United States Department of Labor
Employees' Compensation Appeals Board

D.S., Appellant	)	
and	)	**Docket No. 18-1816**
	)	**Issued: June 20, 2019**
U.S. POSTAL SERVICE, POST OFFICE, San Diego, CA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 28, 2018 appellant, through counsel, filed a timely appeal from a July 31, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met her burden of proof to establish that she sustained more than 10 percent permanent impairment of each upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On February 17, 1998 appellant, then a 34-year-old letter carrier, filed a notice of occupational disease (Form CA-2), alleging that she sustained a "knuckle/index finger" injury due to factors of her federal employment, including delivering mail and operating her vehicle ignition and door locks. OWCP accepted the claim for bilateral tendinitis and bilateral carpal tunnel syndrome. It also authorized right carpal tunnel release surgery, which appellant underwent on April 19, 1999 and left carpal tunnel release surgery, which she underwent on May 5, 1999.[3]

By decision dated February 15, 2000, OWCP granted appellant a schedule award for 10 percent permanent impairment of each upper extremity. The award ran for 62.40 weeks for the period November 22, 1999 to February 1, 2001.[4]

On November 5, 2015 appellant filed a claim (Form CA-7) for an increased schedule award.

In a September 23, 2015 report, Dr. Mesfin Seyoum, a family medicine specialist, conducted an impairment rating evaluation. His physical examination found that appellant's right wrist palpation revealed mild tenderness palpable in the wrist and there was full right wrist range of motion (ROM) with her reporting right wrist pan at the end range. The Tinel's sign and Phalen's testing were positive in the right wrist/hand. Examination of the left wrist demonstrated evidence of a well-healed keloid scar, palpation revealed tenderness palpable in the left wrist, and there was full left wrist ROM with appellant reporting left wrist pain at the end range. The Tinel's sign and Phalen's testing were positive in the left wrist/hand. Thumb and index trigger fingers with slight tenderness were noted, bilaterally. Sensory examination showed decreased sensation in the distribution patterns of the median nerve in the hands, bilaterally. Motor strength examination revealed slightly reduced muscle strength in the fingers. Deep tendon reflexes were 2+/4 in the upper extremities. Dr. Seyoum concluded that appellant had reached maximum medical improvement (MMI) as of the date of his examination. Utilizing Table 15-23, page 449, the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*

[3] Appellant had a claim that was previously accepted for left trigger thumb (acquired) under OWCP File No. xxxxxx622. OWCP doubled the claims and then authorized a left median nerve decompression at the wrist, which appellant underwent on January 29, 2003.

[4] In a decision dated September 18, 2002, OWCP terminated appellant's compensation because she had been reemployed as a modified city carrier effective May 29, 1999 with wages of $710.83 per week, which exceeded the wages of her date-of-injury position, and fairly and reasonably represented her wage-earning capacity. By decision dated September 16, 2009, OWCP denied appellant's claim for wage-loss compensation for the period July 29 to September 2, 2009 because the medical evidence failed to establish disability for the period claimed. By decision dated August 13, 2010, it accepted that she had sustained a recurrence of total disability on July 29, 2009 due to her accepted right carpal tunnel syndrome condition and determined that she was entitled to compensation for the period July 29 to September 9, 2009.

(A.M.A., *Guides*), he found that appellant had five percent permanent impairment based on her right carpal tunnel syndrome with a grade modifier of 2 for physical examination (GMPE) due to her decreased sensation in the right hand, a grade modifier of 2 for functional history (GMFH) due to her reported intermittent significant symptoms in the right wrist/hand, and a grade modifier of 2 for clinical studies (GMCS) due to her positive nerve testing for right carpal tunnel syndrome. Dr. Seyoum noted that appellant had a *Quick*DASH score of 50, which corresponded to moderate functional impairment and did not change the final impairment rating. He calculated that she had a default of five percent permanent impairment of the right upper extremity for her right carpal tunnel syndrome. Dr. Seyoum further found that appellant had five percent permanent impairment based on her left carpal tunnel syndrome with a grade modifier of 2 for physical examination (GMPE) due to her decreased sensation in the left hand, a grade modifier of 2 for functional history (GMFH) due to her reported intermittent significant symptoms in the left wrist/hand, and a grade modifier of 2 for clinical studies (GMCS) due to her positive nerve testing for left carpal tunnel syndrome. He noted that she had a *Quick*DASH score of 50, which corresponded to moderate functional impairment and did not change the final impairment rating. Dr. Seyoum calculated that appellant had a default of five percent permanent impairment of the left upper extremity for her left carpal tunnel syndrome. He opined that she had six percent permanent impairment of the bilateral upper extremities due to her bilateral trigger thumb condition based on Table 15-2, page 392, of the A.M.A., *Guides*. Dr. Seyoum found that appellant's most impairing diagnosis was trigger thumb, status post trigger finger release, and assigned a grade modifier of 2 for functional history (GMFH) based on Table 15-7, page 406, grade modifier of 1 for physical examination (GMPE) due to slight palpatory findings, and found that a grade modifier for clinical studies (GMCS) was not applicable since there were no clinical studies of the thumb for review. He concluded that she had a net adjustment of +1, which equated to six percent permanent impairment of the bilateral upper extremities based on her bilateral trigger thumb condition. Regarding appellant's bilateral index trigger finger condition, Dr. Seyoum opined that she had six percent permanent impairment based on Table 15-2, page 392, due to trigger index finger, status post trigger finger release. He assigned a grade modifier of 2 for functional history (GMFH) based on Table 15-7, page 406, a grade modifier of 1 for physical examination (GMPE) due to slight palpatory findings, and found that a grade modifier for clinical studies (GMCS) was not applicable since there were no clinical studies of the index finger for review. Dr. Seyoum calculated that appellant had a net adjustment of +1 and therefore the index finger impairment would be one grade higher, which was seven percent and corresponded to one percent permanent impairment of the upper extremity. He concluded that she had a total of two percent permanent impairment of the bilateral upper extremities for her bilateral index finger impairment. Dr. Seyoum calculated that appellant had a total combined 17 percent permanent impairment of the bilateral upper extremities due to her right carpal tunnel, left carpal tunnel, bilateral thumb trigger finger, and bilateral index trigger finger conditions.

On May 1, 2016 Dr. Herbert White Jr., an OWCP district medical adviser (DMA) and Board-certified internist and occupational medicine specialist, reviewed the medical evidence of record and determined that appellant's date of MMI was the date of Dr. Seyoum's impairment examination. He found, however, that Dr. Seyoum opined that appellant had impairment from her bilateral thumb and index trigger finger releases, he did not conclude that these resulted in any impairment. Dr. White found that appellant's most impairing diagnosis was entrapment/ compression neuropathy of the right and left median nerve based on Table 15-23, page 449, of the A.M.A., *Guides* and he assigned a grade modifier of 0 for clinical studies (GMCS) because the test findings were normal, a grade modifier of 2 for functional history (GMFH) due to significant

intermittent symptoms, and a grade modifier of 3 for physical examination (GMPE) due to weakness. He concurred that appellant's *Quick*DASH score of 50 did not change the impairment rating. Dr. White calculated that the average grade modifier was 2, which equated to a default impairment rating of five percent permanent impairment of the right and left upper extremity based on her right and left entrapment/compression neuropathy conditions. Regarding appellant's impairment due to her bilateral trigger thumb and bilateral trigger index finger conditions, Dr. White found that Dr. Seyoum had indicated that appellant had slight tenderness in the thumbs and index fingers, but he did not document any triggering. He asserted that in order to be put in a class 1 diagnosis, triggering needed to be present. Dr. White further found that the previous examinations of record failed to indicate thumb tenderness being present and concluded that Dr. Seyoum's findings of tenderness in the thumbs and index fingers were inconsistent with the medical record and would, therefore, be excluded from the ratings process. He concluded that without the physical finding of triggering, appellant had zero percent permanent impairment of the bilateral upper extremities due to her bilateral trigger finger conditions in the thumb and index finger. Using the Combined Values Chart, Dr. White concluded that appellant had 10 percent permanent impairment of the bilateral upper extremities based on her bilateral carpal tunnel syndrome condition.

By development letter dated March 1, 2017, OWCP requested a supplemental report from Dr. Seyoum in response to the opinion of the DMA, Dr. White, regarding appellant's impairment rating and afforded him 30 days for submission.

In response, Dr. Seyoum submitted a report dated March 8, 2017 indicating that he did not fully agree with Dr. White's opinion. He argued that his findings of slight tenderness clearly documented that triggering was present and that was why "trigger" was used to describe appellant's conditions. Dr. Seyoum clarified that appellant did have triggering present upon examination and that was why it was documented.

In an amended report dated August 21, 2017, Dr. White reviewed Dr. Seyoum's supplemental report and concurred with his findings of triggering. He recalculated appellant's impairment rating and concurred again with Dr. Seyoum's determinations of seven percent permanent impairment of the left and right upper extremity due to her right trigger thumb condition, which converted to three percent permanent impairment of the left and right upper extremities. Regarding appellant's bilateral trigger index finger condition, however, Dr. White found that Dr. Seyoum did not exclude the GMFH as indicated on page 406, which states that this should be excluded because it was already used to determine to rate the highest diagnosis-based impairment (DBI) in the extremity. He calculated that excluding the GMFH resulted in six percent permanent impairment, which converted to one percent permanent impairment of the right and left upper extremities. Using the Combined Values Chart, Dr. White concluded that appellant had a total of nine percent permanent impairment of each extremity (five percent for bilateral carpal tunnel syndrome, three percent for bilateral trigger thumb, and one percent for bilateral trigger index finger). The DMA noted that appellant had previously received a schedule award for 10 percent permanent impairment of each upper extremity and no additional impairment had been incurred.

By decision dated November 1, 2017, OWCP denied appellant's claim for an increased schedule award because the medical evidence of record failed to establish that she had sustained

more than 10 percent permanent impairment of the right upper extremity or 10 percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

On November 8, 2017 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review and submitted a brief in support of appellant's claim.

A telephonic hearing was held before an OWCP hearing representative on May 16, 2018. Appellant provided testimony and the hearing representative held the case record open for 30 days for the submission of additional evidence.

Counsel subsequently resubmitted his brief arguing that the medical evidence of record was sufficient to establish appellant's entitlement to an increased schedule award and that the proper edition of the A.M.A., *Guides* was not used in this case.

By decision dated July 31, 2018, OWCP's hearing representative affirmed the prior schedule award decision finding that the sixth edition of the A.M.A., *Guides* was properly utilized in appellant's case and the medical evidence was insufficient to establish a rating higher than nine percent permanent impairment of the right upper extremity and nine percent permanent impairment of left upper extremity. As appellant had previously received a schedule award based upon 10 percent permanent impairment of the right and left upper extremity, there was no basis to increase the schedule award.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the OWCP. For 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.[6] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[7]

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).[8] Under the sixth edition, the evaluator identifies the impairment class for the

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

[6] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000). *See also* 5 U.S.C. § 8107.

[7] *D.T.*, Docket No. 12-0503 (issued August 21, 2012); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] A.M.A., *Guides* (6th ed., 2009), p.3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

diagnosed condition (CDX), which is then adjusted by GMFH, GMPE, and GMCS.[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[10]

Regarding the application of ROM or DBI methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.* (Emphasis in the original.)"[11]

The Bulletin further advises that if the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.[12]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than 10 percent permanent impairment of each upper extremity, for which she previously received a schedule award.

OWCP accepted that appellant developed bilateral carpal tunnel syndrome, bilateral tendinitis, and left trigger thumb due to factors of her federal employment. It authorized surgeries and granted her a schedule award for 10 percent permanent impairment of the right upper extremity and 10 percent permanent impairment of the left upper extremity. It is appellant's burden to submit sufficient evidence to establish the extent of permanent impairment.[13]

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

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

[11] *Supra* note 8 at 475, Table 15-34.

[12] *Id.*

[13] *Annette M. Dent*, 44 ECAB 403 (1993).

In a report, Dr. Seyoum indicated that appellant reached MMI on September 23, 2015. He conducted a physical examination and based on his findings, he opined that when utilizing Table 15-23, page 449, the sixth edition of the A.M.A., *Guides*, appellant had nine percent permanent impairment of each upper extremity.[14]

In accordance with its procedures, OWCP properly referred the evidence of record to its DMA, Dr. White, who agreed that appellant's date of MMI was September 23, 2015. Dr. White reviewed Dr. Seyoum's reports and determinations of seven percent permanent impairment of the left and right upper extremity due to her right trigger thumb condition, which converted to three percent permanent impairment of the left and right upper extremities. Regarding appellant's bilateral trigger index finger condition, however, Dr. White found that Dr. Seyoum did not exclude the GMFH as indicated on page 406, as it was already used to determine to rate the highest DBI in the extremity. He calculated that excluding the GMFH resulted in six percent permanent impairment, which still converted to one percent permanent impairment of the right and left upper extremities. Based on these calculations, Dr. White concluded that appellant had a total of nine percent permanent impairment of the right upper extremity and nine percent permanent impairment of the left upper extremity (five percent for bilateral carpal tunnel syndrome, three percent for bilateral trigger thumb, and one percent for bilateral trigger index finger). Nonetheless, the DMA found that appellant had previously received a schedule award for 10 percent permanent impairment of the right upper extremity and 10 percent permanent impairment of the left upper extremity and no additional impairment had been incurred.

The Board finds that the DMA discussed how he arrived at his conclusion by listing appropriate tables and pages in the A.M.A., *Guides*, establishing that appellant sustained nine percent permanent impairment of the right upper extremity and nine percent permanent impairment of the left upper extremity. His opinion represents the weight of the medical evidence and establishes that appellant does not have greater than 10 percent permanent impairment of each upper extremity previously awarded. Thus, the Board finds appellant has not met her burden of proof to establish that she is entitled to an additional schedule award.

The Board further finds that there is no current medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has more than 10 percent permanent impairment of the right upper extremity and 10 percent permanent impairment of the left upper extremity. Accordingly, appellant has not established entitlement to a schedule award greater than that previously awarded.[15]

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.

[14] The Board notes that, while Dr. Seyoum's indicated that appellant has a total combined permanent impairment rating of 17 percent, his calculations total 18 percent permanent impairment of the bilateral upper extremities.

[15] FECA provides for reduction of compensation for subsequent injury to the same body member. It provides that schedule award compensation is reduced by the compensation paid for an earlier injury where the compensation in both cases are for impairment of the same member or function and where it is determined that the compensation for the later disability in whole or part would duplicate the compensation payable for the preexisting disability. 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she sustained more than 10 percent permanent impairment of each upper extremity, for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the July 31, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 20, 2019
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board