United States Department of Labor
Employees' Compensation Appeals Board

C.R., Appellant	)	
and	)	**Docket No. 21-0559**
	)	**Issued: July 17, 2023**
SOCIAL SECURITY ADMINISTRATION, OFFICE OF THE CHIEF ADMINISTRATIVE LAW JUDGE, Tampa, FL, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On February 26, 2021 appellant, through counsel, filed a timely appeal from a January 19, 2021 merit decision of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the

[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] The Board notes that, following the January 19, 2021 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*.

Federal Employees' Compensation Act[3] (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 her burden of proof to establish greater than four percent permanent impairment of her right upper extremity, and one percent permanent impairment of her left upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On July 3, 2017 appellant, then a 59-year-old legal assistant, filed an occupational disease claim (Form CA-2) alleging that she developed cervical disc herniation with neuritis, right elbow epicondylitis, and bilateral carpal tunnel syndrome causally related to factors of her federal employment, including the use of two computer monitors and repetitive work tasks of lifting claim files, and moving carts full of files. She first became aware of her conditions on January 28, 2015 and attributed the conditions to factors of her federal employment on May 19, 2017. Appellant stopped work on September 22, 2015 and received disability retirement. On May 20, 2019 OWCP accepted her claim for bilateral carpal tunnel syndrome and right elbow lateral epicondylitis.

On July 29, 2019 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In an August 8, 2019 development letter, OWCP advised appellant of the deficiencies in her schedule award claim, and requested medical evidence supporting permanent impairment. It afforded her 30 days to respond. No response was received.

By decision dated October 1, 2019, OWCP denied appellant's claim for a schedule award, finding that there was no medical evidence to establish permanent impairment.

Thereafter, OWCP received a September 13, 2019 report, wherein Dr. Sami E. Moufawad, a physician Board-certified in pain medicine, reviewed the medical records, and electrodiagnostic test results, and opined that appellant had attained maximum medical improvement. He provided an impairment rating in accordance with sixth edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] Dr. Moufawad diagnosed bilateral carpal tunnel syndrome and right lateral epicondylitis. On physical examination, he found tenderness on palpation and crepitance of the tendons on the dorsum of the hands bilaterally. Dr. Moufawad found no loss of range of motion (ROM) in the wrists, bilaterally. He provided three measurements for each of the right elbow movements and found forward flexion of 145 degrees, 150 degrees, and 150 degrees; extension of -13 degrees, -10 degrees, and -10 degrees; pronation of 65 degrees, 70 degrees and 70 degrees; and supination of 55 degrees, 60 degrees, and 60 degrees. Appellant's sensory examination showed decreased perception to light touch over the

[3] 5 U.S.C. § 8101 *et seq*.

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

ulnar aspect of the right wrist and the right little finger with two-point discrimination at eight millimeters. She exhibited slight decrease of sensation on the radial aspect of the right upper extremity from the forearm and elbow to the arm. Dr. Moufawad reviewed appellant's June 9, 2017 electromyogram and nerve conduction velocity (EMG/NCV) study and found that it demonstrated mild-to-moderate right ulnar neuropathy across the elbow. The median nerve sensory and motor examination was normal.

Utilizing the A.M.A., *Guides*, Table 15-33, page 474, for the right elbow, Dr. Moufawad found that appellant had two percent permanent impairment of her right elbow due to loss of ROM in extension, one percent for loss of ROM in pronation, and one percent for loss of ROM in supination. He found that her right upper extremity grade modifier for physical examination (GMPE) was 1 and her impairment due to loss of ROM was four percent permanent impairment.

Dr. Moufawad further applied the diagnosis-based impairment (DBI) methodology under the A.M.A., *Guides* to his findings regarding appellant's accepted right elbow condition. Using Table 15-5, page 399, he identified the class of diagnosis (CDX) as Class 1 epicondylitis, status post release of flexor or extensor origins with residual symptoms, which yielded a default value of five[5] percent impairment of the right upper extremity. Dr. Moufawad assigned a grade modifier for functional history (GMFH) of 3, based on a *Quick*DASH score of 70. He opined that a GMPE was not considered because it was used for determining the class. Dr. Moufawad found that the grade modifier for clinical studies (GMCS) was 1 based on the magnetic resonance imaging (MRI) scan findings. He utilized the net adjustment formula (GMFH – CDX) + (GMPE – CDX) = (3 – 1) + (1 – 1) = 2, which resulted in a grade E or seven percent permanent impairment of the upper right extremity due to lateral epicondylitis. Dr. Moufawad noted that the DBI method resulted in the higher impairment rating when compared to the ROM method.

Dr. Moufawad further found that Table 15-23, page 449 of the A.M.A., *Guides* could not be used to evaluate appellant's bilateral carpal tunnel syndrome because of the negative EMG/NCV study findings regarding the medial nerves. He utilized the CDX as Class 1 wrist sprain, found in Table 15-3, page 395 of the A.M.A., *Guides*. Dr. Moufawad applied a GMFH of 3, a GMPE of 1 due to tenderness on palpation of the wrist tendons, and a GMCS of 0, due to the normal MRI scan. Applying the net adjustment formula, he reached (0-1) or -1 which resulted in one percent permanent impairment of each upper extremity due to the accepted condition of carpal tunnel syndrome. Dr. Moufawad combined appellant's right upper extremity impairments and found eight percent permanent impairment. He further found one percent permanent impairment of the left upper extremity.

On October 7, 2019 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated January 10, 2020, OWCP's hearing representative vacated the October 1, 2019 decision and remanded the case for OWCP to refer Dr. Moufawad's September 13, 2019 report to a district medical adviser (DMA) for review.

[5] *Id.* at 399, provides that the default value for lateral epicondylitis without surgery was one percent impairment.

On February 22, 2020 Dr. David J. Slutsky, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), reviewed Dr. Moufawad's September 13, 2019 report and disagreed, in part, with his application of the A.M.A., *Guides*. The DMA found that carpal tunnel syndrome, an entrapment neuropathy, was rated in accordance with Table 15-23, page 449 of the A.M.A., *Guides* which required positive electrodiagnostic studies. As appellant did not have positive electrodiagnostic studies, she had no ratable impairment for carpal tunnel syndrome. The DMA noted that if test results excluded this condition from rating using the entrapment neuropathy method, then page 433 of the A.M.A., *Guides* provides that rating may be performed using the appropriate regional DBI class for nonspecific hand, wrist, or elbow pain. He further noted that the Table 15-3, page 395 of the A.M.A., *Guides*, provided a CDX of 1 with a default value of 1, for wrist pain. The DMA noted that, as appellant's GMFH differed by 2 or more grades from the GMPE or GMCS, it was assumed to be unreliable and excluded from the grading process, in accordance with page 406 of the A.M.A., *Guides*. He applied the net adjustment formula and found one percent permanent impairment of each upper extremity for carpal tunnel syndrome rated under the diagnosis of nonspecific wrist pain. The DMA further noted that Dr. Moufawad had found no loss of ROM in appellant's wrists, and that the DBI method was the more appropriate rating methodology for her bilateral carpal tunnel syndrome. However, he determined that this rating was only applicable to her left upper extremity. The DMA found that, page 389 of the A.M.A., *Guides* provides that if more than one diagnosis in a regional grid could be used, as in appellant's right upper extremity, the highest impairment rating should be used, and that painful disorders in a regional grid are rated only once.

The DMA found that lateral epicondylitis, with history of painful injury, residual symptoms without consistent objective findings was a CDX of 1 with a default value of one, and that Dr. Moufawad incorrectly used the default value of 5 for lateral epicondylitis status postsurgical release of the flexor or extensor origins with residual symptoms. He noted that appellant had never had surgery, that there were no documented subjective findings or physical signs of lateral epicondylitis, and that consequently the elbow regional grid diagnosis for lateral epicondylitis without consistent objective findings was more appropriate. In applying the net adjustment formula, the DMA reached a net adjustment of zero, or one percent permanent impairment for right lateral epicondylitis using the DBI method.

The DMA applied Table 15-33, page 474, to the loss of ROM figures provided by Dr. Moufawad for appellant's right elbow and agreed with his assessment of four percent permanent impairment of the right upper extremity using the ROM method. He determined that this provided her with a greater impairment than the DBI method and utilized four percent permanent impairment of the right upper extremity to reach her permanent impairment for schedule award purposes.

By decision dated March 5, 2020, OWCP granted appellant a schedule award for one percent permanent impairment of the left upper extremity (left arm), and four percent permanent impairment of the right upper extremity (right arm). The schedule award ran for a total of 15.6 weeks during the period September 13 to December 31, 2019.

On March 11, 2020 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

In an addendum dated May 8, 2020, Dr. Moufawad concurred with the DMA's finding of one percent of the left upper extremity. He further agreed that appellant had no impairment of the right upper extremity due to a wrist impairment, noting that he should have used the DBI for wrist pain instead of wrist strain. Dr. Moufawad, however, disagreed with the DMA's calculation of the DBI for right lateral epicondylitis. He noted that appellant did not undergo a surgical release, but found that the April 17, 2017 right elbow MRI scan showed signals consistent with lateral epicondylitis and that she had mild elbow joint effusion. Dr. Moufawad opined that she had residual symptoms and limited ROM which rendered her impairment closer to that of five percent for postsurgical lateral epicondylitis. He concluded that, on reexamination, appellant's impairment rating should be five percent permanent impairment of the right upper extremity and one percent permanent impairment of the left upper extremity.

A telephonic hearing was held on June 23, 2020. By decision dated July 6, 2020, OWCP's hearing representative vacated the March 5, 2020 OWCP decision, and remanded the case for further review by the DMA of Dr. Moufawad's May 8, 2020 report.

In a July 27, 2020 report, the DMA agreed with Dr. Moufawad that appellant had clinical and MRI scan findings consistent with lateral epicondylitis, but asserted that this yielded a one percent default impairment according to the A.M.A., *Guides*, Table 15-4, page 399. He opined that the A.M.A., *Guides* unequivocally asserted that the higher default impairment rating of five percent applies only status postsurgical release of the flexor or extensor origins with residual symptoms and that therefore her impairment rating under the DBI remained at one percent.

By decision dated August 6, 2020, OWCP denied appellant's claim for additional schedule award compensation.

On August 14, 2020 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on November 10, 2020.

By decision dated January 19, 2021, OWCP's hearing representative affirmed the August 6, 2020 decision.

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 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. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, good administrative practice necessitates 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

[6] *Supra* note 3.

[7] 20 C.F.R. § 10.404.

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): A Contemporary Model of Disablement*[10] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by a GMFH, GMPE, and/or 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]

FECA Bulletin No. 17-06 provides guidance in applying ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities.[14] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "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 [A.M.A.,] 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.)[15]

[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 Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* 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.

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

[12] *Id.* at 411.

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

[14] FECA Bulletin No. 17-06 (issued May 8, 2017).

[15] *Id.*

The Bulletin further provides:

> "If the medical evidence of record is [in]sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence."[16]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a 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.[17]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than four percent permanent impairment of her right upper extremity, or one percent permanent impairment of her left upper extremity, for which she previously received schedule award compensation.

In support of her claim, appellant submitted September 13, 2019 and May 8, 2020 reports from Dr. Moufawad who found four percent permanent impairment due to loss of ROM of the right elbow. Dr. Moufawad also found that the most appropriate CDX for rating purposes was Class 1 epicondylitis status post release of flexor or extensor origins with residual symptoms, which yielded a default value of five percent impairment of the right upper extremity.[18] In his May 8, 2020 addendum, he reexamined the A.M.A., *Guides*, and determined that appellant's impairment rating should be five percent permanent impairment of the right upper extremity[19] and one percent permanent impairment of the left upper extremity using the DBI methodology.[20]

OWCP properly determined that appellant had four percent permanent impairment of her right upper extremity, and one percent permanent impairment of her left upper extremity based on the February 22 and July 27, 2020 reports of Dr. Slutsky, the DMA, who interpreted the September 13, 2019 clinical findings of Dr. Moufawad. Dr. Slutsky properly applied the standards of the sixth edition of the A.M.A., *Guides* to the examination findings of record, and correctly utilized the DBI methodology for her left upper extremity. Dr. Moufawad, in his May 8, 2020 addendum, found that, under Table 15-3, page 395, her left upper extremity impairment could only be evaluated as wrist pain which was a Class 1 impairment with a default value of 1, as there were no electrodiagnostic studies supporting her diagnosis of carpal tunnel syndrome and no loss of

[16] *Id.*; *R.L.*, Docket No. 19-1793 (issued August 7, 2020).

[17] *See supra* note 8 at Chapter 2.808.6f (March 2017).

[18] A.M.A., *Guides* 399, Table 15-4.

[19] *Id.*

[20] *Supra* note 18 at 395, Table 15-3.

ROM. He applied the net adjustment formula and determined that appellant had no more than one percent permanent impairment of her left upper extremity.

Dr. Slutsky also agreed with Dr. Moufawad's findings, including the three measurements of each of the right elbow movements necessary to reach the ROM method of calculating appellant's permanent impairment due to right lateral epicondylitis, and agreed with his rating of four percent permanent impairment due to loss of ROM of the right elbow. However, he demonstrated that, under the DBI, appellant had only one percent permanent impairment due to the lateral epicondylitis. Dr. Slutsky noted that the higher percentage utilized by Dr. Moufawad to reach five percent, was only appropriate in situations where the claimant had undergone surgical release of the flexor or extensor origins as specifically outlined by the A.M.A., *Guides*, Table 25-4, page 399. While he agreed with Dr. Moufawad's finding that appellant had continued symptoms of lateral epicondylitis, he found that these symptoms could not be equivalent to surgery, as proposed by Dr. Moufawad. As such, there was no medical evidence properly applying the A.M.A., *Guides*, which resulted in more than four percent permanent impairment of the right upper extremity, or one percent permanent impairment of the left upper extremity.

As the DMA provided a rationalized opinion properly applying the appropriate standards of the sixth edition of the A.M.A., *Guides*, the Board finds that his opinion constitutes the weight of the medical evidence.[21] Thus, appellant has not met her burden of proof to establish greater impairment than that previously awarded.

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 her burden of proof to establish greater than four percent permanent impairment of her right upper extremity and one percent permanent impairment of her left upper extremity, for which she previously received schedule award compensation.

[21] *K.A.*, Docket No. 20-1463 (issued March 16, 2021); *O.F.*, Docket No. 19-0986 (issued February 12, 2020); *M.C.*, Docket No. 15-1757 (issued March 17, 2016) (the only medical evidence that demonstrated a proper application of the A.M.A., *Guides* was the report of the DMA).

ORDER

IT IS HEREBY ORDERED THAT the January 19, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 17, 2023
Washington, DC

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

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

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