United States Department of Labor
Employees' Compensation Appeals Board

M.D., Appellant	)	
and	)	**Docket No. 20-1459**
	)	**Issued: February 26, 2021**
U.S. POSTAL SERVICE, Du QUOIN POST OFFICE, Du Quoin, IL, 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:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 30, 2020 appellant, through counsel, filed a timely appeal from a May 7, 2020 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 to consider 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 permanent impairment of a scheduled member or function of the body, warranting a schedule award.

FACTUAL HISTORY

On June 20, 2016 appellant, then a 62-year-old distribution window clerk, filed an occupational disease claim (Form CA-2) alleging that she developed carpal tunnel syndrome (CTS) as a result of sorting mail and packages every day for 31 years while in the performance of duty. She noted that she first became aware of her condition and its relationship to her federal employment on April 11, 2016. Appellant did not stop work. She submitted medical evidence in support of her claim.

By decision dated September 2, 2016, OWCP denied appellant's occupational disease claim finding that the medical evidence of record failed to establish a diagnosis in connection with the accepted employment factors. It concluded, therefore, that the requirements had not been met to establish an injury as defined by FECA.

On May 2, 2017 appellant, through counsel, requested reconsideration and submitted new medical evidence.

OWCP, by decision dated July 31, 2017, vacated its September 2, 2016 decision. It determined that the newly submitted medical evidence established that appellant sustained right CTS and bilateral ulnar neuropathy as a result of her accepted employment factors. In a letter of even date, OWCP accepted appellant's claim for CTS, right, and ulnar neuropathy, right and left.

On December 6, 2017 appellant filed a claim for a schedule award (Form CA-7). No evidence was submitted in support of her claim.

OWCP, in a development letter dated December 13, 2017, requested that appellant submit a report from her attending physician, which addressed whether she had reached maximum medical improvement (MMI) and, if so, to evaluate permanent impairment in accordance with the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] It afforded her 30 days to submit the requested information.

Appellant submitted a March 24, 2018 medical report from Dr. Neil Allen, a Board-certified internist and neurologist. Dr. Allen utilized the A.M.A., *Guides*, examined appellant on January 15, 2018, and provided findings, and reviewed electromyogram/nerve conduction velocity (EMG/NCV) studies of the bilateral upper extremities which were performed on April 26, 2016. Regarding impairment to the upper limbs, he referred to Table 15-23 (Entrapment/Compression Neuropathy Impairment) on page 449, and determined that each elbow had a grade modifier of 2 for functional history (GMFH) due to significant intermittent symptoms, a grade modifier of 0 for a normal physical examination (GMPE), and a grade modifier of 1 for clinical studies (GMCS) for

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

conduction delay (sensory). Dr. Allen indicated that appellant's *Quick*DASH score was 45 based on the functional scale. Regarding impairment to the right wrist, he again assigned a GMFH of 2 due to significant intermittent symptoms, a GMPE of 0 as it was normal, and a GMCS of 1 for conduction delay (sensory). Dr. Allen also again indicated that appellant's *Quick*DASH score was 45 based on the functional scale. He concluded that according to page 448 of the A.M.A., *Guides*, "Rating Process," appellant had three percent permanent impairment of the right wrist and three percent permanent impairment of the right elbow, totaling six percent permanent impairment of the right upper extremity. Dr. Allen further concluded that she had three percent permanent impairment of the left upper extremity.

On June 30, 2018 Dr. David J. Slutsky, a Board-certified orthopedic surgeon, serving as a district medical adviser (DMA), reviewed a statement of accepted facts (SOAF) and the medical record. He advised that impairment rating evaluations for appellant's right CTS and bilateral cubital tunnel syndrome could not be performed due to a lack of information, including a detailed history of her complaints, physical findings including strength testing, and a legible copy of the April 2016 EMG/NCV studies. The DMA noted that he could not rate appellant's impairment based on an April 21, 2016 narrative summary of the EMG/NCV studies by Dr. Fakhre Alam, a Board-certified neurologist, since the data was required to render an impairment rating.

Thereafter, OWCP received an additional copy of Dr. Alam's April 26, 2016 EMG/NCV studies and summary. Dr. Alam provided impressions of mild bilateral ulnar neuropathy at the elbow, mild right CTS, and no evidence of cervical radiculopathy on the right.

On January 16, 2019 OWCP referred appellant, together with a SOAF and the medical record, to Dr. Michael H. Ralph, a Board-certified orthopedic surgeon, for a second opinion impairment evaluation. In a February 13, 2019 report, Dr. Ralph noted appellant's accepted conditions of ulnar nerve entrapment at both elbows and median nerve entrapment at the right wrist. He reviewed her medical records, examined appellant and provided his findings. Dr. Ralph related that he would not have accepted ulnar nerve entrapment at either elbow had he had initially seen appellant, however, these conditions had been accepted. He explained that she had normal findings related to ulnar nerve entrapment at the elbow. Dr. Ralph maintained that the fact that the NCV studies may have been somewhat elevated across the elbow was not a sufficient reason to make the diagnosis. He noted that he had ordered hundreds of NCV studies on the upper extremities where the only thing he was really looking for was CTS because a patient's symptoms were only that, and yet the NCV studies across the elbow may be slightly elevated, just like in appellant's case, yet they really did not have symptoms. Dr. Ralph nonetheless accepted that Dr. Allen's conclusions were mild bilateral ulnar neuropathy at the elbow, mild right CTS, and no evidence of cervical radiculopathy on the right. He determined that appellant had one percent permanent loss of use of the right upper extremity due to ulnar nerve entrapment at the elbow and one percent permanent loss of use of the same extremity due to right CTS, resulting in two percent permanent impairment of the right upper extremity. Additionally, Dr. Ralph determined that she had one percent permanent impairment of the left upper extremity due to left ulnar nerve entrapment at the elbow. He advised that appellant reached MMI on the date of his impairment evaluation.

On March 16, 2019 the DMA, Dr. Slutsky, reviewed the SOAF and medical record, including Dr. Ralph's February 13, 2019 findings. He disagreed with Dr. Ralph's finding that

appellant had one percent permanent impairment each for right CTS and bilateral elbow ulnar nerve entrapment. The DMA related that her electrodiagnostic studies were normal and did not yield findings sufficient to meet the criteria set forth in the A.M.A., *Guides* at Appendix 15-B on page 445 for rating an impairment due to entrapment/compression neuropathy. He thus used the Wrist Regional Grid at Table 15-3 on page 395. Regarding impairment to the right wrist, the DMA identified the class of diagnosis (CDX) as wrist sprain/strain, which yielded a class 0 impairment. Using Table 15-7 on page 406, he applied a GMFH of 0 as there was no documented wrist pain with activity and no *Quick*DASH score. Using Table 15-8 on page 408, the DMA applied a GMPE of 0 as there were no palpatory findings. Using Table 15-9 on page 410, he applied a GMCS of 0 because there were no imaging studies. The DMA concluded that appellant had zero percent impairment of the right wrist.

Regarding impairment to the right and left elbows, the DMA again identified the CDX as a class 0 wrist sprain/strain under Table 15-3 on page 395 as there was no documented complaints of elbow pain. He applied a GMFH of 0 as there were no difficulties with activities of daily living (ADLs) and no *Quick*DASH score under Table 15-7 on page 406. The DMA applied a GMPE of 0 as there were no palpatory findings under Table 15-8 on page 408. He applied a GMCS of 0 because there were no imaging studies under Table 15-9 on page 410. The DMA concluded that appellant had zero percent permanent impairment each for the right and left elbows.

OWCP, on July 30, 2019, requested that Dr. Ralph review the DMA's March 16, 2019 report and determine whether he agreed with the DMA's impairment rating using the sixth edition of the A.M.A., *Guides*.

In a September 12, 2019 letter, Dr. Ralph indicated that he had reviewed the electrical studies of the upper extremities. He advised that his prior opinion regarding appellant's permanent impairment and date of MMI had not changed.

On September 26, 2019 OWCP requested that its DMA clarify his March 16, 2019 report. It requested that he review Dr. Ralph's September 12, 2019 report and determine whether appellant had permanent impairment of each upper extremity.

In response, on November 16, 2019, the DMA resubmitted his March 16, 2019 report finding that appellant had zero percent impairment of the bilateral upper extremities.

By decision dated December 17, 2019, OWCP denied appellant's claim for a schedule award finding that she had not established permanent impairment of a scheduled member or function of the body in accordance with the A.M.A., *Guides*. It found that the weight of the medical evidence rested with the November 16, 2019 report of its DMA, Dr. Slutsky, who determined that appellant had no permanent impairment of her bilateral upper extremities.

On December 24, 2019 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review, which was held on April 8, 2020.

By decision dated May 7, 2020, an OWCP hearing representative affirmed the December 17, 2019 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[4] and its implementing 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. FECA, however, does not specify the manner in which the percentage of loss of a member 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 and the Board has concurred in such adoption.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, 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 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 ADLs.[9]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must identify the impairment CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and 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 an OWCP medical adviser for an opinion concerning the nature and percentage

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id*. at § 10.404(a); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[7] 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).

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

[9] 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.

[10] A.M.A., *Guides* 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).

of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[13]

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.

In a March 24, 2018 report, Dr. Allen, appellant's attending physician, examined appellant and provided findings, and reviewed Dr. Alam's April 26, 2016 EMG/NCV studies. He found that appellant had reached MMI, and opined that she had six percent permanent impairment of the right upper extremity for right CTS and right elbow ulnar neuropathy, and three percent permanent impairment of the left upper extremity for left elbow ulnar neuropathy utilizing the sixth edition of the A.M.A., *Guides*. Dr. Allen referenced Table 15-23, page 449, for Entrapment/Compression Neuropathy Impairment and assigned a GMFH of 2, a GMPE of 0, and a GMCS of 1. He noted a *Quick*DASH score of 45 based on the functional scale for each elbow and right wrist. Dr. Allen concluded that according to page 448 of the A.M.A., *Guides*, "Rating Process," appellant had six percent right upper extremity permanent impairment and three percent left upper extremity permanent impairment.

OWCP properly routed Dr. Allen's report to its DMA, Dr. Slutsky.[14] In a June 30, 2018 report, the DMA noted that he could not rate appellant's permanent impairment as Dr. Alam's April 2016 EMG/NCV studies, which Dr. Allen relied upon in rating appellant's impairment, were not ratable as the data was necessary to rate impairment.

After OWCP obtained an additional copy of Dr. Alam's April 26, 2016 EMG/NCV studies, it referred appellant to Dr. Ralph for a second opinion. In a February 13, 2019 report, Dr. Ralph found that appellant had one percent permanent impairment of the right elbow due to ulnar nerve entrapment and one percent permanent impairment of the right wrist due to CTS, resulting in two percent permanent impairment of the right upper extremity. Additionally, he found that she had one percent permanent impairment of the left upper extremity due to left ulnar nerve entrapment at the elbow.

In a March 16, 2019 report, the DMA reviewed Dr. Ralph's February 13, 2019 report and disagreed with his finding that appellant had one percent permanent impairment each for right CTS and bilateral elbow ulnar nerve entrapment. He referenced page 445 of the sixth edition of the A.M.A. *Guides* and related that her electrodiagnostic studies were normal. The DMA noted that the EMG/NCV studies did not yield findings sufficient to meet the criteria set forth in the A.M.A., *Guides* at Appendix 15-B on page 445 for rating an impairment due to entrapment/compression neuropathy. Thus, he utilized the Wrist Regional Grid at Table 15-3 on page 395. Regarding impairment to the right wrist, the DMA identified the CDX as wrist sprain/strain, which yielded a class 0 impairment. He applied GMFH of 0, GMPE of 0, and GMCS of 0 under Table 15-7, page 406, Table 15-8, page 408, and Table 15-9, page 410, respectively, which yielded zero percent

[13] *See supra* note 7 at Chapter 2.808.6(f) (March 2017); *see D.J.*, Docket No. 19-0352 (issued July 24, 2020).

[14] *Id*.

permanent impairment of the right wrist. The DMA used the same CDX of wrist sprain/strain to rate permanent impairment to the right and left elbows under Table 15-3, which yielded a class 0 impairment. He then applied GMFH of 0, GMPE of 0, and GMCS of 0 under Table 15-7, Table 15-8, and Table 15-9, respectively, which yielded zero percent permanent impairment each of the right and left elbows.

Dr. Ralph, in a September 12, 2019 supplemental report, reviewed appellant's EMG/NCV studies and advised that his prior opinion regarding her permanent impairment and date of MMI remained the same.

On November 16, 2019 the DMA reiterated the findings and opinion set forth in his March 16, 2019 report that appellant had zero percent permanent impairment of both the right and left upper extremities.

The Board finds that the DMA's March 16 and November 16, 2019 opinions constitute the weight of the medical evidence with respect to the permanent impairment of appellant's bilateral upper extremities because he properly applied the appropriate standards of the A.M.A., *Guides*.[15] As such, appellant has not established permanent impairment of a scheduled member or function of the body, warranting a schedule award.

On appeal counsel contends that the DMA's opinion is not entitled to the weight of the medical evidence. As discussed, however, the DMA's opinion is consistent with the provisions of the A.M.A., *Guides* and thus constitutes the weight of the evidence.[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 permanent impairment of a scheduled member or function of the body, warranting a schedule award.

[15] *See S.H.*, Docket No. 15-0845 (issued July 14, 2015).

[16] *See A.T.*, Docket No. 17-1940 (issued December 20, 2018).

ORDER

IT IS HEREBY ORDERED THAT the May 7, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 26, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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