United States Department of Labor
Employees' Compensation Appeals Board

L.B., Appellant	)	
and	)	**Docket No. 12-1270**
	)	**Issued: January 10, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 24, 2012 appellant, through her attorney, filed a timely appeal from a February 2, 2012 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 the decision.

ISSUE

The issue is whether appellant established that she has more than a 13 percent impairment of the right upper extremity and a 4 percent impairment of the left upper extremity for which she received schedule awards.

On appeal appellant's attorney asserts that the weight of the medical evidence rests with the attending physician or, at a minimum, a conflict in medical evidence has been created.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On March 13, 2009 OWCP accepted that appellant, then a 58-year-old mail handler, sustained employment-related bilateral carpal tunnel syndrome and aggravation of a tear of the triangular fibrocartilage (TFCC) on the right.[2] A February 26, 2008 electromyogram (EMG) study was reported as abnormal on the left, with evidence of median neuropathy at the wrist. The study on the right was suggestive of median neuropathy but was within normal limits.

Appellant stopped work on July 10, 2009 when Dr. A. Lee Osterman, Board-certified in orthopedic and hand surgery, performed surgical decompression on the left hand. Dr. Osterman performed decompression on the right with TFCC debridement on November 17, 2009. Appellant was placed on the periodic compensation rolls and returned to modified duty for four hours a day on April 17, 2010. She continued to receive compensation for four hours daily and on June 1, 2010 began working eight hours a day.

In a July 19, 2010 report, Dr. Osterman reported that appellant's condition had improved following surgery but that she still had occasional pain at work. Physical examination demonstrated full digital motion and intact sensation to all fingers. Dr. Osterman diagnosed bilateral carpal tunnel syndrome, status post bilateral release; carpometacarpal osteoarthritis, left greater than right, status post left injection; right wrist pain, status post right wrist arthroscopy; and debridement of scapholunate and lunotriquetral ligaments. He concluded that appellant's condition should improve over the next several months, with increased function.

On November 13, 2010 appellant filed a schedule award claim and submitted a September 7, 2010 report in which Dr. Nicholas Diamond, an osteopath, reported appellant's medical history. Dr. Diamond advised that she complained of bilateral hand pain and stiffness with decreased grip strength and that work duties and household chores exacerbated her condition. He reported *Quick*DASH scores of 23 percent on the right and 38 percent on the left and provided physical examination findings for both upper extremities. Dr. Diamond diagnosed cumulative and repetitive trauma disorder; right carpal tunnel syndrome with TFCC tear; left carpal tunnel syndrome; bilateral carpometacarpal joint arthritis; status post bilateral carpal tunnel releases and post-traumatic bilateral wrist osteoarthritis. He advised that appellant reached maximum medical improvement on September 7, 2010 and that, in accordance with Table 15-3 and Table 15-7 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[3] (hereinafter A.M.A., *Guides*), she had 15 percent right upper extremity impairment and 12 percent impairment on the left.

In a November 18, 2010 report, Dr. Morley Slutsky, Board-certified in occupational medicine and an OWCP medical adviser, noted his review of the record. He advised that Dr. Diamond did not utilize the proper tables of the A.M.A., *Guides* in rating the right upper extremity because the preoperative electrodiagnostic tests did not meet the criteria for rating the

[2] Appellant filed a claim for left carpal tunnel syndrome on August 4, 2008, adjudicated under file number xxxxxx397. By decision dated January 23, 2009, OWCP denied the claim. The instant claim, accepted for bilateral carpal tunnel syndrome, was adjudicated by OWCP under file number xxxxxx600.

[3] A.M.A., *Guides* (6th ed. 2008).

claimant using Table 15-23. Dr. Slutsky found that under Table 15-21 appellant had 5 percent impairment due to median nerve impairment and 8 percent impairment due to the TFCC tear, for a combined 13 percent right arm impairment. Regarding the left arm, OWCP's medical adviser utilized Table 15-23 and found four percent impairment.

On February 16, 2011 appellant was granted a schedule award for 4 percent left arm impairment and 13 percent impairment on the right, for a total of 53.04 weeks, to run from September 7, 2010 to September 13, 2011.

Appellant, through her attorney, timely requested a hearing, that was held on June 21, 2011. At the hearing she described her work duties and current complaints of shooting wrist pain and tingling bilaterally. Appellant's attorney argued that appellant's right thumb arthritis was preexisting and that, at most, a conflict in medical evidence had been created. In an August 2, 2011 letter, he also asserted that brachial plexus and ulnar neuropathy were also preexisting. Counsel submitted a June 25, 2001 EMG study of the cervical nerve roots, the cervical and brachial plexus components, and in the periphery, the median, ulnar and radial nerves. The EMG demonstrated mild left radial nerve neuropathy at the elbow, borderline normal on the right; mild right median nerve neuropathy at the wrist, borderline on the left; bilateral brachial plexus neuropathies; bilateral ulnar nerve neuropathies at the elbow; and isolated bilateral EMG evidence of moderate loss of motor units on recruitment in the opponens pollicis muscles.

In an October 30, 2001 report, Dr. Scott Fried, an osteopath, provided physical examination findings. He reviewed the June 25, 2001 EMG and reported cervical magnetic resonance imaging (MRI) scan findings of disc disease at C3-4 with disc bulge and no cord impingement. Dr. Fried diagnosed cumulative trauma disorder and repetitive strain injury secondary to mail handling activities with median neuropathy of the left wrist, moderate right; carpometacarpal (CMC) and scaphotrapezotrapezoidal (STT) joint arthrosis with synovitis of the thumbs, secondary to repetitive grasping activities, left greater than right; and proximal radiculitis with plexitis and cervical radicular component secondary to same work activities and neck and head posturing.

By decision dated September 1, 2011, an OWCP hearing representative affirmed the February 16, 2011 decision. On October 28, 2011 appellant's attorney requested reconsideration. He submitted additional evidence including a June 7, 2001 cervical spine MRI scan study that showed moderate degenerative disc disease at C3-4 with a moderate broad spur and herniation and no cord impingement. In a May 30, 2001 fitness-for-duty examination, Dr. Fried described appellant's work duties and complaints regarding her arms. He provided findings and diagnosed cumulative trauma disorder and repetitive strain injury secondary to mail handling activities with median neuropathy in left wrist, moderate right; CMC and STT joint arthrosis with synovitis of the thumbs, secondary to repetitive grasping activities, left greater than right; and proximal radiculitis with plexitis and cervical radicular component secondary to same work activities and neck and head posturing. May 30, 2001 bilateral x-rays of the hands were essentially unremarkable. In a May 7, 2002 report, Dr. Fried reviewed an April 18, 2002 functional capacity evaluation. He reiterated his previous findings and diagnoses and recommended that appellant continue modified duty.

By report dated August 25, 2011, Dr. Diamond reported that, since his September 7, 2010 examination, appellant had developed ulnar neuropathies and a cervical condition with complaints of daily neck stiffness, pain radiating into the left upper extremity, bilateral hand pain and stiffness and decreased grip strength that caused difficulties in performing her work duties and activities of daily living. He found *Quick*DASH scores of 73 percent on the left and 52 percent on the right. Dr. Diamond provided upper extremity physical examination findings and additionally diagnosed bilateral ulnar nerve neuropathies at the elbows, electrodiagnostic testing positive; bilateral brachial plexus neuropathies, electrodiagnostic testing positive; left radial nerve neuropathy at the dorsal elbows, electrodiagnostic testing positive and bilateral opponens pollicis motor unit loss, electrodiagnostic testing positive. He found that, under Table 15-23, appellant's entrapment neuropathy of the right median nerve at the wrist yielded an eight percent impairment, which he reduced to seven percent, based on appellant's *Quick*DASH score. Dr. Diamond rated the right TFCC tear under Table 15-3, at a class 1 impairment, applied the net adjustment formula, and concluded that appellant had eight percent impairment for the TFCC tear. He further found that appellant was entitled to 3 percent impairment under Table 15-23 for entrapment neuropathy of the right ulnar nerve at the elbow, for a total right upper extremity impairment of 19 percent. Regarding the left upper extremity, Dr. Diamond found that under Table 15-23, entrapment neuropathy of the left median nerve at the wrist yielded 8 percent impairment and that entrapment neuropathy of the left median nerve at the elbow yielded 3 percent impairment, for a total left upper extremity impairment of 11 percent.

In a January 31, 2012 report, Dr. Slutsky, OWCP's medical adviser, noted his review of the record beginning with the February 26, 2008 EMG report and including Dr. Diamond's August 25, 2011 report. He advised that appellant's upper extremity impairment rating remained at 4 percent on the left and 13 percent on the right. Dr. Slutsky again noted that he rated her right upper extremity under Table 15-21 because her preoperative testing did not meet the applicable criteria under Table 15-23 and reiterated that appellant had a five percent right upper extremity impairment under Table 15-21 due to median nerve impairment. He agreed with Dr. Diamond that appellant had 8 percent right upper extremity impairment due to the TFCC tear, for a total 13 percent impairment of the right upper extremity. Regarding the left upper extremity, Dr. Slutsky disagreed with the modifiers found by Dr. Diamond and indicated that appellant's left upper extremity rating remained at four percent. He further indicated that none of the treating physicians of record found cubital tunnel syndrome in either upper extremity or evidence of bilateral brachial plexus issues, noting that electrodiagnostic testing of record demonstrated neither. Dr. Slutsky concluded that appellant was not entitled to an increased impairment rating based on these conditions.

In a merit decision dated February 2, 2012, OWCP denied modification of the prior decisions, finding that the weight of the medical evidence rested with the opinion of OWCP's medical adviser.

LEGAL PRECEDENT

The schedule award provision of FECA, and its implementing federal regulations,[4] 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.[5] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[6] For decisions issued after May 1, 2009, the sixth edition will be used.[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, for upper extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10]

Impairment due to carpal 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 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 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 to OWCP's medical adviser for an opinion concerning the nature and

[4] 20 C.F.R. § 10.404.

[5] *Id*. at § 10.404(a).

[6] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[7] FECA Bulletin No. 09-03 (issued March 15, 2009).

[8] A.M.A., *Guides*, *supra* note 3 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[9] *Id*. at 385-419.

[10] *Id*. at 411.

[11] *Id*. at 449.

[12] *Id*. at 448-50.

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

The Board finds this case is not in posture for decision because a conflict in medical evidence has been created between the opinions of Dr. Diamond and Dr. Slutsky. The accepted conditions in this case are bilateral carpal tunnel syndrome and aggravation of a TFCC tear on the right. Appellant was granted a schedule award on February 16, 2011 for 4 percent impairment on the left and 13 percent impairment on the right, based on the opinion of OWCP's medical adviser, Dr. Slutsky.

It is well established that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[14] In the case at hand, the record supports that appellant had preexisting brachial plexus and elbow conditions, as evidenced by a June 25, 2001 EMG study, and in Dr. Fried's reports dated May 30, 2001 to May 7, 2002. In his January 31, 2012 report, while Dr. Slutsky noted his review of Dr. Diamond's newly submitted August 25, 2011 report, his review of the medical record only went back to the February 26, 2008 EMG report. There is no indication that he studied the medical record from 2001 and 2002. Dr. Diamond's impairment rating included diagnoses of entrapment neuropathy of the right median nerve at the wrist and right ulnar nerve at the elbow as well as left median nerve at the wrist and elbow.

Furthermore, the physicians disagreed regarding appellant's impairment due to entrapment neuropathy at the wrist. While they agreed that appellant was entitled to an eight percent impairment for the right TFCC tear under Table 15-3,[15] Dr. Diamond, who utilized Table 15-23,[16] advised that appellant had an additional seven percent impairment due to entrapment neuropathy of the right median nerve at the wrist whereas Dr. Slutsky, who used Table 15-21,[17] advised that appellant was entitled to an additional five percent impairment. They also disagreed regarding the impairment rating for entrapment neuropathy on the left with Dr. Diamond finding eight percent and Dr. Slutsky finding four percent.

If there is disagreement between OWCP's medical adviser and the employee's physician, OWCP will appoint a third physician who shall make an examination.[18] For a conflict to arise,

[13] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[14] *Michael C. Milner*, 53 ECAB 446 (2002); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3(a)(3) (January 2010).

[15] A.M.A., *Guides*, *supra* note 3 at 396.

[16] *Id*. at 449.

[17] *Id*. at 438. It is unclear how Dr. Diamond reached a total of 19 percent right upper extremity impairment since a 7 percent impairment for right median neuropathy at the wrist, plus an 8 percent impairment for the TFCC tear, plus a 3 percent impairment for ulnar entrapment at the elbow yields a total 18 percent impairment.

[18] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

the opposing physician's viewpoints must be of virtually equal weight and rationale.[19] The Board finds the opinions of Dr. Diamond and Dr. Slutsky to be of equal weight as to appellant's upper extremity impairments. The Board will set aside the February 2, 2012 decision and remand the case for OWCP to refer appellant to an impartial medical specialist to resolve the conflict. After such further development as it deems necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds this case is not in posture for decision as a conflict in medical evidence has been created regarding the degree of appellant's bilateral upper extremity impairments.

ORDER

IT IS HEREBY ORDERED THAT the February 2, 2012 decision of the Office of Workers' Compensation Programs is vacated and the case remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: January 10, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[19] *Darlene R. Kennedy*, 57 ECAB 414 (2006).