United States Department of Labor
Employees' Compensation Appeals Board

R.S., Appellant	)	
	)	**Docket No. 18-0023**
and	)	**Issued: July 26, 2018**
	)	
U.S. POSTAL SERVICE, LAKE OTIS STATION, Anchorage, AK	)	

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 October 2, 2017 appellant filed a timely appeal from an August 11, 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 claim.

ISSUE

The issue is whether appellant has met his burden of proof to establish more than one percent permanent impairment of each upper extremity, for which he previously received schedule awards.

FACTUAL HISTORY

On August 12, 2014 appellant, then a 53-year-old letter carrier, filed an occupational disease claim (Form CA-2) for a bilateral hand condition causally related to factors of his federal

[1] 5 U.S.C. § 8101 *et seq.*

employment. He first became aware of his claimed condition on August 11, 2014 and he attributed it to repetitive movements required by his work. He claimed that his hands would close on their own accord. Appellant did not stop work.

OWCP, by development letter dated August 14, 2014, informed appellant of the deficiencies in his claim and afforded him 30 days to submit additional factual and medical evidence.

In an August 11, 2014 medical report, Dr. Lisa A. Rabinowitz, Board-certified in emergency medicine, related that appellant presented with bilateral hand and wrist pain that began approximately one week prior. She noted his complaints and history of his medical and social background. Dr. Rabinowitz examined appellant and provided a final impression of carpal spasm.

By decision dated October 8, 2014, OWCP denied appellant's occupational disease claim, finding that the medical evidence of record failed to establish a diagnosed condition causally related to the accepted employment factors.

On February 23, 2015 appellant requested reconsideration and submitted a January 28, 2015 attending physician's report (Form CA-20) from Dr. David Roberts, a neurosurgeon. Dr. Roberts noted that appellant complained about left wrist pain radiating up to his shoulder. He also noted that in 2011 he underwent a left ulnar nerve transposition. Dr. Roberts reported that an electromyogram (EMG) confirmed left carpal tunnel syndrome. He diagnosed enthesopathy of the wrist and carpus, left carpal tunnel syndrome, and lesion on the left ulnar nerve. Dr. Roberts checked a box marked "yes" that the diagnosed conditions were caused or aggravated by an employment activity, which he identified as repetitive motion. He advised appellant that he could resume light work with limitations as of the date of his examination.

The record contains a memorandum of conference, dated April 2, 2015, between an OWCP claims examiner and appellant. Appellant described his work duties at the employing establishment, which involved casing mail two to two and one-half hours a day and delivering mail five to five and one-half hours a day. He noted changes in his hands about one year ago. Appellant related that both of his hands would ball up after a hard day. He had no prior hand injuries. Appellant was not performing full-time, full-duty work due to a lifting restriction.

On April 6, 2015 OWCP prepared a statement of accepted facts (SOAF).

By letter dated April 8, 2015, OWCP referred appellant to Dr. Thomas Gritzka, a Board-certified orthopedic surgeon, for a second opinion examination to determine whether he had a bilateral arm or hand condition causally related to factors of his federal employment.

In a medical report dated May 19, 2015, Dr. Gritzka reviewed the SOAF and the medical record. He noted appellant's medical and social background, provided a review of systems and findings on physical examination, and diagnosed bilateral carpal tunnel syndrome, left greater than right, related to appellant's work activites. Dr. Gritzka advised that appellant had not yet reached maximum medical improvement (MMI). In an addendum to his August 21, 2015 report, he noted that EMG studies performed on August 6, 2015 revealed that appellant met the criteria for a left carpal tunnel release. Dr. Gritzka related, however, that the EMG studies of his right upper extremity were normal.

By decision dated September 3, 2015, OWCP vacated its October 8, 2014 decision and accepted appellant's claim for bilateral carpal tunnel based on Dr. Gritzka's opinion.

On December 9, 2015 appellant underwent authorized left endoscopic carpal tunnel release performed by Dr. Owen Ala, an orthopedic surgeon. OWCP paid appellant wage-loss compensation benefits on the supplemental rolls as of the date of his surgery. On January 27, 2016 Dr. Ala performed authorized right endoscopic carpal tunnel release. OWCP paid appellant wage-loss compensation on the supplemental rolls as of February 6, 2016. He returned to full-time, modified duty work on February 12, 2016.

In reports dated April 7, 2016, Jenifer Crawley, a certified physician assistant, examined appellant and assessed status post right endoscopic carpal tunnel release, healing well. She related that he was doing well and that he could return to work without restriction on April 8, 2016.

In an April 7, 2016 return to work Form CA-3 worksheet, the employing establishment notified OWCP that appellant had returned to full-time, regular-duty work with no restrictions.

On December 12, 2016 appellant filed a claim for a schedule award (Form CA-7). He did not submit any additional evidence.

By development letter dated December 30, 2016, OWCP requested that appellant submit additional factual and medical evidence in support of his schedule award claim, including an impairment rating, which applied the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] It afforded appellant 30 days to submit the requested information.

Appellant submitted an anesthesia record dated December 9, 2015 and a duplicate copy of Ms. Crawley's April 7, 2016 report.

On March 16, 2017 OWCP denied appellant's claim for a schedule award. It found that the medical evidence submitted failed to establish that he sustained measurable impairment due to his accepted employment injury.

On May 5, 2017 appellant requested reconsideration.

In an April 26, 2017 report, Dr. Sean D. Taylor, a Board-certified physiatrist, noted that Dr. Ala had referred appellant for a permanent impairment evaluation. He related a history of the accepted employment injury and appellant's medical, family, and social background. Dr. Taylor reviewed medical records. On physical examination he reported that appellant was resting comfortably in no acute distress. Dr. Taylor found that strength throughout the bilateral upper extremities was five out of five. There was no atrophy noted on visual inspection of the bilateral upper extremities. Normal muscle bulk was found in the bilateral abductor pollicis brevis. A sensory examination included monofilament testing at 3.61 millimeter (mm) in the left thumb and little finger, 4.31 mm in the left index, middle, and ring fingers, 2.83 mm in the little and ring fingers, and 4.31 mm in the right thumb, index, and middle fingers. An examination of the bilateral

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

wrists and elbows revealed negative Tinel's and Phalen's tests. Dr. Taylor diagnosed bilateral carpal tunnel syndrome. He noted that appellant was status post bilateral carpal tunnel release. Dr. Taylor related that he was medically stable at the time Dr. Ala had referred him for a permanent impairment rating.

Utilizing Table 15-23 (Entrapment/Compression Neuropathy Impairment) on page 449 of the sixth edition of the A.M.A., *Guides*, for the right wrist, Dr. Taylor assigned a grade modifier 0 for clinical studies (GMCS) based on the findings of a September 24, 2014 EMG and nerve conduction velocity (NCV) study.[3] He assigned a grade modifier 2 for functional history (GMFH), which was remarkable for significant intermittent symptoms. Dr. Taylor assigned a grade modifier 2 for physical examination (GMPE). He found an average modifier of 1.33. Dr. Taylor determined that the default grade modifier was one, resulting in a default upper extremity impairment of two percent. He related that appellant had a *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) score of 66 that was consistent with position three, which yielded three percent right upper extremity impairment. Dr. Taylor used Table 15-11 on page 420 to convert the three percent upper extremity impairment rating to a two percent whole person impairment rating. For the left wrist, he applied a grade modifier one for GMCS based on the September 24, 2014 EMG/NCV study results. Dr. Taylor applied a grade modifier two for GMFH, noting that appellant had significant intermittent symptoms. He applied a grade modifier two for GMPE. Dr. Taylor found an average modifier of 1.66, which represented a default grade modifier two and a default upper extremity impairment of five percent. He determined that a *Quick*DASH score of 66 was consistent with position three, which yielded six percent left upper extremity impairment. Utilizing Table 15-11, Dr. Taylor converted the six percent upper extremity impairment rating to four percent whole person impairment rating. Using the combined values chart on page 604, he combined the two percent whole person impairment on the right and the four percent whole person impairment on the left to calculate six percent whole person impairment rating. Dr. Taylor summarized that appellant had sustained six percent whole person impairment as a result of his work-related injury.

On July 31, 2017 Dr. Michael M. Katz, an OWCP medical adviser and a Board-certified orthopedic surgeon, reviewed the April 6, 2015 SOAF and the medical record, including Dr. Taylor's April 26, 2017 findings. He found that Dr. Taylor's report was problematic as the electrodiagnostics performed prior to appellant's surgery did not confirm sufficient changes in the median nerve function to warrant use of Table 15-23 to calculate impairment for carpal tunnel syndrome (no median nerve abnormalities were reported in the September 24, 2014 study). Furthermore, Dr. Katz indicated that ulnar nerve lesion of the left upper extremity was not an accepted condition under the claim. He related that, according to the A.M.A., *Guides*, pages 445 and 446, the diagnosis of focal neuropathy syndrome must be documented by sensory and motor nerve conduction studies and/or needle EMG in order to be ratable as an impairment and that normal electrodiagnostic tests failed to meet the definitions necessary to permit a diagnosis of focal nerve compromise for the purpose of rating impairment. Dr. Katz further related that, under these circumstances, the A.M.A., *Guides*, pages 445 and 446, required the wrists to be rated as nonspecific wrist pain.[4] He determined that, under Table 15-3, Wrist Regional Grid, on page 395, using the diagnosis of wrist pain, nonspecific, residual symptoms, appellant had a class of

[3] The September 24, 2014 EMG/NCV study provided an impression of left cubital tunnel syndrome.

[4] A.M.A., *Guides* 445-46.

diagnosis 1 (CDX 1) impairment, which represented one percent impairment default value. Dr. Katz assigned a grade modifier 1 for GMPE and advised that Dr. Taylor's grade modifier three for GMFH and a GMCS were not applicable. Using the net adjustment formula of (GMPE - CDX) or (1-1), he found that the net adjustment was zero, resulting in one percent permanent impairment, grade C. Dr. Katz noted that the *Quick*DASH score of 66 was not applicable in his determination because the functional history was unreliable. Citing the A.M.A., *Guides* on page 406, he noted that, if functional history differed by two or more grades from the clinical studies or physical examination findings, it should be assumed to be unreliable. Dr. Katz also noted that, if the functional history was unreliable or inconsistent with other documentation, it was excluded from the grading process. He concluded that appellant had one percent impairment of each upper extremity. Dr. Katz determined that appellant had reached MMI on April 26, 2016, the date of Dr. Taylor's examination.

In an August 7, 2017 decision, OWCP vacated its March 16, 2016 decision, finding that appellant had sustained permanent impairment of a scheduled member due to his accepted employment injury. It noted that a decision addressing his claim for a schedule award would be issued under separate cover.

By decision dated August 11, 2017, OWCP granted appellant a schedule award for one percent permanent impairment of each upper extremity. The period of the award, equivalent to 6.24 weeks, ran from April 26 to June 8, 2017. OWCP based its determination on Dr. Katz's July 31, 2017 report, which evaluated the April 26, 2017 findings of Dr. Taylor.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing federal regulations[6] 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.[7] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[9] 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.[10] It is well established that in

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

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

[8] *Id.*

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (March 2017).

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

determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments are to be included.[11]

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

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP 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.[15]

ANALYSIS

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

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome. It authorized left endoscopic carpal tunnel release performed on December 9, 2015 and right endoscopic carpal tunnel release performed on January 27, 2016. Dr. Ala performed the surgeries. Appellant claimed a schedule award on December 12, 2016. By decision dated August 11, 2017, OWCP granted him a schedule award for one percent permanent impairment of each upper extremity. It is appellant's burden of proof to submit sufficient evidence to establish the extent of permanent impairment.[16]

Appellant submitted an April 26, 2017 report from Dr. Taylor who diagnosed bilateral carpal tunnel syndrome. Utilizing the sixth edition of the A.M.A., *Guides*, Dr. Taylor found that appellant had six percent permanent impairment of the whole person due to the accepted employment injury. The overall rating included three percent permanent impairment of the right upper extremity due to appellant's entrapment compression neuropathy, which Dr. Taylor converted to a two percent whole person impairment rating and six percent permanent impairment of the left upper extremity due to the same nerve condition which he converted to a four percent

[11] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); *supra* note 8 at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a.3 (January 2010). This portion of OWCP procedures provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

[12] 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.

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

[14] *Id.* at 521.

[15] *See* Federal (FECA) Procedure Manual, *supra* note 8 at Chapter 2.808.6(f) (February 2013).

[16] *Tania R. Keka,* 55 ECAB 354 (2004).

whole person impairment rating.[17] Dr. Taylor combined the two percent whole person impairment rating for the right upper extremity and the four percent whole person impairment rating for the left upper extremity to calculate a six percent whole person impairment rating.[18] He concluded that appellant had sustained six percent whole person impairment as a result of his work-related injury. The Board notes however that there is no statutory basis for the payment of a schedule award for whole body impairment under FECA.[19]

In accordance with its procedures, OWCP properly referred the evidence of record to its OWCP medical adviser, Dr. Katz. In his July 31, 2017 report, Dr. Katz reviewed the medical evidence of record, including Dr. Taylor's April 26, 2017 findings, and determined that appellant had one percent permanent impairment of each upper extremity due to bilateral wrist nonspecific pain. As noted, however, appellant's claim was accepted for bilateral carpal tunnel syndrome. In addition, the Board notes that the SOAF provided to Dr. Katz did not include the accepted condition, as it was prepared prior to the acceptance of any medical conditions in this claim and was not updated. Thus, Dr. Katz did not provide an impairment rating based on the accepted bilateral carpal tunnel syndrome condition.

OWCP procedures indicate that accepted conditions must be included in a SOAF and further provides that, when an OWCP medical adviser renders a medical opinion based on a SOAF which is incomplete or inaccurate or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is diminished.[20] In this case, Dr. Katz did not have a complete SOAF for review. Since he rendered his medical opinion based on an incomplete factual statement omitting appellant's accepted condition of bilateral carpal tunnel syndrome, the probative value of his report is diminished. The Board finds, therefore, that the case must be remanded to OWCP for further development.[21]

On remand OWCP should prepare an updated SOAF which includes all accepted conditions. The case shall then be forwarded to Dr. Katz for a supplemental opinion addressing whether appellant has permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*. Following this and such further development deemed necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.

CONCLUSION

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

[17] A.M.A., *Guides* 449, 420, Tables 15-23, 15-11, respectively.

[18] *Id*. at 604, Combined Values Chart.

[19] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *K.S.*, Docket No. 15-1082 (issued April 18, 2017); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[20] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

[21] *A.R.*, Docket No. 10-0515 (issued November 16, 2010).

ORDER

IT IS HEREBY ORDERED THAT the August 11, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: July 26, 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