United States Department of Labor
Employees' Compensation Appeals Board

K.G., Appellant	)	
and	)	**Docket No. 22-1307**
	)	**Issued: April 26, 2023**
DEPARTMENT OF THE TREASURY, BUREAU OF ENGRAVING & PRINTING, Washington, DC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On September 13, 2022 appellant filed a timely appeal from an August 30, 2022 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 greater than seven percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On February 6, 2020 appellant, then a 57-year-old COPE[2] pressman, filed an occupational disease claim (Form CA-2) alleging that he developed right-hand carpal tunnel syndrome (CTS) due to factors of his federal employment, which required repetitive movements of his hands and wrists.[3] He noted that he first became aware of his condition on October 1, 2019 and realized its relation to his federal employment on January 9, 2020. Appellant stopped work on January 30, 2020 and underwent right carpal tunnel release on January 31, 2020. On May 12, 2020 OWCP accepted his claim for right CTS.

On September 1, 2020 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On January 15, 2021 OWCP referred appellant, a statement of accepted facts, the medical record, and a series of questions to Dr. Easton Manderson, a Board-certified orthopedic surgeon, for a second opinion examination.

In a February 3, 2021 report, Dr. Manderson noted appellant's history of injury and that appellant had undergone right carpal tunnel release on January 31, 2020. He also noted that appellant reported current symptoms of weakness of grip of the right hand, and numbness of the thumb, index, and long fingers of the right hand. Dr. Manderson diagnosed post-carpal tunnel release on the right with residual weakness of grip, and decreased sensation in touching with a cotton all the fingers of the right hand. He performed a permanent impairment rating utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] Dr. Manderson applied Table 15-23, page 449, Entrapment/ Compression Neuropathy Impairment, to the primary diagnosis of status post-carpal tunnel release. Regarding the grade modifier for functional history (GMFH), he noted that appellant had a history of constant symptoms which resulted in a GMFH of 3. Regarding the grade modifier for clinical studies (GMCS), Dr. Manderson determined that appellant's test findings showed axon loss based on electrodiagnostic testing on December 23, 2019 which resulted in a GMCS of 3. With regard to the grade modifier for physical examination (GMPE), he explained that appellant had weakness of grip of right hand with abnormal two-point discrimination using pinpricks, which resulted in a GMPE of 3, and that he had a functional scale of moderate 41-60 and a *Quick*DASH score of 57.5, which resulted in a grade modifier of 2. Dr. Manderson further explained that he chose a modifier of 3 rather than 2 for the GMPE, because pursuant to Table 15-23, appellant had axon loss, constant symptoms, and weakness. He noted that appellant had nine grade modifiers, which resulted in a nine percent permanent impairment of the right upper extremity, under Table 15-23. Dr. Manderson also noted that appellant's range of motion (ROM) of the right wrist had been

[2] Currency Overprinting Processing Equipment and Packaging.

[3] The front of the CA-2 form indicates it was signed on February 6, 2019; which appears to be a typographical error. On the back of the form, the date was listed as February 7, 2020.

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

measured three times, and that his ROM of the right wrist was normal. He concluded that appellant had reached maximum medical improvement (MMI) on January 3, 2021.

On March 12, 2021 OWCP referred Dr. Manderson's report to Dr. Todd Fellars, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA).

In a March 25, 2021 report, Dr. Fellars reviewed Dr. Manderson's report and applied the A.M.A., *Guides*, Table 15-23, page 449, Entrapment/Compression Neuropathy Impairment. With regard to the GMFH, the DMA noted that it was documented that appellant had constant symptoms and, therefore, the GMFH was 3. He confirmed appellant's test findings revealed axonal loss which resulted in a GMCS of 3. With regard to appellant's physical examination findings, the DMA noted that, weakness in appellant's right hand with abnormal two-point discrimination also resulted in a GMPE of 3; however, he explained that appellant's functional scale was 57.5 on the *Quick*DASH score, therefore, he was only entitled to the decreased middle score. He also noted that appellant was not entitled to a schedule award for loss of ROM. Dr. Fellers concluded that appellant had an eight percent permanent impairment of the right upper extremity.

On April 23, 2021 OWCP determined that additional development was needed because the DMA impairment rating of eight percent impairment was not in agreement with the nine percent rating of Dr. Manderson. It referred the claim back to Dr. Manderson for comment.

In a September 15, 2021 memorandum, OWCP explained that Dr. Manderson was no longer on the panel of second opinion physicians. In a letter also dated September 15, 2021, it advised appellant that OWCP was unable to refer the claim back to Dr. Manderson for comment and a new second opinion examination was needed.

On September 21, 2021 OWCP referred appellant for a second opinion examination with Dr. John C. Barry, an orthopedic surgeon.

In a report dated October 11, 2021, Dr. Barry found that appellant had normal sensation in the right hand involving all five fingers, no evidence of muscle atrophy at the thenar or hypothenar eminence, negative Tinel's and negative Phalen's at carpal tunnel, grip strength diminished compared with the left hand, a well-healed carpal tunnel release scar, full ROM of the wrist in all planes, and full ROM of the fingers. He referred to the A.M.A., *Guides* Table 15-23, page 449, Entrapment/Compression Neuropathy Impairment, and determined that appellant findings of axonal loss, reflected a GMCS of 3. Appellant's history of significant intermittent symptoms reflected a GMFH of 2, and his physical examination including showing weakness of the wrist reflected a GMPE of 3. A functional score Perceived Deficits Questionnaire (PDQ) questionnaire completed that day by the appellant, resulted in a score of 54, which would equal grade modifier 2. Dr. Barry then explained that the total of the grade modifiers was 8, divided by 3 equals 2 2/3, rounded to 3. However, appellant's functional grade scale of 2 would reduce the upper extremity permanent impairment rating from 8 to 7, which would be the final permanent impairment rating of his right wrist. Dr. Barry also explained that ROM methodology was not applicable given appellant's diagnosis.

In a November 16, 2021 report, Dr. Fellars, the DMA, reviewed Dr. Barry's report and concurred, "I agree with [Dr. Barry's] assessment. Based on the documented information,

[appellant] would have a [seven] percent upper extremity impairment given the most current information available." The DMA also confirmed that Dr. Barry's calculation was in accordance with the A.M.A., *Guides* and noted that appellant reached MMI on October 11, 2021 the date of Dr. Barry's report.

By decision dated February 2, 2022, OWCP granted appellant a schedule award for seven percent permanent impairment of his right upper extremity. The period of the award ran for 21.84 weeks from October 11, 2021 to March 12, 2022.

On March 1, 2022 appellant requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review which was held on June 16, 2022.

By decision dated August 30, 2022, an OWCP hearing representative affirmed the February 2, 2022 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing regulations[6] 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. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such adoption.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[8]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must identify the impairment class of diagnosis (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids, and calculations of modifier scores.[11]

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a); *see R.M.*, Docket No. 20-1278 (issued May 4, 2022); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5.a (March 2017); *id.* at Chapter 3.700.2 and Exhibit 1 (January 2010).

[9] A.M.A., *Guides* 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[10] *Id.* at 411.

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

Impairment due to CTS is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[12] In Table 15-23, grade modifiers 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 based on functional scale, an assessment of impact on daily living activities.[13]

ANALYSIS

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

OWCP originally referred the case to Dr. Manderson for a second opinion evaluation. Dr. Manderson found that appellant had a nine percent permanent impairment of the right upper extremity based on a diagnosis of status post-carpal tunnel release of the right wrist. He referred to Table 15-23, page 449, Entrapment/Compression Neuropathy Impairment, of the A.M.A., *Guides*, and determined that appellant had a total of 9 grade modifiers, consisting of 3 each for GMCS, GMFH, and GMPE. With regard to GMPE, Dr. Manderson noted that appellant had weakness of grip in his right hand with abnormal two-point discrimination using pinpricks, which resulted in a grade modifier of 3; however, appellant had a functional scale of moderate 41-60 and a *Quick*DASH score of 57.5, which resulted in a grade modifier of 2. He explained that he still chose a grade modifier of 3, rather than 2, because appellant had axon loss, constant symptoms, and weakness.

The report from Dr. Manderson was properly referred to the DMA, Dr. Fellars, who concurred with the grade 3 modifiers for GMCS and GMFH, however, the DMA concluded that appellant was entitled to a GMPE of 2 due to his functional scale of 57.5 on *Quick*DASH score. The DMA concluded that appellant had eight percent permanent impairment of the right upper extremity.

Because the DMA's permanent impairment rating of eight percent was not in agreement with the second opinion physician's rating of nine percent, OWCP referred the claim back to Dr. Manderson for clarification. However, Dr. Manderson was no longer available and OWCP properly referred the claim to Dr. Barry for a new second opinion evaluation.[14]

Dr. Barry determined that appellant had seven percent right upper extremity impairment, based on Table 15-23, Entrapment/Compression Neuropathy Impairment, page 449, of the A.M.A., *Guides*. He noted that test findings of axonal loss resulted in a GMCS of 3. However, Dr. Barry determined that appellant's significant intermittent symptoms resulted in a GMFH of 2,

[12] A.M.A., *Guides* 449.

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

[14] *See J.W.*, Docket No. 22-0233 (issued August 23, 2022); *J.H.*, Docket No. 19-1476 (issued March 23, 2021); *R.O.*, Docket No. 19-0885 (issued November 4, 2019); *Talmadge Miller*, 47 ECAB 673 (1996).

and that his GMPE also resulted in a grade modifier of 2, based on the PDQ score of 54, completed at the time of his examination. Based on GMCS of 3, GMFH of 2, and GMPE of 2, the second opinion physician concluded that appellant had a right upper extremity permanent impairment rating of seven percent.

Dr. Barry's report was referred to the DMA, Dr. Fellars, who concluded that he agreed with Dr. Barry that appellant had seven percent right upper extremity permanent impairment, based on Dr. Barry's current examination findings. The Board notes that both physicians again determined that appellant had full ROM, and that a permanent impairment rating was not applicable for appellant's loss of ROM.

OWCP granted appellant a schedule award based on the opinions of the second opinion physician, Dr. Barry, and the DMA, Dr. Fellars, who concurred that appellant had seven percent right upper extremity impairment. As appellant bears the burden of proof to establish entitlement to an additional schedule award, he was required to submit rationalized medical evidence to support his claim. However, 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. Thus, the Board finds that appellant has not met his burden of proof to establish more than seven percent permanent impairment of his right 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 permanent impairment.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the August 30, 2022 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 26, 2023
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board