United States Department of Labor
Employees' Compensation Appeals Board

A.B., Appellant	)	
and	)	**Docket No. 22-1332**
	)	**Issued: June 27, 2023**
DEPARTMENT OF THE AIR FORCE, ILLINOIS AIR NATIONAL GUARD, SCOTT AIR FORCE BASE, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On September 20, 2022 appellant filed a timely appeal from a May 3, 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.[2]

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 16 percent permanent impairment of his left upper extremity, and 23 percent permanent impairment of the right upper extremity for which he previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the May 3, 2022 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*.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances as set forth in the Board's prior decisions are incorporated herein by reference. The relevant facts are as follows.

On November 2, 2005 appellant, then a 34-year-old aircraft mechanic, filed an occupational disease claim (Form CA-2) alleging that he developed carpal tunnel syndrome causally related to factors of his federal employment. OWCP accepted the claim for bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, and right lateral epicondylitis.

A September 16, 2005 electromyogram (EMG) and nerve conduction velocity study (NCV) revealed findings consistent with right more than left carpal tunnel syndrome, and mild bilateral ulnar neuropathy.

On February 10, 2006 appellant underwent right carpal tunnel and cubital tunnel releases. On March 2, 2006 he underwent left carpal tunnel and cubital tunnel releases. On October 2, 2006 appellant had an ulnar nerve neurolysis and anterior subcutaneous transposition of the ulnar nerve due to recurrent right cubital tunnel syndrome. The procedures were approved by OWCP.

Appellant, on January 4, 2007, filed a claim for compensation (Form CA-7) for a schedule award.

On May 10, 2007 Dr. Robert W. Wysocki, a Board-certified internist serving as a district medical adviser (DMA), found that appellant had 23 percent permanent impairment of the right upper extremity due to a sensory deficit in the right median and ulnar nerve distributions, and 16 percent permanent impairment of the left upper extremity due to a sensory deficit in the left median nerve distribution.

By decision dated July 3, 2007, OWCP granted appellant a schedule award for 16 percent[4] permanent impairment of the left upper extremity and 23 percent permanent impairment of the right upper extremity pursuant to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] The period of the award ran for 121.68 weeks from April 19, 2007 to August 16, 2009.[6]

On March 28, 2010 appellant filed a claim for an additional schedule award (Form CA-7).

[3] Docket No. 08-1728 (issued April 10, 2009); Docket No. 16-0706 (issued February 15, 2018).

[4] OWCP indicated that the award was for 16.5 percent permanent impairment of the left upper extremity; however, this appears to be a typographical error as the schedule award was partially based on 16 percent impairment of the left upper extremity.

[5] A.M.A., *Guides* (5th ed. 2001).

[6] By decision dated April 10, 2009, the Board affirmed an April 2, 2008 decision finding that OWCP properly calculated appellant's pay rate for compensation purposes. *See* Docket No. 08-1728 (issued April 10, 2009).

In an October 20, 2011 report, Dr. Michael E. Beatty, a Board-certified plastic surgeon, found that appellant had 46 percent bilateral upper extremity permanent impairment.

On May 13, 2013 Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as a DMA, opined that Dr. Beatty's report was not in conformance with the sixth edition of the A.M.A., *Guides*.[7] He found that appellant had eight percent permanent impairment of each upper extremity due to carpal and cubital tunnel syndrome pursuant to Table 15-23 on page 449 of the A.M.A., *Guides*.

By decision dated July 25, 2013, OWCP denied appellant's claim for an increased schedule award.

On June 5, 2014 OWCP expanded its acceptance of the claim to include bilateral upper extremity residual paresthesia and bilateral surgically-treated compressive neuropathies involving the median and ulnar nerves.

On May 13, 2015 appellant filed a claim for an additional schedule award (Form CA-7).

In a June 11, 2015 report, Dr. Michael Hellman, an orthopedic surgeon serving as a DMA, opined that appellant had three percent permanent impairment of each upper extremity due to cubital and carpal tunnel syndrome pursuant to Table 15-23 on page 449 of the A.M.A., *Guides*. He also found an additional one percent right upper extremity permanent impairment for lateral epicondylitis under Table 15-4 on page 399. Dr. Hellman advised that appellant had no more than the previously awarded 16 percent permanent impairment of the left upper extremity and 23 percent permanent impairment of the right upper extremity.

By decision dated June 23, 2015, OWCP denied appellant's claim for an increased schedule award.

On July 16, 2015 appellant requested reconsideration of the June 23, 2015 schedule award decision.

In a July 5, 2015 report, Dr. Robert H. Thompson, a Board-certified vascular surgeon, diagnosed bilateral thoracic outlet syndrome due to appellant's employment duties. He opined that most of appellant's symptoms were related to thoracic outlet syndrome instead of peripheral nerve compression syndromes.

By decision dated December 7, 2015, OWCP denied appellant's request for an increased schedule award.[8]

On February 26, 2016 appellant appealed to the Board.

On June 2, 2016 OWCP expanded its acceptance of the claim to include thoracic outlet syndrome.

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

[8] On November 21, 2015 Dr. Hellman reiterated the findings from his June 11, 2015 report.

By decision dated February 15, 2018, the Board set aside the December 7, 2015 schedule award decision. Citing *T.H.*,[9] it remanded the case for OWCP to develop a consistent method for calculating upper extremity impairments.[10]

In a development letter dated March 23, 2018, OWCP requested that appellant submit an opinion from his physician addressing the extent of any permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*. It afforded him 30 days to submit the required evidence.

Appellant did not respond within the time allotted.

By decision dated May 3, 2018, OWCP denied appellant's claim for an increased schedule award.

On July 17, 2018 appellant filed a Form CA-7 requesting an increased schedule award.

In a development letter dated October 5, 2018, OWCP requested that appellant submit an opinion from his physician addressing the extent of any permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*. It afforded him 30 days to submit the required evidence.

In a December 27, 2018 memorandum of telephone call (Form CA-110), appellant advised that his physician would not perform an impairment rating without prior reimbursement.

On January 14, 2021 OWCP referred appellant to Dr. Michael Mayron, a Board-certified neurologist, for a second opinion examination.

In a report dated March 18, 2021, Dr. Mayron diagnosed a history of bilateral carpal and cubital tunnel syndromes treated with surgical releases and a history of neurogenic thoracic outlet syndrome treated with surgery on July 25, 2016. On examination he found full and symmetrical motor power and decreased sensation to pinprick in the bilateral upper extremities. Dr. Mayron opined that the diagnoses of carpal and cubital tunnel syndrome were minor conditions and attributed appellant's symptoms to his thoracic outlet syndrome. He noted that his physical examination currently revealed "a sensory deficit to pinprick in the distribution of the lower brachial plexus bilaterally." Dr. Mayron identified the class of diagnosis (CDX) as a Class 1 brachial plexus impairment due to mild sensory and motor deficit, which yielded a default impairment of 13 percent according to Table 15-20 on page 434 of the A.M.A., *Guides*. He applied grade modifiers and found a net adjustment of negative one, or seven percent permanent impairment of each upper extremity.

On April 21, 2021 Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA, opined that Dr. Mayron failed to explain his rating for a mild motor deficit given his examination findings of full motor power bilaterally. He further found that Dr. Mayron's finding of seven percent impairment due to a mild sensory and motor deficit did not correlate with Table 15-20, and that he did not provide sufficient detail to confirm the diagnosis of a brachial plexus

[9] Docket No. 14-0943 (issued November 25, 2016).

[10] Docket No. 16-0706 (issued February 15, 2018).

deficit. Dr. Katz recommended that OWCP refer appellant for another second opinion examination.

On June 11, 2021 OWCP referred appellant to Dr. Michael H. Ralph, a Board-certified orthopedic surgeon, for a second opinion examination. It provided a statement of accepted facts (SOAF), describing the accepted conditions and appellant's work history in private employment as a teacher beginning in August 2017.

In a report dated July 8, 2021, Dr. Ralph reviewed the accepted conditions and appellant's surgical history. On examination he found vigorous grip strength bilaterally, a negative Phalen's test, no thenar or hypothenar atrophy, a negative Tinel's sign at the elbow, and no atrophy of the upper extremities. Dr. Ralph measured range of motion (ROM) of the wrists, elbows, and shoulders, three times each, which he found yielded normal findings. He further found a negative impingement test bilaterally, and noted that appellant's only subjective complaint was occasional arm pain. Dr. Ralph advised that appellant had no pain over the lateral epicondyle and no fatigue on the right after his thoracic outlet surgery. He indicated that appellant's left side was "not that problematic for him…." Dr. Ralph found that he had no impairment due to resolved lateral epicondylitis, no findings of either right or left carpal tunnel syndrome, and no impairment due to cubital tunnel syndrome. He indicated that postsurgical diagnostic tests were normal. Dr. Ralph found that appellant had no impairment due to the lesions of his brachial plexus, or bilateral thoracic outlet syndrome. He asserted that the surgery for thoracic outlet syndrome would not cause any impairment. Dr. Ralph noted that the release of the pectoralis minor might cause weakness, but that he had not found weakness on examination. He indicated that the lateral epicondylitis had resolved after bilateral releases. Dr. Ralph advised that he believed that appellant had only experienced mild carpal tunnel syndrome. He concluded that appellant had no impairment under the sixth edition of the A.M.A., *Guides*.

On October 15, 2021 Dr. Katz concurred with Dr. Ralph's conclusion that appellant had no ratable impairment. He noted that, under Table 15-23, preoperative studies should be used to document median and ulnar nerve delays. Dr. Katz indicated that he used the results from the 2005 study which showed medial and ulnar nerve delays. For the conditions of bilateral medial and ulnar nerve entrapment, he applied a grade modifier of one due to the test findings showing electrodiagnostic delay, a grade modifier of zero for physical findings, and a grade modifier of zero for history, which he averaged to find a zero percent impairment according to Table 15-23 on page 449 of the A.M.A., *Guides*. Dr. Katz further found that appellant had no impairment due to right epicondylitis using Table 15-4 on page 399, or a bilateral brachial plexus impairment using Table 15-20 on page 434, as he had no objective abnormal findings as of the date of maximum medical improvement (MMI). He noted that Dr. Ralph had measured normal motion, and thus there was no impairment due to loss of ROM. Dr. Katz determined that appellant had reached MMI on July 7, 2021, the date of Dr. Ralph's examination.

By decision dated October 22, 2021, OWCP denied appellant's claim for an increased schedule award.

On November 2, 2021 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

A telephonic hearing was held on February 16, 2022. Appellant described his impairment evaluations, and noted that Dr. Ralph found that he did not have thoracic outlet syndrome even though he was discharged from the military due to the condition.

By decision dated May 3, 2022, OWCP's hearing representative affirmed the October 22, 2021 decision.

LEGAL PRECEDENT

The schedule award provision of FECA,[11] and its implementing federal regulation,[12] 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.[13] 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.[14]

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*.[15] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS).[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[18]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[19] In

[11] *Supra* note 1.

[12] 20 C.F.R. § 10.404.

[13] 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 2.808.6 (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

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

[15] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3.

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

[17] *Id*. at 411.

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

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

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.[20]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the percentage of permanent impairment using the A.M.A., *Guides*.[21]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 16 percent permanent impairment of his left upper extremity and 23 percent permanent impairment of the right upper extremity for which he previously received schedule award compensation.

In a report dated July 8, 2021, Dr. Ralph, an OWCP referral physician, noted that appellant complained of occasional pain in his arms. On examination he found good grip strength bilaterally, a negative Phalen's test, no atrophy, no impingement, and a negative Tinel's sign at the elbow. Dr. Ralph obtained three ROM measurements of both wrists, elbows, and shoulders, which he found yielded normal findings. He noted that appellant had no pain with dorsiflexion of the wrist or pain over the lateral epicondyle. Dr. Ralph further indicated that appellant had improved on the right side since his thoracic outlet surgery and that his left side was not significantly problematic. He opined that appellant had no impairment due to lateral epicondylitis, bilateral thoracic outlet syndrome, lesions of the brachial plexus, bilateral carpal tunnel syndrome, and bilateral cubital tunnel syndrome. Dr. Ralph noted that electrodiagnostic testing obtained after surgery were normal. He opined that appellant had no impairment under the A.M.A., *Guides*. While Dr. Ralph indicated his belief that appellant had only experienced carpal tunnel syndrome, he considered all the accepted conditions in determining that he had no ratable permanent impairment of either upper extremity.

On October 15, 2021 Dr. Katz reviewed Dr. Ralph's findings. He advised that Table 15-23 of the A.M.A., *Guides*, relevant to determining impairment due to entrapment/compression neuropathy, provided that the evaluator should use preoperative studies to determine median and ulnar nerve delays. Dr. Katz found that electrodiagnostic testing from 2005 showed medial and ulnar nerve delays. Using Table 15-23, he found a grade modifier of one due to the test findings showing electrodiagnostic delay, a grade modifier of zero for physical findings, and a grade modifier of zero for history, which he averaged to find zero percent impairment. Dr. Katz further determined that appellant had no impairment due to right epicondylitis using Table 15-4 on page 399, or a bilateral brachial plexus impairment using Table 15-20 on page 434, based on the lack of objective abnormal findings. He additionally found that as the ROM measurements obtained by Dr. Ralph were normal, appellant had no impairment using the ROM method. Dr. Katz concluded that he had no impairment of either the right or left upper extremities. There is no medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*,

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

[21] *Supra* note 13 at Chapter 2.808.6(f) (March 2017); *B.B.*, Docket No. 18-0782 (issued January 11, 2019).

establishing that appellant has more than 16 percent permanent impairment of his left upper extremity, and 23 percent permanent impairment of the right upper extremity. Accordingly, appellant has not established entitlement to schedule award compensation greater than that previously awarded.

Appellant may request a schedule award or increase 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 16 percent permanent impairment of his left upper extremity and 23 percent permanent impairment of the right upper extremity for which he previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the May 3, 2022 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 27, 2023
Washington, DC

Alec J. Koromilas, 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