United States Department of Labor
Employees' Compensation Appeals Board

D.T., Appellant	)	
and	)	**Docket No. 24-0588**
	)	**Issued: August 21, 2024**
U.S. POSTAL SERVICE, DICKSON POST OFFICE, Dickson, TN, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On May 11, 2024 appellant filed a timely appeal from a January 11, 2024 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.[2]

ISSUE

The issue is whether appellant has met her burden of proof to establish permanent impairment of a scheduled member or function of the body, warranting a schedule award.

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the January 11, 2024 decision, appellant submitted additional evidence to OWCP. However, the Board's *Rules of Procedures* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

FACTUAL HISTORY

On December 9, 2014 appellant, then a 43-year-old rural carrier, filed a traumatic injury claim (Form CA-1) alleging that on November 15, 2014 she sustained a left shoulder injury when she fell from a platform while in the performance of duty.[3] On February 27, 2015 OWCP accepted appellant's claim for sprain of shoulder and upper arm, left rotator cuff, and brachial neuritis or radiculitis, not otherwise specified (NOS). By decision dated June 19, 2015, it expanded the acceptance of appellant's claim to include spinal stenosis of the cervical region. By decision dated December 12, 2017, OWCP further expanded the acceptance of her claim to include other cervical disc degeneration at the C5-6 and C6-7 level.[4]

In a January 2, 2018 form report, Dr. Tarek Elalayli, a Board-certified orthopedic surgeon, reported that appellant had reached maximum medical improvement (MMI) on September 6, 2017, and sustained eight percent permanent impairment of the whole body.

Appellant stopped work on April 28, 2018 and did not return.

By decisions dated May 17, June 20, August 2, and September 24, 2018, and February 7, 2019, OWCP expanded the acceptance of appellant's claim to include carpal tunnel syndrome, bilateral upper limb; unspecified rotator cuff tear or rupture of the left shoulder, not specified as traumatic; impingement syndrome of the left shoulder; other shoulder lesions of the left shoulder; cervical spinal enthesopathy; cervical radiculopathy; occipital neuralgia; lesion of ulnar nerve, left upper limb; lesion of ulnar nerve, right upper limb; and aggravation of intractable migraine headaches.

On May 27, 2023 appellant filed a claim for compensation (Form CA-7) for a schedule award.

By decisions dated June 2 and July 19, 2023, OWCP expanded the acceptance of appellant's claim to include chronic migraines, migraine with aura, intractable, with status migrainosus; other dystonia; chronic migraine without aura, not intractable, without status migrainosus; and sprain of left acromioclavicular joint, initial encounter.

On September 15, 2023 OWCP referred appellant, along with the case record, a statement of accepted facts (SOAF), and a series of questions to Dr. John J. Koehler, a Board-certified occupational medicine specialist, to determine the extent of appellant's permanent impairment for schedule award purposes.

[3] The record reflects that appellant also has a previously accepted July 10, 2008 traumatic injury claim for right shoulder rotator cuff impingement and right rotator cuff tear, under OWCP File No. xxxxxx393. She also has a previously accepted June 16, 2012 traumatic injury claim for sprain of right shoulder and sprain of right hip under OWCP File No. xxxxxx527 and a October 26, 2012 traumatic injury claim for contusion of right knee, right ankle sprain, sprain of elbow and forearm, and left radial collateral ligament, under OWCP File No. xxxxxx777.

[4] The record reflects that on June 29, 2017 appellant underwent surgery for total disc replacement at C6-7. On November 9, 2018 she underwent endoscopic left carpal release and open left cubital tunnel release with anterior subcutaneous transposition. On January 18, 2019 appellant underwent right endoscopic carpal release and right open in situ cubital tunnel release.

In an October 26, 2023 report, Dr. Koehler indicated that he reviewed the medical evidence of record and provided findings on physical examination, including range of motion (ROM) measurements for the right and left wrists, elbows, and shoulders, as well as the cervical and lumbar spine. He noted that strength testing on hand grip, wrist flexion and extension stressing, elbow flexion and extension stressing, as well as push and pull stressing elicited no signs of weakness or pain, other than some minimal left shoulder discomfort with push and pull. Dr. Koehler further reported that adduction testing was pain free at 5/5, provocative maneuvers of the rotator cuff were negative and decompression test was negative. He documented full and fluid cervical range of motion and noted that palpation of the cervical spine revealed some mild discomfort in the right occipital base paracervical region only. Dr. Koehler documented normal lumbar spine palpation without discomfort, reporting that side bending, rotation, and forward flexion revealed good range of motion of the thoracolumbar spine without pain or paresthesias.

Dr. Koehler opined that appellant had excellent strength and ROM with no objective deficits found, cervical motion was normal, neurologic testing was normal, and there was no restricted range of motion of the cervical spine. With respect to appellant's upper extremity conditions, he found that her subjective complaints and objective findings did not correlate as she had no subjective complaints in the upper extremities, and no objective findings in the upper extremities other than the surgical incision sites, which had healed well.

Dr. Koehler referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[5] and utilized the diagnosis-based impairment (DBI) rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 402, the class of diagnosis (CDX) for left shoulder rotator cuff partial thickness tear resulted in a Class 0 impairment due to no significant objective abnormal findings and no residual symptoms or loss of function, which represented zero percent permanent impairment of the left upper extremity. He indicated that Class 0 conditions were not subject to grade modifiers.

Referencing *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), Dr. Koehler determined that appellant had zero sensory or motor deficits resulting in zero percent permanent impairment of the left or right upper extremity as a result of spinal nerve impairments.

Dr. Koehler determined that appellant's bilateral carpal tunnel syndrome resulted in a Class 0 impairment due to no sensory or motor neurologic deficits, which represented zero percent permanent impairment of the right and left upper extremity. He further explained that grade modifiers were not applicable to a Class 0 impairment. Dr. Koehler reported that appellant's bilateral ulnar nerve lesions revealed no sensory motor deficits resulting in Class 0 impairment with no applicable grade modifiers. Therefore, he determined that the right and left bilateral nerve lesions amounted to zero percent permanent impairment. Dr. Koehler concluded that the DBI method resulted in zero prevent permanent impairment of both upper extremities.

Utilizing the ROM method, he determined that appellant had zero percent permanent impairment of the right and left upper extremity. He explained that the ROM measurements performed included wrist flexion, wrist extension, elbow flexion, elbow extension, shoulder flexion, shoulder extension, shoulder abduction, shoulder external rotation, and shoulder internal

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

rotation. Dr. Koehler noted that these ROM measurements were all tested three times on both sides, right and left, and determined that appellant's ROM was within normal limits with no applicable ROM deficit. Therefore, he determined that appellant did not have a ratable impairment utilizing the ROM method for the left or right upper extremity.

On December 7, 2023 OWCP requested Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), review the case for a determination on whether appellant sustained a permanent impairment of the right and/or left upper extremity and date of MMI.

In a December 15, 2023 report, Dr. Katz noted his review of the medical record, including the SOAF. He opined that appellant had attained MMI as of October 26, 2023, the date of Dr. Koehler's impairment evaluation. Dr. Katz referred to the sixth edition of the A.M.A., *Guides*, and concurred with Dr. Koehler's approach and conclusion that there was a zero percent permanent impairment of the left upper extremity impairment, and zero percent permanent impairment of the right upper extremity impairment. He utilized the DBI rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 402, the CDX for both the left and right shoulder rotator cuff partial thickness resulted in a Class 0 impairment due to no significant objective abnormal findings. Utilizing the ROM method of the A.M.A., *Guides*,[6] he found that appellant had zero percent permanent impairment of the right and left upper extremity due to normal ROM examination findings. Dr. Katz explained that because Dr. Koehler's examination documented normal motion present in the bilateral upper extremities, there was no calculable ROM impairment and the DBI impairment would be submitted.

Utilizing Table 15-23 (Entrapment/Compression Neuropathy Impairment), page 449, Dr. Katz determined that appellant sustained zero percent permanent impairment in both the left and right upper extremities as a result of median nerve entrapment. He assigned a grade modifier for functional history (GMFH) of 0; a grade modifier for physical examination (GMPE) of 0; and a grade modifier for clinical studies (GMCS) of 0, amounting to zero percent permanent impairment of the left and right upper extremity. Dr. Katz again utilized Table 15-23 to determine zero percent permanent impairment of both the left and right upper extremity due to ulnar nerve impairment, finding a GMFH of 0 as appellant was asymptomatic; a GMPE of 0 as physical examination was within normal limits; and a GMCS of 0 finding it was not applicable.

Dr. Katz further found no ratable spinal nerve impairments of the upper extremities, explaining Dr. Koehler's October 26, 2023 evaluation revealed no myotomal motor/dermatomal sensory deficits in either upper extremity. He referenced Proposed Table 1 of *The Guides Newsletter*, and reported that appellant was a Class 0 for no motor or sensory deficits of the spinal nerves in the left or right upper extremity. Dr. Katz concluded that appellant had zero percent permanent impairment of the upper extremities. He indicated that impairment ratings for a spinal nerve injury are determined using the method described in *The Guides Newsletter*. Dr. Katz concluded that appellant sustained zero percent permanent impairment of both the right and left upper extremities based on Dr. Koehler's October 26, 2023 examination findings.

[6] *Id.*

By decision dated January 11, 2024, OWCP denied appellant's schedule award claim, finding that the medical evidence of record was insufficient to establish permanent impairment of a scheduled member or function of the body, warranting a schedule award.

LEGAL PRECEDENT

The schedule award provisions of FECA,[7] and its implementing federal 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. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter, which rests in the 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[9] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[10]

The sixth edition requires identifying the impairment class for CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12]

The A.M.A., *Guides* also provides that the ROM impairment is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[13] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[14] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[15]

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides* (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also id.* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2, Exhibit 1 (January 2010).

[10] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[11] A.M.A., *Guides* 494-531.

[12] *Id.* at 521.

[13] *Id.* at 461.

[14] *Id.* at 473.

[15] *Id.* at 474.

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "As the [A.M.A.] *Guides* caution that, if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (via the updated instructions noted above) to the rating physician(s).
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> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used*."[16] (Emphasis in the original.)
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> The Bulletin further advises:
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> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[17]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[18] 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.[19]

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.[20] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[21] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was

[16] FECA Bulletin No. 17-06 (issued May 8, 2017).

[17] *Id*.

[18] A.M.A., *Guides* 449, Table 15-23. *See also L.G.*, Docket No. 18-0065 (issued June 11, 2018).

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

[20] 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).

[21] *Supra* note 9 at Chapter 2.808.5c(3) (February 2022).

designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The 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.[22]

In addressing upper or lower extremity impairment due to peripheral or spinal nerve root involvement, the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter* require identifying the impairment CDX, which is then adjusted by the GMFH and the GMCS. The effective net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[23]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[24]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish permanent impairment of a scheduled member or function of the body, warranting a schedule award.

The Board has reviewed the December 15, 2023 report of Dr. Katz, the DMA, who evaluated the October 26, 2023 examination findings of Dr. Koehler to calculate the permanent impairment of appellant's right and left upper extremity. The Board finds that Dr. Katz properly applied the standards of the sixth edition of the A.M.A., *Guides* to find that she has no permanent impairment of the right or left upper extremity.

The DMA, Dr. Katz, accurately summarized the relevant medical evidence including findings on examination, and reached conclusions about appellant's conditions based on these findings.[25] In his December 15, 2023 report, he properly referred to the A.M.A., *Guides* in calculating appellant's percentage of permanent impairment of the right and left upper extremity. Dr. Katz referenced the sixth edition of the A.M.A. *Guides*, and utilized the DBI rating method to find that, under Table 15-5 (Shoulder Regional Grid), the CDX for both the right and left shoulder rotator cuff, partial thickness tear resulted in a Class 0 impairment due to no significant objective abnormal findings.[26] He found that appellant had zero percent permanent impairment of the right and left upper extremity.

[22] *Id.* at Chapter 3.700, Exhibit 4 (January 2010); *see L.H.*, Docket No. 20-1550 (issued April 13, 2021); *N.G.*, Docket No. 20-0557 (issued January 5, 2021).

[23] *G.W.*, Docket No. 22-0301 (issued July 25, 2022); *see also The Guides Newsletter*; A.M.A., *Guides* 430.

[24] *See D.J.*, Docket No. 19-0352 (issued July 24, 2020).

[25] *K.K.*, Docket No. 20-1532 (issued January 24, 2022); *M.S.*, Docket No. 19-1011 (issued October 29, 2019); *W.H.*, Docket No. 19-0102 (issued June 21, 2019); *J.M.*, Docket No. 18-1387 (issued February 1, 2019).

[26] *M.W.*, Docket No. 23-0832 (issued December 27, 2023).

Dr. Katz, reviewed appellant's history of injury, and reported that Dr. Koehler observed no myotomal motor/dermatomal sensory deficits in either upper extremity in his October 26, 2023 examination. He referenced Proposed Table 1 of *The Guides Newsletter*, and reported that appellant was a Class 0 for no motor or sensory deficits of the spinal nerves in the left or right upper extremity. Dr. Katz concluded that appellant had zero percent permanent impairment of the upper extremities.[27] The Board finds that Dr. Katz correctly applied the appropriate tables and grading schedules of the A.M.A., *Guides* and *The Guides Newsletter*, to find that appellant had zero percent permanent impairment of the upper extremities due to the accepted November 15, 2014 employment injury.[28] Regarding upper extremity impairment for the cervical spine, Dr. Katz properly determined that appellant had zero permanent impairment due to normal sensory and motor findings.[29] As Dr. Katz' report is detailed, well rationalized, and based on a proper factual background, his opinion represents the weight of the medical evidence.[30]

Appellant has not provided medical evidence comporting with FECA and the sixth edition of the A.M.A., *Guides* in support of her request for an increased schedule award. The Board also notes that while Dr. Elalayli, in his January 2, 2018 form report, evaluated appellant's whole body permanent impairment, neither FECA nor its regulations provide for the payment of a schedule award for the body as a whole.[31] The Board has held that an attending physician's report is of diminished probative value where the A.M.A., *Guides* are not properly followed.[32]

As the medical evidence of record is insufficient to establish permanent impairment of a scheduled member or function of the body, the Board finds that appellant has not met her burden of proof to establish her schedule award claim.[33]

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 permanent impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish permanent impairment of a scheduled member or function of the body, warranting a schedule award.

[27] *Id*.

[28] *See D.M.*, Docket No. 21-0792 (issued January 4, 2023); *C.T.*, Docket No. 22-0822 (issued November 29, 2022); *T.B.*, Docket No. 20-0642 (issued September 30, 2020).

[29] *R.S.*, Docket No. 24-0030 (issued March 19, 2024).

[30] *R.G.*, Docket No. 21-0491 (issued March 23, 2023).

[31] 5 U.S.C. § 8107(c); *see C.O.*, Docket No. 24-0240 (issued May 29, 2024); *J.P.*, Docket No. 23-0442 (issued August 29, 2023).

[32] *A.C.*, Docket No. 18-1306 (issued October 18, 2019); *M.C.*, Docket No. 15-1932 (issued March 7, 2016); *J.G.*, Docket No. 09-1128 (issued December 7, 2009).

[33] *R.P.*, Docket No. 24-0119 (issued March 15, 2024).

ORDER

IT IS HEREBY ORDERED THAT the January 11, 2024 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 21, 2024
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board