well as his most recent examination findings. As previously noted above, Dr. Holladay properly used appellant's January 5, 2011 upper extremity EMG/NCV study for purposes of rating compression neuropathy as the A.M.A., *Guides* provide that preoperative electrodiagnostic testing should be used in the impairment rating.[24] As such, Dr. Holladay and Dr. Harris had the necessary reports, examinations, and testing to provide an impairment rating of the right and left upper extremities.

Ultimately, both Dr. Holladay and Dr. Harris, the DMA, agreed that appellant had three percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity.[25] The Board finds that Dr. Holladay and Dr. Harris' bilateral upper extremity impairment rating is consistent with the sixth edition of the A.M.A., *Guides*. Appellant has not demonstrated permanent impairment in excess of what he has already been awarded. He has therefore failed to meet his burden of proof.

Appellant may request a schedule award or 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 more than three percent permanent impairment of his bilateral upper extremities, for which he previously received schedule award compensation.

[22] *M.J.*, Docket No. 13-0598 (issued May 8, 2013).

[23] The Board notes that appellant is not entitled to receive two awards for injury to the same body part. *L.M.*, Docket No. 09-0690 (issued December 29, 2009).

[24] A.M.A., *Guides* 448.

[25] *E.G.*, Docket No. 15-1739 (issued January 28, 2016).

ORDER

IT IS HEREBY ORDERED THAT the October 26, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 10, 2018
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