United States Department of Labor
Employees' Compensation Appeals Board

D.D., Appellant	)	
and	)	**Docket No. 13-1535**
	)	**Issued: April 7, 2014**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Hines, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 14, 2013 appellant filed a timely appeal from a March 8, 2013 decision of the Office of Workers' Compensation Programs (OWCP) regarding a schedule award. 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.

ISSUE

The issue is whether appellant sustained more than a five percent impairment of the right upper extremity and a six percent impairment of the left upper extremity, for which he received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on or before April 22, 2008 appellant, then a 57-year-old vocational rehabilitation specialist, sustained bilateral carpal tunnel syndrome, bilateral trigger fingers and bilateral tenosynovitis of the hands due to repetitive hand motions at work.

Appellant underwent right carpal tunnel release on August 4, 2009 and left carpal tunnel release on September 22, 2009, performed by Dr. John A. Hefferon, an attending Board-certified orthopedic surgeon, who held appellant off work through March 2, 2010 due to postsurgical edema and loss of active motion in all fingers. Dr. Michael I. Vender, an attending physician Board-certified in orthopedic and hand surgery, submitted a March 26, 2010 report diagnosing bilateral flexor stenosing tenosynovitis and wrist synovitis with "trigger" contraction of the left thumb, index and middle fingers.

On March 31, 2010 OWCP obtained a second opinion from Dr. David Trotter, a Board-certified orthopedic surgeon, who found weakness and restricted motion throughout both hands and wrists, with inflammation in the digits and multiple "trigger fingers."

On June 2, 2010 Dr. Vender performed a repeat right carpal tunnel release, right wrist flexor synovectomy and thumb flexor tendon sheath release. On August 25, 2010 he performed a repeat left carpal tunnel release with flexor synovectomy and release of the flexor tendon sheath of the left thumb, index and middle fingers. On January 12, 2011 Dr. Vender performed a release of the right index, middle, ring and small flexor tendon sheaths with debridement. On May 4, 2011 he performed a release of the left ring and small finger tendon sheaths with debridements. Dr. Vender opined that appellant reached maximum medical improvement as of August 24, 2011, with continued pain, swelling and stiffness throughout both hands and wrists and locking of the left index finger. Appellant returned to limited-duty work on September 6, 2011.

On September 8, 2011 appellant claimed a schedule award. OWCP advised him to submit an impairment rating from his attending physician using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*.) Appellant did not submit an impairment rating.

An OWCP medical adviser reviewed the medical record on November 14, 2011 and concurred with Dr. Vender that appellant had reached maximum medical improvement on August 24, 2011. He noted that appellant underwent bilateral carpal tunnel releases as well as A1 pulley releases of the right index, middle ring and small fingers and left ring and small fingers. Referring to Table 15-2[2] of the sixth edition of the A.M.A., *Guides*, the medical adviser found six percent impairment of the left index finger secondary to residual locking, corresponding to one percent impairment of the left upper extremity according to Table 15-12.[3]

[2] Table 15-2, page 391 of the sixth edition of the A.M.A., *Guides* is entitled "Digit Regional Grid: Digit Impairments."

[3] Table 15-1, page 421 of the sixth edition of the A.M.A., *Guides* is entitled "Impairment Values Calculated From Digit Impairment."

He stated that no additional impairment would be awarded for the other digits. The medical adviser opined that appellant had no permanent impairment of the right upper extremity.

By decision dated February 2, 2012, OWCP granted appellant a schedule award for one percent impairment of the left upper extremity. It found that he had no permanent impairment of the right upper extremity.

In a June 21, 2012 letter, appellant requested reconsideration. He submitted a May 2, 2012 impairment rating by Dr. Stephen Gnatz, an attending Board-certified physiatrist. On examination, Dr. Gnatz noted swelling throughout both hands, limited wrist motion bilaterally and inability to make a fist. He also observed diminished sensation in the median nerve distributions bilaterally. Appellant completed a *Quick*DASH questionnaire with a score of 84. Dr. Gnatz diagnosed bilateral median neuropathy with stiffness of both hands.[4] Referring to Table 15-23 of the A.M.A., *Guides*,[5] Dr. Gnatz found nine percent impairment of each upper extremity due to presurgical axonal loss in the median nerve distribution.

In a July 2, 2012 memorandum, OWCP requested that a medical adviser review Dr. Gnatz's report and determine if appellant has sustained greater impairment. It noted that appellant had previously been granted a schedule award for a one percent impairment of the right upper extremity and zero percent to the left upper extremity.

In a July 9, 2012 report, an OWCP medical adviser reviewed Dr. Gnatz's impairment rating and noted that the date of maximum medical improvement remained at August 24, 2011. He explained that Dr. Gnatz did not properly apply the A.M.A., *Guides*, as he included grip strength and the *Quick*DASH score but omitted appellant's history and grade modifier for Physical Examination (GMPE). The medical adviser found a grade modifier for Clinical Studies (GMCS) of 2 for bilaterally decreased sensation in the hands and a grade modifier for Functional History (GMFH) of 2 for significant intermittent symptoms according to Table 15-23. The average Grade 2 modifier equaled five percent impairment of each upper extremity. The *Quick*DASH score of 84 raised the impairment rating one percent bilaterally to equal six percent for each arm. The medical adviser found that appellant had a five percent impairment of the right upper extremity and six percent for the left upper extremity. He opined that there was "no objective evidence to change the previous award as it relates to the trigger digits."

By decision dated July 23, 2012, OWCP vacated its February 2, 2012 decision. It noted that it had previously issued a schedule award for one percent impairment to his right arm. OWCP found that Dr. Gnatz's opinion, as reviewed and corrected by its medical adviser, established the increased percentages of impairment. It advised that Dr. Gnatz included extraneous elements in his rating whereas the medical adviser correctly applied the A.M.A., *Guides.*

[4] Dr. Gnatz commented that appellant had a history of an equivocally positive Lyme titer that could indicate arthropathy but there were no current active signs of Lyme disease.

[5] Table 15-23, page 449 of the sixth edition of the A.M.A., *Guides* is entitled "Entrapment/Compression Neuropathy Impairment"

In a separate July 23, 2012 schedule award decision, OWCP issued appellant a schedule award for five percent impairment of the right arm. For the left arm, it awarded an additional five percent impairment, noting that he previously received a schedule award for one percent left arm impairment.

In a December 6, 2012 letter, appellant requested reconsideration. He asserted that OWCP's medical adviser did not consider the tenosynovectomies of both thumbs and all fingers

In a September 21, 2012 report, Dr. Michael Bednar, an attending Board-certified orthopedic surgeon, found two-point discrimination at more than 15 millimeters and restricted wrist flexion bilaterally. He found that there were no indications for further surgery. In a November 13, 2012 report, Dr. Hefferon noted edema and restricted motion of both hands "unchanged for many months."

By decision dated March 8, 2013, OWCP denied modification on the grounds that the evidence submitted did not demonstrate that the July 23, 2012 schedule award decision should be modified. It found that Dr. Bednar and Dr. Hefferon did not find that appellant's condition had worsened since issuance of the July 23, 2012 schedule award.

LEGAL PRECEDENT

The schedule award provisions of FECA provide for compensation to employees sustaining impairment from loss or loss of use of specified members 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 mater which rests in the sound 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. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[6] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[7]

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).[8] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on functional history, physical examination and clinical studies.[9] The net adjustment formula is (GMFH -

[6] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] A.M.A., *Guides* (6th ed., 2008), page 3, Section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[9] *Id*. at pp. 494-531.

CDX) + (GMPE - CDX) + (GMCS - CDX). The A.M.A., *Guides* divides the upper extremity into regions for rating purposes. The hand is one of the designated regions.[10]

The A.M.A., *Guides* provide a specific rating process for entrapment neuropathies such as carpal tunnel.[11] This rating process requires that the diagnosis of a focal neuropathy syndrome be documented by sensory or motor nerve conduction studies or electromyogram. The A.M.A., *Guides* do not allow additional impairment values for decreased grip strength, loss of motion or pain.[12] Table 15-23 provides a compilation of the grade modifiers for test findings, history and physical findings which are averaged and rounded to the nearest whole number. This table also provides the range of impairment values as well as the function scale modifier which determines the impairment value within the impairment scale.[13]

In some instances, OWCP's medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides*. In this instance, a detailed opinion by OWCP's medical adviser which gives a percentage based on reported findings and the A.M.A., *Guides* may constitute the weight of the medical evidence.[14]

ANALYSIS

The issue is whether appellant established that a July 23, 2012 schedule award for five percent impairment of the right upper extremity and six percent impairment of the left upper extremity should be modified. Appellant requested reconsideration on December 6, 2012, submitting reports from two attending Board-certified orthopedic surgeons. Dr. Hefferon found appellant's condition unchanged, and Dr. Bednar did not offer a new impairment rating. OWCP properly found in its March 8, 2013 decision that the new evidence submitted on reconsideration did not warrant modification of the July 23, 2012 schedule award.

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome, bilateral trigger fingers and bilateral tenosynovitis of the upper extremities. He underwent two bilateral carpal tunnel releases, bilateral wrist flexor synovectomies and flexor tendon sheath releases of all digits bilaterally. Appellant claimed a schedule award on September 8, 2011. On February 2, 2012 OWCP granted him a schedule award for one percent impairment of the left arm due to locking of the left index finger. On reconsideration, appellant submitted a May 2, 2012 impairment rating by Dr. Gnatz, an attending Board-certified physiatrist, who found nine percent impairment of each upper extremity due to residual carpal tunnel syndrome. However,

[10] *Id*. at page 384, Figure 15-1, "Upper Extremity Regions."

[11] *Id*. at pp. 432-50.

[12] *Id.* at 433.

[13] *Id*.

[14] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8(j) (September 2010).

Dr. Gnatz improperly included grip strength as an element of his rating and omitted appellant's history and grade modifier for physical examination.

To determine the appropriate percentages of permanent impairment, OWCP referred Dr. Gnatz's report to an OWCP medical adviser. In its July 2, 2012 referral memorandum, OWCP misstated that appellant had received a schedule award for one percent impairment of the right upper extremity, not the left. In the July 9, 2012 report, an OWCP medical adviser opined that Dr. Gnatz's findings warranted six percent impairment rating of each upper extremity. The medical adviser then relied on the incorrect memorandum, stating that appellant should receive an additional five percent impairment of the right arm in addition to the one percent previously awarded. However, appellant did not receive a prior award for the right upper extremity. In its July 23, 2012 decision, OWCP granted a schedule award for an additional five percent impairment of the left upper extremity, for a total of six percent. This appears to be in accordance with OWCP medical adviser's impairment rating for the left arm. However, OWCP granted only five percent impairment of the right upper extremity, whereas the medical adviser found six percent impairment, but mistakenly subtracted one percent due to confusion regarding the prior schedule award.

The Board finds that the medical evidence establishes that appellant has a six percent impairment of each upper extremity. OWCP's medical adviser properly applied the appropriate portions of the A.M.A., *Guides* to Dr. Gnatz's clinical findings. The medical adviser's opinion is sufficient to represent the weight of the medical evidence.[15] The apparent inconsistency regarding the percentage of impairment was produced by the misstatement in the July 2, 2012 memorandum that appellant received a prior schedule award for the right arm, whereas he received an award for the left arm. From the medical adviser's percentages of impairment it is clear that the medical adviser intended to assess a six percent impairment to each upper extremity. The Board will modify the March 8, 2013 decision to reflect a six percent impairment of each arm.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has established that he sustained a six percent impairment of the left and right arms.

[15] *See* Federal (FECA) Procedure Manual, *supra* note 14 at Chapter 2.810.8(j).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 8, 2013 is affirmed, as modified.

Issued: April 7, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board