

**United States Department of Labor
Employees' Compensation Appeals Board**

J.T., Appellant

and

**DEPARTMENT OF THE ARMY, TOOEELE
ARMY DEPOT, Tooele, UT, Employer**

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**Docket No. 18-0176
Issued: August 21, 2019**

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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On October 30, 2017 appellant filed a timely appeal from a June 22, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (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 met his burden of proof to establish more than seven percent permanent impairment of each upper extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On November 7, 2013 appellant, then a 41-year-old blocker bracer, filed an occupational disease claim (Form CA-2) alleging that he experienced aching and numbness in both hands and

¹ 5 U.S.C. § 8101 *et seq.*

wrists as a result of his repetitive federal-employment duties. He noted that he first became aware of his condition on October 28, 2013 and realized its relation to his federal employment on November 6, 2013. Appellant did not stop work, but began modified duty on November 7, 2013.

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome, bilateral lesion of the ulnar nerve, and bilateral radial styloid tenosynovitis. Appellant continued to receive medical treatment.

On June 5, 2014 appellant underwent authorized right carpal tunnel surgery performed by Dr. Jennifer Nicole Jarrell, an orthopedic surgeon. He subsequently underwent authorized right cubital tunnel release surgery on July 31, 2014 by Dr. Angela A. Wang, a Board-certified orthopedic surgeon. Appellant stopped work and OWCP paid him wage-loss compensation for total disability until he returned to full-time modified-duty work on August 18, 2014.

Appellant subsequently underwent an authorized left cubital tunnel release surgery on September 25, 2014 and an authorized left carpal tunnel release on May 7, 2015 by Dr. Wang. He stopped work and returned to full duty on July 7, 2015.

OWCP received a June 20, 2016 impairment rating report by Dr. Michael M. Hess,² an orthopedic surgeon. Dr. Hess reviewed appellant's history and noted that he underwent bilateral ulnar nerve release and bilateral carpal tunnel release surgeries. Upon physical examination of appellant's right elbow, he observed positive Tinel's sign over the right elbow and negative Tinel's sign over the right wrist. Dr. Hess reported that sensory testing on the right demonstrated two point discrimination in the median and ulnar nerve distribution. Examination of appellant's left elbow and wrist showed negative Tinel's sign. Dr. Hess referenced Table 15-23 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)³ and opined that appellant sustained five percent permanent impairment of the upper extremity for ulnar nerve impairment. He explained that according to page 450 of the A.M.A., *Guides*, involving multiple nerve entrapments, appellant's ulnar nerve had the highest impairment value for all diagnosed conditions. Dr. Hess combined the 5 percent impairment with 50 percent of appellant's carpal tunnel impairment (3 percent permanent impairment), which resulted in 1.5 percent permanent impairment, for a combined 6.5 percent permanent impairment of each upper extremity.

On October 24, 2016 appellant filed a claim for a schedule award (Form CA-7).

In a letter dated November 8, 2016, OWCP informed appellant that it had received an impairment rating report from his physician and would forward the report to an OWCP district medical adviser (DMA) for review. Appellant was afforded 30 days to submit additional documentation that he wanted reviewed in consideration of his schedule award claim.

² The record reveals that Dr. Hess had previously examined appellant on December 8, 2014. In a report of the same date, Dr. Hess provided a history of appellant's injury and physical examination findings. He related that it was too early to determine a date of maximum medical improvement (MMI) for appellant's cubital tunnel symptoms because his surgery had occurred less than six months prior.

³ A.M.A., *Guides* (6th ed. 2009).

On April 28, 2017 OWCP routed Dr. Hess' June 20, 2016 report, a statement of accepted facts (SOAF), and the case file to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA, for review and determination regarding whether appellant sustained permanent impairment of his bilateral upper extremities and the proper date of MMI.

In an April 29, 2017 report, the DMA noted appellant's accepted conditions and reviewed his history, noting appellant's previous surgeries. He reviewed Dr. Hess' June 20, 2016 report and noted that his physical examination findings revealed diminished sensation in the bilateral ulnar and median nerve distribution. The DMA agreed with Dr. Hess' finding that appellant sustained 6.5 percent permanent impairment of each upper extremity and provided a date of MMI of June 20, 2016, the date of Dr. Hess' examination.

Regarding appellant's right upper extremity, the DMA referenced Table 15-23, page 449, and indicated that appellant sustained five percent permanent impairment (grade modifier 2B) for residual problems with moderate cubital tunnel symptoms status post cubital tunnel surgery. He opined that appellant sustained three percent permanent impairment (grade modifier 1D) for residual problems with mild carpal tunnel symptoms status post carpal tunnel release. The DMA explained that in patients with multiple compression neuropathies, the second or smaller nerve impairment was rated at 50 percent of the impairment listed in Table 15-23, page 449. He assigned 1.5 percent permanent impairment for appellant's right carpal tunnel symptoms, which he rounded up to 2 percent permanent impairment. Utilizing the Combined Values Chart, the DMA calculated that appellant had a combined of seven percent permanent impairment of the right upper extremity.

Regarding appellant's left upper extremity, the DMA assigned the same impairment rating of five percent (grade modifier 2B) for residual problems with moderate cubital tunnel symptoms and three percent impairment (grade modifier 1D) for residual problems with mild carpal tunnel symptoms status post carpal tunnel release. He calculated that 50 percent of the smaller nerve impairment (3 percent) resulted in 1.5 percent permanent impairment, which he rounded up to 2 percent, finding 7 percent permanent impairment of the left upper extremity.

The DMA concluded that appellant had seven percent permanent impairment of each upper extremity.

On June 22, 2017 OWCP granted appellant a schedule award of seven percent permanent impairment for each upper extremity. The period of the award ran for 43.68 weeks from June 20, 2016 to April 21, 2017. OWCP found that the schedule award was based on Dr. Hess' June 20, 2016 report and the DMA's April 29, 2017 report.

LEGAL PRECEDENT

The schedule award provisions of FECA⁴ 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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For

⁴ *Supra* note 1.

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.⁵ For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.⁶

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).⁷ Under the sixth edition, the evaluator identifies the impairment for the class of diagnosis condition (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).⁸ Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnosis from regional grids and calculations of modifier scores.⁹

However, permanent impairment due to carpal tunnel and cubital tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text in section 15.4f of the A.M.A., *Guides*.¹⁰ In Table 15-23, grade modifier levels (ranging from zero to four) are described for the categories of 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 based on functional scale, an assessment of impact on daily living activities.¹¹

OWCP's procedures provide that, if a claimant's physician provides an impairment rating, the case should be routed to a DMA 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.¹²

⁵ 20 C.F.R. § 10.404 (1999); *see also* *Jacqueline S. Harris*, 54 ECAB 139 (2002).

⁶ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.806.6.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

⁷ A.M.A., *Guides* 3, section 1.3 (6th ed. 2009).

⁸ *Id.* at 385-419.

⁹ *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

¹⁰ *Supra* note 7 at 449.

¹¹ *Id.* at 448-49.

¹² *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(e) (February 2013); *Tommy R. Martin*, 56 ECAB 273 (2005).

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than seven percent permanent impairment of each upper extremity, for which he previously received schedule award compensation.

In support of his claim, appellant submitted a June 20, 2016 impairment rating report by Dr. Hess in which he found a combined 6.5 percent permanent impairment of each upper extremity. Thereafter, OWCP properly routed the report of Dr. Hess to a DMA. In an April 29, 2017 report, Dr. Harris, the DMA, reviewed Dr. Hess' June 20, 2016 impairment report and agreed with his finding that appellant had 7 percent permanent impairment of both upper extremities. He noted a date of MMI of June 20, 2016, when appellant was examined by Dr. Hess. In calculating permanent impairment, the DMA utilized Table 15-23, page 449, of the A.M.A., *Guides* and indicated that appellant had five percent permanent impairment (grade modifier of 2B) for residual problems with moderate cubital tunnel symptoms status post cubital tunnel surgery. He assigned three percent permanent impairment (grade modifier of 1D) for residual problems with mild carpal tunnel symptoms status post carpal tunnel release. The DMA calculated that according to page 450 of the A.M.A., *Guides* for multiple compression neuropathies, appellant had 1.5 percent impairment (50 percent of 3 percent impairment) for his carpal tunnel symptoms. Utilizing the Combined Values Chart, he calculated that appellant had a total of 6.5 percent, which he rounded to 7 percent permanent impairment of the right upper extremity.

Regarding appellant's left upper extremity, the DMA assigned the same impairment rating of five percent (grade modifier of 2B) for residual problems with moderate cubital tunnel symptoms and three percent impairment (grade modifier of 1D) for residual problems with mild carpal tunnel symptoms status post carpal tunnel release. He calculated that 50 percent of the smaller nerve impairment (3 percent) resulted in 1.5 percent permanent impairment, which he rounded to 2 percent. The DMA indicated that appellant had seven percent permanent impairment of the left upper extremity.

OWCP granted appellant's schedule award based on the opinions of his treating physician Dr. Hess and the DMA. There is no current medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, showing a greater percentage of permanent impairment. As appellant bears the burden of proof to establishment entitlement to an additional schedule award, he was required to submit rationalized medical evidence on which an additional award could be based. He has not done so for his claim. Therefore, the Board finds that appellant has not met his burden of proof to establish more than seven percent permanent impairment of each upper extremity.

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 his burden of proof to establish more than seven percent permanent impairment of each upper extremity, for which he previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the June 22, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 21, 2019
Washington, DC

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

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board