United States Department of Labor
Employees' Compensation Appeals Board

J.C., Appellant	)	
and	)	**Docket No. 21-0541**
	)	**Issued: August 25, 2025**
U.S. POSTAL SERVICE, MAIL PROCESSING & DISTRIBUTION CENTER, Trenton, NJ, Employer	)	

Appearances:
Russell T. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On February 5, 2021, appellant, through counsel, filed a timely appeal from an August 14, 2020 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] By order dated February 23, 2022, the Board dismissed appellant's February 5, 2021 appeal. *Order Dismissing Appeal, J.C.*, Docket No. 21-0541 (issued February 23, 2022). On August 15, 2025, the Board granted appellant's timely petition for reconsideration and reinstated the appeal. *Order Granting Petition for Reconsideration and Reinstating Appeal, J.C.,* Docket No. 21-0541 (issued August 15, 2025).

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.[4]

ISSUE

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

FACTUAL HISTORY

On July 6, 2015 appellant, then a 36-year-old auto tech, filed a traumatic injury claim (Form CA-1) alleging that on July 1, 2015 he injured his left hand when he tightened a bolt while in the performance of duty. OWCP accepted the claim for carpal tunnel syndrome (CTS) of the left upper limb; sprain of the metacarpophalangeal (MCP) joint of the thumb; sprain of the hand, MCP; and left-hand contusion.

On February 4, 2016 appellant underwent surgery to his left thumb performed by Dr. A. Lee Osterman, a Board-certified orthopedic hand surgeon, including reconstruction of ligaments of the left thumb with internal fixation and capsulodesis and arthroscopic carpometacarpal (CMC) synovectomy.

On June 23, 2017 appellant underwent a subsequent surgery to the left wrist by Dr. Osterman, including median neurolysis and decompression and flexor tenosynovectomy and bursectomy.

In a December 7, 2017 permanent impairment evaluation report, Dr. Nicholas Diamond, a physiatrist, found that appellant had reached maximum medical improvement (MMI) and had residual symptoms of pain, stiffness, numbness, tingling, decreased grip strength, and clumsiness in the left hand. On physical examination, he observed tenderness to the palmar aspect of the left wrist, reduced grip and pinch key strength of the left hand compared to the right, and positive Tinel's sign, reverse Phalen's test, and Finklestein test. Dr. Diamond noted normal range of motion (ROM) findings throughout the left thumb and wrist and recorded a *Quick*DASH score of 79. He diagnosed post-traumatic tear of the anterior oblique ligament of the left thumb with instability status post reconstruction of the left thumb and post-traumatic median nerve compression and flexor tenosynovitis of the left wrist status postmedian nerve neurolysis and decompression and flexor tenosynovectomy and bursectomy. Regarding left wrist, Dr. Diamond utilized the diagnosis-based impairment (DBI) rating method, under Table 15-23, Entrapment/ Compression Neuropathy Impairment, page 449, of the sixth edition of the American Medical

[3] 5 U.S.C. § 8101 *et seq*.

[4] The Board notes that, following the August 14, 2020 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*.

Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] and assigned a grade modifier for physical examination (GMPE) of 3 for decreased pinch, a grade modifier for functional history (GMFH) of 3, and a grade modifier for clinical studies (GMCS) of 1, which resulted in an average grade modifier of 2 and a default value of five percent permanent impairment of the left upper extremity. He found that the *Quick*DASH score of 79 raised the percentage to six percent permanent impairment of the left upper extremity. Regarding the left thumb, Dr. Diamond referenced Table 15-2, Digit Regional Grid, page 392, and found the class of diagnosis (CDX) for left thumb strain and sprain was a Class 1 impairment with a default impairment rating of six percent. He assigned a GMPE of 2 and a GMCS of 0 and found that a GMFH was not applicable. Dr. Diamond applied the net adjustment formula, which resulted in 0, for a final rating of six percent digit impairment which converted to two percent permanent impairment of the left upper extremity. He indicated that there were no ROM deficits in the left wrist or thumb and therefore the DBI rating method should be used. Referencing the Combined Values Chart, Dr. Diamond calculated that these upper extremity impairments of the wrist and thumb equated to eight percent left upper extremity permanent impairment.

On February 1, 2018 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On July 23, 2018 OWCP referred the case record, along with a statement of accepted facts (SOAF), to Dr. James W. Butler, a physician Board-certified in occupational medicine, serving as OWCP's district medical adviser (DMA), for review and an opinion regarding appellant's permanent impairment.

In an August 2, 2018 report, Dr. Butler noted that the January 27, 2016 electromyogram and nerve conduction velocity (EMG/NCV) study did not yield sufficient findings to meet the criteria set forth in the A.M.A., *Guides* at Appendix 15-B, page 445, for rating an impairment due to entrapment/compression neuropathy. He also noted that ROM was within normal limits and excluded Dr. Diamond's *Quick*DASH score of 79 because the functional history was determined to be unreliable or inconsistent with other documentation. Dr. Butler concluded that there was "no impairment for either the diagnosis of wrist contusion, wrist strain, or thumb sprain."

By decision dated September 19, 2018, OWCP denied appellant's schedule award claim.

On September 24, 2018 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

OWCP thereafter received a September 19, 2018 supplemental report by Dr. Diamond, who noted his disagreement with Dr. Butler's conclusions. He found that the October 6, 2015 EMG/NCV study was consistent with moderate-to-severe CTS on the left and that the discussion section of the January 27, 2016 EMG/NCV noted the possibility of a false negative. Dr. Diamond also opined that appellant was still entitled to an impairment rating for a Class 1 left thumb strain and sprain even if the GMFH was excluded.

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

Following a preliminary review, by decision dated January 4, 2019, OWCP's hearing representative set aside the September 18, 2018 decision and remanded the case for OWCP to prepare an updated SOAF and refer the case to a DMA for an opinion on permanent impairment, followed by a *de novo* decision.

On February 7, 2019 OWCP referred the case record, along with an updated SOAF, to Dr. Butler, the DMA, for review and an opinion regarding appellant's permanent impairment.

In a supplemental report dated March 28, 2019, Dr. Bulter found no permanent impairment of the left upper extremity for the left wrist or thumb.

By *de novo* decision dated May 2, 2019, OWCP denied appellant's schedule award claim.

On May 9, 2019 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

In a July 24, 2019 supplemental report, Dr. Diamond reiterated his finding of eight percent permanent impairment of the left upper extremity, again noting the October 6, 2015 EMG/NCV findings and that appellant consistently complained of left-hand pain and stiffness with decreased grip, tenderness to palpation over the dorsal aspect of the left thumb.

A hearing was held on August 22, 2019.

By decision dated October 11, 2019, OWCP's hearing representative vacated the May 2, 2019 decision and remanded the case to OWCP for further development, including providing Dr. Diamond's July 24, 2019 supplemental report to its DMA for review and comment, followed by a *de novo* decision.

On October 25, 2019 OWCP referred the case record and an updated SOAF to Dr. Jovito Estaris, a Board-certified occupational medicine specialist and general surgeon serving as a DMA, an opinion regarding permanent impairment.

In a November 15, 2019 report, Dr. Estaris applied the sixth edition of the A.M.A., *Guides* to Dr. Diamond's physical examination findings. Regarding left CTS, he utilized the DBI rating method, under Table 15-21, Peripheral Nerve Impairment: Upper Extremity Impairments, page 438, and found a Class 1 impairment for left median neuropathy with motor deficits, with a default value of 1. Dr. Estaris assigned a GMCS of 0 and a GMFH of 3 based upon the *Quick*DASH score of 79 percent, but noted that a GMPE could not be used as the examination defined the impairment value and that the GMFH of 3 had to be excluded as unreliable.[6] He applied the net adjustment formula and found one percent permanent impairment of the left upper extremity for left CTS. Dr. Estaris indicated that he disagreed with Dr. Diamond's use of Table 15-23, Entrapment/ Compression Neuropathy Impairment, and explained that if multiple nerve conduction tests had been performed, the A.M.A., *Guides* necessitated the use of the most recent preoperative test for rating purposes. He further explained that in appellant's case, the most recent preoperative test

[6] A.M.A., *Guides* (6th ed. 2009) 406.

was the normal January 27, 2016 EMG/NCV and the A.M.A., *Guides* precluded the use of Table 15-23 in the presence of normal electrodiagnostic testing.[7]

Regarding the left thumb, Dr. Estaris applied Table 15-2, Digit Regional Grid, page 392, and found that the CDX for left thumb strain and sprain was a Class 1 impairment with a default impairment rating of six percent. He assigned a GMPE of 2, a GMCS of 0, and found that a GMFH was not applicable. Dr. Estaris applied the net adjustment formula, which resulted in 0, for a final rating of six percent digit impairment, or two percent permanent impairment of the left hand for the left thumb strain/sprain. He opined that appellant had reached MMI as of December 7, 2017, the date of Dr. Diamond's examination.

On January 14, 2020 OWCP requested clarification from Dr. Estaris.

In a supplemental report dated January 28, 2020, Dr. Estaris indicated that two percent permanent impairment of the left hand due to the left thumb converted to one percent permanent impairment of the left upper extremity. Referencing the Combined Values Chart, he calculated that the upper extremity impairments for the left thumb and wrist equated to two percent left upper extremity permanent impairment.

By decision dated February 5, 2020, OWCP granted appellant a schedule award for two percent permanent impairment of the left upper extremity. The award ran for 6.24 weeks from December 7, 2017 through January 19, 2018.

On February 13, 2020 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review, which was held on June 15, 2020.

OWCP thereafter received a July 22, 2020 addendum report by Dr. Diamond, who referenced Table 15-11, page 420, and noted that two percent permanent impairment of the left hand equated to two percent left upper extremity impairment.

By decision dated August 14, 2020, OWCP's hearing representative affirmed the February 5, 2020 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[8] and its implementing regulations[9] 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 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.,

[7] *Id*. at pp 446, 447.

[8] *Supra* note 3.

[9] 20 C.F.R. § 10.404.

Guides as the uniform standard applicable to all claimants.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, is used to calculate schedule awards.[11]

Impairment due to carpal tunnel syndrome 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 zero to four) are described for the categories of 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]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating of upper extremity impairments.[14] FECA Bulletin No. 17-06 provides:

> "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.*"[15] (Emphasis in the original).

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the fingers and hand, the relevant portions of the arm for the present case, reference is made to Table 15-2 (Digital Regional Grid) beginning on page 391. After the CDX is determined from the appropriate regional grid (including identification of a default grade value), the net adjustment formula is applied using a GMFH, a GMPE, and/or a GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to its DMA for an opinion concerning the nature and percentage of impairment

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[10] *Id*.; *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also*, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[12] A.M.A., *Guides* (6th ed. 2009) 449.

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

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

[15] *Id.*

[16] *See* A.M.A., *Guides* (6th ed. 2009) at 405-12. Table 15-2 also provides that, if motion loss is present for a claimant with certain diagnosed digit conditions, permanent impairment may alternatively be assessed using Section 15.7 (ROM impairment). Such a ROM rating stands alone and is not combined with a DBI rating. *Id.* at 394, 468-469.

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 his burden of proof to establish greater than two percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

In his November 15, 2019 and January 28, 2020 reports, Dr. Estaris applied the sixth edition of the A.M.A., *Guides* to Dr. Diamond's physical examination findings and found a total of two percent permanent impairment of the left upper extremity. Regarding the left thumb, he applied Table 15-2, Digit Regional Grid, and found one percent permanent impairment of the left upper extremity. Regarding left-sided CTS, Dr. Estaris utilized Table 15-21, Peripheral Nerve Impairment: Upper Extremity Impairments, and found one percent permanent impairment of the left upper extremity for left CTS. He explained that if multiple nerve conduction tests had been performed, the A.M.A., *Guides* necessitated the use of the most recent preoperative test for rating purposes. Dr. Estaris further explained that in appellant's case, the most recent preoperative test was the normal January 27, 2016 EMG/NCV and the A.M.A., *Guides* precluded the use of Table 15-23 in the presence of normal electrodiagnostic testing.[18]

Dr. Estaris' November 15, 2019 and January 28, 2020 reports establish that he properly applied the A.M.A., *Guides* to his examination findings. As they are detailed, well rationalized, and based on a proper factual background, his opinion represents the weight of the medical evidence.[19]

As the medical evidence of record is insufficient to establish greater than two percent permanent impairment of the left upper extremity, for which he previously received a schedule award, the Board finds that appellant has not met his burden of proof.

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 two percent permanent impairment of the left upper extremity for which he previously received a schedule award.

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[17] *Supra* note 11 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017).

[18] *Id*. at pp 446, 447.

[19] *See L.C.,* Docket No. 23-0293 (issued June 9, 2025); *A.T.,* Docket No. 25-0272 (issued March 17, 2025); *L.M.,* Docket No. 24-0620 (issued September 9, 2024); *K.M.,* Docket No. 23-1103 (issued February 6, 2024).

ORDER

IT IS HEREBY ORDERED THAT the August 14, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 25, 2025
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board