United States Department of Labor
Employees' Compensation Appeals Board

J.M., Appellant	)	
	)	
and	)	**Docket No. 18-1334**
	)	**Issued: March 7, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Springfield, MO, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 26, 2018 appellant filed a timely appeal from a June 14, 2018 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 met his burden of proof to establish more than eight percent permanent impairment of his left upper extremity for which he has previously received a schedule award.

FACTUAL HISTORY

On September 14, 2015 appellant, then a 61-year-old mail processing clerk, filed an occupational disease claim (Form CA-2) alleging that he sustained an aggravation of his

[1] 5 U.S.C. § 8101 *et seq.*

preexisting left carpal tunnel syndrome while in the performance of his federal employment duties. On April 27, 2016 OWCP accepted the claim for left carpal tunnel syndrome.[2]

On May 13, 2011 appellant underwent nerve conduction velocity testing which demonstrated bilateral trans carpal median neuropathies, greater on the right side.

In a report dated August 19, 2015, Dr. Victoria D. Kubik, a Board-certified orthopedic surgeon, recommended left carpal tunnel surgical intervention. On August 19, 2015 she performed left carpal tunnel release, left wrist ulnar nerve release, and left radial tunnel and extensor carpi radialis brevis releases. Dr. Kubik found compression of the ulnar nerve at the Guyon's canal, left upper extremity radial tunnel, recurrent carpal tunnel, and lateral epicondylitis.

Dr. Kubik, in a February 23, 2016 report, summarized appellant's medical history and treatment for his carpal tunnel condition and tendinitis. Following the August 19, 2015 surgery appellant reported tingling numbness, and some forearm pain, but overall significant improvement. Dr. Kubik released him as his symptoms significantly improved following the August 19, 2015 surgery.

In a May 3, 2016 report, Dr. Kubik opined that appellant had reached maximum medical improvement (MMI) and was status post ulnar nerve through Guyon's canal, left carpal tunnel release, and left radial tunnel release with extensor carpi radialis brevis tendon release.

In a letter dated June 4, 2016, appellant filed a claim for a schedule award (Form CA-7).

By development letter dated June 16, 2016, OWCP informed appellant that additional medical evidence was necessary to establish his schedule award claim. It advised him to submit a report from his treating physician which evaluated his permanent impairment pursuant to the sixth edition of the American Medical Association *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] OWCP afforded him 30 days to submit the necessary evidence.

Appellant subsequently submitted a report dated June 21, 2016, wherein Dr. Kubik indicated that she did not perform permanent impairment ratings.

OWCP forwarded Dr. Kubik's reports of record to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA). In a November 2, 2016 report, Dr. Katz reviewed the medical evidence of record and found that it lacked sufficient detail for a permanent impairment determination. He recommended that a second opinion physician who is familiar with the sixth edition of the A.M.A., *Guides* examine and rate appellant's permanent impairment.

On February 13, 2017 OWCP referred appellant for a second opinion evaluation with Dr. Michael S. Clarke, a Board-certified orthopedic surgeon. In a February 22, 2017 report,

[2] Under OWCP File No. xxxxxx371, OWCP had accepted appellant's March 14, 2003 claim for bilateral carpal tunnel syndrome and on June 5, 2006 granted a schedule award for an eight percent permanent impairment of his left upper extremity.

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

Dr. Clarke, reviewed the medical record, a statement of accepted facts (SOAF), and a list of questions regarding appellant's permanent impairment. He related appellant's complaints of left fingertip numbness of his four lateral fingers and grip weakness. Appellant's physical examination revealed no decreased medical nerve sensation, an equivocal Phalen's test, positive reverse Phalen's test, negative Froment's and Finkelstein's tests, negative carpal tunnel Tinel's sign, and no old sensitivity. Dr. Clarke attributed appellant's persistent lateral elbow pain to lateral epicondylitis, which he advised could be treated by injections. He provided an impairment rating utilizing Table 15-23, Entrapment/Compression neuropathy of the A.M.A., *Guides*.[4] Dr. Clarke noted that the diagnosis of carpal tunnel syndrome had been confirmed prior to his two carpal tunnel release surgeries. He concluded that test findings of reduced conduction delay resulted in a grade modifier of 1.[5] Dr. Clarke noted that appellant's complaints of numbness and pain resulted in a grade modifier of 1 for history. He found that his physical findings of decreased sensation resulted in a grade modifier of 2 for physical findings. Dr. Clarke averaged these grade modifiers and found that the appropriate grade modifier was 1.33, which he rounded down to 1. He then proceeded to modify the default impairment for Grade 2 based on the functional scale grade. Dr. Clarke found that appellant's *Quick*DASH score was 43, which equaled a moderate grade. Dr. Moore concluded that appellant had a total of three percent permanent impairment of the left upper extremity.

On April 22, 2017 Dr. Katz reviewed Dr. Clarke's February 22, 2017 report and concurred with his finding of three percent left upper extremity permanent impairment. In a supplemental report dated April 27, 2017, he reviewed additional information under OWCP File No. xxxxxx371, along with Dr. Clarke's February 22, 2017 report. Dr. Katz noted that appellant had previously been granted a schedule award for eight percent left upper extremity permanent impairment based on a May 10, 2006 DMA report under OWCP File No. xxxxxx371. He again concurred with Dr. Clarke that appellant currently had three percent permanent impairment of the left upper extremity.

By decision dated June 14, 2018, OWCP denied appellant's claim for an additional schedule award. It found that he had not established more than the eight percent left upper extremity permanent impairment previously awarded under OWCP File No. xxxxxx371.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing regulations[7] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions 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 discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that

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

[5] *Id.*

[6] *Supra* note 1.

[7] 20 C.F.R. § 10.404.

there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[8] 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.[9] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related impairment, preexisting impairments are to be included.[10]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[11] In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories 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.[12]

OWCP's 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.[13]

ANALYSIS

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

The Board notes that on June 5, 2006, OWCP granted appellant a schedule award for eight percent permanent impairment of the left upper extremity due to his accepted left carpal tunnel syndrome under OWCP File No. xxxxxx371.[14]

In support of his current claim appellant submitted reports dated February 23 and May 3, 2016 from Dr. Kubik. Dr. Kubik noted that appellant was released from her care in the

[8] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides is used*. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[9] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[10] *P.R., id.*; *Carol A. Smart*, 57 ECAB 340 (2006).

[11] A.M.A., *Guides* 449, Table 15-23; 449. *See also L.G.*, Docket No. 18-0065 (issued June 11, 2018).

[12] *Id.* at 448-49.

[13] *See supra* note 8 at Chapter 2.808.6(d) (March 2017).

[14] *See supra* note 2.

February 22, 2016 report and indicated that he had reached MMI. She indicated that she did not perform permanent impairment ratings.

In his February 22, 2017 second opinion report, Dr. Clarke, a Board-certified orthopedic surgeon, calculated three percent permanent impairment of the left upper extremity for appellant's accepted left carpal tunnel syndrome under the A.M.A., *Guides* using the formula set forth above.

Dr. Clarke provided clinical findings and explained how those objective elements warranted the percentages assessed.

OWCP's DMA, Dr. Katz, concurred with Dr. Clarke's three percent left upper permanent impairment rating and methodology.

The Board finds that OWCP properly found the impairment ratings by Dr. Clarke and Dr. Katz constituted the weight of the medical evidence. Dr. Clarke's opinion was based on an accurate SOAF and the complete medical record. He provided a thorough impairment rating, utilizing the appropriate portions of the A.M.A., *Guides*. Dr. Clarke 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 eight percent permanent impairment of his left upper extremity previously awarded due to his accepted left upper extremity carpal tunnel syndrome under OWCP File No xxxxxx371. Thus, appellant has not met his burden of proof.[15]

On appeal appellant disagrees with OWCP's impairment rating and contends that OWCP failed to properly review his claim. As set forth above, the Board has found that the opinion of Dr. Clarke constituted the weight of the evidence. Appellant further asserts that OWCP failed to timely process his schedule award claim. The Board finds that there is no evidence of record establishing a delay in the processing and adjudication of the schedule award claim.

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 eight percent permanent impairment of his left upper extremity, for which he has previously received a schedule award.

[15] OWCP should consider combining OWCP File Nos. xxxxxx533 and xxxxxx371. It's procedures provide that cases should be combined when correct adjudication of the issue(s) depends on frequent cross-reference between files. *Supra* note 8 at Part 2 -- Claims, *File Maintenance & Management*, Chapter 2.400.8(c) (February 2000).

ORDER

IT IS HEREBY ORDERED THAT the June 14, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 7, 2019
Washington, DC

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

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

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