United States Department of Labor
Employees' Compensation Appeals Board

M.L., Appellant	)	
and	)	**Docket No. 19-0415**
	)	**Issued: September 4, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Detroit, MI, Employer	)	

Appearances:
Alan J. Shapiro, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 18, 2018 appellant, through counsel, filed a timely appeal from a September 24, 2018 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 has met her burden of proof to establish more than five percent permanent impairment of each upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On July 5, 1990 appellant, then a 29-year-old postal clerk, filed an occupational disease claim (Form CA-2) alleging that she sustained bilateral carpal tunnel syndrome and tendinitis due to repetitive employment duties including keyboard usage. OWCP accepted her claim for bilateral carpal tunnel syndrome, thoracic outlet syndrome (brachial plexus lesions), and depression, and paid her wage-loss compensation for periods of work stoppage.[3]

On April 25, 2012 appellant filed a claim for a schedule award (Form CA-7) due to her accepted employment-related conditions. By decision dated September 26, 2012, OWCP denied her schedule award claim because she had not provided an impairment rating from her physician.

On October 9, 2012 appellant, through counsel, requested a telephonic hearing with a representative of OWCP's Branch of Hearings and Review. She submitted an October 10, 2012 report from Dr. John L. Dunne, an osteopath Board-certified in occupational medicine. Dr. Dunne utilized Table 15-23 (Entrapment/Compression Neuropathy Impairment) on page 449 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] He indicated that appellant's *Quick*DASH score was 43 and used that score as the basis for a grade modifier of 3 for functional scale. Dr. Dunne found that the average of the grade modifiers for test findings, history, and physical findings was 3. He calculated that, under Table 15-23, this warranted an eight percent permanent impairment for each upper extremity due to bilateral carpal tunnel syndrome. Dr. Dunne noted that there was zero percent permanent impairment of the upper extremities for brachial plexus lesions because his physical examination did not reveal evidence of brachial neuritis or brachial plexus lesion.

On November 1, 2012 OWCP referred appellant's case to an OWCP district medical adviser (DMA) for review.

Prior to a hearing being held, OWCP's hearing representative issued a December 12, 2012 decision which set aside the September 26, 2012 decision and remanded the case for a *de novo* decision upon receipt of a report from a DMA.

On remand, OWCP referred appellant's case to Dr. Brian M. Tonne, a Board-certified orthopedic surgeon, for review in his a capacity as a DMA.

In a May 13, 2013 report, Dr. Tonne advised that maximum medical improvement (MMI) was reached on October 10, 2012. Utilizing Table 15-23 for each upper extremity, he derived a

[3] Appellant retired on disability effective July 1, 1990.

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

grade modifier of 1 for test findings and grade modifiers of 3 for history and physical findings. Dr. Tonne calculated the average of these grade modifiers to arrive at an average grade of 2.[5] He indicated that based upon the *Quick*DASH score of 43 noted by Dr. Dunne, the default value of five percent applied for each upper extremity. Dr. Tonne concluded that appellant had five percent permanent impairment of each upper extremity due to her bilateral carpal tunnel syndrome.

By decision dated June 7, 2013, OWCP granted appellant a schedule award for five percent impairment of each upper extremity. The award ran for 31.2 weeks from October 10, 2012 to May 16, 2013 and was based on the opinion of Dr. Tonne.

On November 21, 2015 appellant filed a claim for an additional schedule award (Form CA-7) and submitted a November 24, 2015 report from Dr. Neil Allen, a Board-certified internist and neurologist. Dr. Allen indicated that appellant reported undergoing electromyogram and nerve conduction velocity (EMG/NCV) studies in 1994 which confirmed bilateral carpal tunnel syndrome. However, he indicated that these studies were not available for review. Following his physical examination Dr. Allen applied a grade modifier of 1 for test findings and grade modifiers of 3 for history and physical findings, as derived from Table 15-23 on page 449. He noted that the functional scale modifier was based on appellant's *Quick*DASH score of 61. Dr. Allen concluded that, according to the "Rating Process" associated with Table 15-23, appellant had six percent permanent impairment of each upper extremity.

OWCP referred the case record, including Dr. Allen's November 24, 2015 report, to Dr. Jovito B. Estaris, a Board-certified occupational medicine physician, for review in his capacity as a DMA. It requested that he provide an opinion on the extent of appellant's upper extremity impairment under the sixth edition of the A.M.A., *Guides*.

In a February 2, 2016 report, the DMA indicated that Dr. Allen had not reviewed any particular EMG/NCV findings, but rather accepted the information from appellant that her EMG/NCV studies showed bilateral carpal tunnel syndrome. Using Table 15-23, he assigned a grade modifier of 0 for test findings and grade modifiers of 3 for history for both upper extremities. For physical findings, the DMA applied a grade modifier of 2 for the right upper extremity (due to no atrophy noted on examination and insignificant motor weakness) and a grade modifier of 3 for the left upper extremity (due to weakness without atrophy). With respect to the functional scale modifier, he noted that the *Quick*DASH score by Dr. Allen was 61 and the *Quick*DASH score by Dr. Dunne was 43. The DMA indicated that the determinations by these physicians were inconsistent and that the *Quick*DASH score was therefore excluded from the grading process per pages 406 and 407 of the A.M.A., *Guides* where it is noted, "If the functional history is determined to be unreliable or inconsistent with other documentation, it is excluded from the grading process." He added the grade modifiers and obtained an average of 2 for each upper extremity.[6] The DMA concluded that appellant had five percent permanent impairment of each upper extremity.

[5] Dr. Tonne rounded down to 2 from the average value of 2.33.

[6] For the right upper extremity, Dr. Estaris rounded up to 2 from the average value of 1.66.

By decision dated June 8, 2016, OWCP denied appellant's claim for an additional schedule award, noting that the DMA had properly applied the standards of the A.M.A., *Guides*.

On June 16, 2016 appellant, through counsel, requested a telephonic hearing with a representative of OWCP's Branch of Hearings and Review. Appellant submitted an August 3, 2016 addendum report from Dr. Allen and a report of June 30, 2016 EMG/NCV studies which showed normal findings in both upper extremities. In his August 3, 2016 report, Dr. Allen provided an assessment of appellant's upper extremity permanent impairment which was similar to the assessment he provided in his November 24, 2015 report. He disagreed with the DMA's exclusion of the functional scale in the grading process by explaining that there were no such indications for said exclusion in A.M.A., *Guides*. Dr. Allen concluded that appellant had six percent permanent impairment of each upper extremity.

During the hearing held on February 14, 2017, counsel argued that Dr. Allen's August 3, 2016 supplemental report established that appellant had six percent permanent impairment of each upper extremity.

By decision dated April 25, 2017, the hearing representative affirmed the June 8, 2016 decision, noting that the DMA had properly applied the standards of the A.M.A., *Guides*.

On April 3, 2018 appellant, through counsel, requested reconsideration of the April 25, 2017 decision.

Appellant submitted a July 26, 2017 report from Dr. Allen, who again disagreed with the DMA's exclusion of the functional scale score in the grading process. Dr. Allen indicated that it was reasonable that an individual's functional capacity might vary from week to week or from month to month.

On July 20, 2018 OWCP referred Dr. Allen's July 26, 2017 report to the DMA for review. In a July 25, 2018 report, he referenced the report of June 30, 2016 EMG/NCV studies which showed normal findings in both upper extremities. The DMA noted that, under Table 15-23, the normal findings of these EMG/NCV studies meant that appellant fell under the grade modifier 0 category for each upper extremity and, therefore, appellant presently had no permanent impairment of either upper extremity.

By decision dated September 24, 2018, OWCP denied modification of the April 25, 2017 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[7] and its implementing regulation[8] 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

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999).

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. The sixth edition of the A.M.A., *Guides* has been adopted by OWCP as the appropriate standard for evaluating schedule losses.[9]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[10] In Table 15-23, grade modifiers levels (ranging from 0 to 4) are described for the categories 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 by one percent based on the functional scale modifier, an assessment of impact on daily living activities.[11]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than five percent permanent impairment of each upper extremity, for which she previously received schedule award compensation.

In a February 2, 2016 report, Dr. Estaris, the DMA, discussed his review of the medical records and provided an opinion that appellant had five percent permanent impairment of each upper extremity under the standards of the sixth edition of the A.M.A., *Guides.* He properly applied these standards to calculate appellant's upper extremity permanent impairment. The DMA correctly made reference to Table 15-23 (Entrapment/Compression Neuropathy Impairment) on page 449 of the sixth edition of the A.M.A., *Guides.*[12] For each upper extremity, he chose grade modifiers from the table for the various categories, including test findings, history, and physical findings based on Dr. Allen's findings. The DMA then correctly averaged the grade modifiers and identified the default value of five on Table 15-23 for the grade modifier 2 category. He then noted that the *Quick*DASH score by Dr. Allen was 61 and the *Quick*DASH score by Dr. Dunne was 43 and properly determined that, because the determinations by these physicians were inconsistent, that the functional scale score was therefore excluded from the grading process per pages 406 and 407 of the A.M.A., *Guides*.[13] Therefore, the DMA determined that the functional scale analysis

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

[10] *See* A.M.A., *Guides* 449, Table 15-23.

[11] A survey completed by a given claimant, known by the name *Quick*DASH, may be used to determine the function scale score. *Id.* at 448-49. However, if the functional history is determined to be unreliable or inconsistent with other documentation, it is excluded from the grading process. *Id.* at 406-07.

[12] *Supra* note 10.

[13] *See supra* note 11.

did not result in movement from the default value of five percent and concluded that appellant had five percent permanent impairment of each upper extremity.

The Board notes that Dr. Allen provided assessments in several reports, including those dated November 13, 2015 and August 3, 2016, that appellant had six percent permanent impairment of each upper extremity. This higher rating was based on Dr. Allen's opinion that the functional scale score was not excluded from the grading process, but the Board has explained why it was proper to exclude the functional scale score under the relevant standards. The Board has held that an opinion on permanent impairment is of limited probative value if it is not derived in accordance with the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses.[14] As such, Dr. Allen's reports are of limited probative value.

Moreover, after the DMA produced his February 2, 2016 report, appellant submitted a report of June 30, 2016 EMG/NCV studies which showed normal findings in both upper extremities. In his July 25, 2018 report, the DMA referenced this June 30, 2016 report and properly noted that, under Table 15-23, the normal findings of the EMG/NCV studies meant that appellant fell under the grade modifier 0 category for each upper extremity and that she had no permanent impairment of either upper extremity at that time.

As there is no medical evidence of record establishing that appellant has more than five percent permanent impairment of each upper extremity, the Board finds that appellant has not met her burden of proof to establish greater impairment than that previously awarded.

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 impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than five percent permanent impairment of each upper extremity, for which she previously received schedule award compensation.

[14] *See N.A.*, Docket No. 19-0248 (issued May 17, 2019); *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989).

ORDER

IT IS HEREBY ORDERED THAT the September 24, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 4, 2019
Washington, DC

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

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

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