United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 10-1613**
	)	**Issued: March 24, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Forest Park, IL, Employer	)	

Appearances:
Alan J. Shapiro, 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 June 2, 2010 appellant timely appealed the April 28, 2010 merit decision of the Office of Workers' Compensation Programs, which denied her request for a schedule award. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over this decision.

ISSUE

The issue is whether appellant has a ratable permanent impairment of the right or left upper extremity.

FACTUAL HISTORY

On November 22, 2002 appellant, a 47-year-old distribution clerk, filed an occupational disease claim alleging that she sustained injuries to her upper extremities as a result of repetitive

[1] 5 U.S.C. § 8101 *et seq.*

employment activities.[2] The Office accepted her claim for bilateral tendinitis of the wrists and bilateral carpal tunnel syndrome. Appellant underwent right carpal tunnel release surgery on February 11, 2004 and returned to full duty on September 2, 2004.

In a May 3, 2006 decision, the Office denied appellant's request for a schedule award, finding that she had no residual impairment under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. It found that the date of maximum medical improvement (MMI) was September 2, 2004, the date she returned to full-time employment.

On February 2, 2007 appellant filed a separate occupational disease claim under File No. xxxxxx304. The claim was accepted for bilateral carpal tunnel syndrome. Appellant stopped work on August 14, 2007. The Office combined the File Nos. xxxxxx850 and xxxxxx304, with File No. xxxxxx850 serving as the master file.[3]

On January 24, 2008 the Office authorized carpal tunnel release surgery. Appellant did not undergo carpal tunnel release surgery due to the occurrence of a rash at the surgery site.

On February 19, 2008 Dr. Victor Romano, a Board-certified orthopedic surgeon, released appellant to return to limited duty. She was restricted from performing any repetitive activities, typing and lifting more than five pounds.

On December 12, 2008 appellant requested a schedule award.

Appellant was also treated for chronic lower back pain. On February 11, 2009 Dr. Alan Wilson, a treating physician, opined that she was totally disabled and completely incapacitated due to her lumbar condition as of July 19, 2007.

On February 24, 2009 Dr. Romano reported that appellant was experiencing persistent pain and weakness in both hands due to her diagnosed carpal tunnel syndrome. He referred to a February 5, 2009 functional capacity evaluation, which reflected her ability to lift no more than 10 pounds.

The Office referred appellant to Dr. David Trotter, a Board-certified orthopedic surgeon, for a second opinion evaluation and an opinion as to whether she had any permanent impairment due to her accepted upper extremity conditions.[4] Dr. Trotter was instructed to provide a full description of any permanent impairment, including any decrease in strength, atrophy of muscles, changes in sensation. He was also asked to describe any subjective complaints of a chronic nature, such as pain and weakness. Dr. Trotter was advised to provide range of motion

[2] Appellant initially filed a claim for a recurrence of disability. The Office developed her claim as one for a new occupational disease.

[3] Appellant's 1995 traumatic injury claim (File No. xxxxxx235) was accepted for spinal stenosis and sciatica.

[4] On February 25, 2009 the Office informed appellant that she should provide an impairment rating from her physician. On May 8, 2009 appellant informed the Office that Dr. Romano did not conduct impairment ratings.

measurements, expressed in degrees. Finally, all findings were to be correlated with the provisions of the sixth edition of the A.M.A., *Guides*.

In an August 7, 2009 report, Dr. Trotter noted appellant's reports of persistent symptoms at both the right and left wrist and hands, with multiple fingers going numb and tingling. His gross neurologic evaluation of both the upper and lower extremities revealed 5/5 motor power; and completely intact subjective sensation has also been documented. Dr. Trotter found full range of motion of the shoulders, elbows and wrists. Appellant had negative Phalen's maneuver of the wrists bilaterally, as well as no apparent tenderness or swelling. There was good color, capillary refill and temperature of the digits of the upper extremities were noted with excellent function of the median, ulnar and radial nerve innervated digits/dermatomes and the corresponding motor power at the ulnar nerve in particular along the palmar side. The examinee had no tenderness volarly or dorsally at the level of the flexor or extensor tendons and negative Finkelstein's maneuver bilaterally at the wrist along with no tenderness at the first dorsal compartment.

Dr. Trotter's review of the medical records included reference to an April 25, 2007 electromyogram (EMG), "which was read as negative ..." and a February 5, 2009 functional capacity evaluation. He noted that appellant returned to full duty on September 2, 2004 following carpal tunnel release surgery, with no evidence of complications and minimal residual complaints. Dr. Trotter reviewed October 9, 2008 records from Trinity Orthopedics and February 11, 2009 records from Dr. Wilson regarding appellant's lumbar condition.

Dr. Trotter opined that appellant had no permanent impairment to her bilateral upper extremities due to her accepted November 10, 2002 injury. He stated that her intermittent mild and highly subjective complaints of numbness, tingling, and/or pain appeared to be disproportionate to the unremarkable examination findings and were consistent with symptom magnification. Dr. Trotter found no evidence of any significant motion deficit. Appellant had approximately 40 degrees of flexion/extension of both wrists, 10 degrees of ulnar and radial deviation and 85 degrees of supination/pronation at the wrists and no evidence of any deficit of any motion in the fingers and hands bilaterally. Dr. Trotter assigned a Grade Modifier 0 under Table 15-23 on page 449 of the sixth edition of the A.M.A., *Guides*, entrapment/compression neuropathy impairment. Based on appellant's sensory/subjective complaints and unremarkable examination findings and postoperatively normal electrodiagnostics, he concluded that appellant had zero percent upper extremity impairment. Dr. Trotter opined that appellant reached MMI as early as September 2, 2004, the date of her release to full duty. He stated: "Subsequent to that date there has been no reasonable and/or credible documentation that would support that this individual has sustained any recurrent or residual bilateral carpal tunnel syndrome."

In a report dated October 19, 2009, the district medical adviser (DMA) determined that appellant had no ratable impairment of either upper extremity due to wrist tendinitis and carpal tunnel syndrome. He based his determination on Dr. Trotter's August 7, 2009 report, which reflected full strength in both upper and lower extremities; completely intact sensation; full ROM of the shoulders, elbows, and wrists; negative Finklestein's test bilaterally; and no tenderness along the first dorsal compartment. The DMA noted a reference to "an EMG which apparently was read as 'negative.'" Noting the "highly subjective complaints which are disproportionate to the completely normal physical examination as well as electrical studies," the he indicated that

there was no objective basis for a schedule award. The DMA opined that the date of MMI remained September 2, 2004, when appellant was released back to work full duty.

By decision dated November 10, 2009, the Office denied appellant's request for a schedule award. On November 10, 2009 appellant requested a telephonic hearing, which was conducted on February 17, 2010. She testified that she experienced significant pain due to her accepted carpal tunnel syndrome. Appellant stated that she had been unable to attend an appointment with her physician for another impairment rating due to her inability to drive.

By decision dated April 28, 2010, an Office hearing representative affirmed the Office's November 10, 2009 decision, finding that the weight of the medical evidence was represented by Dr. Trotter's August 7, 2009 report.

LEGAL PRECEDENT

Section 8107 of the Act sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[5] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[6] Effective May 1, 2009, schedule awards are determined in accordance with the A.M.A., *Guides* (6th ed. 2008).[7]

ANALYSIS

The Board finds that this case is not in posture for a decision as to whether appellant has a ratable permanent impairment of the right or left upper extremity.

Under the sixth edition of the A.M.A., *Guides*, impairments of the upper extremities are covered by Chapter 15. Entrapment neuropathy, such as carpal tunnel syndrome, is addressed at section 15-4f.[8] Having established the diagnosis of carpal tunnel syndrome, the next step in the rating process is to consult Table 15-23, entitled *Entrapment/Compression Neuropathy Impairment*.[9] The table provides a series of grade modifiers from zero to four and a range of corresponding upper extremity impairments from zero to nine percent. Grade modifiers are

[5] For a total loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1) (2006).

[6] 20 C.F.R. § 10.404 (2009).

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Example 1 (January 2010).

[8] A.M.A., *Guides* 432.

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

assigned based on a combination of factors including test findings, history and physical findings.[10]

Citing Table 15-23, Dr. Trotter indicated that he had assigned appellant a Grade 0 modifier. Based on appellant's sensory/subjective complaints and unremarkable examination findings and postoperatively normal electrodiagnostics, he concluded that appellant had zero percent upper extremity impairment. Dr. Trotter did not adequately explain, however, how he arrived at a Grade 0 modifier. The Board notes that, according to Table 15-23, a Grade 0 modifier is appropriate in the presence of normal test findings and where the patient is asymptomatic. Where the patient's history includes mild intermittent symptoms, a Grade 1 modifier is appropriate. Dr. Trotter noted that appellant's complaints were highly subjective. The Board notes, however, that complaints of pain and weakness are necessarily subjective. Moreover, the medical history reflects repeated complaints of pain, which would qualify as a Grade Modifier 1. Dr. Trotter did not address reports from appellant's treating physician, Dr. Romano, which documented her complaints of pain and weakness. Further, his findings of "normal electrodiagnostics," were based on an April 25, 2007 EMG report, which predated the Office's acceptance of appellant's second occupational disease claim (File No. xxxxxx304) on August 14, 2007 and the Office's authorization for carpal tunnel release surgery on January 24, 2008.[11] Therefore, Dr. Trotter's reliance on the April 25, 2007 test results was inappropriate. The Board finds that his explanation as to how he arrived at a Grade Modifier 0 is inadequate.

Finally, Dr. Trotter opined that appellant reached MMI as early as September 2, 2004, the date of her release to full duty, stating that subsequent to that date there had been no reasonable and/or credible documentation that would support any recurrent or residual bilateral carpal tunnel syndrome. He failed to address appellant's 2007 occupational disease claim, which was also accepted for carpal tunnel syndrome, and the Office's authorization for carpal tunnel release surgery on January 28, 2008, nor did he explain why the February 24, 2009 report from Dr. Romano and the February 5, 2009 functional capacity evaluation, both of which supported appellant's continuing carpal tunnel syndrome symptoms, were not credible. The determination of whether MMI has been reached is based on the probative medical evidence of record and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[12] The Board, therefore, requires persuasive evidence of MMI for selection of a retroactive date of MMI.[13] The opinion of Dr. Trotter dated August 7, 2009 identifies a date of MMI, September 2, 2004 and an inference concerning an event five years earlier requires significant, well-rationalized support. In this case, neither Dr. Trotter nor the Office medical adviser provided the persuasive proof necessary to support a retroactive date of MMI.

[10] *Id.*

[11] It is on the date of examination that a physician has the best opportunity to examine the patient. Where there is significant medical evidence in the record to support an earlier date of MMI, the physician should identify that evidence and explain its significance to his or her opinion that an earlier date is appropriate.

[12] *Mark A. Holloway*, 55 ECAB 321 (2004).

[13] *Id.*

Without adequate explanation, the medical adviser agreed with Dr. Trotter's opinion on the absence of a ratable impairment and the date of MMI. As he failed to provide rationale for his opinion or to properly address the provisions of the A.M.A., *Guides*, his report is also deficient. Accordingly, the Board finds that the case is not in posture for decision. The matter will be remanded to the Office for further development. After such development as it deems necessary, the Office will issue an appropriate decision regarding appellant's entitlement to schedule award compensation.

CONCLUSION

The Board finds that the case is not in posture for decision as to whether appellant has a ratable permanent impairment of either upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the April 28, 2010 decision of the Office of Workers' Compensation Programs be set aside. The case is remanded for further action consistent with this decision.

Issued: March 24, 2011
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