United States Department of Labor
Employees' Compensation Appeals Board

J.R., Appellant	)	
and	)	**Docket No. 21-1030**
	)	**Issued: August 21, 2023**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PATROL, Falfurrias, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On June 23, 2021 appellant filed a timely appeal from a May 27, 2021 merit decision and a June 4, 2021 nonmerit 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.

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish permanent impairment of the left upper extremity, warranting a schedule award; and (2) whether OWCP properly denied appellant's request for reconsideration of the merits of his claim, pursuant to 5 U.S.C. § 8128(a).

[1] 5 U.S.C. § 8101 *et seq*.

FACTUAL HISTORY

On March 16, 2020 appellant, then a 48-year-old supervisory border patrol agent, filed an occupational disease claim (Form CA-2) alleging that he experienced pain and numbness in his left arm, from his forearm to his fingers, due to typing on a daily basis for 24 years while in the performance of duty. OWCP accepted his claim for left upper limb carpal tunnel syndrome (CTS), left upper limb lesion of the ulnar nerve, and left elbow lateral epicondylitis. On July 13, 2020 appellant underwent an OWCP-authorized left carpal tunnel release.

On December 4, 2020 appellant filed a claim for a schedule award (Form CA-7). In support of his claim, he submitted a November 4, 2020 medical report and an amended November 4, 2020 report from Dr. Rafath Quraishi, a pain medicine specialist. On physical examination of the left elbow, Dr. Quraishi found mild tenderness on palpation over the lateral epicondyle with full range of motion (ROM). He provided three sets of ROM measurements that included 140 degrees, 140 degrees, and 143 degrees of flexion; 0 degrees, 0 degrees, and 0 degrees of extension; 75 degrees, 70 degrees, and 70 degrees of supination; and 80 degrees, 90 degrees, and 90 degrees of pronation. There was no joint effusion or swelling when compared to the opposite elbow. Muscle strength in the elbow was graded at +5/5. Deep tendon reflexes were +2/4. Appellant had continued tingling and numbness in the left wrist into the thumb and index finger. Capillary refills were normal with no swelling or edema. On physical examination of the left wrist, Dr. Quraishi reported only mild tenderness on palpation with no swelling or joint crepitation. He provided ROM measurements that included 60 degrees of flexion, 60 degrees of extension, 20 degrees of ulnar deviation, and 30 degrees of radial deviation. Tinel's signs were positive and Phalen's tests were positive for sensory changes and tingling and numbness in appellant's thumb index and middle fingers. Muscle strength was 5/5 in flexion, extension, ulnar and radial deviation, and grip strength was normal at 5/5. Appellant was right-hand dominant and had increased strength when comparing the right versus the left. Dr. Quraishi noted appellant's difficulties with activities of daily living (ADLs). He diagnosed the accepted conditions of left elbow lateral epicondylitis, left upper limb lesion of ulnar nerve/CTS, and left ulnar nerve lesion. Dr. Quarishi determined that appellant reached maximum medical improvement (MMI) on the date of his evaluation. He referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[2] and utilized the diagnosis-based impairment (DBI) rating method to assign a Class of diagnosis (CDX) of 1 for left elbow lateral epicondylitis with a history of painful injury with residual symptoms, which represented a default value of one percent impairment under Table 15-4 (Elbow Regional Grid). Dr. Quraishi assigned a grade modifier for functional history (GMFH) of 2 based on painful symptoms with normal activity with or without medication to control symptoms and the ability to perform self-care activities with modifications. He assigned a grade modifier for physical examination (GMPE) of 1 due to appellant's *Quick*DASH score of 50 and normal examination. Dr. Quraishi did not assign a grade modifier for clinical studies (GMCS). He utilized the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (2 - 1) + (0 - 1) = 0, which resulted in a grade C or one percent permanent impairment of the left elbow. Dr. Quraishi advised that ROM was within normal limits and resulted in no higher impairment rating under Section 15.7.

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

Regarding impairment to the left wrist, Dr. Quraishi utilized the DBI method in Table 15-23 (Entrapment/Compression Neuropathy Impairment). He assigned a GMFH of 1 based on mild intermittent symptoms, a GMPE of 2 due to decreased sensation in the thumb and index and middle fingers and a *Quick*DASH score of 50, and a GMCS of 1 due to conduction sensory delay. Dr. Quraishi found that appellant had one percent permanent impairment of the left wrist. He concluded that appellant had two percent left upper extremity permanent impairment.

On December 28, 2020 OWCP referred Dr. Quraishi's November 4, 2020 report, the medical evidence, and a statement of accepted facts (SOAF) to Dr. David J. Slutsky, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA).

In a March 7, 2021 report, the DMA found that appellant did not have permanent impairment as a result of his accepted diagnosis of left CTS. He noted that, according to the sixth edition of the A.M.A., *Guides*, page 489, the criteria for conduction delay in CTS included distal motor latencies longer than 4.5 milliseconds from an 8 centimeter study, a distal peak sensory latency longer than 4.0 milliseconds for a 14 centimeter distance, and a distal peak compound nerve latency longer than 2.4 milliseconds for a mid-palmar study of 8 centimeters. The DMA further noted that the diagnosis of a focal neuropathy syndrome must be documented by electromyogram (EMG) and/or nerve conduction velocity (NCV) studies in order to be ratable as permanent impairment in accordance with appendix 15-B, page 445, of the A.M.A., *Guides*. He explained that, if the NCV testing is not performed or does not meet the diagnostic criteria, there is no permanent impairment for entrapment neuropathy in accordance with this section. The DMA applied page 446 of the A.M.A., *Guides* which noted that CTS could be rated in Section 15.2 DBI, page 395, Table 15-3 using the CDX of nonspecific wrist pain, a Class 1 impairment with a default grade of one percent. He determined that a GMFH was not applicable under Table 15-7, page 406, because there was no documented wrist pain with activity and there was a *Quick*DASH score of 50. The DMA assigned a GMPE of 1 in accordance with Table 15-8, page 408, due to mild tenderness. He determined that a GMCS was not applicable as there were no electrodiagnostic studies. The DMA then applied the net adjustment formula (GMPE - CDX) = (1 - 1) = 0, resulting in a Class 1 grade C or one percent permanent impairment of the left wrist. He also utilized the DBI method in Table 15-4, page 399, and found that appellant's left lateral epicondylitis fell under a Class 1 impairment with a default value of one percent. Using Table 15-7, page 406, the DMA applied a GMFH of 2 based on difficulty with ADLs and a *Quick*DASH score of 50 for mild pain. Using Table 15-8, page 408, he applied a GMPE of 1 based on a completely normal physical examination. The DMA advised that a grade modifier for GMCS was not applicable as there were no relevant imaging studies. He applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (2 - 1) + (0 - 1) = 0, resulting in a Class 1 grade C impairment, or one percent permanent impairment of the left elbow.

The DMA noted that peripheral nerve compression could not be rated using the ROM impairment method as it was rated under Table 15-23. He also noted that Dr. Quraishi reported only one measurement for wrist ROM impairment with regard to flexion, extension, radial deviation, and ulnar deviation. The DMA advised that GMPE and GMFH under Table 15-36, page 477, were not applicable. He concluded that an ROM impairment rating could not be calculated due to a lack of three validated ROM measurements.

The DMA utilized the ROM method to rate impairment to the left elbow. He found that 140 degrees, 140 degrees, and 143 degrees of flexion represented 0 percent impairment; 0 degrees, 0 degrees, and 0 degrees of extension represented 0 percent impairment; 75 degrees, 70 degrees, and 70 degrees of supination represented 0 percent impairment; and 80 degrees, 90 degrees, and 90 degrees of pronation represented 0 percent impairment, resulting in 0 percent permanent ROM impairment. The DMA again advised that GMPE and GMFH under Table 15-36, page 477, were not applicable. He concluded that appellant had 0 percent permanent ROM impairment of the left elbow.

The DMA noted that the discrepancy between his and Dr. Quraishi's impairment ratings was that Dr. Quraishi assigned a GMCS of 1 based on an apparent conduction delay in appellant's left wrist when there were no electrodiagnostic studies or progress notes of record. Thus, the DMA opined that there was no permanent impairment. He related that if electrodiagnostic studies became available then the impairment rating may change accordingly. The DMA determined that appellant reached MMI on November 4, 2020 the date of Dr. Quraishi's impairment evaluation.

OWCP, in a March 9, 2021 letter, requested that Dr. Quraishi review the DMA's March 8, 2021 report and address the deficiencies raised in his report. It received a copy of Dr. Quraishi's amended November 4, 2020 report.

OWCP also received a November 20, 2019 EMG/NCV study regarding appellant's upper extremities. The study provided an impression of mild-to-moderate compressive neuropathies of the bilateral median nerves at the wrists, *i.e.*, significant bilateral CTS. The study also provided impressions of no evidence of cervical radiculopathy, brachial plexopathy, or more proximal entrapment neuropathy.

On April 6, 2021 OWCP requested that the DMA review a SOAF and the medical record, including the November 20, 2019 EMG/NCV study and provide a supplemental opinion regarding the extent of appellant's permanent impairment.

In a May 2, 2021 supplemental report, the DMA noted his review of the SOAF and the November 20, 2019 EMG/NCV study. He reiterated his prior impairment calculations based on the diagnoses of left CTS and left lateral epicondylitis, and concluded that appellant had one percent permanent impairment of the left upper extremity for each diagnosis. Additionally, the DMA opined that he had zero percent left upper extremity permanent impairment due to a diagnosis of left elbow cubital tunnel syndrome. He found that the November 20, 2019 EMG/NCV study yielded normal findings. The DMA noted that the EMG/NCV study measured distal ulnar motor latencies of 3.9 milliseconds, distal ulnar sensory latencies of 1.9 milliseconds, and conduction velocity of 59 milliseconds from the AE to BE segments. The study was not silent regarding abductor digiti minimi/first dorsal interosseous. The DMA concluded that the test findings were zero, and thus, the diagnosis of left cubital tunnel syndrome was not ratable. The DMA again noted that the discrepancy between his and Dr. Quraishi's impairment ratings was that Dr. Quraishi did not provide an impairment rating for appellant's left CTS. Regarding the diagnosis of cubital tunnel syndrome, he indicated that Dr. Quraishi assigned a GMCS of one based on an apparent sensory conduction delay while the November 20, 2019 electrodiagnostic studies were normal, and thus, there was no ratable impairment. Additionally, the DMA indicated that, while Dr. Quraishi reported decreased sensation in the thumb and index and middle fingers,

this was the median nerve distribution and not the ulnar nerve distribution. He restated his prior opinion that MMI was reached on November 4, 2020.

By decision dated May 27, 2021, OWCP denied appellant's schedule award claim, finding that the medical evidence of record was insufficient to establish permanent impairment of the left upper extremity, warranting a schedule award. It explained that appellant was previously paid a schedule award for the left upper extremity and that the opinion of its DMA established that he had no greater left upper extremity permanent impairment.

On May 28, 2021 appellant requested reconsideration. He submitted copies of Dr. Quraishi's November 4, 2020 report and the November 20, 2019 EMG/NCV study.

OWCP, by decision dated June 4, 2021, denied appellant's request for reconsideration of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

LEGAL PRECEDENT -- ISSUE 1

It is the claimant's burden of proof to establish permanent impairment of the left upper extremity, warranting a schedule award.[3]

The schedule award provisions of FECA[4] and its implementing federal regulations[5] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

Impairment due to CTS is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[8] 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

[3] *See T.H.*, Docket No. 19-1066 (issued January 29, 2020); *D.F.*, Docket No. 18-1337 (issued February 11, 2019); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id.*

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

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

be modified up or down by one percent based on functional scale, an assessment of impact on ADLs.[9]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must identify the CDX, which is then adjusted by a GMFH, GMPE, and/or GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids, and calculations of modifier scores.[12]

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

ANALYSIS -- ISSUE 1

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

In denying appellant's schedule award claim, OWCP incorrectly found that the DMA's reports established that appellant had no greater permanent impairment of his left upper extremity, as he had previously received schedule award compensation for permanent impairment of his left upper extremity. The case record indicates that appellant previously received schedule award compensation for 7 percent permanent impairment of the right lower extremity, 3 percent permanent impairment of the right upper extremity, and 24 percent permanent impairment of the left lower extremity. The case record does not establish that he previously received a schedule award for permanent impairment of his left upper extremity. The Board therefore finds that appellant is entitled to a schedule award for his left upper extremity, based upon the medical evidence of record.

Appellant submitted reports dated November 4, 2020 from Dr. Quraishi who opined that appellant had two percent permanent impairment of the left upper extremity in accordance with the sixth edition of the A.M.A., *Guides* based on the DBI methodology for the elbow and wrist. However, his one percent impairment rating for the left wrist is of diminished probative value as Dr. Quraishi assigned a GMCS of 1 due to conduction sensory delay when the record did not contain electrodiagnostic studies at the time of his impairment evaluation.

On March 7, 2021 Dr. Slutsky, the DMA, utilized the findings provided by Dr. Quraishi in his November 4, 2020 report to calculate appellant's impairment under the DBI method and found

[9] A survey completed by a given claimant, known by the name *Quick*DASH, may be used to determine the functional scale score. *Id.* at 448-49.

[10] *Id.* at 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[11] *Id.* at 411.

[12] *See R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[13] *Supra* note 7 at Chapter 2.808.6(f) (March 2017); *see S.H.*, Docket No. 20-0253 (issued June 17, 2020).

one percent permanent impairment of the left wrist and one percent permanent impairment of the left elbow. Further he properly found that peripheral nerve compression could not be rated using the ROM impairment method as it was rated under the DBI method in Table 15-23. The DMA properly found that Dr. Quraishi did not provide three sets of ROM measurements as required by the A.M.A., *Guides*. Additionally, he used the ROM method and opined that appellant had zero percent permanent impairment of the left elbow. The DMA explained that the difference between his and Dr. Quraishi's impairment ratings was that Dr. Quraishi assigned a grade modifier of 1 for GMCS due to an apparent conduction delay in rating appellant's left wrist impairment when there were no electrodiagnostic studies of record. He related, however, that his left wrist impairment rating could change if electrodiagnostic studies became available. The DMA determined that appellant's date of MMI was November 4, 2020.

In a May 2, 2021 response to OWCP's April 6, 2021 request to review the November 20, 2019 EMG/NCV study, the DMA properly reported the EMG/NCV study provided normal results and opined that appellant had zero percent permanent impairment of the left wrist based on a diagnosis of left cubital tunnel syndrome. He also reiterated his prior impairment calculations based on the diagnoses of left CTS and left lateral epicondylitis and opinion that appellant had one percent permanent impairment of the left upper extremity for each diagnosis.

The Board finds that the DMA, properly applied the A.M.A., *Guides* and provided rationale to explain his opinion that appellant had one percent permanent impairment of the left upper extremity due to permanent impairment of his elbow for the diagnosis of left lateral epicondylitis and one percent permanent impairment of the left upper extremity due to permanent impairment of his wrist based on the diagnosis of CTS. However, the effects of multiple impairments are accounted for by use of the Combined Values Chart of the A.M.A., *Guides* at page 604,.[14] The DMA did not indicate that he utilized the Combined Values Chart on page 604 to combine the two impairment values for the left upper extremity.[15] This case will therefore be remanded for OWCP to obtain a supplemental opinion from the DMA, which explains how appellant's left upper extremity values are to be combined. After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision.[16]

[14] *See* the A.M.A., *Guide*s 22-23 and 604.

[15] *P.J.*, Docket No. 20-0549 (issued December 18, 2020).

[16] In light of the Board's disposition of Issue 1, Issue 2 is rendered moot.

ORDER

IT IS HEREBY ORDERED THAT the June 4 and May 27, 2021 decisions of the Office of Workers' Compensation Programs are set aside and remanded for additional development consistent with this decision.

Issued: August 21, 2023
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board