United States Department of Labor
Employees' Compensation Appeals Board

M.B., Appellant	)	
	)	**Docket No. 15-0230**
and	)	**Issued: October 6, 2016**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Kearny, NJ, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On November 12, 2014 appellant filed a timely appeal from an August 5, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[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] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant established more than six percent impairment of the left upper extremity and six percent impairment of the right upper extremity, for which she received a schedule award.

FACTUAL HISTORY

OWCP accepted that on or before December 12, 2002 appellant, then a 39-year-old small parcel bundle sorter, sustained bilateral carpal tunnel syndrome in the performance of duty.[3]

On April 28, 2004 Dr. John T. Capo, an attending Board-certified orthopedic surgeon, diagnosed bilateral carpal tunnel syndrome, left greater than right.

Dr. Monica Mehta, an attending Board-certified physiatrist, opined on February 1, 2006 that appellant's complaints of weakness and paresthesias in both hands were caused by the combined effects of bilateral carpal tunnel syndrome and cervical disc herniations at C2-3, C3-4, and C4-5.[4] She noted that appellant sustained cervical spine injuries in 1987, 1993, and 1994, motor vehicle accidents.[5]

Dr. Mehta submitted reports from April 9, 2006 to July 12, 2007, finding appellant totally disabled from work due to bilateral carpal tunnel syndrome, cervical radiculopathy, cervical radiculitis, and aggravation of a left rotator cuff tear. She attributed these diagnoses to "work-related injuries."

OWCP accepted a recurrence of disability from September 22, 2006 to mid-January 2007, when appellant returned to work in a light-duty position. It terminated appellant's wage-loss and medical compensation benefits, effective March 9, 2009, as her accepted bilateral carpal tunnel syndrome had resolved, based on the opinion of Dr. James Charles, a Board-certified neurologist, who attributed appellant's ongoing symptoms to diabetic neuropathy.

On February 23, 2012 appellant claimed a schedule award (Form CA-7). She submitted a July 26, 2011 impairment rating from Dr. Irwin A. Moskowitz, a Board-certified orthopedic surgeon. Dr. Moskowitz found that appellant had reached maximum medical improvement (MMI). He related her complaints of intermittent cervical spine pain, paresthesias in both hands, and difficulty with driving and fine motor activities. Appellant completed *Quick*DASH questionnaires with a score of 63 percent on the right and 65 percent on the left. Dr. Moskowitz noted that appellant had a history of diabetes mellitus and thyroid disease. On examination he

[3] December 12, 2002 electromyogram (EMG) and nerve conduction velocity (NCV) studies showed left carpal tunnel syndrome.

[4] A January 23, 2006 magnetic resonance imaging (MRI) scan of the cervical spine showed disc dehydration from C2 to C6, and disc herniations at C2-3, C3-4, and C4-5. A March 16, 2006 MRI scan of the left shoulder showed a partial thickness tear of the supraspinatus tendon with mild degenerative acromioclavicular changes. There was no interval change compared to a June 11, 2003 MRI scan study.

[5] On March 27, 2006 OWCP obtained a second opinion from Dr. John E. Robinton, a Board-certified neurologist, regarding the nature and extent of the accepted condition. Dr. Robinton diagnosed bilateral carpal tunnel syndrome and found appellant able to perform full-time work with restrictions.

found limited cervical motion, tenderness in the left shoulder over the bicipital tendon and subacromial bursa, restricted abduction and external rotation of the left shoulder, tenderness over both carpal canals, loss of sensation in the median nerve bilaterally, and diminished pinch strength. Dr. Moskowitz diagnosed bilateral carpal tunnel syndrome, a cervical spine strain superimposed on right-sided C2-3 and C3-4 disc herniations, a broad-based C4-5 disc herniation, contusion and strain superimposed on a partial left supraspinatus tear, and degenerative changes of the left subacromial bursa. He attributed all diagnosed conditions to appellant's federal employment.

Referring to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*), Dr. Moskowitz, using Table 15-23,[6] "Entrapment/Compression Neuropathy Impairment," he found a grade modifier of 1 for test findings, a grade modifier of 3 for history, and a grade modifier of 2 for physical findings. These totaled to six, and were averaged to a total of two. According to Table 15-7[7] for *Quick*DASH scores of 63 and 65 percent represented a grade 2 modifier for functional scale due to sensory loss. This moved the default value of three to six percent for both the left and right wrist.

Dr. Moskowitz also found an additional five percent permanent impairment of the left shoulder for a class 1 partial rotator cuff tear "with residual loss," with a grade modifier of 3 for functional history (again based on the *Quick*DASH score of 65 percent), a grade modifier of 2 for clinical studies, and a grade modifier of 1 for physical examination. Applying the net adjustment formula, he found a net adjustment of plus three, raising the default value from three to five. Dr. Moskowitz then combined the left arm impairments of 6 plus 5 to equal 11 percent impairment of the left upper extremity.

In an October 12, 2012 report, an OWCP medical adviser concurred with Dr. Moskowitz's calculation of six percent impairment of each upper extremity due to carpal tunnel syndrome. He did not address appellant's left shoulder. On May 7, 2013 an OWCP medical adviser clarified that while a partial rotator cuff tear was noted in the July 26, 2011 examination of Dr. Moskowitz, OWCP had only asked him to provide an impairment rating for the bilateral carpal tunnel syndrome.

By decision issued December 6, 2013, OWCP granted a schedule award for six percent permanent impairment of the right upper extremity and six percent impairment of the left upper extremity, based on Dr. Moskowitz's opinion as reviewed by OWCP's medical adviser. The award ran from July 26, 2011 to April 1, 2012.

Counsel requested a hearing, which he later changed to a request for a review of the written record. He contended that there was a conflict of medical opinion between Dr. Moskowitz and OWCP's medical adviser on whether to include appellant's left shoulder conditions in the impairment rating. Counsel further contended that appellant was entitled to augmented compensation as she had an eligible dependent at the time of her schedule award.

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

[7] Table 15-7, page 406 of the sixth edition of the A.M.A., *Guides* is entitled "Functional History Adjustment: Upper Extremities."

By decision dated August 5, 2014, an OWCP hearing representative affirmed the December 6, 2013 schedule award determination. She found that there was no basis for including the left rotator cuff tear in the impairment rating because it was not an accepted condition.

LEGAL PRECEDENT

The schedule award provisions of FECA[8] 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 matter 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.[9] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[10]

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).[11] Under the sixth edition, the evaluator identifies the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[12] 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 functional history, physical examination, and clinical studies.[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14]

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

[8] 5 U.S.C. § 8107.

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

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

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

[12] *Id*. at 494-531 (6th ed. 2009).

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

[14] *Id*. at 411.

[15] *Id*. at 449.

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 (*Quick*DASH).[16]

ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome in the performance of duty. Dr. Mehta, an attending Board-certified physiatrist, opined that appellant sustained a partial left rotator cuff tear in the performance of duty. The supraspinatus tear was demonstrated by a March 16, 2006 MRI scan. Following MMI, in a July 26, 2011 impairment rating pursuant to appellant's schedule award claim, Dr. Moskowitz, a Board-certified orthopedic surgeon, opined that appellant had six percent impairment of each arm due to carpal tunnel syndrome. He also found an additional five percent impairment of the left arm due to the partial supraspinatus tear. An OWCP medical adviser did not address appellant's left shoulder in his impairment assessment. He noted this omission in his May 7, 2013 report, commenting that OWCP had not requested an impairment rating for the left shoulder condition.

The Board notes that there is no dispute regarding appellant's impairment due to her bilateral carpal tunnel syndrome as Dr. Moskowitz, an OWCP medical adviser, and a medical consultant concurred as to the six percent rating for each arm due to carpal tunnel syndrome.

The Board finds that OWCP has not accepted a left shoulder condition as being work related. Although appellant's treating physicians Drs. Mehta and Moskowitz diagnosed a partial left shoulder tear and attributed it to her federal employment, the condition has not yet been accepted by OWCP.[17] Appellant, therefore, has not established more than six percent permanent impairment of each upper extremity.[18]

On appeal counsel contends that OWCP should have included preexisting acromioclavicular joint degeneration and a partial supraspinatus tendon tear of the left shoulder, as demonstrated by a September 10, 2003 MRI scan, in calculating the schedule award. In determining the amount of impairment for a given member of the body, preexisting impairments of that same scheduled member of the body are to be included.[19] Although appellant argues that the preexisting shoulder conditions should have been included in the impairment rating for the bilateral carpal tunnel syndrome, the Board notes that the shoulder is not the level of the arm for which appellant had received his schedule award. Accordingly OWCP properly denied to include the shoulder conditions in the rating for the left and right wrist conditions.

[16] *Id.* at 448-449

[17] *See Theron J. Barham*, 34 ECAB 1070 (1983) (vague and unrationalized medical opinions on causal relationship have little probative value).

[18] *See Veronica Williams*, 56 ECAB 367 (2005) (a schedule award can be paid only for a condition related to an employment injury; the claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment).

[19] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b. (June 1993). (The impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function); *Carl J. Cleary*, 57 ECAB 563 (2006).

Counsel also asserts a conflict of medical opinion exists between appellant's physicians and OWCP's medical adviser as to whether appellant's left shoulder condition should be included in the impairment rating. As noted above, OWCP has not accepted a left shoulder condition as work related and that issue is not before the Board on this appeal. Therefore, the Board finds that appellant has not established more than six percent permanent impairment for her right and her left upper extremity based on the diagnosis of bilateral carpal tunnel syndrome.

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 not established more than six percent permanent impairment of the left upper extremity and six percent permanent impairment of the right upper extremity, for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 5, 2014 is affirmed.

Issued: October 6, 2016
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board