United States Department of Labor
Employees' Compensation Appeals Board

M.R., Appellant	)	
and	)	**Docket No. 25-0020**
	)	**Issued: March 13, 2025**
DEPARTMENT OF LABOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, San Francisco, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 10, 2024, appellant filed a timely appeal from a September 24, 2024 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]

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that following the September 24, 2024 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*.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 13 percent permanent impairment of his right upper extremity and 14 percent permanent impairment of his left upper extremity, for which he has previously received schedule award compensation.

FACTUAL HISTORY

On May 31, 2019 appellant, then a 61-year-old supervisory claims examiner, filed an occupational disease claim (Form CA-2) alleging that he developed bilateral carpal tunnel syndrome and bilateral carpometacarpal (CMC) joint degeneration due to factors of his federal employment, which included over 21 years of repetitive typing, using a keyboard and mouse, reviewing imaged documents, and performing office work. He noted that he first became aware of his condition and realized its relation to his federal employment on March 14, 2019. OWCP accepted the claim for unilateral primary osteoarthritis of first CMC joint, right hand; unilateral primary osteoarthritis of first CMC joint, left hand; bilateral carpal tunnel syndrome; lesion of ulnar nerve, upper limb; primary osteoarthritis, right hand; primary osteoarthritis, left hand; and trigger thumb, right thumb.

On July 7, 2020, appellant underwent a CMC arthroplasty of the left thumb, left abductor pollicis longus (APL) transfer/suspension, and left carpal tunnel release. On December 17, 2021, he underwent a CMC arthroplasty of the right thumb, right carpal tunnel release, right ulnar nerve release at the elbow, and right trigger finger release. OWCP paid him appropriate wage-loss compensation.[3]

On March 10, 2021, appellant filed a claim for compensation (Form CA-7) requesting a schedule award.

On December 17, 2021, appellant underwent a right arthroplasty of the CMC joint, a right carpal tunnel release, a right ulnar nerve decompression at the elbow, and a right trigger finger release.

By decision dated February 17, 2022, OWCP granted appellant a schedule award for 14 percent permanent impairment of the left upper extremity (arm) and 7 percent permanent impairment of the right upper extremity (arm). The period of the award ran for 65.52 weeks from July 29, 2021 through October 30, 2022.

On December 13, 2022, appellant filed a Form CA-7 requesting an increased schedule award. No additional evidence was received.

In a December 22, 2022 letter, OWCP noted that a new rating for the right upper extremity was necessary as appellant had undergone an additional surgical procedure to the right hand and wrist on December 17, 2021. It outlined the requirements for rating a permanent impairment of a scheduled member under the sixth edition of the American Medical Association, *Guides to the*

[3] On January 11, 2022, appellant elected to receive retirement benefits from Office of Personnel Management (OPM) in lieu of FECA benefits effective January 29, 2022.

Evaluation of Permanent Impairment (A.M.A., *Guides*).[4] OWCP requested that appellant present the letter to his treating physician and advised that if his physician was unable or unwilling to provide the required report or if the medical evidence of record was not sufficient to determine his permanent impairment, it would schedule him to be seen by a second opinion specialist. It provided appellant 30 days to submit the required medical evidence from his physician.

In a March 7, 2023 report, Dr. Laura N. Sciaroni, a Board-certified orthopedic surgeon, indicated that appellant continued to have significant residual disability in both hands. She related that she could not provide an impairment rating, but opined that appellant was permanent and stationary in the right upper extremity and had previously been found stationary for the left upper extremity.

OWCP referred appellant, along with a statement of accepted facts, the medical record, and a series of questions, to Dr. Charles F. Xeller, a Board-certified orthopedic surgeon, for a second opinion evaluation on the issue of permanent impairment. In a December 2, 2023 impairment evaluation, Dr. Xeller determined that appellant had reached maximum medical impairment (MMI) as he declined further surgery. He found 14 percent total permanent impairment of the left upper extremity and 18 percent total permanent impairment of the right upper extremity under the sixth edition of the A.M.A., *Guides*. Dr. Xeller opined that appellant had five percent permanent impairment for the right carpal and cubital tunnel syndrome and three percent permanent impairment for left carpal tunnel syndrome. For the bilateral index finger distal interphalangeal (DIP) arthritis, he indicated that impairment was rated under the range of motion (ROM) methodology under Table 15-31 and resulted in 10 percent digit impairment, which equated to 2 percent upper extremity impairment. The right trigger thumb was rated under the diagnosis-based impairment (DBI) methodology under Table 15-2 as a Class 1 impairment with all grade modifiers of 1 except imaging, which was not applicable, and resulted in six percent impairment, which equated to two percent upper extremity impairment. For the bilateral thumb CMC arthroplasty, Dr. Xeller utilized Table 15-2 and found a grade 1 impairment with all grade modifiers of 1 except for imaging, which was not applicable. This resulted in 26 percent thumb impairment or 9 percent upper extremity impairment. Dr. Xeller indicated worksheets contained his impairment calculations. The record, however, is devoid of any impairment worksheets.

Dr. Michael Minev, a Board-certified internist serving as a district medical adviser (DMA), in a February 6, 2024 report, reviewed Dr. Xeller's report and indicated that appellant had reached MMI on December 2, 2023. Dr. Minev found that appellant's physical examination findings and imaging were consistent with bilateral thumb basal joint arthroplasties and bilateral index finger arthritis, but did not support bilateral carpal tunnel syndrome and right ulnar cubital tunnel syndrome diagnoses as he had negative Tinel and Phalen signs and there were no nerve conduction studies of record. He also indicated that under the A.M.A., *Guides*, appellant's findings of right trigger thumb should not be rated as the impairment due to right thumb basal joint arthroplasty was the highest rated condition involving the right thumb.

Using the DBI methodology for thumb arthroplasty, Dr. Minev found under Table 15-2, the Digit Regional Grid: Digit Impairments, that appellant had a Class 3 thumb arthroplasty which

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

had a default digit impairment rating of 30 percent. He assigned a grade modifier for functional history (GMFH) of 1 and a grade modifier for physical examination (GMPE) of 1 and noted that clinical studies were not available. Utilizing the net adjustment formula, Dr. Minev found a net adjustment of -4 for a Class 3 thumb arthroplasty, which resulted in a final digit impairment of 30 percent for each thumb. He indicated that appellant's file did not contain sufficient information to calculate an impairment rating under the ROM impairment methodology. Using the DBI impairment methodology for bilateral index finger DIP joint, Dr. Minev found under Table 15-2 a Class 1 finger DIP sprain, which had a default impairment rating of three percent. He assigned GMFH of 1, GMPE of 1 and again noted that clinical studies were not available. Utilizing the net adjustment formula, Dr. Minev found a net adjustment of 0, for a final digit impairment rating of three percent. He also utilized the ROM impairment methodology and found that right index DIP flexion of 40 degrees equated to 10 percent digit impairment and right index DIP extension of 0 degrees equated to 0 percent impairment, for a total of 10 percent impairment for each index finger. Dr. Minev, therefore, determined that appellant had 10 percent final index finger impairment under the ROM impairment methodology as the higher of the two impairment ratings took precedence. He converted the final bilateral thumb digit impairment rating of 30 percent to an 11 percent upper extremity impairment rating and converted the final bilateral index finger digit impairment rating of 10 percent to 2 percent upper extremity impairment rating. Dr. Minev concluded that the final right upper extremity impairment rating equaled 13 percent permanent impairment and the final left upper extremity impairment rating equaled 13 percent permanent impairment. He noted that his impairment rating differed from Dr. Xeller's as the additional impairment ratings for bilateral carpal tunnel syndrome and right ulnar cubital tunnel syndrome were not supported by physical examination findings of record and the lack of nerve conduction studies. Dr. Minev also indicated that, since Dr. Xeller's impairment worksheets were not of record, it was not possible to analyze any further differences in impairment ratings.

On February 27, 2024, OWCP requested clarification from Dr. Xeller as to whether he agreed with the DMA's impairment ratings of the bilateral upper extremities and, if not, to provide a response to the DMA's February 6, 2024 report, along with additional evidence. No response was received.

By decision dated February 27, 2024, OWCP granted appellant a schedule award for an additional 6 percent permanent impairment of the right upper extremity, for a total of 13 percent permanent impairment. The period of the award ran for 18.72 weeks from December 2, 2023 through April 11, 2024. OWCP further noted that appellant had no increased left upper extremity impairment.

In a March 6, 2024 addendum report, Dr. Xeller reviewed Dr. Minev's December 6, 2024 DMA report and recalculated appellant's total impairment to reflect 12 percent total impairment for both sides, comprised of 9 percent impairment for CMC arthroplasty and 3 percent impairment for DIP arthritis of the index finger. He agreed that it was reasonable to discount the bilateral carpal tunnel release and right cubital tunnel release surgeries as appellant had a negative Tinel sign and there were no recent electrodiagnostic studies on file. Dr. Xeller also agreed that it was proper to discount the right trigger thumb condition as the basal joint arthroplasty subsumed that condition. He noted that, while there was no specific category in the A.M.A., *Guides* to account for DIP arthritis, he would accept the DMA's higher rating of three percent impairment for a finger strain. For the basal joint thumb arthroplasties, Dr. Xeller indicated that Dr. Minev did not reduce

the default impairment rating of 30 percent by the grade modifiers, which resulted in a grade A or 26 percent permanent digit impairment.

On September 17, 2024, OWCP received appellant's September 10, 2024 request for reconsideration. Appellant indicated that he underwent a repeat electromyogram/nerve conduction velocity (EMG/NCV) study on August 30, 2024. The August 30, 2024 EMG/NCV study indicated no electrodiagnostic evidence of right or left ulnar neuropathy across the wrist or elbow; mild bilateral median neuropathy across the wrist; and findings consistent with mild/old bilateral C7 radiculopathy.

By decision dated September 24, 2024, OWCP denied modification of its February 27, 2024 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. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[7] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (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]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment class of diagnosis (CDX), which is then adjusted by a GMFH, a GMPE, and/or a grade modifier for clinical studies (GMCS).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] Under Chapter 2.3, evaluators are directed to provide reasons for

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.*; *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[8] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.* at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

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

[10] A.M.A., *Guides* 383-492.

[11] *Id.* at 411.

their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[12]

The A.M.A., *Guides* also provide that the ROM impairment methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[13] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[14] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[15]

Regarding the application of ROM or DBI methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "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*."[16] (Emphasis in the original.)

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

[12] *Id*. at 23-28.

[13] *Id*. at 461.

[14] *Id*. at 473.

[15] *Id*. at 474.

[16] FECA Bulletin No. 17-06 (issued May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[17] *See supra* note 8 at Chapter 2.808.6f (March 2017); *see also P.W.*, Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan*, 57 ECAB 349 (2006).

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 13 percent permanent impairment of his right upper extremity and 14 percent permanent impairment of his left upper extremity, for which he previously received schedule award compensation.

In accordance with its procedures, OWCP properly referred the medical record to Dr. Minev, a DMA,[18] for review and a determination of whether appellant sustained permanent impairment of his upper extremities. In a December 6, 2024 report, Dr. Minev opined that appellant had 13 percent permanent impairment of the left upper extremity and 13 percent permanent impairment of the right upper extremity, explaining, in relevant part, that the current examination and electrodiagnostic findings did not support bilateral carpal tunnel syndrome and right ulnar cubital tunnel syndrome diagnoses as there were no recent NCV studies of record. Dr. Minev also opined that further analysis of differences in impairment ratings were not possible as Dr. Xeller's impairment worksheets were not of record.

Based on Dr. Minev's December 6, 2024 report, by decision dated February 27, 2024, OWCP granted appellant an additional 6 percent permanent impairment of the right upper extremity, for a total of 13 percent permanent impairment. It subsequently received Dr. Xeller's March 6, 2024 addendum, in which Dr. Xeller reviewed Dr. Minev's December 6, 2024 report and opined that appellant had a lower impairment rating of 12 percent permanent impairment to the left and right upper extremities. In relevant part, Dr. Xeller agreed with Dr. Minev that the bilateral carpal tunnel release and the right cubital tunnel release surgeries could be discounted due to appellant's negative Tinel sign and the fact that there were no recent electrodiagnostic findings on file.

Appellant subsequently submitted an August 30, 2024 EMG/NCV study, which contained positive bilateral median neuropathy findings. However, the Board has held that diagnostic studies, standing alone, lack probative value if they do not address the relevant issue.[19]

As the medical evidence of record is insufficient to establish greater than 13 percent permanent impairment of his right upper extremity or 14 percent permanent impairment of his left upper extremity, 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.

[18] *See B.W.*, Docket No. 24-0223 (issued July 17, 2024); FECA Bulletin No. 17-06 (issued May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[19] *See generally E.B.*, Docket No. 20-0477 (issued January 3, 2023); *J.S.*, Docket No. 17-1039 (issued October 6, 2017).

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish greater than 13 percent permanent impairment of his right upper extremity and 14 percent permanent impairment of the left upper extremity, for which he previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the September 24, 2024 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 13, 2025
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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