United States Department of Labor
Employees' Compensation Appeals Board

C.M., Appellant	)	
and	)	**Docket No. 13-22**
	)	**Issued: September 6, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Aurora, 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
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On October 3, 2012 appellant, through her attorney, filed a timely appeal from an Office of Workers' Compensation Programs' (OWCP) merit decision dated September 12, 2012. 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 six percent permanent impairment of her right upper extremity.

FACTUAL HISTORY

On April 8, 2008 appellant, a 46-year-old mail carrier, filed a claim for benefits alleging that she developed a bilateral carpal tunnel condition causally related to employment factors. OWCP accepted the claim for bilateral carpal tunnel syndrome.

[1] 5 U.S.C. § 8101 *et seq.*

Appellant underwent right-sided carpal tunnel release surgery on October 27, 2008. The procedure was performed by Dr. Suresh Velagapudi, Board-certified in orthopedic surgery,whoalsoperformed a left-sided carpal tunnel release procedure on November 17, 2008.

In a report dated May 21, 2009, Dr. Velagapudi stated that appellant's wrists and hands were doing fine and that she was doing her regular work. While appellant experienced some soreness from the right carpal tunnel incision, both hands were nice and supple with excellent intrinsic strength. Dr. Velagapudi recommended activities as tolerated and considered her to be at maximum medical improvement with no permanent residuals.

In an August 4, 2009 report, Dr. Velagapudi related that appellant had been experiencing right thumb pain for several weeks; she stated that her thumb felt as if it was going out of place. He stated that on examination she had tenderness along the A1 pulley with good motion of the thumb. Based on her history Dr. Velagapudi opined that these symptoms were consistent with trigger thumb; this was a condition which occasionally followed carpal tunnel release procedures.

In a December 8, 2009 report, Dr. Velagapudi reiterated that appellant had complaints of pain and triggering related to her right thumb, within the area of the A1 pulley. He stated that she might need injections and advised her to continue with her regular work.

In a Form CA-7 dated January 4, 2010, appellant requested a schedule award based on a partial loss of use of her right upper extremity.

On February 18, 2010 OWCP accepted expansion of the claim for right thumb trigger finger and authorized surgery.

By report dated February 10, 2010, Dr. Velagapudi submitted an impairment evaluation form and a report in which he indicated that appellant's impairment was related to right trigger thumb and could be addressed with a trigger thumb release. He indicated that she could continue to do her regular work. On the form Dr. Velagapudi stated that appellant had loss of function due to trigger thumb in the right thumb and right hand. He further indicated that she had pain related to her right trigger thumb but found that she had no weakness, atrophy, loss of function or loss of range of motion in the right upper extremity. Dr. Velagapudi found that appellant reached maximum medical improvement on February 10, 2010.

In order to determine the degree of appellant's right upper extremity impairment stemming from her accepted right carpal tunnel and right thumb conditions, OWCP referred the statement of accepted facts and her medical records to Dr. David H. Garelick, Board-certified in orthopedic surgery and an OWCP medical adviser, for an impairment evaluation. In a January 11, 2011 report, Dr. Garelick found that appellant had a six percent impairment of the right thumb pursuant to the American Medical Association,*Guides to the Evaluation of Permanent Impairment*(A.M.A., *Guides*) (sixth edition). He noted that a report from Dr. Velagapudi dated June 21, 2009[2] indicated no permanent residuals from right carpal tunnel

[2] This appears to be an error on the part of Dr. Garelick. Dr. Velagapudi did not submit a report dated June 21, 2009. The facts referenced by Dr. Garelick are contained in Dr. Velagapudi's report dated May 21, 2009.

syndrome, although she continued to have some locking in the right trigger thumb. Dr. Garelick stated that under page 392 of the A.M.A., *Guides*, right trigger thumb yielded a six percent right upper extremity impairment, with no change to this award with use of the net adjustment formula. He advised that under Table 15-12 at page 421 of the A.M.A., *Guides*, a six percent digit impairment correlated with a two percent upper extremity impairment.

In an October 14, 2010 report, Dr. Velagapudi stated that both of appellant's hands were in good condition and that her trigger thumb condition had resolved. He advised that on examination she showed full motion of all of her fingers, hands and her right wrist, with no evidence of any triggering of her thumbs. Dr. Velagapudi opined that appellant had resolved symptoms from bilateral carpal tunnel syndrome and right trigger thumb and was at maximum medical improvement with no particular residuals at that point.

By decision dated February 16, 2010, OWCP granted appellant a schedule award for a six percent permanent impairment of the left upper extremity[3] for the period June 21 to July 22, 2009, for a total of 4.5weeks of compensation.

On February 16, 2010 appellant requested reconsideration.

Appellant underwent a functional capacity test for her right hand and right wrist on February 16, 2011.

In a June 27, 2011 report, Dr. Garelick reviewed the results of appellant's February 16, 2011 functional capacity test. He indicated that such a test did not provide a basis for an additional schedule award because it did not examine all of the components necessary to determine permanent partial impairment for residual carpal tunnel syndrome and right thumb trigger finger; he stated, for example, that while the test did discuss grip strength, one of the criteria for rating carpal tunnel syndrome, she showed inconsistency with grip strength testing. In addition, Dr. Garelick reviewed Dr. Velagapudi's October 21, 2010 report and noted that the physician had opined that appellant's bilateral carpal tunnel syndrome and right trigger thumb symptoms had resolved and that she was at maximum medical improvement with no particular residuals. He concluded that there was no objective basis for an additional schedule award and no grounds to change the date of maximum medical improvement.

By decision dated July 15, 2011, OWCP denied modification of the February 16, 2011 decision, finding that there was not sufficient medical evidence to support an additional schedule award.

In a July 21, 2011 decision, OWCP again denied an additional schedule award. It, however, corrected and modified the February 16, 2011 decision, noting that appellant had an impairment of the right upper extremity from her accepted right thumb condition.

By letter dated July 26, 2011, appellant's attorney requested an oral hearing, which was held on November 10, 2011.

[3] The Board notes that OWCP's finding of an impairment to the left upper extremity in this schedule award decision was erroneous. OWCP corrected this to the right upper extremity in a subsequent decision.

By decision dated January 26, 2012, an OWCP hearing representative affirmed the February 16, July 15 and 21, 2011 OWCP decisions.

In a January 20, 2012 report, received by OWCP on February 17, 2012, Dr. William N. Grant, Board-certified in internal medicine, stated that appellant had a 19 percent impairment of the right upper extremity and a 9 percent left upper extremity impairment. He stated that on examination she was experiencing constant pain, stiffness and weakness in both hands. Dr. Grant advised that on a scale of 1 to 10 the least amount of discomfort appellant had was a level four; he stated that this discomfort often became unbearable when she tried to hold on to objects and use her hands to perform even the simplest tasks such as signing her name. Dr. Grant found that, due to her constant painful paresthesias, she had difficulty performing multiple activities of daily living, including buttoning buttons, opening doors, toileting, bathing without assistance, hand-writing, using hand tools or performing any repetitive motion requiring the use of her wrists. He stated that appellant's*Quick*Dash score on the left was 62.5 and on the right was 72.5. Dr. Grantdiagnosed bilateral carpal tunnel syndrome, right trigger finger and right hand contusion.

Dr. Grant calculated the impairment rating for the accepted diagnosis of bilateral carpal tunnel syndrome by relying on Table 15-23, page 449 of the A.M.A., *Guides*, the table used for calculating entrapment/compression neuropathy impairment.[4] Using this table, he stated that appellant had a grade 3 modifier for clinical diagnoses for the left and right wrists because of significant constant symptoms (history) and a maximum *Quick*Dash score of 72 (functional scale). Dr. Grant found that this yielded a nine percent upper extremity impairment for the left wrist and a nine percent upper extremity impairment for the right wrist under this table.

With regard to an impairment for the right trigger finger, Dr. Grant, applying the net adjustment formula at section 15, pages 392, 406 and 408 of the A.M.A., *Guides,*[5] he found that appellant had a grade modifier of 1 for clinical diagnoses at Table 15-2, page 392, the table used to rate digit regional grid impairments; a grade modifier 2 at Table 15-7, page 406 for functional history, a moderate problem; and a grade modifier 3 at Table 15-8, page 408 for physical examination adjustment, for a severe problem. Pursuant to the rating process set forth at page 448, he determined that the net adjusted, default impairment average value for these modifiers, based on adding 3 plus 1 plus 2, divided by 3, equaled 2; this produced an eight percent impairment under Table 15-11, page 420 of the A.M.A., *Guides*.[6] Using the Combined Values Chart, Dr. Grant calculated a total 19 percent right upper extremity impairment in addition to a nine percent left upper extremity impairment.

By letter dated May 30, 2012, appellant's attorney requested modification of the January 26, 2012 OWCP decision.

[4] A.M.A.,*Guides* 449.

[5] *Id.*at 392, 406, 408.

[6] *Id.*at 420, 448.

In a report dated July 9, 2012, Dr. Garelick found that appellant had no additional impairment under the A.M.A., *Guides*. He reviewed Dr. Grant's January 20, 2012 report/impairment rating and found that it should be "disregarded" for numerous reasons, including the fact that he recommended a grade 3 modifier for functional history under Table 15-23. Dr. Garelick reiterated that appellant's treating physician, Dr. Velagapudi, indicated in his October 21, 2010 report that appellant's bilateral carpal tunnel syndrome and right trigger thumb symptoms had resolved and that she showed inconsistent effort in grip strength testing in her February 16, 2011 functional capacity evaluation; based on these records, he opined, there was no objective basis to award a grade 3 modifier for physical examination. He advised that the opinion of appellant's longtime treating physician was entitled to greater weight than that of Dr. Grant, a physician Board-certified in internal medicine, who did not have a background in the musculoskeletal system and was chosen by appellant's attorney. Dr. Garelick did suggest, however, that in the event of continued "confusion" in this case appellant should be referred to an orthopedic hand surgeon to perform an impartial medical evaluation and provide an objective impairment rating.

By decision dated September 12, 2012, an OWCP hearing representative affirmed the January 26, 2012 decision.

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 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 to all claimants, good administrative practice necessitates 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 the implementing regulations as the appropriate standard for evaluating schedule losses.[9] The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.[10]

ANALYSIS

The Board finds that a conflict in medical opinion exists between Dr. Garelick and Dr. Grant concerning the nature and the extent of permanent impairment caused by the accepted right carpal tunnel and right thumb conditions. Dr. Grant rated a 19 percent impairment to the right upper extremity pursuant to the sixth edition of the A.M.A., *Guides* based on a nine percent impairment for right carpal tunnel syndrome and an eight percent digit impairment for the right

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.Effective May 1, 2009, OWCP began using the A.M.A., *Guides* (6th ed. 2009).

[9] *Id.*

[10] *Veronica Williams*, 56 ECAB 367, 370 (2005).

thumb.[11] This contrasted with the opinion of Dr. Garelick, who found that Dr. Grant's report was not sufficient to warrant an additional schedule award because there was a lack of objective findings supporting additional impairment and because appellant's treating physician, Dr. Velagapudi, had found in his October 21, 2010 report that her bilateral carpal tunnel syndrome and right trigger thumb symptoms had resolved without residuals.[12] A conflict exists in the medical opinion evidence as to whether her accepted conditions caused additional impairment of the right upper extremity.

Accordingly, the Board will set aside the September 12, 2012 OWCP decision and remand for referral of appellant, the case record and a statement of accepted facts to an appropriate independent medical specialist to determine the nature and the degree of her permanent impairment due to her accepted right carpal tunnel and right thumb conditions.On remand, OWCP should instruct the impartial medical specialist to resolve the conflict as to whether she had any additional impairment of the right upper extremity based on her accepted conditions and to clearly indicate the specific background and protocols of the A.M.A., *Guides* upon which the opinion is based.After such further development of the record as it deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision.The case is remanded for further development of the medical evidence.

[11] The Board notes that Dr. Grant also rated a nine percent impairment for left carpal syndrome. As OWCP has not adjudicated an impairment rating for the left upper extremity, the Board will not address this finding.

[12] As noted above, Dr. Garelick suggested in his July 9, 2012 report that referral to an impartial medical examiner might be an appropriate course of action in this case.

ORDER

IT IS HEREBY ORDERED THAT the September 12, 2012 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for further action consistent with this decision of the Board.

Issued: September 6, 2013
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board