United States Department of Labor
Employees' Compensation Appeals Board

H.N., Appellant	)	
and	)	**Docket No. 19-1388**
	)	**Issued: March 20, 2020**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, New Haven, CT, Employer	)	

Appearances:
Peter M. Appleton, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
CHRISTOPHER J. GODFREY, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 10, 2019 appellant, through counsel, filed a timely appeal from an April 1, 2019 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 one percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On March 30, 2015 appellant, then a 54-year-old tax specialist, filed an occupational disease claim (Form CA-2) alleging that she developed cubital tunnel and carpal tunnel syndromes of the right upper extremity as a result of repetitive employment duties. She first became aware of her condition and of its relationship to factors of her federal employment on September 24, 2014. After denial of the claim on June 30, 2015 and February 29, 2016, on July 12, 2016 OWCP accepted the claim for right cubital tunnel and carpal tunnel syndromes in OWCP File No. xxxxxx263.[3]

On November 10, 2014 appellant underwent OWCP-approved anterior transposition of the right ulnar nerve and endoscopic carpal tunnel release.

In a report dated March 26, 2015, Dr. Daniel J. Mastella, a Board-certified orthopedic hand surgeon, examined appellant for complaints of locking of her small and ring finger. On examination of the right upper extremity, he noted full range of motion at the elbow, wrist, and digits, with no numbness or tingling in her fingers. At the wrist, Dr. Mastella noted negative articular nonarticular, scaphoid shift, and finger extension testing. He noted tenderness to palpation of the right ring and small fingers with no locking or catching along with sensitivity over the right cubital tunnel incision at the anterior transposed nerve. Thenar strength was 4+/5, first dorsal interosseous strength was at 4/5, and flexor pollicis longus strength was at 5/5. Dr. Mastella diagnosed status post anterior transposition of the ulnar nerve and carpal tunnel release with postoperative stenosing tenosynovitis (STS) of the ring finger and small finger.

On May 12, 2015 appellant followed up with Dr. Mastella for her right upper extremity condition. On examination, Dr. Mastella noted that she had full range of motion of the elbow, but ongoing symptoms attributable to the ulnar nerve on the right.

On August 3, 2016 appellant filed a claim for a schedule award (Form CA-7).

In an April 12, 2016 report, Dr. Mastella noted that appellant was status post anterior transposition of the ulnar nerve and endoscopic carpal tunnel release. On examination of the right elbow, he observed 140 degrees of flexion to slight hyperextension. On examination of the right wrist, Dr. Mastella observed 60 degrees of flexion and extension, and 80 degrees of pronation and supination. On examination of the right digits, he noted full range of motion and extension. Dr. Mastella observed a positive Tinel's sign at the carpal tunnel and a positive Phalen's test, as well as positive elbow compression, cubital tunnel compression, and positive forearm compression testing. Referencing the sixth edition of the American Medical Association, *Guides to the*

[3] Under OWCP File No. xxxxxx807, OWCP accepted that appellant sustained a contusion of the right ring finger due to a stapler hitting her ring finger on September 24, 2014. It has administratively combined File No. xxxxxx263 and File No. xxxxxx807, with File No. xxxxxx263 serving as the master file.

Evaluation of Permanent Impairment,[4] he determined that appellant had eight percent permanent impairment of the right upper extremity due to her right-sided anterior transposition of the ulnar nerve and endoscopic carpal tunnel release.

In a development letter dated August 9, 2016, OWCP requested that appellant submit a detailed medical report from her attending physician, which included a statement that the accepted condition had reached maximum medical improvement (MMI) and an impairment rating utilizing the appropriate tables of the sixth edition of the A.M.A., *Guides*. It afforded her 30 days to submit the necessary evidence.

In a letter dated August 11, 2016, OWCP requested that Dr. Mastella submit an addendum report which provided a date of MMI, a detailed description of any preexisting permanent impairment of the right upper extremity, and rationale for his calculation of eight percent permanent impairment of the right upper extremity with reference to the appropriate criteria and tables of the A.M.A., *Guides*. It afforded him 30 days to submit the addendum.

On August 22, 2016 Dr. Mastella responded and noted that appellant was last seen on April 12, 2016, at which time she was determined to be at MMI. He noted that no permanent impairment of the right upper extremity preexisted her injury. Dr. Mastella explained that criteria from the sixth edition of the A.M.A., *Guides* were referenced to neurologic evaluation guides, which were used to determine that appellant had eight percent permanent impairment of the right upper extremity.

On December 27, 2016 OWCP referred the case record and a statement of accepted facts (SOAF) to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), for review as to whether appellant sustained permanent impairment of the right upper extremity as a result of her accepted conditions.

In a report dated December 28, 2016, the DMA recommended that OWCP contact Dr. Mastella and afford him the opportunity to submit a detailed, corrective supplemental report. He recommended that, if Dr. Mastella was unable to comply, a second opinion evaluation should be obtained from a Board-certified specialist in orthopedic surgery or physical medicine and rehabilitation. The DMA noted that Dr. Mastella's August 22, 2016 report could not be accepted as probative because he had not provided worksheets, narrative, or calculations to explain how he had arrived at the eight percent permanent impairment rating.

In a letter dated December 30, 2016, OWCP requested that Dr. Mastella review the December 28, 2016 report from the DMA and provide a supplemental report. In an accompanying note, it requested that appellant submit the supplemental report from Dr. Mastella within 30 days. No report was received.

On May 1, 2017 OWCP referred appellant to Dr. Robert Moskowitz, a Board-certified orthopedic surgeon serving as a second opinion examiner, to provide an assessment of appellant's work-related right upper extremity conditions and any resulting permanent impairment.

In a June 5, 2017 report, Dr. Moskowitz indicated that he had reviewed the SOAF, the medical record, and appellant's history of injury. He noted that appellant's physical examination

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

had not demonstrated significant physical findings that would be consistent with her severe subjective complaints. While appellant reported pain of 9/10, Dr. Moskowitz noted that appellant was two and a half years postsurgery and thus her chronic pain was psychosocial. He opined that appellant had reached MMI. Using Table 15-23, page 449 of the sixth edition of the A.M.A., *Guides*, Dr. Moskowitz noted that appellant's subjective responses to physical testing of her areas of claimed sensory changes showed areas that would not be consistent with her carpal tunnel syndrome or cubital tunnel syndrome diagnoses. He noted that appellant's clinical studies evidenced a conduction delay, which would be a grade modifier of 1. Because her history and physical findings were inconsistent, Dr. Moskowitz assigned grade modifiers of zero, resulting in a finding of zero percent permanent impairment of the right upper extremity due to carpal tunnel syndrome. Applying the above criteria to appellant's cubital tunnel syndrome, in which the modifiers for history and physical findings were also zero due to inconsistency, he noted that conduction delay would qualify for a grade modifier of 2, which would result in one percent impairment of the right upper extremity.

On February 27, 2018 OWCP routed Dr. Moskowitz's June 5, 2017 report, a statement of accepted facts (SOAF), and the case file to the DMA for review as to whether appellant sustained permanent impairment as a result of her accepted conditions.

In a report dated February 27, 2018, the DMA reviewed the SOAF, the case file, and Dr. Moskowitz's June 5, 2017 report. Using the sixth edition of the A.M.A., *Guides*, Table 15-23, page 449, he rated appellant's ulnar nerve impairment due to clinical studies as grade modifier 2, with zero grade modifiers for physical examination (GMPE) and clinical studies (GMCS) due to unreliability, resulting in a permanent impairment of one percent. With regard to appellant's median nerve impairment, Dr. Moskowitz rated GMCS of 1, with GMPE and grade modifier for functional history (GMFH) of zero, resulting in zero percent permanent impairment. As such, he concurred with Dr. Moskowitz's calculation of permanent impairment of the right upper extremity. Dr. Moskowitz noted that the accepted conditions were not eligible for an alternative range of motion (ROM) based impairment calculation. He opined that appellant reached MMI on June 5, 2017.

By decision dated August 9, 2018, OWCP granted appellant a schedule award for one percent permanent impairment of the right upper extremity for 3.2 weeks of compensation during the period June 5 to 26, 2017.

On December 18, 2018 appellant, through counsel, requested reconsideration of OWCP's August 9, 2018 decision. With her request, she submitted a letter from Dr. Mastella dated November 2, 2018. Dr. Mastella noted that appellant continued to have significant problems, including elbow pain at the area of her anterior transposition, ongoing numbness, and tingling in the small finger with stiffness. He further noted that he had rendered a permanent impairment evaluation of eight percent of the right upper extremity on April 12, 2016. Dr. Mastella argued that the A.M.A., *Guides* offered a limited view as it only rated findings that were easily measured. He added that he had used appellant's complaints to complete his evaluation and had taken into account observations of dysfunction in her hand, results of provocative tests, and measurement of function of bones, joints, nerves, and tendons. Dr. Mastella concluded that he stood by his rating of eight percent permanent impairment of appellant's right upper extremity.

By decision dated April 1, 2019, OWCP denied modification of the decision dated August 9, 2018.

LEGAL PRECEDENT

Under section 8107 of FECA[5] and section 10.404 of the implementing federal regulations,[6] schedule awards are payable for permanent impairment of specified body members, functions or organs. FECA, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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 A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[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 of diagnosis (CDX) condition, which is then adjusted by GMFH, GMPE, and GMCS.[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10]

Permanent impairment due to carpal tunnel syndrome and cubital tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[11] In Table 15-23, grade modifier levels (ranging from zero to four) 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.[12]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[13]

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[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *D.J.*, 59 ECAB 620 (2008); *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[8] *Supra* note 5, page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[9] *Id*. at 383-419.

[10] *Id*. at 411.

[11] *Id*. at 449.

[12] *Id*. at 448-49.

[13] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013). *See J.T.*, Docket No. 17-1465 (issued September 25, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than one percent permanent impairment of the right upper extremity, for which she has previously received a schedule award.

In an April 12, 2016 report, Dr. Mastella noted appellant's residual symptoms from post-carpal tunnel release and anterior transposition of the ulnar nerve on the right. Referencing the sixth edition A.M.A., *Guides*, he found a permanent impairment of eight percent of the right arm related to her right-sided anterior transposition of the ulnar nerve and endoscopic carpal tunnel release. On December 28, 2016 the DMA recommended that OWCP contact Dr. Mastella and afford him the opportunity to submit a detailed corrective supplemental report as his first report did not indicate how the rating method and how it had been calculated. In a letter dated November 2, 2018, Dr. Mastella indicated that the A.M.A., *Guides* offered a limited view as it only rated findings that were easily measured. He explained that he had noted appellant's complaints and had taken into account observations of dysfunction, results of provocative tests, and measurement of function of bones, joints, nerves, and tendons. Dr. Mastella confirmed his rating of eight percent permanent partial impairment of appellant's right upper extremity. The Board notes that, while Dr. Mastella rendered an impairment rating of eight percent and made a general reference to the A.M.A., *Guides,* he did not explain how the sixth edition of the A.M.A., *Guides* supported his impairment rating with references to tables and page numbers. To be of probative value, the medical evidence must describe the impairment in sufficient detail so that it can be visualized on review and utilized to compute the percentage of impairment in accordance with the A.M.A., *Guides*.[14] Dr. Mastella failed to adequately explain how the A.M.A., *Guides* supported his findings.[15] Since Dr. Mastella failed to explain how he arrived at an impairment rating of eight percent with reference to tables and page numbers of the sixth edition of the A.M.A., *Guides*, his opinion is of limited probative value.

OWCP properly referred appellant for a second opinion evaluation. Dr. Moskowitz, the second opinion physician, using Table 15-23, page 449 of the sixth edition of the A.M.A., *Guides*, determined that appellant had zero percent permanent impairment of the right upper extremity due to carpal tunnel syndrome and one percent permanent impairment of the right upper extremity due to cubital tunnel syndrome. He noted that appellant had GMCS of 1 for carpal tunnel syndrome and 2 for cubital tunnel syndrome and he provided his calculations.

The DMA, using the sixth edition A.M.A., *Guides*, Table 15-23, page 449, rated appellant's ulnar nerve impairment due to GMCS 2, with zero grade modifiers for GMPE and GMFH due to unreliability, which were added and averaged resulting in a permanent impairment of one percent. With regard to appellant's median nerve impairment, he rated a GMCS 1, with zero grade modifiers for GMPE and GMFH, which were added and averaged resulting in zero percent permanent impairment. As such, he concurred with Dr. Moskowitz's calculation of permanent impairment of the right upper extremity.

[14] *See J.T.,* Docket No. 17-1465 (issued September 25, 2019); *G.D.*, Docket No. 16-1712 (issued August 11, 2017).

[15] *Id.*

The Board finds that Dr. Moskowitz and the DMA properly reviewed the medical evidence of record and explained their findings with regard to GMCS, GMFH, and GMPE by reviewing the medical findings of record and applying them to the criteria set forth in the A.M.A., *Guides*. The Board thus finds that the well-rationalized opinions of the second opinion physician, Dr. Moskowitz, and the DMA represent the weight of the medical evidence regarding permanent impairment of appellant's right upper extremity.[16]

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 one percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the April 1, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 20, 2020
Washington, DC

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

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

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

[16] *See id.*