United States Department of Labor
Employees' Compensation Appeals Board

S.G., Appellant	)	
and	)	**Docket No. 11-611**
	)	**Issued: October 11, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Eatontown, NJ, 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 January 13, 2011 appellant filed a timely appeal from an October 4, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has established that she sustained more than an eight percent impairment of the left upper extremity, for which she received a schedule award.

On appeal, counsel asserts a conflict of medical evidence between an attending physician and an OWCP medical adviser regarding the appropriate percentage of permanent impairment.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on or before May 22, 2002 appellant, then a 40-year-old mail processor and mark-up clerk, sustained bilateral carpal tunnel syndrome. She received wage-loss compensation for work absences related to the accepted condition.

Dr. Scott M. Fried, an attending osteopath and Board-certified orthopedic surgeon, followed appellant beginning in 2002. In an August 7, 2002 report, he diagnosed bilateral carpal tunnel syndrome, cumulative trauma disorder, repetitive strain and bilateral brachial plexopathy. Dr. Fried opined that all of the diagnosed conditions were work related. He stated that October 16, 2002 electromyography (EMG) and nerve conduction velocity (NCV) testing showed bilateral carpal tunnel syndrome, bilateral brachial plexopathy and bilateral ulnar neuropathy at the elbows. On February 17, 2004 Dr. Fried performed a left median nerve release with flexor tenosynovectomy. He performed the same procedures on the right wrist on August 31, 2004. September 20, 2004 x-rays showed grade 1 change in the distal interphalangeal joints of the left hand, mild flexor tenosynovitis of the left wrist and no other "severe abnormality" of the left hand or wrist. Dr. Fried submitted reports through August 2006 newly diagnosing a left trigger thumb and long thoracic nerve neuritis on the right.[2]

On January 7, 2005 OWCP obtained a second opinion from Dr. Robert Dennis, a Board-certified orthopedic surgeon, who diagnosed bilateral carpal tunnel syndrome, 85 to 90 percent improved after surgery. Dr. Dennis noted the recent onset of a left trigger thumb, unrelated to work factors as it developed while appellant was off work after surgery. He released her to four hours a day full duty.

OWCP found a conflict of medical opinion between Dr. Fried, for appellant and Dr. Dennis, for the government, regarding the nature and extent of any residuals of the accepted conditions. To resolve the conflict, it selected Dr. Ian Blair Fries, a Board-certified orthopedic surgeon, as impartial medical examiner.

In a November 7, 2006 report, Dr. Fries reviewed the medical record and statement of accepted facts. On examination, he found mild fullness of the right carpal tunnel compared to the left. Dr. Fries stated that appellant did not have cervical radiculopathy or brachial plexopathy. He explained that she no longer had stenosing tenosynovitis of the left thumb and that such condition was not work related as it occurred "long after she had left work and [was] a common spontaneous condition." Dr. Fries diagnosed bilateral carpal tunnel syndrome and musculoskeletal pain. He ordered EMG and NCV testing, performed on November 17, 2006, which showed bilateral carpal tunnel syndrome. No radiculopathy or brachial plexopathy was demonstrated. In a December 29, 2006 report, Dr. Fries opined that appellant had objective residuals of bilateral carpal tunnel syndrome and had attained maximum medical improvement. He noted permanent work restrictions.

[2] An August 12, 2005 EMG study showed bilateral brachial plexopathy and neuropathies of the median nerve and the left ulnar nerve at the elbow.

Appellant returned to part-time modified duty in September 2007 and to full-time limited duty on January 19, 2009.[3] Dr. Fried submitted periodic reports through August 2009 noting continued bilateral elbow, hand, wrists and brachial plexus neuropathies. He reviewed July 27, 2006 and June 5, 2009 EMG and NCV studies showing bilateral median nerve compromise, bilateral brachial plexus compromise, left ulnar nerve neuropathy at the elbow and right radial nerve compression.

On December 7, 2009 appellant claimed a schedule award. In a December 18, 2009 letter, OWCP advised her to submit an impairment rating from her attending physician referring to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (hereinafter).

Appellant submitted a July 16, 2009 impairment rating by Dr. Arthur Becan, an orthopedic surgeon to whom she was referred by counsel. Dr. Becan obtained *Quick*DASH scores of 75 percent for each upper extremity for chronic pain and difficulties with activities of daily living. On examination of the left hand, he found metacarpophalangeal joint tenderness on the left with thickening of the flexor tendon and locking on active flexion. Dr. Becan noted limited motion in both wrists.[4] He measured grip strength at 6 kilograms (kg) on the right and 12 kg on the left and pinch key strength at 4 kg on the right and 3 kg on the left. Dr. Becan diagnosed bilateral carpal tunnel syndrome with postsurgical status, left trigger thumb and "[c]umulative and repetitive occupational trauma."

Dr. Becan relied on Table 15-23[5] of the sixth edition of the A.M.A., *Guides* to evaluate appellant's right wrist, finding a diagnosis (CDX) of median nerve entrapment neuropathy, a grade modifier for Functional History (GMFH) of three, a grade modifier for Clinical Studies (GMCS) of three, a grade modifier for Physical Examination (GMPE) of three due to decreased pinch strength. Dr. Becan determined that these grade modifiers equaled an eight percent impairment of the right arm. For the left wrist, he found a diagnosis (CDX) of median nerve entrapment neuropathy, a GMCS of three, a GMFH of three and a GMPE of three for pinch strength. Dr. Becan calculated that these grade modifiers warranted an eight percent impairment of the left upper extremity. Regarding the left trigger thumb, he found a class 1 CDX for symptomatic digital stenosis according to Tablet 15-2,[6] a GMFH of three according to Table 15-

[3] The record contains a June 6, 2008 decision denying compensation on March 6, 8 and 13, 2008 due to a lack of medical evidence and a June 22, 2009 overpayment decision. Neither decision is before the Board on the present appeal.

[4] For the right wrist, Dr. Becan found dorsiflexion at 50 degrees, palmar flexion at 60 degrees, radial deviation at 15 degrees and ulnar deviation at 25 degrees. On the left he observed dorsiflexion at 60 degrees, palmar flexion at 65 degrees, full radial deviation and ulnar deviation at 30 degrees.

[5] Table 15-23, page 449 of the sixth edition of the A.M.A., *Guides* is entitled "Entrapment/Compression Neuropathy Impairment"

[6] Table 15-2, pages 391-393 of the sixth edition of the A.M.A., *Guides* is entitled "Digit Regional Grid: Digit Impairments."

7,[7] a GMPE of three according to Table 15-8[8] and a GMCS of zero according to Table 15-9.[9] Using the net adjustment formula of (GMFH - CDX) + (GMPE - DCX) + (GMCS - CDX), Dr. Becan noted an eight percent impairment of the left arm. He then combined the two 8 percent impairments to equal 15 percent.

On February 12, 2010 OWCP asked an OWCP medical adviser to review Dr. Becan's report and provide a schedule award calculation. In a February 24, 2010 report, an OWCP medical adviser opined that appellant had eight percent impairment of the right upper extremity and eight percent impairment of the left upper extremity due to carpal tunnel syndrome. He concurred with Dr. Becan's assessment of an eight percent impairment of the left upper extremity due to median nerve entrapment neuropathy. However, the medical adviser explained that Dr. Becan should not have included an impairment for left trigger thumb, as the A.M.A., *Guides* stated that "in general only one major diagnosis should be selected for a specific region of the extremity." The medical adviser opined that appellant's was not a rare or unusual situation necessitating evaluating both impairments.

By decision dated March 30, 2010, OWCP granted appellant a schedule award for eight percent permanent impairment of the right arm and eight percent impairment of the left arm. The period of the award ran from September 1, 2009 to August 16, 2010.

In an April 6, 2010 letter, appellant requested an oral hearing held on July 20, 2010. At the hearing, counsel contested only the left upper extremity rating, asserting that the left trigger thumb entitled her to a greater percentage of impairment. Appellant asserted that her left trigger thumb preexisted the carpal tunnel syndrome or developed simultaneously. Following the hearing, she submitted additional evidence. In a June 25, 2008 report, Dr. Fried renewed work restrictions. In a July 8, 2010 report, he noted paracervical and left trapezial muscle spasm, grade 2 scapular winging on the right and positive Roos and Hunter tests. Dr. Fried diagnosed postsurgical status, bilateral thoracic outlet/brachial plexus involvement of the upper extremities and right-sided long thoracic neuritis.

By decision dated and finalized October 4, 2010, an OWCP hearing representative affirmed the March 30, 2010 decision. The hearing representative noted that both Dr. Becan and an OWCP medical adviser agreed that appellant had an eight percent impairment of the left upper extremity due to the accepted carpal tunnel syndrome. Dr. Becan found an additional seven percent impairment due to stenosing tenosynovitis of the left thumb. However, the medical adviser explained that a second major diagnosis affecting the same region of the left arm should not be rated in conjunction with carpal tunnel syndrome. Also, Dr. Fries found that the left trigger thumb had resolved and was not occupationally related. Moreover, there was no

[7] Table 15-7, page 406 of the sixth edition of the A.M.A., *Guides* is entitled "Functional History Adjustment: Upper Extremities."

[8] Table 15-8, page 408 of the sixth edition of the A.M.A., *Guides* is entitled "Physical Examination Adjustment: Upper Extremities."

[9] Table 15-9, pages 409-10 of the sixth edition of the A.M.A., *Guides* is entitled "Clinical Studies Adjustment: Upper Extremities."

evidence that the left trigger thumb was a preexisting condition which would have been incorporated into the schedule award rating.

LEGAL PRECEDENT

The schedule award provisions of FECA[10] provide for compensation to employees sustaining impairment from loss or loss of use of specified members 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 determination is a mater which rests in the sound 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. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[11] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[12]

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).[13] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[14] The net adjustment formula is (GMFH-CDX) + (GMPE-DCX) + (GMCS-CDX).

ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome. Dr. Fried, an attending Board-certified orthopedic surgeon, performed a left median nerve release and flexor tenosynovectomy on February 17, 2004 and a right median nerve release and flexor tenosynovectomy on August 31, 2004. Appellant claimed a schedule award on December 7, 2009. On July 16, 2009 counsel obtained an impairment rating from Dr. Becan, an orthopedic surgeon, who found a combined 15 percent impairment of the left upper extremity, 8 percent due to carpal tunnel syndrome and 8 percent due to a left trigger thumb.

An OWCP medical adviser reviewed Dr. Becan's report on February 24, 2010 and concurred with the eight percent rating for carpal tunnel syndrome. However, the medical adviser explained that Dr. Becan should not have included an impairment rating for left trigger thumb as it was a second diagnosis-based impairment (CDX) in the same region of the extremity. The A.M.A., *Guides* divides the upper extremity into regions for rating purposes. The hand is

[10] 5 U.S.C. § 8107.

[11] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[13] A.M.A., *Guides* (6th ed. 2008), page 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[14] *Id*. at 494-531.

one of the designated regions.[15] When using diagnosis-based impairment to evaluate the percentage of upper extremity impairment, in most cases only one diagnosis will be appropriate. If there are two significant diagnoses, "the examiner should use the diagnosis with the highest causally-related impairment rating for the impairment calculation."[16] Following this principle, Dr. Becan should not have rated both the carpal tunnel syndrome and left trigger thumb as they both affected the same region of the left upper extremity.

An additional problem with Dr. Becan's inclusion of the left trigger thumb is that it was not an accepted condition. OWCP accepted only carpal tunnel syndrome. Neither Dr. Fried nor Dr. Becan provided medical rationale explaining a pathophysiologic link between work factors and stenosing tenosynovitis of the left thumb. Therefore, their opinions are insufficient to establish causal relationship.[17] Also, the Board notes that, in his November 7, 2006 report, Dr. Fries, a Board certified orthopedic surgeon and impartial medical examiner, opined that the left trigger thumb had resolved.

The Board notes that, although OWCP did not accept a left trigger thumb, the condition could be included in an impairment rating if it was established as a preexisting condition.[18] Appellant's carpal tunnel syndrome was sustained on or before May 22, 2002. September 20, 2004 x-rays of the left and hand wrist did not demonstrate a trigger thumb. The first mention of a left trigger thumb in the medical record is by Dr. Dennis, a Board-certified orthopedic surgeon and second opinion physician, who noted its recent onset in his January 7, 2005 report. Dr. Fried first noted the left trigger thumb in his June 13, 2005 report. Thus, Dr. Dennis and Dr. Fried noted that onset of left trigger thumb after May 22, 2002. Therefore, the medical record does not support that the left trigger thumb preexisted the accepted carpal tunnel syndrome.

The Board finds that Dr. Becan should not have included appellant's left trigger thumb as an element of his impairment rating. Therefore, OWCP properly relied on an OWCP medical adviser's interpretation of Dr. Becan's findings in assessing an eight percent impairment of the left upper extremity.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

On appeal, counsel asserts a conflict of medical evidence between Dr. Becan and an OWCP medical adviser regarding the appropriate percentage of permanent impairment. As stated, Dr. Becan improperly included left trigger thumb in his impairment rating, whereas an OWCP medical adviser included only the appropriate elements of impairment according to the A.M.A., *Guides*. Therefore, there is no conflict of medical opinion.

[15] *Id*. at 384, Figure 15-1, "Upper Extremity Regions."

[16] *Id*. at 387, section 15.2, "Diagnosis-Based Impairment."

[17] *Deborah L. Beatty*, 54 ECAB 340 (2003).

[18] *Michael C. Milner*, 53 ECAB 446, 450 (2002).

CONCLUSION

The Board finds that appellant has not established that she sustained more than an eight percent impairment of the left upper extremity, for which she received schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 10, 2010 is affirmed.

Issued: October 11, 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