United States Department of Labor
Employees' Compensation Appeals Board

B.W., Appellant	)	
and	)	**Docket No. 11-2146**
	)	**Issued: May 2, 2012**
DEPARTMENT OF LABOR, EMPLOYEES' COMPENSATION APPEALS BOARD, Washington, DC, Employer	)	

Appearances:
Appellant, pro se
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 September 23, 2011 appellant filed a timely appeal from the April 1, 2011 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.

ISSUE

The issue is whether appellant has more than a three percent impairment of either upper extremity, for which she received schedule awards.

FACTUAL HISTORY

On October 29, 1999 appellant, a 39-year-old attorney adviser, filed an occupational disease claim alleging that repetitive page turning and typing in the course of her employment

[1] 5 U.S.C. § 8101 *et seq.*

caused bilateral tendinitis and probable bilateral carpal tunnel syndrome. OWCP accepted her claim for bilateral de Quervain's disease. It expanded its acceptance to include bilateral carpal tunnel syndrome.

Appellant filed a schedule award claim. On October 29, 2010 a panel of Board-certified orthopedic surgeons[2] evaluated her permanent impairment. The panel noted that appellant had been diagnosed with bilateral carpal tunnel syndrome and de Quervain's disease. It noted her surgeries and related her residual symptoms and complaints. The panel reported clear sensory deficit with distorted two-point discrimination, as well as decreased pinch and grip strength. Therefore, the panel concluded, appellant was in the category of nerve root impairment. Referencing Table 15-21 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009), the panel found that appellant had a class 2 impairment of 17 percent for each upper extremity -- with zero grade modifiers -- and an additional 3 percent impairment of the right upper extremity for de Quervain's disease.

An OWCP medical adviser reviewed the panel's report and observed that carpal tunnel syndrome must be rated using Table 15-23 of the A.M.A., *Guides*. He noted that the panel's report included no examination findings relevant to appellant's status at the time of maximum medical improvement. The medical adviser recommended a second opinion.

OWCP referred appellant, together with the medical record and a statement of accepted facts, to Dr. Robert Franklin Draper, Jr., a Board-certified orthopedic surgeon, who reviewed appellant's history, her medical records and her statement. Dr. Draper reviewed her systems and related his findings on physical examination. He diagnosed left carpal tunnel syndrome and left de Quervain's tenosynovitis. Dr. Draper also diagnosed right carpal tunnel syndrome and de Quervain's tenosynovitis of the right wrist.

Dr. Draper evaluated impairment for de Quervain's disease using Table 15-3, page 395 of the A.M.A., *Guides*. As appellant's functional history, physical examination findings and clinical studies were all mild, she received the default impairment value of one percent for each upper extremity.

Dr. Draper evaluated impairment for carpal tunnel syndrome using Table 15-23, page 449, as well as Example 15-18 on pages 449 and 450. Given this information, and the physical examination findings, he found that appellant had a grade modifier 1 or mild entrapment or compression neuropathy impairment. As all the grade modifiers were 1, appellant received the default impairment value of two percent for each upper extremity. Dr. Draper concluded that appellant had a three percent impairment of each upper extremity as a result of de Quervain's disease and carpal tunnel syndrome.

OWCP's medical adviser reviewed Dr. Draper's evaluation and found it to be correct.

On April 1, 2011 OWCP issued a schedule award for a three percent impairment of each upper extremity. It noted that appellant's pay rate was capped at the maximum allowed.

[2] Dr. Rida N. Azer, Dr. Peter S. Trent and Dr. Hampton J. Jackson, Jr.

Appellant argues on appeal that Dr. Draper provided an inaccurate work and medical history in reaching his opinion. She argues that, since the degree of impairment provided by the panel was supported by three Board-certified physicians, her case, at a minimum, should have been referred to an independent medical examiner.

Appellant also argues that the maximum salary rate treats her in a disparate manner from awardees at lower grade levels. She notes that she did not receive 75 percent of her salary; she received approximately 62.5 percent.

LEGAL PRECEDENT

FECA authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body.[3] Such loss or loss of use is known as permanent impairment. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[4]

Section 8112 of FECA places a limit on the monthly rate of compensation for disability, including augmented compensation.[5]

ANALYSIS

Diagnosis-based impairment is the primary method of evaluation for the upper limbs. The diagnosis and specific criteria determine the impairment class. This is adjusted by such nonkey factors as functional history, physical examination and clinical studies.[6] The first step in determining an impairment rating is to choose the diagnosis that is most applicable for the region being assessed. Selection of the optimal diagnosis requires judgment and experience. If more than one diagnosis can be used, the highest causally related impairment rating should be used; this will generally be the more specific diagnosis. Typically, one diagnosis will adequately characterize the impairment and its impact on activities of daily living.[7]

OWCP has accepted two diagnoses: bilateral de Quervain's disease and bilateral carpal tunnel syndrome. Both are conditions of the wrist region. Whichever contributes the higher impairment should be used.

Table 15-3, page 395 of the A.M.A., *Guides* shows impairment values for de Quervain's disease. The default impairment value is one percent. Grade modifiers can adjust this value up or down by one percent. But Dr. Draper, the second-opinion orthopedic surgeon, found that

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404. 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).

[5] 5 U.S.C. § 8112.

[6] A.M.A., *Guides* 387.

[7] *Id*. at 389.

appellant's functional history, physical examination findings and clinical studies were all in the mild category.[8] In such a case, there is no modification of the default impairment value. Appellant properly received an impairment rating of one percent for de Quervain's disease in each upper extremity.

Table 15-23, page 449 of the A.M.A., *Guides* shows impairment values for carpal tunnel syndrome. With test findings, functional history and physical findings on examination all in the mild category, the default impairment value is two percent. This can be adjusted up or down one percent based on appellant's Disabilities of the Arm, Shoulder and Hand (*Quick*DASH) score. It does not appear that Dr. Draper obtained a *Quick*DASH score.

Nonetheless, the highest impairment rating appellant can receive for mild residual carpal tunnel syndrome is three percent. As this is higher than the one percent impairment rating she received for de Quervain's disease, the impairment for carpal tunnel syndrome should be used.

OWCP issued a schedule award for a three percent impairment of each upper extremity, which is the maximum impairment rating possible for mild residual carpal tunnel syndrome. The Board will therefore affirm OWCP's April 1, 2011 decision.

Appellant argues that Dr. Draper provided an inaccurate work and medical history in reaching his opinion. Assuming, for the sake of argument only, that this is the case, Dr. Draper has not shown how any inaccuracy affected the calculation of his impairment rating under the sixth edition of the A.M.A., *Guides*. The Board has explained that diagnosis-based impairment is the primary method of evaluation for the upper limbs. So long as Dr. Draper had accurate information concerning appellant's symptoms, his findings on physical examination and his clinical studies, it is not clear how the inaccuracies he discusses on appeal are material to the April 1, 2011 schedule award. Appellant argues that Dr. Draper examined her for about 15 minutes, and she alleges that he used improper tools to test her ability to distinguish sharp and dull. There is no evidence that his examination was inadequate or otherwise improper under the sixth edition of the A.M.A., *Guides*.

Appellant also argues that the degree of impairment provided by the panel was supported by three Board-certified physicians, and she questions what was deficient about its report. In assessing medical evidence, of course, the number of physicians supporting one position or another is not controlling.[9] Chapter 15.4f, page 433 explains: "Entrapment neuropathy is determined using the methods described in this section alone." Page 448 explains further: "To rate impairment for focal nerve compromise, use Table 15-23, Entrapment/Compression Neuropathy Impairment." The panel evaluated appellant's impairment due to carpal tunnel syndrome under Table 15-21, which provides impairment values for peripheral nerve impairment (the panel mentioned nerve root impairment). Thus, the panel did not properly apply the A.M.A., *Guides*. The panel also found an additional three percent impairment for de Quervain's disease on the right, but in doing so made no reference to the A.M.A., *Guides*. The Board is unable to determine how the panel arrived at this rating. As the Board indicated earlier, the

[8] *See* Table 15-7, Table 15-8 and Table 15-9 for the characteristics of a mild medical problem.

[9] *K.W.*, 59 ECAB 714 (2007).

maximum impairment rating any claimant may receive for de Quervain's disease is a two percent diagnosis-based estimate under Table 15-3, page 395 (the Wrist Regional Grid). Because the panel did not properly evaluate appellant's impairment under the A.M.A., *Guides*, its conclusion carries little probative weight and is insufficient to create a conflict with Dr. Draper.[10]

As for appellant's argument that FECA's maximum rate of compensation does not give her 75 percent of her monthly pay, 5 U.S.C. § 8112 places a limit on the monthly rate of compensation for disability, including augmented compensation, which may not be more than 75 percent of the monthly pay of the maximum rate of basic pay for GS-15. To the extent that section 8112 limits appellant's schedule award, it is a function of how Congress designed FECA to operate. Neither OWCP nor the Board has the authority to enlarge the terms of FECA.

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.

CONCLUSION

The Board finds that appellant has no more than a three percent impairment of either upper extremity, for which she received schedule awards.

[10] *Richard A. Neidert*, 57 ECAB 474 (2006) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

ORDER

IT IS HEREBY ORDERED THAT the April 1, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 2, 2012
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