United States Department of Labor
Employees' Compensation Appeals Board

H.K., Appellant	)	
and	)	**Docket No. 18-0528**
	)	**Issued: November 1, 2019**
NATIONAL ARCHIVES & RECORDS ADMINISTRATION, FEDERAL RECORDS CENTER, Suitland, MD, 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:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On January 18, 2018 appellant, through counsel, filed a timely appeal from an October 6, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider 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 his burden of proof to establish greater than one percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On February 27, 2012 appellant, then a 47-year-old motor vehicle operator, filed an occupational disease claim (Form CA-2) alleging that he developed carpal tunnel syndrome and a cervical disc condition as a result of repetitive motion of driving and lifting boxes required by factors of his federal employment. By decision dated June 21, 2012, OWCP accepted his claim for cervicalgia, cervical spondylosis without myelopathy, and left carpal tunnel syndrome. It authorized a left carpal tunnel release that was performed on January 23, 2013. Appellant did not stop work.

Reports from Dr. Adam Ellison, a Board-certified orthopedist, dated from March 30, 2012 to January 17, 2013, noted treatment for neck, low back, and wrist pain. He noted performing injections at the left wrist, low back, and bilateral shoulders. Dr. Ellison diagnosed cervical pain, cervical spondylosis without myelopathy, left wrist pain, and right carpal tunnel syndrome. On January 23, 2013 he performed a release of the left carpal tunnel and diagnosed left carpal tunnel syndrome.

On March 13, 2013 appellant filed a claim for a schedule award (Form CA-7).

In a June 5, 2013 development letter, OWCP requested that appellant submit a detailed report from his treating physician which provided an impairment evaluation pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] Appellant was afforded 30 days to respond.

Dr. Ellison treated appellant in follow up on July 15, 2013 status post carpal tunnel release on the left side. He noted appellant's symptoms of numbness and tingling down his left arm. On January 16, 2014 Dr. Ellison advised that status post one year from the left carpal tunnel release appellant still experienced middle finger pain with numbness and was referred for therapy.

On March 1, 2014 OWCP referred appellant to Dr. D. Burke Haskins, a Board-certified orthopedic surgeon, for a second opinion evaluation of appellant's permanent impairment under the A.M.A., *Guides*. In a report dated April 1, 2014, Dr. Haskins noted his review of a statement of accepted facts (SOAF) along with the medical record and case history. He noted full range of motion (ROM) to flexion and extension of the cervical spine, Spurling sign was negative, and there was no atrophy or deformity in the shoulder musculature. Inspection of the left wrist revealed a well-healed surgical scar in the transverse carpal ligament, no atrophy or deformity of the left hand, strong distal pulses, Phalen sign produced shoulder pain and Tinel sign of the left wrist was negative, two-point discrimination was intact in the left hand, but diminished to one point discrimination at about the volar aspect left third finger proximal and middle phalanges.

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

Dr. Haskins diagnosed carpal tunnel syndrome established by abnormal conduction studies, cervical spondylosis, and disc disease established by imaging studies. He noted that appellant reached maximum medical improvement (MMI). Utilizing *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) Dr. Haskins cited Proposed Table 2, Spinal Nerve Impairment, Upper Extremity and found that appellant was a class zero impairment for his accepted cervical spine conditions, which resulted in zero percent permanent impairment.

With regard to peripheral nerve impairment, utilizing the A.M.A., *Guides*, Dr. Haskins noted a grade 1 class of diagnosis (CDX) due to carpal tunnel syndrome. Referring to Table 15-23,[4] he assessed a grade modifier of 1 for clinical studies (GMCS) for conduction delay, a grade modifier of 1 for functional history (GMFH), and a grade modifier of 2 for findings on physical examination (GMPE). Applying the net adjustment formula of (GMFH - CDX) + (GMPE – CDX) + (GMCS - CDX), he found an average modifier of 1.33, rounded down to 1, which equates to a default permanent impairment of two percent. Utilizing the functional scale which was normal (0-20) with a grade modifier of zero, shifted the impairment to the left for a total one percent impairment to the upper extremity according to the A.M.A., *Guides*.

In a report dated May 8, 2014, Dr. Lawrence A. Manning, an orthopedic surgeon serving as an OWCP district medical adviser (DMA), concurred with Dr. Haskins' determination as to permanent impairment. He concluded that pursuant to the A.M.A., *Guides* appellant had one percent impairment of the left upper extremity.

By decision dated May 23, 2014, OWCP granted appellant a schedule award for one percent permanent impairment of his left upper extremity. The period of the award ran for 3.12 weeks from January 23 through February 13, 2014.

On June 3, 2014 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative. The hearing was held on January 14, 2015.

Appellant submitted a February 4, 2015 report from Dr. Allan H. Macht, a Board-certified orthopedist. Dr. Macht noted the history of injury and treatment. He diagnosed status post left carpal tunnel release. Dr. Macht noting findings on examination of moderate weakness of left hand grip strength using a Jaymar dyanometer, maximum strength on the left was 5 kilograms and the right was 45 kilograms, which was repeated at least three times for accuracy. He noted decreased sensation to light touch about his left thumb, index, and little fingers and sensation was intact to two-point discrimination. Utilizing the A.M.A., *Guides*, Dr. Macht found six percent impairment of appellant's left upper extremity due to carpal tunnel syndrome based on Table 15-23, on page 449. He calculated a GMCS of 1 (based on an electromyogram study dated March 16, 2012), appellant had mild bilateral carpal tunnel syndrome affecting both sensory and motor components; GMFH of 2 for significant intermittent symptoms with a *Quick*Dash score of 76 out of 100, and a GMPE of 3. Dr. Macht opined that the average of test findings, history, and physical findings was a grade modifier 2. However, since a *Quick*DASH score was higher, he assigned six percent permanent impairment of the left upper extremity. Dr. Macht determined that appellant had reached MMI on August 31, 2014.

[4] Table 15-23, page 449 of the A.M.A., *Guides* is entitled "Entrapment/Compression Neuropathy Impairment."

By decision dated March 11, 2015, the hearing representative set aside the May 23, 2014 decision and remanded the matter for further medical development. He instructed OWCP to refer the medical record to a DMA for an updated report addressing whether the physical examination findings by Dr. Macht altered his prior opinion regarding permanent impairment.

OWCP referred appellant's case record to Dr. Arnold T. Berman, a Board-certified orthopedic surgeon serving as a DMA, who reviewed the medical record and a SOAF and indicated that there was a clear discrepancy between physical examination findings in the record. The DMA opined that Dr. Haskins' examination was more detailed, had greater accuracy and specificity, and was more consistent with the electrodiagnostic testing results than Dr. Macht's report. He also indicated that Dr. Haskins was a Board-certified orthopedic surgeon. The DMA concurred with the findings of Dr. Haskins that appellant sustained one percent permanent impairment of the left upper extremity.

By decision dated July 9, 2015, OWCP denied appellant's request for an increased schedule award.

On July 20, 2015 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative.

By decision dated February 5, 2016, an OWCP hearing representative set aside the decision dated July 9, 2015 and remanded the case for further medical development as she had determined that there was a conflict of opinion between Dr. Macht, appellant's treating physician and Dr. Haskins, the second opinion physician.

On April 27, 2016 OWCP referred appellant to Dr. Robert F. Draper, Jr., a Board-certified orthopedic surgeon selected to act as a referee physician. Dr. Draper indicated, in a June 17, 2016 report, that he reviewed the record and examined appellant. He noted that appellant had reached MMI on January 3, 2014 one year from the carpal tunnel release surgery. Physical examination of the cervical spine revealed limited ROM, negative Spurling's sign, intact motor function, grip strength and reflexes of the bilateral upper extremities, and normal light touch sensation at dermatomes C2-C8, and T1. Examination of the left wrist revealed wrist extension and flexion of 45 degrees, wrist ulnar deviation of 20 degrees, and wrist radial deviation of 10 degrees. Dr. Draper noted a well-healed volar incision over the proximal palmer crease of the left hand, Tinel's sign was negative over the median and ulnar nerve of the left wrist and elbow, there was no thenar of hypothenar atrophy of the left hand, normal light touch sensation was noted over the tips of the left index finger and left little finger, no sensory deficit noted, and grip strength was intact. He concluded that there was no evidence of cervical radiculopathy and therefore it would not be rated. With regard to peripheral nerve impairment of the upper extremity, Dr. Draper noted a CDX of 1 due to carpal tunnel syndrome. Referring to Table 15-23,[5] Entrapment/Compression Neuropathy Impairment, the test findings and conduction delay were most consistent with a GMCS of 1 for test findings. Dr. Draper noted that the history was consistent with mild intermittent symptoms involving the left upper extremity. He noted that the examination of the left hand revealed no sensory deficit on examination, history of paresthesias involving the left hand, and findings consistent with carpal

[5] Table 15-23, page 449 of the sixth edition of the A.M.A., *Guides* is entitled "Entrapment/Compression Neuropathy Impairment."

tunnel syndrome. Dr. Draper noted that appellant had left carpal tunnel release and the sensory deficit did not manifest itself during examination. He opined that the functional scale was mild, consistent with 1 percent impairment of the left upper extremity. Dr. Draper further opined that all factors in Table 15-23 indicate a grade modifier of 1 was consistent with one percent impairment of the left upper extremity.

By decision dated July 6, 2016, OWCP denied appellant's claim for an increased schedule award.

On July 15, 2016 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative.

By decision dated January 3, 2017, an OWCP hearing representative set aside the July 6, 2016 decision and remanded the case for further medical development. The hearing representative found that, pursuant to the FECA Procedure Manual, cases involving a schedule award must be referred to the medical a DMA for review. As OWCP had not referred Dr. Draper's report to a DMA as procedurally required, the July 6, 2016 decision was set aside and remanded.

In a report dated February 11, 2017, Dr. James W. Butler, Board-certified in occupational and aviation medicine and serving as a DMA, reviewed Dr. Draper's June 17, 2016 report and noted that there was no evidence of residual cervical radicular findings. The DMA noted that appellant had a previous history of left carpal tunnel release with diagnostic test findings consistent with motor and sensory deficit. Pursuant to Table 15-23, page 449 of the A.M.A., *Guides* he assigned grade modifiers and applied the net adjustment formula to find an average grade modifier of .66, which he rounded up to 1. The DMA noted that appellant's functional history using the *Quick*DASH report of Dr. Haskin's was a functional class normal (0-20) for no grade modifier adjustment. He opined that this equaled one percent impairment of the left upper extremity. The DMA concurred with Dr. Draper's independent medical examination report and findings as to permanent impairment. He discounted Dr. Macht's *Quick*DASH report because it was inconsistent with the examination of Drs. Haskin or Draper. Pursuant to the A.M.A., *Guides* if the functional history is inconsistent with the examination it must be discarded.

By decision dated February 23, 2017, OWCP denied appellant's claim for an increased schedule award.

On February 28, 2017 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative. The hearing was held on August 16, 2017.

By decision dated October 6, 2017, an OWCP hearing representative affirmed the decision dated February 23, 2017.

LEGAL PRECEDENT

The schedule award provision of FECA,[6] and its implementing federal regulations,[7] 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 loss of a member shall be determined. The method used in making such a 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 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]

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).[10] Under the sixth edition, the evaluator identifies the CDX, which is then adjusted by grade modifiers of GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[13]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[14] 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

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[6] *Supra* note 2.

[7] 20 C.F.R. § 10.404. By decision dated February 5, 2018, an OWCP hearing representative remanded appellant's schedule award claim of her right upper extremity for further development as to the extent of her permanent impairment under the ROM method of evaluating permanent impairment. Therefore, the issue of the extent of appellant's right upper extremity schedule award is not presently before the Board. *See* 20 C.F.R. § 501.2(c).

[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 id.* 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] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, ICF: A Contemporary Model of Disablement.

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

[12] *Id*. 411.

[13] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[14] *See* A.M.A., *Guides* 449, Table 15-23.

value may be modified up or down by one percent based on Functional Scale, an assessment of impact on daily living activities.[15]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to consultant DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the DMA providing rationale for the percentage of impairment specified.[16]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than one percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

OWCP had determined that there was a conflict in the medical opinion evidence between Dr. Macht, an attending physician, and Dr. Haskins, an OWCP referral physician, on the issue of the extent of appellant's upper extremity permanent impairment due to his accepted conditions. In order to resolve the conflict, it properly referred appellant, pursuant to section 8123(a) of FECA,[17] to Dr. Draper, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on the matter.

In a June 17, 2016 report, Dr. Draper reviewed the medical record and SOAF and provided examination findings. Based on his examination findings he determined that appellant had a CDX of 1 due to carpal tunnel syndrome. Pursuant to Table 15-23, Entrapment/Compression Neuropathy Impairment, the diagnostic test findings were most consistent with a GMCS of 1. Dr. Draper noted that the GMFH was consistent with mild intermittent symptoms involving the left upper extremity for a GMFH of 1. He noted that the examination of the left hand revealed no sensory deficit for a GMPE of zero. Dr. Draper opined that the functional scale was mild, consistent with 1 percent impairment of the left upper extremity. He further opined that all factors in Table 15-23 indicated a grade modifier of 1 consistent with 1 percent impairment of the left upper extremity. Dr. Draper noted that he had not found evidence on physical examination for cervical radiculopathy, there was no impairment rating provided for that condition.

On February 11, 2017 a DMA reviewed Dr. Draper's June 17, 2016 report and concurred in his rationale and determination.

The Board finds that the well-rationalized report by Dr. Draper represents the special weight of the medical evidence with respect to appellant's upper extremity permanent impairment.[18] Dr. Draper applied the appropriate tables and grading schemes of the A.M.A.,

[15] A survey completed by a given claimant, known by the name *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand), may be used to determine the function scale score. A.M.A., *Guides* 448-49.

[16] *See supra* note 8 at Chapter 2.808.6(d) (August 2002).

[17] 5 U.S.C. § 8123.

[18] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

Guides to his findings on examination. His opinion was also based on a thorough clinical examination and an accurate SOAF. Accordingly, OWCP properly accorded determinative weight to Dr. Draper's June 17, 2016 findings.[19] Therefore, the Board finds that OWCP properly denied appellant's claim for an increased schedule award.

On appeal counsel asserts that the conflict in the medical evidence was not resolved with the opinion of Dr. Draper as he did not give deference to the physical findings of the attending physician and because he relied upon stale medical evidence. The Board does not find that these assertions are meritorious and for the reasons set forth above it finds that appellant has not established greater than one percent permanent impairment of his left upper extremity.

Appellant may request a schedule award or increased schedule award 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 greater than one percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the October 6, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 1, 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

[19] *Id.*