United States Department of Labor
Employees' Compensation Appeals Board

M.C., Appellant	)	
and	)	**Docket No. 16-1645**
	)	**Issued: May 3, 2018**
U.S. POSTAL SERVICE, VEHICLE MAINTENANCE FACILITY, Baltimore, MD, 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 August 9, 2016 appellant filed a timely appeal from a July 7, 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 to consider the merits of the case.

ISSUE

The issue is whether appellant has more than 13 percent permanent impairment of her left upper extremity and 6 percent permanent impairment of her right upper extremity, for which she previously received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On March 4, 2013 appellant, a 59-year-old clerk, filed an occupational disease claim (Form CA-2) under OWCP File No. xxxxxx451, alleging that she developed bilateral carpal tunnel syndrome (CTS) causally related to factors of her federal employment. She indicated on the claim form that she first became aware of her condition and its relation to her federal employment on December 5, 2012.[2]

On December 23, 2013 OWCP received a bilateral upper extremity nerve conduction velocity (NCV) study and a medical report from Dr. Margit L. Bleecker, a Board-certified neurologist. Dr. Bleecker diagnosed right neurogenic thoracic outlet syndrome (TOS), which she explained was supported by examination findings (positive Adson's maneuver) and electrodiagnostic studies.[3] She noted that appellant worked for the employing establishment since 1986, and her duties as a general clerk involved frequent filing.[4] Dr. Bleecker further noted that appellant frequently had to reach above her shoulder height for filing, and also the file drawers were extremely tight and required a lot of force to pull open. She explained that these were risk factors for right TOS, which diagnosis had been demonstrated on appellant's physical examination and her NCV studies. Dr. Bleecker further explained that constant flexion and extension with filing put stress on the ulnar nerve in the cubital tunnel, which diagnosis was also demonstrated both by examination and NCV studies.[5]

On January 29, 2014 appellant filed a claim for a schedule award (Form CA-7) based on a partial loss of use of her left and right upper extremities.

In a February 11, 2014 report, Dr. Bleecker advised that appellant had five percent left upper extremity impairment for left CTS and six percent right upper extremity impairment for right CTS under the sixth edition of the American Medical Association, *Guides to the Evaluation*

[2] Appellant has two other claims with OWCP. In File No. xxxxxx753, appellant filed a traumatic injury claim (Form CA-1) on January 11, 2012, alleging that she injured her left shoulder and neck while carrying heavy folders. OWCP accepted this claim for sprain of the shoulder and upper left arm (ICD-9 840.9), and sprain of the neck (ICD-9 847.0). In File No. xxxxxx032, appellant filed an occupational disease claim (Form CA-2) on January 8, 2014 for a work-related right upper extremity injury that she allegedly sustained on or about December 23, 2013. She indicated that her employment duties included computer data input. Appellant also indicated that she had already been diagnosed with bilateral CTS, and that she recently experienced shocking nerve pain and swelling in her right forearm, elbow, and shoulder. File Nos. xxxxxx451. xxxxxx753, and xxxxxx032 have been administratively combined, with File No. xxxxxx451 serving as the master file.

[3] Dr. Bleecker reported that the NCV study results revealed right ulnar neuropathy at the elbow, which supported the clinical presentation of right cubital tunnel syndrome. She also noted that a right brachial plexus lesion involving the lower roots supported a positive examination for right thoracic outlet syndrome.

[4] Appellant's duties also included extensive keyboarding and use of a mouse. Dr. Bleecker explained that constant flexion and extension of the elbow and reaching above shoulder height had proved to be difficult for appellant.

[5] Dr. Bleecker also submitted narrative reports dated September 10, November 14, and December 19, 2013. These reports pertained to appellant's December 5, 2012 injury. Dr. Bleecker diagnosed neck sprain, left shoulder sprain, bilateral CTS, and left brachial plexus lesions/TOS.

of Permanent Impairment (A.M.A., *Guides*).[6] With regard to the left upper extremity, she arrived at her five percent impairment rating by relying on Table 15-23 at page 449.[7] Dr. Bleecker found that under the heading of "Test Findings" appellant had a grade modifier of 2, for conduction delay and motor conduction block; under the heading of "History," she rated a grade modifier of 2, based on significant intermittent symptoms; and under the heading of "Physical Findings" she found that appellant's physical examination yielded a grade modifier of 2 for decreased sensation. Pursuant to the rating process set forth at page 448,[8] Dr. Bleecker determined that the average value for these modifiers, based on adding 2 plus 2 plus 2, divided by 3, equaled 2, which produced a mid-range impairment of 5 under Table 15-23. Given that appellant's *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) test score was 50, she found that this yielded a mild grade modifier of 2, which produced five percent impairment rating for left carpal tunnel syndrome.

Dr. Bleecker utilized the identical findings and analysis to render her six percent right upper extremity impairment for right-sided CTS, except with regard to the *Quick*DASH score of 68. She found that this was a severe problem which yielded a grade modifier of 2, producing six percent permanent impairment rating for right carpal tunnel syndrome.

Dr. Bleecker also found that appellant had four percent left upper extremity impairment for tendinitis of the left shoulder; and four percent left upper extremity impairment for left neurogenic thoracic outlet syndrome.

In a statement of accepted facts dated February 28, 2014, OWCP advised that it had accepted the conditions of sprain of the shoulder and upper left arm (ICD-9 840.9), sprain of the neck (ICD-9 847.0), bilateral CTS (ICD-9 354.0), and left brachial plexus (ICD-9 353.0).

In a March 23, 2014 report, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and district medical adviser (DMA), found that appellant had 10 percent permanent impairment of the left upper extremity impairment and 6 percent permanent impairment of the right upper extremity. He found that appellant had 1 percent permanent impairment of the left upper extremity for the left shoulder; 5 percent permanent impairment of the left upper extremity based on left-sided carpal tunnel syndrome, and 1 percent permanent impairment for cervical spine discogenic disease, for a combined total of 10 percent left upper extremity permanent impairment. Dr. Berman further found that appellant had six percent right upper extremity permanent impairment based on right-sided CTS.

In addition, Dr. Berman reviewed a February 11, 2014[9] report of Dr. Bleecker, who rated permanent impairment of the bilateral upper extremities based in part on a diagnosis of TOS. He advised that TOS was not an accepted condition, and there was no clinical evidence to support that

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

[7] *Id*. at 449.

[8] *Id*. at 448.

[9] The Board notes that DMA Dr. Berman referred to a February, 11, 2012 report of Dr. Bleecker. However, this appears to have been a typographical error as Dr. Bleecker's initial impairment rating report was dated February 11, 2014.

diagnosis. Dr. Berman calculated 16 percent permanent impairment of the bilateral upper extremities.

By decision dated April 4, 2014, OWCP granted appellant a schedule award for 10 percent permanent impairment of her left upper extremity and 6 percent permanent impairment of her right upper extremity. The award ran for 6.24 weeks, covering the period February 11, 2014 to January 26, 2015. It based this award on the Dr. Berman's March 23, 2014 impairment rating.[10]

On April 17, 2014 appellant requested reconsideration of the April 4, 2014 schedule award decision.

On March 26, 2015 appellant filed a claim for an additional schedule award (Form CA-7) based on a partial loss of use of her left and right upper extremities.

In a May 4, 2015 report, OWCP's medical adviser, Dr. Berman, amended his March 23, 2014 report and substituted four percent impairment for left-sided TOS, a condition which he had not rated in his previous report, for the one percent impairment for cervical spine disease. This amendment resulted in an additional three percent permanent impairment rating for the left upper extremity.

On September 1, 2015 appellant again filed a Form CA-7 claim for an additional schedule award under File No. xxxxxx451 based on a partial loss of use of her left and right upper extremities.

By decision dated October 29, 2015, OWCP awarded appellant a schedule award for an additional three percent permanent impairment of the left upper extremity for 6.24 weeks, covering the period January 27 to April 2, 2015.

On November 4, 2015 OWCP accepted the condition of brachial plexus disorders. It indicated that it had originally accepted a condition for left brachial plexus lesions under ICD-9 353.0 and noted that the condition was also commonly referred to as TOS (left), which had been added under ICD-10, G540.

In a November 23, 2015 report, Dr. Bleecker found, using the Combined Values Chart, that appellant had 13 percent left upper extremity permanent impairment and 3 percent right upper extremity permanent impairment. She derived this rating by calculating three percent impairment for the left and right upper extremities based on three percent impairment for bilateral CTS; five

[10] By decision dated April 11, 2014, under OWCP File No. xxxxxx032, OWCP denied appellant's request to expand the accepted conditions to include right TOS. OWCP determined that Dr. Bleecker's December 23, 2013 narrative report was insufficient to establish that appellant's TOS was causally related to the accepted work conditions. OWCP further noted that TOS had already been rejected under appellant's prior claim in File No. xxxxxx451, and that File No. xxxxxx032 was just an attempt to add a medical condition that had already been reviewed and ruled out. On March 17, 2015 appellant requested reconsideration of the April 11, 2014 decision. By decision dated June 11, 2015, OWCP denied appellant's request for reconsideration, finding that the evidence submitted was insufficient to warrant review of its April 11, 2014 merit decision. Appellant subsequently appealed the June 11, 2015 decision to the Board. By decision dated October 22, 2015, the Board set aside OWCP's June 11, 2015 decision and remanded the case for further development as File Nos. xxxxxx451 and xxxxxx032 had not at that time been administratively combined. Docket No. 15-1706 (issued October 22, 2015).

percent impairment for left thoracic outlet syndrome; and five percent impairment for left shoulder tendinitis.

OWCP subsequently referred appellant to Dr. Robert A. Smith, a Board-certified orthopedic surgeon, for a second opinion examination and impairment rating. In a January 8, 2016 report, he found that appellant had five percent left upper extremity impairment for left CTS and five percent right upper extremity rating for right CTS under the A.M.A., *Guides*. Dr. Smith found on examination that the upper extremities revealed no dystrophic findings, focal muscle atrophy, engorgement, dependent rubor or increased collateralization. He noted no muscle atrophy in the arm, forearm or hand, with mild loss of sensation in the tips of the index and middle fingers, negative Tinel's signs at the elbows and equivocal Tinel's signs at the volar wrists, mildly positive Phalen's maneuvers, bilaterally, normal motor strength in gripping, pinch and opposition, bilaterally, dynamometer testing showing equal grip strength of 20 pounds on average, bilaterally, and normal finger abduction and adduction strength.

Dr. Smith calculated five percent permanent impairment of the right and left upper extremities due to bilateral CTS, utilizing Table 15-23 at page 449 of the A.M.A., *Guides*.[11] He found pursuant to the heading of "Test Findings" that appellant had a grade modifier of 2, for sensory delay and motor conduction block, pursuant to the heading of "History," he rated a grade modifier of 2, based on significant intermittent symptoms, and pursuant to the heading of "Physical Findings" he found that appellant's physical examination yielded a grade modifier of 2, for decreased sensation. Utilizing the rating process at page 448,[12] Dr. Smith added 2 plus 2 plus 2, divided by 3, which equaled 2, yielding a mid-range impairment of 5 under Table 15-23. Given that appellant's *Quick*DASH test score was 55, he found that this yielded a mild grade modifier of 2, which produced a five percent permanent impairment rating for bilateral CTS.

With regard to the additional accepted conditions, Dr. Smith opined that, based on appellant's current clinical findings, the conditions of cervical sprain, left shoulder/arm sprain, and left brachial plexus had objectively resolved without discernible residuals. He noted on examination that the cervical spine was functional, with no finding of spasm, atrophy, trigger points, or deformity. Dr. Smith reported that appellant had satisfactory cervical range of motion and no muscle spasm or rigidity during excursion, with no deformity, atrophy, or scapular winging. He found that appellant had essentially full range of motion of her left shoulder, with findings of 180 degrees adduction, 170 degrees abduction, 50 degrees abduction, 50 degrees extension, 80 degrees internal rotation and 60 degrees external rotation. There were no signs of instability, crepitation or impingement and negative Tinel's signs at the thoracic outlets. Dr. Smith advised that degenerative disease of the cervical spine and left shoulder were not accepted conditions for this claim either by direct causation or aggravation; therefore, the only ratable condition for this claim was bilateral carpal tunnel syndrome.

In a May 28, 2016 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA, reviewed Dr. Smith's January 8, 2016 report and concurred with his five percent bilateral upper extremity impairment rating for bilateral CTS. He opined that his report

[11] *Supra* note 5.

[12] *Id*. at 448.

was in conformance with the protocols of A.M.A., *Guides*. OWCP's medical adviser found that, because Dr. Smith's rating did not exceed the prior award for five percent left upper extremity impairment and six percent right upper extremity impairment for bilateral CTS, appellant was not entitled to an additional schedule award.

By decision dated July 7, 2016, OWCP denied appellant's claim for an additional schedule award. It found that she had not established more than the 13 percent permanent impairment of her left upper extremity and 6 percent permanent impairment of her right upper extremity, for which she had previously received schedule awards.

LEGAL PRECEDENT

The schedule award provisions of FECA[13] and its implementing regulations[14] 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.[15] The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to her employment.[16]

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).[17] Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment of the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS.[18] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[19]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[20] In Table 15-23, grade modifiers levels (ranging from zero to four) are described for the categories

[13] 5 U.S.C. § 8107.

[14] 20 C.F.R. § 10.404.

[15] *Id.*

[16] *Veronica Williams*, 56 ECAB 367, 370 (2005).

[17] *Supra* note 5 at 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[18] *Id.* at 385-419.

[19] *Id.* at 411.

[20] *Id.* at 449.

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.[21]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[22]

ANALYSIS

OWCP accepted the conditions of bilateral CTS, left brachial plexus lesions/left thoracic outlet syndrome, sprain of left shoulder and upper arm, and cervical sprain. In its April 4, 2014 decision, OWCP awarded appellant 10 percent left upper extremity impairment, for 1 percent impairment of the left shoulder, 5 percent impairment for left-sided CTS, and 1 percent impairment for cervical spine discogenic disease, and 6 percent impairment of the right upper extremity, for right-sided CTS. Appellant subsequently requested reconsideration and filed a claim for an additional schedule award. OWCP awarded an additional three percent left upper extremity permanent impairment for left-sided TOS in an October 29, 2015 decision.

Appellant subsequently submitted Dr. Bleecker's November 23, 2015 report. She found that appellant had 10 percent left upper extremity permanent impairment and 6 percent right upper extremity permanent impairment based on 3 percent impairment for bilateral CTS, 5 percent impairment for left TOS, and 5 percent impairment for left shoulder tendinitis. Dr. Smith, OWCP's referral physician, reported findings on examination, reviewed the medical history and statement of accepted facts and found that appellant had no ratable impairment from her accepted cervical sprain, left shoulder/arm sprain, and left brachial plexus conditions. He opined that these conditions had objectively resolved without discernible residuals. Dr. Smith reported that she had a normal cervical spine examination and normal left shoulder examination, with essentially normal range of motion. He further found that there were no signs of instability, crepitation or impingement and negative Tinel's signs at the thoracic outlets. Dr. Smith advised that degenerative disease of the cervical spine and left shoulder were not accepted conditions for this claim either by direct causation or aggravation. He therefore concluded that the only ratable condition for this claim was bilateral CTS.[23]

As noted above, impairment due to CTS is evaluated pursuant to Table 15-23 of the A.M.A., *Guides*, which sets forth grade modifier levels for test findings, history, and physical

[21] *Id.* at 448-450.

[22] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[23] The Board notes that appellant had already received a schedule award for one percent impairment of the left upper extremity for the left shoulder and four percent left upper extremity impairment for left-sided TOS.

findings; these grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value.[24]

The Board finds that appellant has not met her burden of proof to establish more than the 13 percent permanent impairment of her left upper extremity and 6 percent permanent impairment of her right upper extremity previously awarded.

In his January 8, 2016 second opinion report, Dr. Smith, a Board-certified orthopedic surgeon, calculated five percent bilateral permanent impairment of the upper extremities from the accepted bilateral CTS under the A.M.A., *Guides* using the formula set forth above. He found that her other accepted upper extremity conditions had resolved and did not warrant an additional impairment rating.

Dr. Smith provided clinical findings and explained how those objective elements warranted the percentages assessed. OWCP medical adviser, Dr. Katz, concurred with Dr. Smith's 5 percent bilateral permanent impairment rating and methodology. OWCP then issued the July 7, 2016 decision finding that appellant was not entitled to an additional impairment for her accepted bilateral CTS, or any other accepted condition, as the impairment calculated by Dr. Smith did not exceed the impairment for which she had already received a schedule award.

The Board finds that OWCP properly accorded Dr. Smith's impairment rating the weight of the medical evidence. Dr. Smith's opinion was based on a statement of accepted facts and the complete medical record. He provided a thorough impairment rating, utilizing the appropriate portions of the A.M.A., *Guides*. Dr. Smith described how the objective clinical findings, intermittent symptoms, and physical examination warranted the specified percentage of impairment. There is no probative medical evidence of record demonstrating that appellant sustained more than the 13 percent permanent impairment of her left upper extremity and 6 percent permanent impairment of her right upper extremity previously awarded due to her accepted upper extremity conditions. Thus, appellant has not met her 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 met her burden of proof to establish more than 13 percent permanent impairment of her left upper extremity and 6 percent permanent impairment of her right upper extremity, for which she previously received schedule awards.

[24] *Supra* note 5 at 448-50.

ORDER

IT IS HEREBY ORDERED THAT the July 7, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 3, 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