United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
and	)	**Docket No. 14-1812**
	)	**Issued: February 10, 2015**
DEPARTMENT OF VETERANS AFFAIRS, CLEVELAND MEDICAL CENTER, Cleveland, OH, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On August 18, 2014 appellant, through her attorney, filed a timely appeal of a June 4, 2014 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 to consider the merits of the case.

ISSUE

The issue is whether appellant has more than one percent impairment of each upper extremity for which she received schedule awards.

FACTUAL HISTORY

On December 18, 2011 appellant, then a 64-year-old supervisory social worker, filed an occupational disease claim alleging that on June 5, 2008 she developed carpal tunnel syndrome

[1] 5 U.S.C. § 8101 *et seq.*

due to factors of her federal employment. She stated that she was required to type patient notes and e-mails and to fill out computerized forms and evaluations.

In a report dated June 13, 2011, Dr. Mark F. Hendrickson, a Board-certified surgeon, stated that he first examined appellant on August 17, 2009 and diagnosed rheumatoid arthritis and bilateral carpal tunnel syndrome. He stated that an electromyogram (EMG) on March 27, 2009 demonstrated bilateral median neuropathies in the wrists. Dr. Hendrickson found that appellant's second EMG on September 20, 2010 demonstrated mild progression of her carpal tunnel syndrome on the right, but no change on the left. He opined that appellant's bilateral carpal tunnel syndrome was caused and continued to be aggravated by typing at work.

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome on December 28, 2011. Appellant underwent an additional EMG on January 26, 2012 which demonstrated right median nerve entrapment at the wrist affecting both the sensory and motor nerve fibers and, electrodiagnostically, the right median nerve mononeuropathy was of a moderate degree. EMG also demonstrated a very mild left medial entrapment at the wrist which affected only the sensory fibers and was borderline abnormal. Dr. Hendrickson performed a right carpal tunnel release on May 3, 2012.

Appellant filed a claim for a schedule award on May 26, 2013. On July 2, 2013 OWCP requested additional medical evidence in support of her claim. Appellant submitted a report from Dr. John L. Dunne, an osteopath, dated June 27, 2013. Dr. Dunne noted her employment duties and her resulting right carpal tunnel release on May 3, 2012. He found that appellant had continued right wrist pain, numbness, and tingling as well as an inoperable ganglion cyst in the right wrist. Dr. Dunne opined that her *Quick*DASH score was 75 on the right and 22 on the left. On physical examination he identified a symptomatic ganglion cyst, markedly positive Tinel's sign, and positive Phalen's test. Dr. Dunne found two-point discrimination at seven to nine millimeters with no atrophy of the thenar or hypothenar eminences.

Dr. Dunne applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] (A.M.A., *Guides*) and noted that appellant had reached maximum medical improvement. He applied Table 15-23, Entrapment/Compression Neuropathy Impairment[3] and determined that her clinical studies were grade modifier 2, functional history was grade modifier 3 due to constant symptoms, and physical examination were grade modifier 2. Dr. Dunne added the grade modifiers and obtained an average of 2 for the final rating category. He stated that appellant's *Quick*DASH score was severe or 3 for a final upper extremity impairment of six percent impairment of the right upper extremity.

In regard to appellant's left upper extremity, Dr. Dunne found that she had no atrophy of the thenar or hypothenar eminence with strong pinch and grip strength. He stated that she had a positive Tinel's sign and positive Phalen's test with widened two-point discrimination at seven millimeters. Dr. Dunne stated that appellant's *Quick*DASH score on the left was 22. He again

[2] A.M.A., *Guides* (6th ed. 2009). For impairment ratings calculated on and after May 1, 2009, OWCP should advise any physician evaluating permanent impairment to use the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

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

applied Table 15-23 and determined that clinical studies were grade modifier 1, functional history grade modifier 1 due to mild intermittent symptoms, and physical examination grade modifier 2. Dr. Dunne totaled and averaged the grade modifiers to reach category 1 for two percent impairment of the left upper extremity.

The medical adviser reviewed this report on July 20, 2013 and requested a copy of EMG and nerve conduction studies. He stated that, if this testing was not available, then appellant's condition would be rated as nonspecific wrist pain rather than as compression neuropathy. In accordance with Table 15-3,[4] Wrist Regional Grid, the medical adviser found that she had one percent impairment of each upper extremity due to nonspecific wrist pain following surgery or acute injury.[5]

In a decision dated August 26, 2013, OWCP granted appellant schedule awards for one percent impairment of both upper extremities.

On November 25, 2013 appellant filed a claim for an additional schedule award. She submitted a report dated February 24, 2014 from Dr. Catherine Watkins Campbell, a physician Board-certified in occupational medicine, who noted appellant's history of injury and employment duties, reviewed the September 20, 2010 EMG and appellant's pain questionnaire, and found moderate tendencies towards symptom amplification. Dr. Watkins Campbell noted a *Quick*DASH score of 61. On physical examination she found mild thenar atrophy on the right and a negative Tinel's sign. Dr. Watkins Campbell utilized Table 15-23 to rate appellant's nerve entrapment due to carpal tunnel syndrome and found that constant symptoms were history grade modifier 3. She further determined that with normal two-point discrimination and mild muscle atrophy physical examination grade modifier 2 was appropriate. Dr. Watkins Campbell stated that appellant's EMG reflected mild conduction delay that had progressed and applied a clinical studies grade modifier 1. She found that appellant's average was 2 and concluded that, with a *Quick*DASH score of 61 grade and a modifier 3, the total upper extremity impairment for right carpal tunnel syndrome was six percent.

In regard to appellant's left upper extremity, Dr. Watkins Campbell found that appellant's history of constant but less severe symptoms fit grade modifier 2 and that physical examination supported grade modifier 1 and that the September 20, 2010 EMG reflected a very mild conduction delay or grade modifier 1. She applied the formula and reached an average of 1 with a *Quick*DASH score of 61 for a total impairment rating of three percent.

Appellant filed a request for reconsideration on April 17, 2014. The medical adviser reviewed Dr. Watkins Campbell's report on April 25, 2014. He stated that additional medical information was needed, specifically the electrodiagnostic numbers for EMG testing. The medical adviser requested that appellant provide the complete EMG test reports with the numbers which are applied to Appendix 15-B of the A.M.A., *Guides*[6] to determine if her carpal tunnel syndrome may be rated using the compression neuropathy provision of Table 15-23.

[4] A.M.A., *Guides* 395, Table 15-3.

[5] *Id.*

[6] A.M.A., *Guides* 487.

On May 14, 2014 counsel provided the electrodiagnostic test results from September 20, 2010. This report included both a sensory nerve conduction and a motor nerve conduction section. Appellant's sensory nerve conduction of the median nerve demonstrated on the left latency of 3.2 milliseconds and on the right 3.8 milliseconds. Her motor nerve conduction demonstrated distal motor latency of 2.7 milliseconds on the left and 3.4 milliseconds on the right.

The medical adviser reviewed this report on May 15, 2014 and stated that the September 20, 2010 EMG test provided did not meet the criteria for use in the compression neuropathy table. In comparing the September 20, 2010 test to Appendix 15-B: Electrodiagnostic Evaluation of Entrapment Syndromes, he stated that the measured distal motor latency needed to be longer than 4.5 milliseconds for an 8 centimeter study, while appellant's study on the right was 3.4 milliseconds. The medical adviser stated that measured distal peak sensory latency was required to be longer than 4.0 milliseconds for a 14 centimeter study. Appellant's testing on the right demonstrated 3.6 milliseconds.

On the left appellant's testing demonstrated 2.7 milliseconds rather than the required 4.5 milliseconds for distal motor latency and 3.2 milliseconds rather than the required 4 milliseconds for distal peak sensory latency. The medical adviser opined that as appellant's electrodiagnostic test did not meet the criteria of the A.M.A., *Guides*, her for compression neuropathy, wrists should be rated for nonspecific wrist pain in accordance with Table 15-3 of the A.M.A., *Guides*. He stated that the range of impairment for this condition was from zero to one percent rather than from zero to nine percent as found in Table 15-23. The medical adviser determined that appellant's final impairment rating was one percent for each upper extremity. He stated that her functional history grade modifier was unreliable as it was two grade modifiers greater than clinical studies. The medical adviser found that physical examination grade modifier was 2 based on appellant's partial loss of two-point discrimination. As previously stated he found that the clinical studies were not appropriate under the A.M.A., *Guides* and resulted in a grade modifier of zero. Applying the formula of the A.M.A., *Guides*, the medical adviser concluded that appellant had one percent impairment of each of her upper extremities for which she had received a schedule award.

By decision dated June 4, 2014, OWCP found that appellant had no more than one percent impairment of each upper extremity for which she had received a schedule award. It found that the medical adviser properly applied the A.M.A., *Guides* finding the electrodiagnostic criteria for allowing the median nerves to be rated using the compression neuropathy table of the A.M.A., *Guides* had not been met.

LEGAL PRECEDENT

The schedule award provision of FECA[7] and its implementing regulations[8] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method

[7] 5 U.S.C. §§ 8101-8193, 8107.

[8] 20 C.F.R. § 10.404.

used in making such determination is a matter which rests in the 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[9]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[10] In Table 15-23, grade modifiers levels (ranging from 0 to 4) are described for the categories, of clinical studies, functional history, and physical examination. 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.[11] The maximum impairment rating for carpal tunnel syndrome is nine.[12] This section specifically provides that if test findings are grade modifier zero because the electrodiagnostic testing is normal or does not meet standards, then this section is not to be used. The A.M.A., *Guides* provide an appendix for the evaluation of electrodiagnostic evidence of entrapment syndromes.[13] This appendix specifically states that testing must demonstrate distal motor latency longer than 4.5 milliseconds for an 8 centimeter study, that distal peak sensory latency must be longer than 4.0 milliseconds for a 14 centimeter distance and that distal peak compound nerve latency must be longer than 2.4 milliseconds for a transcarpal or midpalmar study of 8 centimeters.

The Board notes that the A.M.A., *Guides* provide that the diagnosis-based impairments is the method of choice for calculating impairment.[14] In addressing upper extremity impairments, the sixth edition requires identification of the impairment class for the diagnosed condition Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15]

ANALYSIS

OWCP accepted that appellant developed carpal tunnel syndrome due to her employment duties and authorized a right carpal tunnel release. Appellant filed a claim for a schedule award. In support of her claim she submitted reports from Drs. Watkins Campbell and Dunne evaluating

[9] For new decisions issued after May 1, 2009, OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides* (6th ed. 2009); *see supra* note 2 at Chapter 2.808.5 (February 2014).

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

[11] A survey completed by a given claimant, known by the name *Quick*DASH, may be used to determine the function scale score. A.M.A., *Guides* 448-49.

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

[13] *Id*. at 487.

[14] *Id*. at 461.

[15] *Id*. at 411.

her permanent impairment in accordance with Table 15-23 Entrapment/Compression Neuropathy Impairment.[16] This section of the A.M.A., *Guides* is only applicable if electrodiagnostic testing is abnormal and meets with the standards of Appendix 15-b Electrodiagnostic Evaluation of Entrapment Syndromes.[17] Neither Dr. Watkins Campbell nor Dr. Dunne correlated appellant's electrodiagnostic test results with this section of the A.M.A., *Guides*. The physicians did not explain how or how appellant's test results complied with this standard. It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment and OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings of the attending physician.[18]

The medical adviser reviewed the September 20, 2010 electrodiagnostic study and found that this test did not comply with the standards of the A.M.A., *Guides*. He stated that neither the measured distal motor latency nor the measured distal peak sensory latency met the respective standards of 4.5 and 4.0 milliseconds respectively. Appellant's testing on the right demonstrated 3.4 and 3.8[19] milliseconds, while on the left her testing demonstrated 2.7 and 3.2 milliseconds. Due to the lack of compliant electrodiagnostic testing, the medical adviser correctly determined that her carpal tunnel syndrome could not be rated under the entrapment neuropathy provisions of the A.M.A., *Guides*.

The medical adviser determined that appellant's wrist conditions should be rated for nonspecific wrist pain in accordance with Table 15-3 of the A.M.A., *Guides* as this was a diagnosis-based estimate as preferred under the A.M.A., *Guides*. He determined that her functional history grade modifier was unreliable as it was two grade modifiers greater than clinical studies. The medical adviser further agreed with appellant's physicians that physical examination grade modifier 2 based on her partial loss of two point discrimination. As noted above, he determined in accordance with the A.M.A., *Guides* that the clinical studies were not appropriate and resulted in a grade modifier of zero. Applying the formula of the A.M.A., *Guides*, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) to the remaining grade modifiers resulted in (2-1) or 1 percent impairment in accordance with Table 15-3. The medical adviser concluded that appellant had one percent impairment of each of her upper extremities for which she had received schedule awards.

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.

[16] *Id*. at 449.

[17] *Id*. at 487.

[18] *Linda Beale*, 57 ECAB 429 (2006).

[19] The Board notes that appellant's test result was 3.8 milliseconds and that the medical adviser improperly listed this figure as 3.6. As neither result complies with the standard of 4.0 milliseconds this misstatement is harmless error.

CONCLUSION

The Board finds that appellant has no more than one percent impairment of each of her upper extremities for which she has received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT June 4, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 10, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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