United States Department of Labor
Employees' Compensation Appeals Board

C.F., Appellant	)	
and	)	**Docket No. 22-1271**
	)	**Issued: November 21, 2023**
DEPARTMENT OF THE ARMY, U.S. ARMY AVIATION & MISSILE COMMAND, CORPUS CHRISTI ARMY DEPOT, Corpus Christi, TX, 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 August 31, 2022 appellant filed a timely appeal from an April 21, 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 to consider the merits of this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than two 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 September 21, 2016 appellant, then a 40-year-old aircraft engineer repairer, filed an occupational disease claim (Form CA-2) alleging that he sustained pain in both hands as a result of repetitive factors of his federal employment, including using power tools and hand wrenches. On January 30, 2017 OWCP accepted the claim for bilateral carpal tunnel syndrome (CTS) and bilateral ulnar nerve lesions. It paid appellant wage-loss compensation on the periodic rolls beginning May 1, 2017.

On March 3, 2017 appellant underwent electromyogram and nerve conduction velocity (EMG/NCV) studies which revealed prolonged median inter latency bilaterally and prolonged median-ulnar palm mixed nerve action potentials, bilaterally. The left median, radial and bilateral ulnar nerves demonstrated normal distal latencies and amplitudes. These studies demonstrated mild left and moderate right CTS.

On May 1, 2017 Dr. Ryan Thomas, a Board-certified orthopedic surgeon, performed an OWCP-authorized left ulnar nerve compression at the elbow, left medial condylectomy at the elbow, and left open carpal tunnel release. On July 10, 2017 he performed an OWCP-authorized right ulnar nerve neuroplasty at the elbow, right open carpal tunnel release, and right medial condylectomy at the elbow. Appellant returned to modified full-duty position on September 20, 2017.

On August 15, 2019 Dr. Thomas performed an OWCP-authorized revised left ulnar nerve transposition and lengthening of the common flexor origin of the medial elbow. On January 7, 2020 he performed an OWCP-authorized revision of the right cubital tunnel with intramuscular placement of the ulnar nerve and lengthening of the common flexor origin, right elbow.

OWCP paid appellant wage-loss compensation on the periodic rolls beginning January 5, 2020. Appellant returned to work on January 30, 2020.

On May 4, 2020 appellant underwent postoperative EMG/NCV studies with normal findings except for mid-palmar stimulation bilaterally. These findings were diagnostic for mild residual bilateral CTS.

On July 27, 2020 appellant filed a claim for compensation (Form CA-7) requesting a schedule award.

In a report dated July 7, 2020, Dr. Thomas E. Martens, an osteopath, found that appellant had reached maximum medical improvement (MMI) with regard to his accepted upper extremity conditions of bilateral CTS and bilateral ulnar nerve lesions. He applied Table 15-23, (Entrapment/Compression Neuropathy Impairments) on page 449 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[2] to reach an impairment rating. Dr. Martens determined that the May 4, 2020 EMG/NCV study showed a grade modifier of one for test findings in regard to the bilateral ulnar nerves. He assigned a grade modifier of one for a history of mild intermittent symptoms, and a grade modifier of three for

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

physical findings of weakness. Dr. Martens averaged the three grade modifiers to find a final rating category of grade modifier of one with a default impairment value of two percent permanent impairment. He then utilized appellant's *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) score to find a grade modifier functional scale of one. Dr. Martens found two percent impairment of each upper extremity due to the ulnar nerve lesions. He noted that the rating for the second nerve on the same side was reduced by half in accordance with Multiple Simultaneous Neuropathies, page 448 of the A.M.A., *Guides*, and found that appellant, therefore, had an additional one percent impairment of the upper extremities bilaterally due to median nerve impairments, resulting in three percent permanent impairment of the upper extremities, bilaterally.

In an August 7, 2020 development letter, OWCP requested that appellant submit an impairment evaluation from his attending physician addressing whether he had reached MMI and, if so, the extent of any permanent impairment in accordance with the A.M.A., *Guides*. It afforded him 30 days to submit the necessary evidence.

Dr. Martens responded in an August 25, 2020 report and repeated that appellant had reached MMI on July 7, 2020 and that he had three percent permanent impairment of each upper extremity due to his accepted bilateral CTS and ulnar nerve lesions in accordance with the A.M.A., *Guides*. He noted that the diagnosis-based impairment (DBI) method was the correct method for evaluating appellant's permanent impairment under the A.M.A., *Guides* and that the range of motion (ROM) method was not appropriate.

On June 8, 2021 OWCP referred appellant's medical record, including Dr. Martens' July 7 and August 25, 2020 impairment ratings, a series of questions, and a statement of accepted facts (SOAF) to a district medical adviser (DMA) for a schedule award determination. It also asked him to assess appellant's impairment and review and address any areas of disagreement with Dr. Martens.

On June 15, 2021 Dr. David J. Slutsky, a Board-certified orthopedic surgeon, serving as a DMA, reviewed the SOAF and the medical record. Utilizing the sixth edition of the A.M.A., *Guides*, Entrapment Neuropathy, on pages 432 through 449, he noted that postoperative EMG/NCV studies should not be utilized in the impairment rating unless the postoperative study is clearly worse. Dr. Slutsky found that there was insufficient medical evidence to determine appellant's impairment rating and requested further development by OWCP.

In a July 7, 2021 development letter, OWCP requested additional medical evidence including all previous EMG/NCV studies and a further report from Dr. Martens.

On August 11, 2021 Dr. Charles Xeller, a physician specializing in orthopedic surgery, diagnosed status postbilateral peripheral neuropathy surgery to address bilateral carpal and cubital tunnel syndromes. He reviewed appellant's physical findings and advised that a preoperative EMG/NCV showed conduction showing of the median nerves. Dr. Xeller applied Table 15-23 on page 449 of the A.M.A., *Guides* and found a grade modifier of one for test findings showing a slight delay of the bilateral ulnar nerves, a grade modifier of one for a history of mild intermittent symptoms, and a grade modifier of three for physical findings of weakness. He averaged the three grade modifiers and found that appellant fell under grade modifier one with a default value of two. Dr. Xeller applied a grade modifier of 1 for functional scale due to a *Quick*DASH score of 25

resulting in two percent impairment of the ulnar nerves, bilaterally. He found that the median nerves were within the same perimeters, but as the rating for the second nerve on the same side was half the value in accordance with page 448 of the A.M.A., *Guides*, appellant had three percent permanent impairment of each upper extremity.

In an August 26, 2021 report, Dr. Kyriakos Tsalamandris, Board-certified in emergency medicine, reviewed appellant's preoperative EMG/NCV studies and found evidence of conduction slowing of the median nerves, but normal ulnar nerve values. He found that appellant had two percent permanent impairment of each upper extremity for CTS and no rating for cubital tunnel syndrome based on the normal EMG/NCV studies results.

On March 31, 2022 OWCP referred appellant's medical record, including the additional reports from Drs. Xeller and Martens, a series of questions, and SOAF to the DMA for a schedule award determination.

On April 10, 2022 Dr. Slutsky, serving as a DMA, reviewed the SOAF and the medical record. Utilizing the sixth edition of the A.M.A., *Guides*, Entrapment Neuropathy, on pages 432 through 449, he found that appellant had two percent permanent impairment of the right upper extremity due to CTS and no other ratable impairments. Dr. Slutsky noted that, in accordance with Appendix 15-B: Electrodiagnostic Evaluation of Entrapment Syndromes, on page 487 of the A.M.A., *Guides*, the criteria for CTS was distal motor latency longer than 4.5 milliseconds for an 8 centimeter study, distal peak sensory latency longer than 4.0 milliseconds for 14 centimeter distances, and distal peak latency longer than 2.4 milliseconds for a transcarpal or midpalmar study of 8 centimeters. He found that the March 3, 2017 EMG/NCV tests met these requirements for the right median nerve resulting in a grade modifier of 1 for test findings according to Table 15-23 (Entrapment/Compression Neuropathy Impairment), on page 449. The DMA also assigned a grade modifier of one for history, and a grade modifier of two for physical findings due to decreased sensation. Averaging the three grade modifiers resulted in a grade modifier of one on Table 15-23 with a default impairment value of two percent permanent impairment. The DMA indicated that the *Quick*DASH score of 25 was grade modifier of 1 for functional scale, and therefore did not modify the rating from the default of two percent permanent impairment of the right upper extremity.

In regard to the left median nerve, Dr. Slutsky noted that, as the distal median motor latency did not meet the criteria of Appendix 15-B, page 487 of the A.M.A., *Guides*, there was no ratable impairment for CTS. He thus rated appellant's left CTS using Table 15-3, the wrist regional grid, on page 395. Dr. Slutsky identified the class of diagnosis (CDX) for wrist pain resulted in a Class 1 impairment, which yielded a default value of one percent. He applied a grade modifier for functional history (GMFH) of zero for no documented wrist pain, a grade modifier for physical examination (GMPE) of zero for no palpatory findings, and found that a grade modifier for clinical studies (GMCS) was not applicable. Applying the net adjustment formula yielded a net adjustment of negative two and no impairment due to wrist pain.

Addressing the accepted bilateral ulnar nerve injuries, Dr. Slutsky found that the March 3, 2017 EMG/NCV findings were not ratable in accordance with Appendix 15-B, page 487 through 488 of the A.M.A., *Guides*. He thus rated the cubital tunnel syndrome using Table 15-4, the elbow regional grid, on page 398 of the A.M.A., *Guides*. Dr. Slutsky identified the CDX for elbow

sprain/strain as a Class 1 impairment, which yielded a default value of one percent. He applied a GMFH of zero for no documented elbow pain, a GMPE of zero for no palpatory findings, and determined that a GMCS was not applicable. Utilizing the net adjustment formula, Dr. Slutsky found a net adjustment of minus two, which yielded no impairment due to elbow sprain/strain.

By decision dated April 21, 2022, OWCP granted appellant a schedule award for two percent permanent impairment of the right upper extremity (right wrist). The award ran for 6.24 weeks during the period August 26 through October 8, 2021.

LEGAL PRECEDENT

The schedule award provisions of FECA[3] and its implementing regulations[4] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for 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 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.[5] 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.[6] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related impairment, preexisting impairments are to be included.[7]

Impairment due to CTS is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[8] 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

[3] *Supra* note 1.

[4] 20 C.F.R. § 10.404.

[5] 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 id.* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[6] *M.B.*, Docket No. 22-0157 (issued August 26, 2022); *G.L.*, Docket No. 22-0166 (issued August 24, 2022); *V.C.*, Docket No. 21-1228 (issued April 7, 2022); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[7] *G.L.*; *P.R.*, *id.*; *Carol A. Smart*, 57 ECAB 340 (2006).

[8] A.M.A., *Guides*, 448, Table 15-23; 449; Appendix 15-B, 487-488. *See also M.B.*, *supra* note 6; *G.L.*, *id.*; *L.G.*, Docket No. 18-0065 (issued June 11, 2018).

be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[9]

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.[10]

ANALYSIS

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

In a report dated August 11, 2021, Dr. Xeller calculated appellant's impairment of the median and ulnar nerves as three percent of his upper extremities, bilaterally. On August 26, 2021 Dr. Tsalamandris reviewed the postoperative EMG/NCV studies and opined that appellant had two percent permanent impairment of each upper extremity for CTS and no impairment due to cubital tunnel syndrome.

In accordance with its procedures, OWCP forwarded these reports to Dr. Slutsky, serving as the DMA, for review. In a report dated April 10, 2022, Dr. Slutsky noted the accepted conditions and reviewed the medical records, including the March 3, 2017 EMG/NCV studies testing. Referring to the sixth edition of the A.M.A., *Guides*, the DMA found that appellant had two percent permanent impairment of the right upper extremity due to CTS and no other ratable impairments. He applied the requirements of Appendix 15-B: Electrodiagnostic Evaluation of Entrapment Syndromes, on page 487 of the A.M.A., *Guides*, to the March 3, 2017 EMG/NCV test results and found that these requirements were met only for the right median nerve. Dr. Slutsky then applied Table 15-23 (Entrapment/Compression Neuropathy Impairment), on page 449 of the sixth edition of the A.M.A., *Guides*, to the findings regarding the right median nerve to reach two percent permanent impairment of the right upper extremity. He found that appellant had no impairment due to left CTS as the distal median motor latency failed to meet the criteria of Appendix 15-B on page 487. Dr. Slutsky thus applied Table 15-3 on page 395 and found a CDX for left wrist sprain resulted in a Class 1 impairment, which yielded a default value of one percent.[11] He applied a GMFH and a GMPE of zero and found a GMCS was not applicable, which after applying the net adjustment formula yielded no ratable impairment due to left wrist pain.[12]

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

[10] *See supra* note 5 at Chapter 2.808.6d (March 2017).

[11] Dr. Slutsky indicated that he was rating the impairment due to left wrist pain, but applied the diagnosis of left wrist sprain; however, both diagnoses yielded the same results under Table 15-3.

[12] Applying the net adjustment formula, (GMFH - CDX) + (GMPE - CDX), or (0-1) + (0-1) = -2, yielded an adjustment downward of two.

Dr. Slutsky further determined that the findings of the EMG/NCV studies for the bilateral ulnar nerve did not show a ratable impairment. He consequently applied Table 15-4 on page 398 and found a CDX for elbow sprain/strain resulted in a Class 1 impairment, which yielded a default value of one percent.[13] Dr. Slutsky found a GMFH and a GMPE of zero and that a GMCS was not applicable, which after applying the net adjustment formula resulted in no ratable impairment due to elbow strain.[14]

The Board finds that Dr. Slutsky, serving as DMA, adequately explained how he arrived at his rating of permanent impairment by listing specific tables and pages in the A.M.A., *Guides* and explained why his rating differed from that of Drs. Xeller and Tsalamandris. Dr. Slutsky properly interpreted and applied the standards of the sixth edition of the A.M.A., *Guides* to conclude that appellant had no greater than two percent permanent impairment of his right upper extremity, and that he had no ratable impairments of his left upper extremity or right ulnar nerve.[15]

The Board finds that there is no current medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has more than two percent permanent impairment of the right upper extremity. Accordingly, appellant has not established entitlement to a schedule award greater than that previously awarded.[16]

Appellant may request a schedule award or increased schedule award at any time based on evidence of new exposure, or medical evidence showing a 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 two percent of the right upper extremity for which he previously received a schedule award.

[13] Dr. Slutsky advised that he was rating the impairment due to left elbow pain, but identified the CDX as an elbow sprain; however, both diagnoses yielded the same results under Table 15-4.

[14] *Supra* note 12.

[15] *See J.L.*, Docket No. 22-1299 (issued May 17, 2023); *P.S.*, Docket No. 22-1051 (issued May 4, 2023); *N.M.*, Docket No. 19-1925 (issued June 3, 2020).

[16] *P.S.*, *id.*; *M.H.*, Docket No. 20-1109 (issued September 27, 2021); *R.H.*, Docket No. 20-1472 (issued March 15, 2021); *L.D.*, Docket No. 19-0495 (issued February 5, 2020).

ORDER

IT IS HEREBY ORDERED THAT the April 21, 2022 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 21, 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