# United States Department of Labor
# Employees' Compensation Appeals Board

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| **P.J., Appellant** | ) | |
| **and** | ) | **Docket No. 20-0549** |
| | ) | **Issued: December 18, 2020** |
| **DEPARTMENT OF COMMERCE, U.S. PATENT & TRADEMARK OFFICE, PATENT PUBLICATIONS OFFICE, Arlington, VA, Employer** | ) | |

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

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Deputy Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

### ***JURISDICTION***

On January 13, 2020 appellant filed a timely appeal from a December 10, 2019 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 appellant has met her burden of proof to establish greater than 35 percent permanent impairment of her right upper extremity and 37 percent permanent impairment of her left upper extremity, for which she previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

## ***FACTUAL HISTORY***

On March 1, 2001 OWCP accepted under OWCP File No. xxxxxx548 that appellant, then a 39-year-old legal instrument examiner, sustained an occupational disease in the form of bilateral carpal tunnel syndrome due to performing the repetitious duties of her job.[2] Appellant stopped work on March 12, 2001 and OWCP paid her disability compensation beginning that day based on a pay rate of $691.52 per week. She returned to part-time work (four hours per day) on September 4, 2007 and stopped work on September 20, 2007.[3]

On July 7, 2015 appellant underwent OWCP-authorized cervical surgery, including anterior cervical fusion and arthrodesis at C5-6, and partial cervical corpectomy with spinal cord and foraminal decompression at C5-6.

On March 4, 2016 appellant filed a claim for a schedule award (Form CA-7) due to her accepted employment injuries. By decision dated December 5, 2016, OWCP granted her a schedule award for nine percent permanent impairment of her left upper extremity due to impairment stemming from her cervical spine. The award ran for 28.08 weeks from August 16, 2016 to February 28, 2017. OWCP indicated that appellant had a weekly pay rate of $691.52, effective March 12, 2001. The award was based on a September 15, 2016 report of Dr. Michael M. Katz, a Board-certified orthopedic surgeon, who served as an OWCP district medical adviser (DMA). The DMA had evaluated August 16, 2016 findings of Dr. Burke Haskins, a Board-certified orthopedic surgeon, who served as an OWCP referral physician. In reaching his permanent impairment rating of nine percent of the left upper extremity, he applied *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), which is a supplemental publication of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairmen*t (A.M.A., *Guides*),[4] and found sensory and motor deficits associated with the left C6 nerve distribution.

In a June 6, 2018 report, Dr. David Dorin, an attending Board-certified orthopedic surgeon, noted that appellant presented complaining of numbness, tingling, and pain in both her hands. He detailed physical examination findings, noting a mildly positive Tinel's sign in the right hand. Dr. Dorin diagnosed neuralgia of the right upper extremity and right carpal tunnel syndrome.

On August 5, 2019 appellant filed a claim for an increased schedule award.

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[2] Appellant underwent several OWCP-authorized upper extremity and cervical surgeries. OWCP previously accepted under OWCP File No. xxxxxx385 that, due to an April 19, 1999 reaching incident, she sustained intervertebral cervical disc disorder with myelopathy, cervical disc herniation at C6-7, cervical sprain, myalgia/myositis, fibromyalgia, brachial neuritis/radiculitis, and right shoulder/arm sprain. It administratively combined OWCP File Nos. xxxxxx385 and xxxxxx548, designating the latter file to serve as the master file.

[3] Beginning June 8, 2008, OWCP paid appellant disability compensation based on a weekly pay rate of $868.63. However, it later determined in an August 3, 2017 decision that this pay rate was improper because, when she sustained a recurrence of disability on September 20, 2007, her weekly pay was $434.32 due to the part-time nature of her work. Because appellant's date-of-injury weekly pay rate of $691.52 was higher than the $434.32 figure, she effectively had a weekly pay rate of $691.52.

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

In an August 22, 2019 report, Dr. Daniel R. Ignacio, Board-certified in physical medicine and rehabilitation, discussed appellant's factual and medical history and reported findings upon physical examination. He noted that her physical examination documented decreased sensation in the bilateral C5 and C6 nerve distributions, as well as in the right C4 nerve distribution. Dr. Ignacio found that the examination also showed weakness in the bilateral C5 and C6 nerve distributions, as well as the in the right C4 nerve distribution. He also advised that appellant had decreased sensation and weakness in the bilateral median nerve distributions, and limited bilateral shoulder motion. Dr. Ignacio provided range of motion (ROM) findings for her shoulders. He evaluated the permanent impairment of appellant's right upper extremity noting that, applying *The Guides Newsletter,* the right C4 cervical radiculopathy warranted four percent impairment due to sensory defect and six percent impairment due to motor defect. With regard to the right C5 cervical radiculopathy, appellant had four percent impairment due to sensory defect and six percent impairment due to motor defect. Dr. Ignacio indicated that, with regard to the right C6 cervical radiculopathy, she had six percent impairment due to sensory defect and eight percent impairment due to motor defect. He advised that these impairment values totaled to 34 percent impairment of the right upper extremity. Dr. Ignacio noted that appellant had chronic right median neuritis and noted "I will give [appellant] a permanent impairment due to the sensory defect, 6 [percent] to motor defect, that is 10 [percent] impairment related to the right median neuritis." He noted that, with regard to the limited motion along the right shoulder, he assigned 15 percent impairment. Dr. Ignacio opined that appellant had a combined 59 percent permanent impairment of the right upper extremity.

With regard to the left upper extremity, Dr. Ignacio indicated that appellant's left C5 cervical radiculopathy warranted four percent impairment due to sensory defect and six percent impairment due to motor defect. He indicated that, with regard to the left C6 cervical radiculopathy, she had six percent impairment due to sensory defect and eight percent impairment due to motor defect. Dr. Ignacio advised that these impairment values totaled to 24 percent permanent impairment of the left upper extremity. He noted that appellant had chronic left median neuritis and noted that she had "[four percent] impairment due to sensory defect, [six percent] impairment due to motor defect." Dr. Ignacio noted that, with regard to the limited motion along the left shoulder, he assigned a rating of 10 percent permanent impairment. He concluded that appellant had a combined 44 percent permanent impairment of the left upper extremity.

OWCP referred appellant's case to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA. It requested that the DMA review Dr. Ignacio's August 22, 2019 report and provide an opinion regarding the nature and extent of permanent impairment of her upper extremities under the standards in the sixth edition of the A.M.A., *Guides*.[5]

In an October 15, 2019 report, the DMA noted that he had reviewed Dr. Ignacio's August 22, 2019 report and indicated that, utilizing *The Guides Newsletter*, appellant had four percent right upper extremity impairment for residual problems with pain/impaired sensation from her right C5 cervical radiculopathy, six percent for residual problems with motor weakness from her right C5 cervical radiculopathy, six percent for residual problems with pain/impaired sensation from her right C6 cervical radiculopathy, and seven percent for residual problems with motor weakness from her right C6 cervical radiculopathy. He found that this resulted in a combined 22

[5] *Id.*

percent permanent impairment of the right upper extremity. The DMA advised that, utilizing Table 15-23 on page 449 of the sixth edition of the A.M.A., *Guides*, appellant also had nine percent permanent impairment of the right upper extremity for residual problems with right carpal tunnel syndrome status post carpal tunnel release. He noted that her condition fell under grade modifier 3 on Table 15-23. The DMA also indicated that, utilizing the diagnosis-based impairment (DBI) rating method under Table 15-5 beginning on page 401, appellant had five percent permanent impairment of her right upper extremity impairment for her right partial rotator cuff tear. With regard to the ROM impairment rating method for the right shoulder, appellant had, utilizing Table 15-34 on page 475, three percent right upper extremity impairment for loss of flexion, one percent for loss of extension, three percent for loss of abduction, and two percent for loss of internal rotation. The DMA indicated that this resulted in nine percent impairment based on the ROM impairment rating method and resulted in greater impairment than the DBI rating method. He advised that, per Table 2-1 on page 20, the A.M.A., *Guides* noted that "if the [A.M.A., *Guides*] provides more than one method to rate a particular impairment condition, the method producing the higher rating must be used." The DMA advised that he utilized the Combined Values Chart on page 604 to add the various impairment values for the right upper extremity and concluded that appellant had 35 percent permanent impairment of the right upper extremity.

For the left upper extremity, the DMA again utilized *The Guides Newsletter* and noted that appellant had four percent left upper extremity impairment for residual problems with pain/impaired sensation from her left C5 cervical radiculopathy, six percent for residual problems with motor weakness from her left C5 cervical radiculopathy, six percent for residual problems with pain/impaired sensation from her left C6 cervical radiculopathy, and seven percent for residual problems with motor weakness from her left C6 cervical radiculopathy. He found that this resulted in 22 percent permanent impairment of the left upper extremity impairment. The DMA advised that, utilizing Table 15-23 on page 449 of the sixth edition of the A.M.A., *Guides*, appellant also had nine percent permanent impairment of the left upper extremity for residual problems with left carpal tunnel syndrome status post carpal tunnel release. He noted that her condition fell under grade modifier 3 on Table 15-23. The DMA also indicated that, utilizing the DBI rating method under Table 15-5 beginning on page 401, appellant had five percent permanent impairment of her left upper extremity impairment for her partial rotator cuff tear. With regard to the ROM impairment rating method for the left shoulder, appellant had, utilizing Table 15-34 on page 475, three percent right upper extremity impairment for loss of flexion, one percent for loss of extension, three percent for loss of abduction, and four percent for loss of internal rotation. The DMA indicated that this resulted in 11 percent impairment based on the ROM impairment rating method and resulted in greater impairment than the DBI rating method. He advised that he utilized the Combined Values Chart on page 604 to add the various impairment values for the left upper extremity and concluded that appellant had a combined 37 percent permanent impairment of the left upper extremity.

OWCP requested that the DMA provide clarification of the methodology applied in his October 15, 2019 report and, in a supplemental November 19, 2019 report, he noted that on October 15, 2019 he found that appellant had 22 percent permanent impairment of the right upper extremity due to motor and sensory deficits evaluated under *The Guides Newsletter*. The DMA clarified that such impairments for nerve radiculopathy are to be combined utilizing the Combined Values Chart on page 604 of the sixth edition of the A.M.A., *Guides* and were not to be mathematically added together. He noted that appellant was found to have nine percent upper extremity impairment for right carpal tunnel syndrome and nine percent upper extremity

impairment for the right shoulder. The DMA advised that utilizing the Combined Values Chart to combine the impairment values due to cervical radiculopathy, carpal tunnel syndrome, and right shoulder deficits resulted in 35 percent permanent impairment of the right upper extremity. He noted that, when patients have multiple impairments in the same extremity, the A.M.A., *Guides* directs evaluators to use the Combined Values Chart. The DMA noted that multiple impairments in the same extremity were not to be mathematically added together in order to determine the total impairment in a given extremity. He provided a similar description of his assessment of the permanent impairment of appellant's left upper extremity. The DMA noted that he used the Combined Values Chart to combine the 22 percent permanent impairment of appellant's left upper extremity due to motor and sensory deficits evaluated under *The Guides Newsletter*, the 9 percent permanent impairment due to left carpal tunnel syndrome, and the 11 percent permanent impairment due to left shoulder deficits. He concluded that she had a combined 37 permanent impairment of her left upper extremity.

By decision dated December 10, 2019, OWCP granted appellant a schedule award for 35 percent permanent impairment of her right upper extremity and an additional 28 percent permanent impairment of her left upper extremity.[6] The award ran for 196.56 weeks from August 22, 2019 to May 28, 2023 and the amount paid was based on a weekly compensation rate of $691.52.

## ***LEGAL PRECEDENT***

The schedule award provisions of FECA[7] and its implementing regulations[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 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, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10]

Neither FECA nor its implementing regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[11] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[12] The sixth edition of the A.M.A., *Guides* (2009) provides a specific

[6] Appellant previously received a schedule award on September 29, 2016 for nine percent permanent impairment of her left upper extremity due to impairment stemming from her cervical spine.

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id. See also T.T.*, Docket No. 18-1622 (issued May 14, 2019).

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

[11] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see A.G.*, Docket No. 18-0815 (issued January 24, 2019); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[12] *Supra* note 10 at Chapter 2.808.5c(3) (March 2017).

methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the Federal (FECA) Procedure Manual.[13]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[14] In Table 15-23, grade modifier 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 functional scale, an assessment of impact on daily living activities.[15]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With regard to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401. After the class of diagnosis (CDX) is determined from the Shoulder Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for functional history (GMFH), grade modifier for physical examination (GMPE), and grade modifier for clinical studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16]

## ***ANALYSIS***

The Board finds that appellant has not met her burden of proof to establish greater than 35 percent permanent impairment of her right upper extremity and 37 percent permanent impairment of her left upper extremity, for which she previously received schedule award compensation.

The Board has carefully reviewed the October 15 and November 19, 2019 reports of Dr. Harris, the DMA, who evaluated the August 22, 2019 examination findings of Dr. Ignacio to calculate the permanent impairment of appellant's upper extremities. The Board finds that the DMA properly applied the standards of the sixth edition of the A.M.A., *Guides* to find that she has 35 percent permanent impairment of her right upper extremity and 37 percent permanent impairment of her left upper extremity.

[13] *Supra* note 10 at Chapter 3.700, Exhibit 4 (January 2010).

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

[15] 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.

[16] *See* A.M.A., *Guides* (6th ed. 2009) 405-12. Table 15-5 also provides that, if motion loss is present for a claimant with certain diagnosed conditions, permanent impairment may alternatively be assessed using Section 15.7 (ROM impairment). Such a ROM assessment stands alone and is not combined with a DBI rating. *Id.* at 401-05, 475-78.

In his October 15, 2019 report, the DMA noted that he had reviewed Dr. Ignacio's August 22, 2019 report and indicated that, utilizing *The Guides Newsletter*,[17] appellant had four percent right upper extremity impairment for residual problems with pain/impaired sensation from her right C5 cervical radiculopathy, six percent for residual problems with motor weakness from her right C5 cervical radiculopathy, six percent for residual problems with pain/impaired sensation from her right C6 cervical radiculopathy, and seven percent for residual problems with motor weakness from her right C6 cervical radiculopathy. He found that this resulted in 22 percent permanent impairment of the right upper extremity impairment. The DMA advised that, utilizing Table 15-23 on page 449 of the sixth edition of the A.M.A., *Guides*, appellant also had nine percent permanent impairment of the upper extremity for residual problems with right carpal tunnel syndrome status post carpal tunnel release.[18] He noted that her condition fell under grade modifier 3 on Table 15-23. The DMA also noted that, utilizing the DBI method under Table 15-5 beginning on page 401, appellant had five percent permanent impairment of her right upper extremity impairment for her partial rotator cuff tear.[19] With regard to the ROM impairment rating method for the right shoulder, appellant had, utilizing Table 15-34 on page 475, three percent right upper extremity impairment for loss of flexion, one percent for loss of extension, three percent for loss of abduction, and two percent for loss of internal rotation. The DMA indicated that this resulted in nine percent impairment based on the ROM impairment rating method and resulted in greater impairment than the DBI rating method. He advised that, per Table 2-1 on page 20, the A.M.A., *Guides* noted that "if the [A.M.A., *Guides*] provides more than one method to rate a particular impairment condition, the method producing the higher rating must be used." The DMA noted that he utilized the Combined Values Chart on page 604 to combine the various impairment values for the right upper extremity and concluded that appellant had 35 percent permanent impairment of the right upper extremity.

For the left upper extremity, the DMA again utilized *The Guides Newsletter* and noted that appellant had four percent left upper extremity impairment for residual problems with pain/impaired sensation from her left C5 cervical radiculopathy, six percent for residual problems with motor weakness from her left C5 cervical radiculopathy, six percent for residual problems with pain/impaired sensation from her left C6 cervical radiculopathy, and seven percent for residual problems with motor weakness from her left C6 cervical radiculopathy. He found that this resulted in 22 percent permanent impairment of the left upper extremity. The DMA advised that, utilizing Table 15-23 on page 449, appellant also had nine percent upper extremity impairment for residual problems with left carpal tunnel syndrome status post carpal tunnel release. He noted that her condition fell under grade modifier 3 on Table 15-23. The DMA also noted that, utilizing the DBI method under Table 15-5 beginning on page 401, appellant had five percent permanent impairment of her left upper extremity impairment for her partial rotator cuff tear. With regard to the ROM impairment rating method for the left shoulder, appellant had, utilizing Table 15-34 on page 475, three percent right upper extremity impairment for loss of flexion, one percent for loss of extension, three percent for loss of abduction, and four percent for loss of internal rotation. The DMA indicated that this resulted in 11 percent impairment based on the ROM impairment rating method and resulted in greater impairment than the DBI rating

[17] *See supra* notes 9 through 11.

[18] *See supra* notes 12 and 13.

[19] *See supra* note 14.

method. He advised that he utilized the Combined Values Chart on page 604 to add the various impairment values for the left upper extremity and concluded that appellant had 37 percent permanent impairment of the left upper extremity.[20]

The Board notes that Dr. Ignacio determined in his August 22, 2019 report that appellant had 59 percent permanent impairment of the right upper extremity and 44 percent permanent impairment of the left upper extremity. However, this impairment rating is of limited probative value because Dr. Ignacio did not adequately explain how it was derived in accordance with the standards of the sixth edition of the A.M.A., *Guides.* Dr. Ignacio's brief permanent impairment evaluation lacks substantial explanation. For example, he provided impairment ratings for bilateral median nerve neuritis and unnamed bilateral shoulder deficits, but he did not provide an adequate explanation for these ratings, which included specific references to the sixth edition of the A.M.A., *Guides.* 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.[21]

On appeal appellant asserts that it was improper for her December 10, 2019 schedule award to be based on a weekly pay rate of $691.52 per week. However, she did not provide any support for this assertion and has not otherwise shown that she received an incorrect amount of schedule award compensation.

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 greater than 35 percent permanent impairment of her right upper extremity and 37 percent permanent impairment of her left upper extremity, for which she previously received schedule award compensation.

[20] In his November 19, 2019 report, the DMA provided further discussion of his impairment rating method with emphasis on the manner in which he combined various impairment rating values.

[21] *See N.A.*, Docket No. 19-0248 (issued May 17, 2019); *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the December 10, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 18, 2020
Washington, DC

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

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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