United States Department of Labor
Employees' Compensation Appeals Board

E.P., Appellant	)	
and	)	**Docket No. 16-0582**
	)	**Issued: July 20, 2016**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, Anthony, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On February 8, 2016 appellant filed a timely appeal from a January 15, 2016 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.

ISSUE

The issue is whether OWCP properly determined that appellant had no more than 12 percent permanent impairment of the right upper extremity and 4 percent permanent impairment of the left upper extremity, for which he received schedule awards.

FACTUAL HISTORY

OWCP accepted that on or before February 26, 2013 appellant, then a 49-year-old drug treatment specialist, sustained bilateral carpal tunnel syndrome and bilateral tenosynovitis of the

[1] 5 U.S.C. § 8101 *et seq.*

hand and wrist due to repetitive keyboarding and clerical tasks. It had accepted right elbow and forearm sprain under a prior claim (File No. xxxxxx776) on August 2, 2006.

By decision dated September 29, 2010 under File No. xxxxxx776, OWCP granted appellant a schedule award for six percent impairment of the right upper extremity.

On July 18, 2013 appellant underwent surgery to remove a spur and sutures from the right triceps tendon at the elbow. He returned to restricted duty on September 1, 2013 and to full duty on December 4, 2013.

Dr. Robert R. Bell, an attending Board-certified orthopedic surgeon, performed a right carpal tunnel release on March 3, 2014, authorized by OWCP. He received compensation for work absences.

By decision dated April 2, 2014 under File No. xxxxxx776, OWCP issued a schedule award for an additional two percent impairment of the right upper extremity.

Dr. Bell performed a left carpal tunnel release on August 4, 2014 authorized by OWCP. He received wage-loss compensation from August 4 to September 14, 2014.

On September 15, 2014 appellant filed a claimed for a schedule award (Form CA-7). In an October 15, 2014 letter, OWCP advised him to submit a report from his attending physician establishing that the accepted bilateral carpal tunnel syndrome and tenosynovitis had reached maximum medical improvement. The physician was also to provide an impairment rating according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, the A.M.A., *Guides*) and to establish that the accepted conditions had reached maximum medical improvement. Appellant was afforded 30 days to submit such evidence.

In response, appellant submitted a January 19, 2015 report from Dr. Andrew Palafox, an attending Board-certified orthopedic surgeon. Dr. Palafox reviewed the history of injury and treatment, and opined that appellant had reached maximum medical improvement as of January 19, 2015. Appellant completed a *Quick*DASH questionnaire with a score of 40. Dr. Palafox related appellant's complaints of intermittent numbness and tingling in both hands. Appellant stated that he did not experience difficulties with activities of daily living. On examination, Dr. Palafox noted slightly reduced normal two-point discrimination in both hands. Referring to Table 15-23 of the A.M.A., *Guides*,[2] he noted a class 1 diagnosis-based impairment (DBI) Class of Diagnosis (CDX) of bilateral carpal tunnel syndrome, with a default grade 5. For the right hand, Dr. Palafox found a grade 1 modifier for Clinical Studies (GMCS) for a conduction delay on electromyography studies. He also found a grade 2 modifier for Functional History (GMFH) for significant intermittent paresthesias and a grade 2 modifier for findings on Physical Examination (GMPE) for slightly diminished two-point discrimination. Dr. Palafox calculated that according to the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or "1+2+2," appellant had an average modifier of 2.25, rounded downward to

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

2, which left the default CDX of 5 unchanged. He opined that the *Quick*DASH score of 40 raised the default five percent to six percent on the right. Dr. Palafox used the same method to calculate five percent impairment of the left hand, as the *Quick*DASH score was not included for the second extremity, so as not to use the grade modifier twice. Using the Combined Values Chart, 6 percent for the right combined with 5 percent for the left provided a total upper extremity impairment of 11 percent.

In a March 30, 2015 report, an OWCP medical adviser reviewed Dr. Palafox's report and concurred with his assessment of five percent impairment of the left upper extremity. He agreed with Dr. Palafox that the grade modifiers established five percent impairment of the right upper extremity, but differed in concluding that the *Quick*DASH score would not raise the total impairment to six percent. The medical adviser noted that the *Quick*DASH of 40 resulted in a modifier of 1 and that Dr. Palafox apparently misread Table 15-23. Therefore, appellant had five percent impairment of the right arm. As to the left, the medical adviser found a default value of five percent and noted that Dr. Palafox did not use the functional modifier, but as this is not the same extremity he could have.

On June 1, 2015 the medical adviser provided an updated report noting errors in his prior report and inclusion of the schedule awards under File No. xxxxxx776. He opined that appellant had four percent impairment of each upper extremity, as the *Quick*DASH score of 40 reduced the default five percent CDX to four percent. No rationale was provided for using the modifier of the *Quick*DASH to reduce the right upper extremity rating. The medical adviser did note that it was his opinion that it is permissible to use the functional modifier more than one in determining impairment based on entrapment neuropathy. He noted that appellant had received a schedule award for eight percent impairment of the right arm under File No. xxxxxx776. Combining the prior 8 percent with the current 4 percent for carpal tunnel syndrome under the present claim resulted in 12 percent impairment of the right upper extremity. Subtracting the eight percent previously awarded resulted in an additional four percent right arm impairment due to accepted carpal syndrome and tendinitis.

By decision dated July 24, 2015, OWCP awarded appellant four percent permanent impairment of the left upper extremity and an additional four percent permanent impairment of the right upper extremity. It noted that he had previously been granted a schedule award for an 8 percent permanent impairment of the right upper extremity due to a bicep tendon tear and olecranon bursitis under File No. xxxxxx776, which corresponds to a total right upper extremity of 12 percent.

Appellant disagreed and in an August 6, 2015 letter requested a review of the written record. He contended that he had not received prior schedule awards for his right upper extremity. Appellant submitted November 17 and 25, 2015 reports from Dr. Bell, an attending Board-certified orthopedic surgeon, who diagnosed bilateral carpal tunnel syndrome and prescribed compression gloves. Dr. Bell did not address the issue of permanent impairment.

By decision dated January 15, 2016, an OWCP hearing representative affirmed OWCP's July 24, 2015 decision, finding that properly applied the appropriate portions of the A.M.A., *Guides* to Dr. Palafox's clinical findings.

LEGAL PRECEDENT

The schedule award provisions of FECA[3] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. It, 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.[4] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[5]

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).[6] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[7] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

In addressing upper extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[8] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9]

The adjustment grid for functional history notes that this grade modifier should be applied only to the single, highest DBI. Specific jurisdictions may modify the process such that functional history adjustment is considered for each DBI or not considered at all as a modifier.[10] The evaluating physician may use the *Quick*DASH functional assessment outcome questionnaire as part of the process of evaluating functional symptoms…. The inventory is used only to assist the

[3] 5 U.S.C. § 8107.

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

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[6] A.M.A., *Guides*, at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement" (6th ed. 2009).

[7] *Id*. at 494-531 (6th ed. 2008).

[8] *Id*. at 385-419, *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[9] *Id*. at 411.

[10] *Supra* note 2, section 15.3a Adjustment Grid: Functional History, at 406.

examiner in defining the grade modifier for functional history and does not serve as a basis for defining further impairment, nor does the score reflect an impairment percentage.[11]

ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome and bilateral tenosynovitis of the hand and wrist. Appellant underwent right carpal tunnel release on March 3, 2014 and left carpal tunnel release on August 4, 2014, authorized by OWCP. He claimed a schedule award on September 15, 2014. In support of his claim, appellant submitted a January 19, 2015 report from Dr. Palafox, an attending Board-certified orthopedic surgeon.

Dr. Palafox opined that appellant had five percent impairment of the left upper extremity and six percent impairment of the left upper extremity due to carpal tunnel syndrome. Referring to Table 15-23 of the A.M.A., *Guides*, he found a class 1 DBI of bilateral carpal tunnel syndrome, with a default grade 5. For each hand, Dr. Palafox found a grade 1 modifier for GMCS due to a conduction delay on electrodiagnostic studies, a grade 2 modifier for GMFH for paresthesias, and a grade 2 modifier for findings on GMPE for slightly diminished two-point discrimination. As the modifiers did not result in a net adjustment, Dr. Palafox found five percent impairment of each arm, increased to six percent on the right due to the *Quick*DASH score.

In March 30 and June 1, 2015 reports, an OWCP medical adviser explained that Dr. Palafox misunderstood the interrelationship of Table 15-23 and the *Quick*DASH score. He opined that based on Dr. Palafox's clinical findings, appellant had four percent impairment of each arm due to carpal tunnel syndrome and tenosynovitis. OWCP then issued the July 24, 2015 schedule award for four percent impairment of the right arm and four percent impairment of the left arm. It noted that this was in addition to the eight percent impairment for the right arm previously awarded under File No. xxxxxx776.

The Board finds that this case is not in posture for a decision. Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[12] The Board finds that neither the January 19, 2015 report of Dr. Palafox nor the March 30 and June 1, 2015 reports of the OWCP medical adviser provide sufficient medical rationale as to the extent of appellant's permanent impairment of his bilateral upper extremities. Neither physician provided an explanation as to the proper use of the *Quick*DASH score in the calculation of permanent impairment. There is np explanation as to why the *Quick*DASH was used by Dr. Palafox only on the right upper extremity and not on the left. There is also no explanation from the medical adviser to explain why the *Quick*DASH score should be used to reduce the extent of impairment from the default value of five percent to four percent for both upper extremities. Accordingly, the case will be remanded to OWCP for further development of the medical evidence as to the extent of bilateral upper extremity impairment. On remand, OWCP should further develop the medical evidence by preparing a statement of accepted facts and referring appellant for a second opinion examination in accordance with its

[11] *Id.*

[12] *See B.C.*, Docket No. 15-1853 (issued January 2016).

procedures.[13] After such further development, as it deems necessary, it should issue a *de novo* decision.

On appeal, appellant contends that the medical adviser improperly reduced his impairment rating to four percent of each upper extremity because he mistakenly believed that appellant received prior schedule awards for an eight percent right upper extremity impairment under File No. xxxxxx776. He also contends that he did not receive prior schedule awards for right upper extremity impairment. The Board notes, however, that this case is not currently in posture for decision.

CONCLUSION

The Board finds that this matter is not in posture for a decision.

ORDER

IT IS HEREBY ORDERED THAT the January 15, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision.

Issued: July 20, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[13] OWCP's procedures provide that, if a medical adviser provides an opinion which is not strong enough to constitute a conflict with the opinion of the treating physician, but is of sufficient value to warrant additional action, OWCP may refer the claim for a second opinion examination. *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluation Medical Evidence*, Chapter 2.810.8(h) (September 2010).