United States Department of Labor
Employees' Compensation Appeals Board

J.L., Appellant	)	
	)	**Docket No. 22-1299**
and	)	**Issued: May 17, 2023**
	)	
U.S. POSTAL SERVICE, MANAGER COLUMBUS PROCESSING & DISTRIBUTION CENTER, Columbus, OH, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 1, 2022 appellant filed a timely appeal from a March 22, 2022 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]

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the issuance of the March 22, 2022 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* 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*.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 10 percent permanent impairment of each upper extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board on different issues.[3] The facts and circumstances of the case as set forth in the Board's prior decisions are incorporated herein by reference. The relevant facts are as follows.

On May 31, 2012 appellant, then a 55-year-old processing clerk, filed an occupational disease claim (Form CA-2) alleging that he sustained bilateral carpal tunnel syndrome (CTS) while in the performance of his federal employment duties. OWCP assigned this claim OWCP File No. xxxxxx201. OWCP accepted the claim for bilateral CTS.

Appellant underwent OWCP-authorized left carpal tunnel release on February 15, 2013 and right carpal tunnel release on August 2, 2013. On December 10, 2013 he returned to full-time, limited-duty work.[4]

On June 19, 2019 appellant filed a claim for compensation (Form CA-7) for a schedule award.

OWCP, by development letter dated June 25, 2019, requested that appellant submit a permanent impairment evaluation from his attending physician addressing whether he had reached maximum medical improvement (MMI) and, if so, the extent of any permanent impairment in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] It afforded him 30 days to submit the necessary evidence. No response was received.

By decision dated July 26, 2019, OWCP denied appellant's schedule award claim, finding that he had not submitted medical evidence of permanent impairment to a scheduled member or function of the body due to his accepted employment-related conditions.

On August 15, 2019 appellant requested reconsideration and submitted medical evidence. In a July 18, 2019 letter, Dr. Charles J. Kistler, Jr., a family practitioner, utilized the A.M.A.,

[3] Docket No. 15-0530 (issued July 29, 2015); Docket No. 18-0212 (issued June 8, 2018).

[4] On January 20, 2015 appellant filed a notice of a recurrence (Form CA-2a) of his accepted employment injury. OWCP converted his recurrence claim to a new occupational disease claim. It assigned that claim OWCP File No. xxxxxx781. By decision dated April 1, 2015, OWCP initially denied appellant's occupational disease claim, but in a subsequent decision dated July 16, 2015, it vacated the April 1, 2015 decision and accepted the claim for bilateral CTS and bilateral ulnar nerve lesion. OWCP administratively combined OWCP File No. xxxxxx781 and OWCP File No. xxxxxx201, with the latter serving as the master file.

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

Guides and applied the diagnosis-based impairment (DBI) method of evaluating permanent impairment referencing Table 15-23 for entrapment/compression neuropathy impairment. He determined that appellant had 4 percent permanent impairment of each upper extremity of his ulnar nerve condition for a combined 11 percent whole person permanent impairment. Dr. Kistler noted that he had reached MMI on the date of his impairment evaluation.

On January 14, 2020 OWCP routed Dr. Kistler's July 18, 2019 report, a statement of accepted facts (SOAF), and the case record to Dr. Jovito B. Estaris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), for review and determination of permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.

In a January 28, 2020 report, Dr. Estaris reviewed the SOAF and the medical record, including Dr. Kistler's report. The DMA indicated that he used the DBI rating method for entrapment/compression neuropathy to determine appellant's permanent impairment as the range of motion (ROM) rating method was not applicable because it involved soft tissues and not joints. He referred to Table 15-23, page 449, and identified a class of diagnosis (CDX) of bilateral CTS. The DMA assigned a grade modifier for functional history (GMFH) of 2 due to significant intermittent symptoms; grade modifier for physical examination (GMPE) of 3 due to significant weakness; and grade modifier for clinical studies (GMCS) of 1 due to conduction delay. He added these grade modifiers which totaled 6 and then divided this figure by 3 which resulted in a grade modifier of 2 or a default value of five percent. The DMA noted that appellant had a *Quick*DASH score of 44, which did not change the impairment rating. He concluded that appellant had five percent permanent impairment of each upper extremity due to bilateral CTS. The DMA also identified a CDX of bilateral cubital tunnel syndrome under Table 15-23. He assigned a GMFH of 2 for significant intermittent symptoms; GMPE of 3 for hypothenar atrophy; and GMCS of 1 for conduction delay. The DMA added these grade modifiers which totaled 6 and then divided this figure by 3 which resulted in a grade modifier of 2 or a default value of five percent. He reported a *Quick*DASH score of 32 which moved one grade to the left and resulted in four percent permanent impairment of each upper extremity due to bilateral cubital tunnel syndrome. The DMA referenced the A.M.A., *Guides*, page 448, noting that when there were multiple simultaneous neuropathies in the same upper extremity, the smaller impairment was rated at 50 percent of the impairment. Therefore, appellant had seven percent permanent impairment of each upper extremity for bilateral CTS and bilateral cubital tunnel syndrome. The DMA agreed with Dr. Kistler that the ROM method was not applicable. He determined that MMI was reached on July 18, 2019, the date of Dr. Kistler's impairment evaluation. Additionally, the DMA explained that he was unable to compare his impairment ratings with those of Dr. Kistler because Dr. Kistler did not provide details of his impairment ratings in accordance with the A.M.A., *Guides*. Instead, Dr. Kistler only noted that he used Table 15-23. He did not provide grade modifiers or calculations to support his seven percent permanent impairment rating for bilateral CTS and four percent permanent impairment rating for bilateral cubital syndrome. Additionally, the DMA explained that Dr. Kistler did not use the guidelines for rating multiple simultaneous neuropathies.

By letter dated February 27, 2020, OWCP requested that Dr. Kistler review Dr. Estaris' January 28, 2020 report and address the deficiencies raised in his report. It afforded Dr. Kistler 30 days to respond. No response was received.

By decision dated October 6, 2020, OWCP granted appellant a schedule award for seven percent permanent impairment of each upper extremity. The period of the award ran for 43.68 weeks from July 18, 2019 through May 18, 2020, and was based on the opinion of Dr. Estaris, the DMA.

On December 14, 2021 appellant filed a Form CA-7 claim for an increased schedule award.

In a development letter dated December 28, 2021, OWCP requested that appellant submit a permanent impairment evaluation from his attending physician addressing whether he had reached MMI and, if so, the extent of any permanent impairment in accordance with the A.M.A., *Guides*. It afforded him 30 days to submit the necessary evidence. No response was received.

OWCP, by decision dated February 1, 2022, denied appellant's claim for an increased schedule award, finding that he had not submitted medical evidence establishing greater than the seven percent permanent impairment of each upper extremity previously awarded.

OWCP subsequently received an October 25, 2021 report from Dr. Catherine Watkins Campbell, an occupational medicine and a family medicine specialist. Dr. Watkins Campbell reviewed appellant's medical record and discussed her findings on physical examination. She reported ROM measurements for the bilateral wrists. On further examination of the right wrist, Dr. Watkins Campbell found abnormal two-point discrimination at 10 millimeters (mm) on the ulnar aspect of the "RRF" and 15 mm in the "RIF," a one-to-two-centimeter scar at the base of the right palm. There was a three-mm scar on the medial right elbow, a negative Tinel's sign at the right wrist and elbow, a positive Phalen's sign with ulnar numbness, tenderness at the first carpometacarpal joint in the right hand, diffuse variable tenderness in the right wrist, variable medial epicondylar tenderness and moderate lateral epicondylar tenderness in the left elbow, and thenar atrophy was present, right greater than left. The right forearm measured 31.5 cm. Dr. Watkins Campbell reported ROM and grip strength measurements for the left wrist and elbow. Additionally, she reported an abnormal two-point discrimination for the left hand. There was a positive Tinel's sign for the left elbow, a negative Tinel's sign for the left wrist, and a positive Phalen's sign with ulnar numbness and tingling. There was no left lateral epicondylar tenderness. There was moderate medial epicondylar tenderness at the left elbow and hypothenar atrophy, greater right than left. The left forearm measured 30 cm. Utilizing Table 15-23 of the sixth edition of the A.M.A., *Guides*, Dr. Watkins Campbell identified a CDX of right CTS. She found a GMFH of 2; a GMPE of 3; and a GMCS of 3 due to axon loss. Dr. Watkins Campbell added these grade modifiers which totaled 8 and then divided this figure by 3 which resulted in a grade modifier of 2.66 or 3, which represented a category 3, grade A, or seven percent permanent impairment of the right upper extremity due to right CTS. She also identified a CDX of right cubital tunnel syndrome under Table 15-23. Dr. Watkins Campbell found a GMFH of 2; a GMPE of 3; and a GMCS of 1 due to conduction delay. She added these grade modifiers which totaled 6 and then divided this figure by 3 which resulted in a grade modifier of 3, which represented a category 2, grade C, or six percent permanent impairment of the right upper extremity due to cubital tunnel syndrome. Dr. Watkins Campbell further concluded that appellant had a total 13 percent permanent impairment of the right upper extremity. Regarding impairment to the left upper extremity, she continued to reference Table 15-23 and identified a CDX of left CTS. Dr. Watkins Campbell assigned a GMFH of 2; a GMPE of 3; and a GMCS of 3 due to axon loss. She added these grade

modifiers which totaled 8 and then divided this figure by 3 which resulted in a grade modifier of 2.66 or 3, which represented a category 3, grade A, or seven percent permanent impairment of the left upper extremity due to CTS. Dr. Watkins Campbell identified a CDX of left cubital tunnel syndrome under Table 15-23. She assigned a GMFH of 2; a GMPE of 3; and a GMCS of 1 due to conduction delay. Dr. Watkins Campbell added these grade modifiers which totaled 6 and then divided this figure by 3 which resulted in a grade modifier of 2, which represented a category 2, grade C, or six percent permanent impairment of the left upper extremity due to cubital tunnel syndrome. She concluded that appellant had a total of 13 percent permanent impairment of the left upper extremity. Dr. Watkins Campbell determined that he had reached MMI on October 25, 2018, the date of an examination performed by Dr. Ralph Rohner, Jr., a Board-certified orthopedic surgeon.

On February 15, 2022 appellant requested reconsideration of the February 1, 2022 schedule award decision.

On February 17, 2022 OWCP routed Dr. Watkins Campbell's October 25, 2021 report, an updated SOAF, and the case record to Dr. Todd Fellars, a Board-certified orthopedic surgeon serving as a DMA, for review and determination of permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.

In a March 9, 2022 report, Dr. Fellars applied the DBI rating method and identified a CDX of bilateral CTS under Table 15-23. He assigned a GMFH of 2; a GMPE of 3; and a GMCS of 3 due to axonal loss, which resulted in an average of category 3. Based on appellant's *Quick*DASH score, the DMA noted that a move one category to the left which resulted in seven percent permanent impairment of each upper extremity due to bilateral CTS. He also identified a CDX of bilateral cubital tunnel syndrome under Table 15-23. The DMA assigned a GMFH of 2; a GMPE of 3; and a GMCS of 1 due to conduction delay, which resulted in an average of category 3. Based on appellant's *Quick*DASH score, he noted that a move one category to the left resulted in six percent permanent impairment of each upper extremity due to bilateral cubital tunnel syndrome. The DMA noted, however, that when there are two compressive neuropathies in a limb, the second neuropathy is rated at 50 percent. He found that appellant had an additional three percent permanent impairment of each upper extremity impairment for cubital tunnel syndrome. Therefore, the DMA concluded that he had 10 percent permanent impairment of each upper extremity due to bilateral CTS and cubital tunnel syndrome. He noted that the ROM rating method was not applicable. The DMA determined that MMI was reached on October 25, 2021, the date of Dr. Watkins Campbell's impairment evaluation. He reviewed Dr. Watkins Campbell's October 25, 2021 report and agreed with her overall assessment of impairment. However, the DMA indicated that she did not rate the second neuropathy at 50 percent as required by the A.M.A., *Guides*.

OWCP, by decision dated March 22, 2022, granted appellant an increased schedule award for three percent permanent impairment of each upper extremity, less the 7 percent previously awarded, resulting in a total of 10 percent permanent impairment of each upper extremity, based on the opinion of Dr. Fellars, the DMA. The award ran for 18.72 weeks from October 25, 2021 through March 5, 2022.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing regulations[7] 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, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[8] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (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]

Impairment due to CTS is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[11] In Table 15-23, grade modifiers 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 based on functional scale, an assessment of impact on daily living activities.[12]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's *International Classification of Functioning Disability and Health (ICF): A Contemporary Model of Disablement*.[13] Under the sixth edition, the evaluator identifies the CDX, which is then adjusted by the GMFH, GMPE, and GMCS.[14] The net adjustment formula

[6] *Id.* at § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id. See also, Ronald R. Kraynak*, 53 ECAB 130 (2001).

[9] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

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

[11] A.M.A., *Guides* 449.

[12] 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; *see also J.H.*, Docket No. 19-0395 (issued August 10, 2020).

[13] A.M.A., *Guides* 3, section 1.3(a).

[14] *Id.* at 493-556.

is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15] Evaluators are directed to provide reasons for their impairment rating, including the choice of diagnoses from regional grids and the calculation of the modifier score.[16]

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 impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[17]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 10 percent permanent impairment of each upper extremity, for which he previously received schedule award compensation.

By decision dated October 6, 2020, OWCP granted appellant a schedule award for seven percent permanent impairment of each upper extremity. It found that the weight of the medical evidence rested with the opinion of Dr. Estaris, an OWCP DMA. On December 14, 2021 appellant filed a Form CA-7 for an increased schedule award. In support thereof, appellant submitted an October 25, 2021 report from Dr. Watkins Campbell. Dr. Watkins Campbell provided examination findings of appellant's bilateral hands, wrists, and elbows and found that he had reached MMI. She determined that, under the DBI method for rating impairment of the sixth edition of the A.M.A., *Guides*, appellant had 13 percent permanent impairment of each upper extremity due to bilateral CTS and bilateral cubital tunnel syndrome. Dr. Watkins Campbell referenced Table 15-23 for a CDX of right CTS. She assigned a GMFH of 2, a GMPE of 3, and a GMCS of 3. Dr. Watkins Campbell added the values of the grade modifiers. The sum of 8 was then divided by 3 to obtain an average value for these three modifiers which, when rounded up, equaled 3. This placed appellant in grade 3 as the final rating category, which represented a grade A, or seven percent permanent impairment of the right upper extremity due to right CTS. Dr. Watkins Campbell found a CDX of right cubital tunnel syndrome under Table 15-23. She assigned a GMFH of 2; a GMPE of 3; and a GMCS of 1. Dr. Watkins Campbell added the values of the grade modifiers. The sum of 6 was then divided by 3 to obtain an average value for these three modifiers which, equaled 2. This placed appellant in grade 2 as the final rating category, which represented a grade C, or six percent permanent impairment of the right upper extremity due to cubital tunnel syndrome. Dr. Watkins Campbell determined that appellant had a total 13 percent permanent impairment of the right upper extremity. Regarding impairment to the left upper extremity, she again referenced Table 15-23 and identified a CDX of left CTS. Dr. Watkins Campbell assigned a GMFH of 2; a GMPE of 3; and a GMCS of 3. She added the values

[15] *Id*. at 521.

[16] *M.C.*, Docket No. 20-1234 (issued January 27, 2022); *E.W.*, Docket No. 19-1720 (issued November 25, 2020); *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[17] *See supra* note 8 at Chapter 2.808.6(f) (March 2017). *See also P.W.*, Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan*, 57 ECAB 349 (2006).

of the grade modifiers. The sum of 8 was then divided by 3 to obtain an average value for these three modifiers which, when rounded up, equaled 3. This placed appellant in category 3 as the final rating category, which represented a grade A, or seven percent permanent impairment of the right upper extremity due to left CTS. Again, utilizing Table 15-23, Dr. Watkins Campbell identified a CDX of cubital tunnel syndrome. She assigned a GMFH of 2; a GMPE of 3; and a GMCS of 1. Dr. Watkins Campbell added the values of the grade modifiers. The sum of 6 was then divided by 3 to obtain an average value for these three modifiers which, equaled 2. This placed appellant in grade 2 as the final rating category, which represented a grade C, or six percent permanent impairment of the left upper extremity due to cubital tunnel syndrome. Dr. Watkins Campbell concluded that appellant had 13 percent permanent impairment of the left upper extremity.

In accordance with its procedures,[18] OWCP properly referred the evidence of record to Dr. Fellars, serving as the DMA. By report dated March 9, 2022, Dr. MA Fellars reviewed the medical evidence of record, including Dr. Watkins Campbell's October 25, 2021 report and determined that appellant had 10 percent permanent impairment of each upper extremity due to bilateral CTS and bilateral cubital tunnel syndrome based on the sixth edition of the A.M.A., *Guides*. Utilizing the DBI method under Table 15-23, he identified a CDX of bilateral CTS. The DMA assigned a GMFH of 2, a GMPE of 3, and a GMCS of 3, which resulted in an average of category 3. He applied appellant's *Quick*DASH score to move one category to the left, which resulted in seven percent permanent impairment of each upper extremity due to bilateral CTS. Additionally, the DMA identified a CDX of bilateral cubital tunnel syndrome under Table 15-23, page 449, for Entrapment/Compression Neuropathy Impairment. He assigned a GMFH of 2; a GMPE of 3; and a GMCS of 1, which resulted in an average of category 3. The DMA applied appellant's *Quick*DASH score to move one category to the left, which resulted in six percent permanent impairment of each upper extremity due to bilateral cubital tunnel syndrome. He referenced the A.M.A., *Guides*, page 448, noting that when there were multiple simultaneous neuropathies in the same upper extremity the second is rated at 50 percent of the impairment. As such, the DMA found that appellant had an additional three percent permanent impairment of each upper extremity impairment for cubital tunnel syndrome. Thus, he concluded that he had 10 percent permanent impairment of each upper extremity due to bilateral CTS and cubital tunnel syndrome. The Board finds that the DMA properly noted that the ROM rating method was not permitted under the A.M.A., *Guides* for the given diagnoses.[19] The DMA agreed with Dr. Watkins Campbell's overall assessment of impairment, but noted that she did not rate the second neuropathy at 50 percent as required by the A.M.A., *Guides*.

The Board finds that the DMA properly applied the A.M.A., *Guides* to find that appellant had no more than 10 percent permanent impairment of each upper extremity, for which he previously received schedule award compensation. Dr. Fellars' report is detailed, well rationalized, and based on a proper factual background, and thus his opinion represents the weight of the medical evidence. As such, the Board finds that appellant has not met his burden of proof

[18] *Id*.

[19] *See* A.M.A., *Guides* 387; *see also V.C*, Docket No. 21-1228 (April 7, 2022).

to establish greater permanent impairment of each upper extremity than the 10 percent permanent impairment previously awarded.

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 his burden of proof to establish greater than 10 percent permanent impairment of each upper extremity, for which he previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the March 22, 2022 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 17, 2023
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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