



Pursuant to the Federal Employees' Compensation Act<sup>2</sup> (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.<sup>3</sup>

### **ISSUE**

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

### **FACTUAL HISTORY**

On September 13, 2013 appellant, then a 47-year-old drug treatment specialist, filed an occupational disease claim (Form CA-2) alleging that she developed right carpal tunnel syndrome due to factors of her federal employment which included inputting data on a computer. OWCP accepted her claim for right carpal tunnel syndrome.

On June 20, 2013 appellant had undergone electromyogram and nerve conduction velocity (EMG/NCV) testing which contained an impression of moderately severe right carpal tunnel syndrome.

Appellant received treatment for her right upper extremity condition from Dr. Laura Reese, an osteopath Board-certified in orthopedic surgery, who performed OWCP-authorized right carpal tunnel release surgery on January 15, 2014.<sup>4</sup>

During a follow-up care visit on May 16, 2014, Dr. Reese advised that appellant reported that her right hand numbness and tingling were gone, but indicated that she experienced arthritic-type pain in her right fingers which was not associated with the carpal tunnel. She noted physical examination findings of a well-healed right wrist incision without tenderness, and some crepitus at the right carpometacarpal joint. Appellant exhibited full range of motion of the right wrist upon flexion, extension, radial deviation, and ulnar deviation. Dr. Reese reported that sharp/dull sensation testing in the right median nerve distribution was normal and opined that appellant reached maximum medical improvement (MMI) from her carpal tunnel surgery.

On August 25, 2014 appellant filed a claim for a schedule award (Form CA-7).

In a September 22, 2014 letter, OWCP advised Dr. Reese that it had received her May 16, 2014 report, but that additional medical evidence was necessary to establish appellant's

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<sup>2</sup> 5 U.S.C. § 8101 *et seq.*

<sup>3</sup> The Board notes that following the September 7, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

<sup>4</sup> Appellant stopped work on January 15, 2014 and returned to work on March 3, 2014. OWCP paid her wage-loss compensation on the supplemental rolls for disability from work.

schedule award claim. It requested that she submit a report which evaluated appellant's permanent impairment pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).<sup>5</sup> OWCP afforded Dr. Reese 30 days to submit the requested evidence.

Dr. Reese did not submit evidence within the afforded period. However, on October 20, 2014, OWCP received a September 26, 2014 report from Dr. Martin Fritzhand, a Board-certified urologist, who advised that appellant reported that prolonged use of her right arm exacerbated her right hand pain. Appellant also reported diminished grip strength and sporadic numbness in her right hand, and she indicated that her right hand hurt when she had to repeatedly open doors at work. Dr. Fritzhand indicated that appellant reported it took longer for her to "complete things" with her right hand at home and that she could not participate in her daughters' basketball and softball activities. He noted that the physical examination revealed an equivocally positive right Tinel's sign, diminished pinprick and light touch over the right thumb, well-preserved grip strength of the right hand, and no right upper extremity atrophy. Dr. Fritzhand opined that appellant reached MMI in May 2014. He provided a permanent impairment rating for the right upper extremity utilizing Table 15-23 (Entrapment/Compression Neuropathy Impairment) on page 449 of the sixth edition of the A.M.A., *Guides*. Dr. Fritzhand determined that appellant's condition fell under grade modifier 1 for test findings, grade modifier 2 for history, and grade modifier 2 for physical findings. He averaged these grade modifiers to 1.67, which he rounded up to 2, and he then noted that appellant fell under grade modifier 2 with a default impairment value of five percent for the right upper extremity. Dr. Fritzhand determined that, utilizing the functional scale portion of Table 15-23, appellant's *QuickDASH* score of 68 required movement one space to the right of the default value. He therefore concluded that appellant had a total of six percent permanent impairment of the right upper extremity.

By decision dated August 12, 2015, OWCP denied appellant's claim for a schedule award because the medical evidence did not establish permanent impairment to a scheduled member or function of the body.

On August 31, 2015 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. Prior to the hearing being held, OWCP's hearing representative conducted a preliminary review and determined that the case was not in posture for decision. She issued a February 23, 2016 decision vacating the August 12, 2015 decision and remanding the case to OWCP for further development. The hearing representative determined that OWCP failed to consider Dr. Fritzhand's October 20, 2014 impairment rating report and directed OWCP, upon remand, to refer the report to an OWCP district medical adviser (DMA) for review.

On February 29, 2016 OWCP referred the case record, including Dr. Fritzhand's October 20, 2014 report, to Dr. Morley Slutsky, a Board-certified occupational medicine physician serving as a DMA. It requested that the DMA provide an opinion on permanent impairment under the sixth edition of the A.M.A., *Guides*. In a March 6, 2016 report, the DMA advised that he needed the most recent EMG/NCV study to determine whether appellant met the criteria for the

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<sup>5</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009).

diagnosis of right carpal tunnel syndrome. He also requested a copy of the statement of accepted facts (SOAF).

On May 13, 2016 OWCP routed the June 20, 2013 EMG/NCV study, the SOAF, and rest of the case file to the DMA, for review and an opinion on permanent impairment in accordance with the A.M.A., *Guides*. On May 22, 2016 the DMA reported that appellant reached MMI on May 16, 2014, the date of Dr. Reese's examination and discussed his disagreement with Dr. Fritzhand's impairment rating. Utilizing Table 15-23 of the sixth edition of the A.M.A., *Guides*, the DMA determined that the June 20, 2013 EMG/NCV study showed that appellant fell under grade modifier 1 for test findings because the study met the criteria for right carpal tunnel syndrome and demonstrated sensory and motor conduction delays associated with the median nerve. He assigned a grade modifier 1 for history given that appellant had mild intermittent symptoms (without evidence that she was unable to perform at least one activity of daily living or that someone consistently did an activity of daily living for her). The DMA assigned a grade modifier of 1 for physical findings. He noted that Dr. Fritzhand found diminished pinprick and light touch in the right medial nerve distribution, but did not perform appropriate two-point discrimination testing.<sup>6</sup> Averaging the three grade modifiers meant that appellant fell under grade modifier 1 on Table 15-23 with a default impairment value of two percent. The DMA determined that appellant's *QuickDASH* score of 68 was invalid. He explained the A.M.A., *Guides* provides that, when the *QuickDASH* score exceeds 60 in the context of mild physical findings, there may be other diagnoses being overlooked which impact the subject's answers and, therefore, the score is considered to be invalid. The DMA concluded that appellant's condition did not warrant movement from the default impairment value of two percent and, therefore, the total permanent impairment of appellant's right upper extremity was two percent.

By decision dated June 23, 2016, OWCP granted appellant a schedule award for two percent permanent impairment of the right upper extremity (right arm). The award ran for 6.24 weeks from July 25 to September 6, 2014 and was based on the May 22, 2016 impairment rating of the DMA.

On June 30, 2016 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. Counsel submitted an August 20, 2016 report from Dr. Fritzhand who noted that the DMA downgraded his assessment of appellant's history from grade modifier 2 to grade modifier 1. Dr. Fritzhand argued that appellant had significant intermittent symptoms in her right upper extremity which Table 15-23 identified as defining grade modifier 2 for history. He noted that he used a discriminator wheel (two-point wheel) during his examination and indicated that his statement that pinprick and light touch were diminished implied greater than six millimeter discrimination, a finding which met the definition of grade modifier 2. Dr. Fritzhand opined that appellant had six percent permanent impairment of the right upper extremity.

Prior to a hearing being held, OWCP's hearing representative conducted a preliminary review and issued a November 16, 2016 decision vacating the June 23, 2016 decision and remanding the case to OWCP for further development. The hearing representative determined that

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<sup>6</sup> The DMA also indicated that appellant had no atrophy or muscle loss associated with the right median nerve.

Dr. Fritzhand's August 20, 2016 report warranted further development, including referral of the report to a DMA for review.

On December 2, 2016 OWCP routed Dr. Fritzhand's August 20, 2016 report to the DMA for review and evaluation of appellant's permanent impairment. In a December 10, 2016 report, the DMA confirmed his rating of two percent permanent impairment of the right upper extremity. Utilizing Table 15-23 of the sixth edition of the A.M.A., *Guides*, he determined that the June 20, 2013 EMG/NCV study showed that appellant fell under grade modifier 1 for test findings because the study met the criteria for right carpal tunnel syndrome and demonstrated sensory and motor conduction delays associated with the right median nerve. The DMA assigned a grade modifier 1 for history, noting that appellant's right upper extremity symptoms were not constant, she could perform all of her activities of daily living despite her symptoms, and there was no mention that she required someone else to consistently perform an activity of daily living for her. He referenced the standards for evaluating the grade modifier for history found on page 433 of the A.M.A., *Guides*, and noted that a further reason that appellant did not qualify for grade modifier 2 or higher was that her right median nerve entrapment was not severe enough to make failure to function in a specific activity of daily living "believable."

The DMA further determined that appellant fell under a grade modifier of 1 for physical findings, noting that the A.M.A., *Guides* provides on page 446 that an individual's grade modifier for physical findings is determined by objective sensory loss findings (observed after a specific testing regimen) and motor loss findings (due to recognized neurologic atrophy of innervated muscle). He indicated that Dr. Fritzhand found diminished pinprick and light touch in the right medial nerve distribution, but noted that he did not perform proper two-point discrimination testing. The DMA noted that Dr. Fritzhand's use of a discriminator wheel to test for two-point discrimination and light touch was inappropriate because the number of millimeters between the two points tested must first be measured and then applied to the skin to determine the minimum number of millimeters between the two points in order to determine if the discrimination is within normal limits (six millimeters or less).<sup>7</sup> He found that the average of appellant's three grade modifiers fell under grade modifier 1 with a default impairment value of two percent. The DMA determined that appellant's severe *QuickDASH* score of 68 was invalid given her mild findings<sup>8</sup> and concluded that, because there was no movement from the default impairment value derived from Table 15-23, the total permanent impairment of appellant's right upper extremity was two percent.

By decision dated December 15, 2016, OWCP denied appellant's request for an increased schedule award. It based its determination on the opinion of the DMA.

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<sup>7</sup> The DMA referenced the process for correctly measuring two-point discrimination on page 424 and 426 of the A.M.A., *Guides*. He also indicated that appellant had no atrophy or muscle loss associated with the right median nerve.

<sup>8</sup> The DMA indicated the A.M.A., *Guides* provides on page 445 that, when the *QuickDASH* score exceeds 60 in the context of mild physical findings, there may be other diagnoses being overlooked which impact the subject's answers and, therefore, the score is considered to be invalid.

On December 20, 2016 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. During the June 13, 2017 hearing, counsel argued that OWCP should have accepted the impairment rating of Dr. Fritzhand.

By decision dated August 23, 2017, OWCP's hearing representative vacated the December 15, 2016 decision and remanded the case to OWCP for further development. She determined that neither the DMA nor Dr. Fritzhand applied FECA Bulletin No. 17-06 which requires consideration of both a diagnosis-based impairment rating method and a range of motion impairment rating method when calculating permanent impairment due to certain upper extremity conditions. The hearing representative directed OWCP, upon remand, to refer appellant to a second opinion physician for an examination and proper evaluation of permanent impairment under the sixth edition of the A.M.A., *Guides*.

On August 31, 2017 OWCP referred appellant for a second opinion evaluation with Dr. Anbu K. Nadar, a Board-certified orthopedic surgeon. In a November 14, 2017 report, Dr. Nadar discussed appellant's complaints of residual pain and numbness in her right hand, occasional numbness in her right thumb and index finger, and some difficulty in gripping with her right hand. He noted that he conducted a physical examination on September 20, 2017 which revealed a well-healed incision over the palm of appellant's right hand, tenderness to deep palpation of her right wrist/hand, negative Tinel's and Phalen's signs, no thenar/hypothenar wasting, and two-point sensation of six millimeters involving her right thumb, index, and middle finger. Appellant had full range of motion of the right wrist with flexion to 70 degrees, extension to 70 degrees, radial deviation to 25 degrees, and ulnar deviation to 30 degrees. Dr. Nadar provided an impairment rating utilizing Table 15-23 of the sixth edition of the A.M.A., *Guides*. He found that the findings of appellant's EMG/NCV study fell under grade modifier 1 for test findings and noted that appellant continued to have intermittent symptoms which qualified her for grade modifier 2 for history. Dr. Nadar determined that her physical examination findings were grossly within normal limits and fell under grade modifier 1 for physical findings. He averaged these grade modifiers and found that the appropriate grade modifier was 1.33, which he rounded down to 1. Dr. Nadar indicated that appellant's condition fell under the default impairment value of two percent for grade modifier 1 and concluded that she had a total of two percent permanent impairment of the right upper extremity.<sup>9</sup>

On November 24, 2017 OWCP referred the case record, including Dr. Nadar's November 14, 2017 report, to the DMA for review and an evaluation of appellant's permanent impairment under the A.M.A., *Guides*.

In a December 11, 2017 report, the DMA noted that the A.M.A., *Guides* provides that the range of motion method does not apply to rating permanent impairment due to carpal tunnel syndrome. He then proceeded to calculate appellant's right upper extremity impairment utilizing Table 15-23 on page 449 of the sixth edition of the A.M.A., *Guides*. The DMA determined that the June 20, 2013 EMG/NCV study showed that appellant fell under grade modifier 1 for test findings because the study met the criteria for right carpal tunnel syndrome and demonstrated

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<sup>9</sup> Dr. Nadar determined that the date of MMI was September 20, 2017, the date of his examination.

sensory and motor conduction delays associated with the right median nerve.<sup>10</sup> He noted that appellant fell under grade modifier 1 for history because she only had mild intermittent symptoms related to carpal tunnel syndrome. Appellant did not qualify for a higher grade modifier because there was no documentation that she was unable to perform at least one of the activities of daily living, that someone else consistently performed an activity of daily living for her, or that there was conduction block and/or axonal involvement on EMG/NCV testing. The DMA then assigned grade modifier 0 for physical findings given that two-point discrimination testing was normal (six millimeters or less) and that there was no documentation of atrophy or muscle loss associated with the right median nerve. He advised that the average of the three grade modifiers rounded to the nearest integer would be assigned grade modifier 1 with a default impairment value of two percent. The DMA noted that a *QuickDASH* score was not obtained, but determined that, given appellant's mild symptoms, mild EMG/NCV findings, and no significant physical loss, she had a mild functional score which would also be assigned grade modifier 1. Therefore, appellant's functional score did not require movement from the default impairment value of two percent. The DMA concluded that the total permanent impairment of appellant's right upper extremity was two percent.<sup>11</sup>

By decision dated January 10, 2018, OWCP denied appellant's claim for an increased schedule award. It based its determination on the opinion of the DMA.

On January 19, 2018 appellant, through counsel, requested a telephonic oral hearing before a representative of OWCP's Branch of Hearings and Review. During the June 26, 2018 hearing, counsel argued that the DMA's impairment rating was improper. By decision dated September 7, 2018, OWCP's hearing representative affirmed the January 10, 2018 decision.

### **LEGAL PRECEDENT**

The schedule award provision of FECA<sup>12</sup> and its implementing federal regulation<sup>13</sup> 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 for all claimants, OWCP has adopted

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<sup>10</sup> The DMA indicated that there was no conduction block and/or axonal involvement seen on the June 20, 2013 EMG/NCV study which would warrant a greater grade modifier for test findings.

<sup>11</sup> The DMA indicated that the date of MMI was September 20, 2017, the date of Dr. Nadar's examination.

<sup>12</sup> 5 U.S.C. § 8107.

<sup>13</sup> 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.<sup>14</sup> As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.<sup>15</sup>

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.<sup>16</sup> 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.<sup>17</sup>

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.<sup>18</sup>

### ANALYSIS

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

In his December 11, 2017 report, the DMA properly calculated appellant's right upper extremity impairment utilizing Table 15-23 of the sixth edition of the A.M.A., *Guides*.<sup>19</sup> He determined that the June 20, 2013 EMG/NCV study showed that appellant fell under grade modifier 1 for test findings because the study, which demonstrated sensory and motor conduction delays, met the criteria for right carpal tunnel syndrome.<sup>20</sup> The DMA noted that appellant fell under grade modifier 2 for history because she only had mild intermittent symptoms in her right upper extremity. He then assigned grade modifier 0 for physical findings given that two-point discrimination testing was normal and that there was no documentation of atrophy or muscle loss associated with the right median nerve. The average of the three grade modifiers was rounded to

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<sup>14</sup> *Id.*

<sup>15</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

<sup>16</sup> See A.M.A., *Guides* 449, Table 15-23.

<sup>17</sup> A survey completed by a given claimant, known by the name *QuickDASH*, may be used to determine the functional scale score. *Id.* at 448-49.

<sup>18</sup> See *supra* note 15 at Chapter 2.808.6(d) (March 2017).

<sup>19</sup> A.M.A., *Guides* 449, Table 15-23.

<sup>20</sup> The DMA indicated that there was no conduction block and/or axonal involvement seen on the June 20, 2013 EMG/NCV study which would warrant a greater grade modifier for test findings.

the nearest integer and assigned grade modifier 1 with a default impairment value of two percent. The DMA noted that a *QuickDASH* score was not obtained, but properly determined that, given appellant's mild symptoms, mild EMG/NCV findings, and no significant physical loss, she had a mild functional score of grade modifier 1 which did not require movement from the default impairment value of two percent.<sup>21</sup> The DMA correctly concluded that the total permanent impairment of appellant's right upper extremity was two percent.<sup>22</sup>

The case record contains reports of Dr. Fritzhand, an attending physician, which includes higher impairment rating calculations for the right upper extremity,<sup>23</sup> but the Board finds that Dr. Fritzhand's impairment rating analysis is of little probative value because he did not adequately explain how his calculations were conducted in accordance with the standards of the sixth edition of the A.M.A., *Guides*.<sup>24</sup> The DMA properly identified the deficiencies in Dr. Fritzhand's impairment rating analysis.<sup>25</sup> For example, he explained that it was improper for Dr. Fritzhand to assign grade modifier 2 for history (rather than grade modifier 1) because appellant did not qualify for this higher grade modifier given there was no documentation that she was unable to perform at least one of the activities of daily living, that someone else consistently performed an activity of daily living for her, or that there was conduction block and/or axonal involvement on EMG/NCV testing.<sup>26</sup> The DMA also explained that it was improper for Dr. Fritzhand to assign grade modifier 2 for physical findings (rather than grade modifier 1) because Dr. Fritzhand did not conduct a proper evaluation of sensory loss under the standards of the sixth edition of the A.M.A., *Guides*.<sup>27</sup>

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<sup>21</sup> See A.M.A., *Guides* 449.

<sup>22</sup> The Board notes that Dr. Nadar assigned higher grade modifiers for history and physical examination than the DMA, but he did not provide any notable explanation for these ratings and Dr. Nadar ultimately found the same level of permanent impairment for the right upper extremity as the DMA, *i.e.*, two percent. OWCP requested that Dr. Nadar use the range of motion rating method for evaluating appellant's permanent impairment due to right carpal tunnel syndrome, but he, like the DMA, applied the appropriate method found at Table 15-23. See *supra* note 16.

<sup>23</sup> In September 20, 2014 and August 20, 2016 reports, Dr. Fritzhand determined that appellant had six percent permanent impairment of her right upper extremity.

<sup>24</sup> See *N.A.*, Docket No. 19-0248 (issued May 17, 2019); *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).

<sup>25</sup> The DMA directly evaluated Dr. Fritzhand's opinion on permanent impairment in reports dated May 22 and October 10, 2016.

<sup>26</sup> See A.M.A., *Guides* 433.

<sup>27</sup> See *id.* at 424, 426. The DMA properly explained that Dr. Fritzhand's use of a discriminator wheel to test for two-point discrimination and light touch was inappropriate because use of this device did not allow for proper sensory testing. He indicated that the number of millimeters between the two points tested had to first be measured and then applied to the skin to determine the minimum number of millimeters between the two points in order to determine if the discrimination was within normal limits (six millimeters or less). See *id.*

He also correctly found that Dr. Fritzhand's calculation of appellant's functional scale was invalid and did not require movement from the default impairment value described in Table 15-23.<sup>28</sup>

There is no probative medical evidence of record demonstrating that appellant sustained more than two percent permanent impairment of her right upper extremity due to her accepted condition of right carpal tunnel syndrome, for which she previously was received a schedule award.

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 two percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

### **ORDER**

**IT IS HEREBY ORDERED THAT** the September 7, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 10, 2020  
Washington, DC

Janice B. Askin, Judge  
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge  
Employees' Compensation Appeals Board

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

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<sup>28</sup> The DMA determined that the *QuickDASH* score of 68 obtained by Dr. Fritzhand was invalid given appellant's mild findings. He properly noted that, under the sixth edition of the A.M.A., *Guides*, when the *QuickDASH* score exceeds 60 in the context of mild physical findings, there may be other diagnoses being overlooked which impact the subject's answers and, therefore, the score is considered to be invalid. *See id.* at 445.