United States Department of Labor
Employees' Compensation Appeals Board

L.C., Appellant	)	
and	)	**Docket No. 13-2013**
	)	**Issued: April 23, 2014**
DEPARTMENT OF DEFENSE, DEFENSE AGENCIES, Columbus, 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:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 3, 2013 appellant, through her attorney, filed a timely appeal from an April 22, 2013 merit decision of the Office of Workers' Compensation Programs' (OWCP) hearing representative. 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 the schedule award claim.

ISSUE

The issue is whether appellant has established any ratable impairment of both upper extremities as a result of her accepted bilateral carpal tunnel syndrome and tendinitis.

FACTUAL HISTORY

On June 27, 2003 appellant, then a 36-year-old financial technician, filed an occupational disease claim alleging that she developed bilateral tendinitis as a result of keying and typing over

[1] 5 U.S.C. § 8101 *et seq.*

250 invoices a day in the performance of duty. She became aware of her condition on April 2, 2003 and realized it resulted from her employment on April 18, 2003. OWCP accepted appellant's claim for bilateral carpal tunnel syndrome and tendinitis. Appellant stopped work on June 30, 2003 and returned to modified duty on December 22, 2003.

In a December 3, 2003 electromyogram (EMG) and nerve conduction velocity (NCV) report, Dr. Timothy R. Gatens, Board-certified in physical medicine and rehabilitation, noted appellant's history of bilateral carpal tunnel syndrome and bilateral arm tendinitis. He found no evidence of cervical radiculopathy, carpal tunnel syndrome or underlying peripheral neuropathy. Dr. Gatens opined that the examination was a normal EMG/NCV study of appellant's neck and upper extremities.

On December 11, 2003 OWCP referred appellant to Dr. Manhal A. Ghanma, a Board-certified orthopedic surgeon, for a second-opinion examination to determine whether she continued to suffer residuals of her work-related injury and whether she was capable of returning to work. In a January 20, 2004 report, Dr. Ghanma accurately described her duties as a financial technician and reviewed her history, including the statement of accepted facts. He noted that a May 2003 EMG/NCV examination was negative for carpal tunnel syndrome. Upon examination of the upper extremities, Dr. Ghanma observed equal sensation in both of her arms, forearms, wrists and hands. He found no discoloration, swelling, tenderness or crepitation and no evidence of nerve entrapment or joint instability. Dr. Ghanma opined that there were no objective findings to indicate that appellant had either bilateral carpal tunnel syndrome or bilateral arm tendinitis. He concluded that she was no longer suffering residuals of her work-related injury and could return to work full time without restrictions.

On February 11, 2004 Dr. Matthew Sokos, a family practitioner, authorized appellant to return to full duty.[2]

On September 29, 2005 appellant was approved for disability retirement.

Appellant's treating physician, Dr. Robert J. Nowinsky, an osteopath, by examination on March 15, 2006, found mildly positive Phalen's and Tinel's signs and referred her for nerve conduction test. The tests performed on March 28, 2006 were normal.

In a June 25, 2007 letter, appellant's counsel requested a schedule award and submitted a report by Dr. Nancy Renneker, Board-certified in physical medicine and rehabilitation, who provided findings on examination and opined that, according to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) appellant had 22 percent right upper extremity impairment and 21 percent left upper extremity impairment. Dr. Renneker reported that appellant's permanent impairment resulted from her April 2, 2003 work injury.

[2] On July 14, 2004 appellant submitted a recurrence claim alleging that on June 30, 2003 she sustained a recurrence. In a decision dated September 2, 2004, OWCP denied her recurrence claim finding insufficient medical evidence to establish a recurrence of the accepted injury. By letter dated September 19, 2004, appellant's counsel requested an oral hearing. Appellant requested withdrawal of the hearing. By decision dated June 21, 2005, OWCP accepted her request for withdrawal and affirmed the September 2, 2004 denial decision.

OWCP referred appellant's schedule award claim to a district medical adviser. In an April 29, 2008 report, Dr. Anthony F. Skalak, a Board-certified orthopedic surgeon and district medical adviser, reported that he reviewed the medical file, including the statement of accepted facts and noted a date of maximum medical improvement of June 14, 2007. He provided examination findings and opined that according to the fifth edition of the A.M.A., *Guides* appellant had 47 percent impairment of the right upper extremity and 34 percent impairment of the left upper extremity.

By letter dated June 12, 2009, appellant's counsel requested that OWCP issue a decision and order concerning appellant's schedule award claim.

On June 25, 2009 OWCP referred appellant's schedule award claim to Dr. Skalak for clarification and requested that he translate his April 29, 2008 report into the sixth edition of the A.M.A., *Guides.* In a July 15, 2009 letter, Dr. Skalak informed OWCP that he would not be able to translate his April 29, 2008 report to the sixth edition of the A.M.A., *Guides* and suggested that her treating physician provide an impairment rating for him to review.

By letter dated January 12, 2010, OWCP advised appellant to provide a report from her treating physician regarding her loss of function and provide an impairment rating according to the sixth edition of the A.M.A., *Guides.*

In a May 4, 2010 report, Dr. Richard M. Ward, a Board-certified orthopedic surgeon, stated that appellant developed symptoms of pain, numbness, tingling and weakness of grip strength in both hands as a result of working on the computer. He noted her accepted claims of bilateral carpal tunnel syndrome and tendinitis. Upon examination, Dr. Ward observed pain over the distal volar aspect of appellant's forearms, across her wrists and into her hands and limitation of motion at both elbows. Tinel's sign was positive on both sides. Range of motion of appellant's right and left elbows were 50 degrees on pronation and 50 degrees on supination.

Dr. Ward opined that appellant sustained bilateral elbow tendinitis and carpal tunnel syndrome as a result of the April 2, 2003 injury. He opined that, according to the sixth edition of the A.M.A., *Guides*, Table 15-23 with grade modifiers 3 for history, 2 for physical findings and 3 for function, she had nine percent left and right upper extremity impairment. Dr. Ward also reported that, according to Table 15-3, with grade modifiers 3 for history, 2 for physical findings and 3 for function, appellant was a class 1 with 13 percent impairment on the right and 9 percent on the left. Relying on Table 15-4, class 1, he opined that she had five percent right upper extremity impairment and three percent left upper extremity impairment. Dr. Ward calculated that appellant had a combined 25 percent right upper extremity impairment and 19 percent left upper extremity impairment, for a combined impairment of 39 percent.

In a November 28, 2011 report, Dr. Nabil F. Angley, a Board-certified orthopedic surgeon and district medical adviser, reviewed the statement of accepted facts and appellant's medical records, including Dr. Ward's May 4, 2010 report. He stated that he was unable to provide a permanent impairment rating due to deficiencies in Dr. Ward's report. Dr. Angley disagreed with Dr. Ward's impairment rating and stated that Dr. Ward did not explain why he used class 1 in Table 15-3 or different modifiers to calculate appellant's impairment rating for her elbow tendinitis. He opined that Dr. Ward's rating was ambiguous and unacceptable because

he was unable to determine how Dr. Ward calculated those figures. Dr. Angley also noted that Dr. Ward did not provide a date of maximum medical improvement. He advised that OWCP refer appellant's schedule award claim to an impartial medical examiner to obtain an accurate and reliable permanent impairment rating and date of maximum medical improvement.

On December 13, 2011 OWCP noted that a conflict in medical opinion existed between Dr. Ward and Dr. Angley and referred appellant's case to an impartial medical examiner to resolve the conflict in medical opinion.

In an August 14, 2012 report, Dr. Ralph Rohner, a Board-certified orthopedic surgeon selected as the impartial medical examiner, related that appellant worked as a financial technician and her duties involved repetitively using her upper extremities in the performance of her duties, specifically keyboard operations. He noted that her claim was accepted for bilateral carpal tunnel syndrome and tendinitis. Dr. Rohner reviewed the medical record and described the medical treatment appellant received from various physicians. He noted that EMG/NCV studies performed in May and December 2003 and March 2006 revealed normal findings of both upper extremities. Upon examination of appellant's upper extremities, Dr. Rohner observed mild discomfort on percussion of the lateral epicondyle and mild tenderness on palpation of the medial epicondyle bilaterally anterior to the epicondyle. He also noted tenderness in the groove of the left ulnar and questionably tender in the right. The tenderness on palpation, however, was not associated with distal paresthesias along the ulnar distribution. No swelling, warmth, redness or induration of the upper extremities was found. Dr. Rohner reported tingling on the right forearm on percussion of the antecubital fossa, but none on the left and bilateral lateral elbow pain on wrist extension but no pain with wrist flexion. Percussion of the carpal tunnels bilaterally yielded no peripheral dysesthesias. Instead, Dr. Rohner found that appellant complained of her pain radiating proximally into the lower three inches of the forearm. Flexion of the right and left wrists were 50 and 55 degrees respectively. Extension of the right wrist was 70 degrees and the left was 60 degrees. Ulnar deviation was bilaterally 30 and radial deviation was bilaterally 20 degrees.

Regarding appellant's diagnosis of bilateral carpal tunnel syndrome, Dr. Rohner opined that based on his physical examination, history and diagnostic studies there was no evidence to support the diagnosis of carpal tunnel syndrome. He stated that she reached maximum medical improvement on December 3, 2003 when the EMG/NCV study demonstrated normal findings of both upper extremities. Dr. Rohner concluded that appellant had zero impairment rating for bilateral carpal tunnel syndrome. Regarding the diagnosis of left wrist tenosynovitis, he reported that, according to the sixth edition of the A.M.A., *Guides,* Table 15-3 for wrist regional grid, she was a class 0. Regarding the diagnosis of bilateral epicondylitis Dr. Rohner stated that, although this diagnosis was mentioned at various places in the medical record, it was not accepted by OWCP according to the referral sheet, but even under Table 15-4 appellant had zero impairment.

On August 28, 2012 OWCP referred appellant's claim to Dr. Brian M. Tonne, as an OWCP medical adviser to review Dr. Rohner's impairment rating. In his September 17, 2012 report, Dr. Tonne reviewed the medical record and agreed with Dr. Rohner's August 14, 2012 report. He noted that there was no evidence by physical examination, history or diagnostic study to support a diagnosis of carpal tunnel syndrome. Utilizing Table 15-23 of the sixth edition of the A.M.A., *Guides,* Dr. Tonne noted grade modifiers 0 for test findings, physical examination

and clinical history, which resulted in a rating category of zero default impairment. He reported a date of maximum medical improvement as August 14, 2012, the date of Dr. Rohner's impairment rating.

In a decision dated September 20, 2012, OWCP denied appellant's claim for a schedule award finding that the medical evidence did not establish that she sustained any ratable impairment as a result of her accepted bilateral carpal tunnel syndrome and tendinitis. It found that the weight of medical opinion rested with Dr. Tonne's September 11, 2012 report as he correctly applied the sixth edition of the A.M.A., *Guides* and provided an explanation of his calculations.

By letter dated September 24, 2012, appellant requested a telephone hearing, which was held on January 31, 2013. She was represented by her attorney, Geoffrey Shapiro, who expressed his disapproval that the case was delayed for so long and alleged that appellant should have received her schedule award a long time ago. Mr. Shapiro contended that Dr. Rohner's report was faulty because Dr. Rohner determined that the diagnosis of carpal tunnel syndrome was not substantiated even though OWCP had accepted the condition as work related. Dr. Rohner also alleged that appellant submitted sufficient evidence to establish that she sustained 25 percent right upper extremity impairment and 19 percent left upper extremity impairment.

By decision dated April 22, 2013, an OWCP hearing representative affirmed the September 20, 2012 decision denying appellant's schedule award claim. He found that Dr. Rohner's impartial medical opinion carried the weight of the medical evidence. The hearing representative pointed out that although appellant's claim was initially accepted for carpal tunnel syndrome Dr. Rohner's August 14, 2012 report demonstrated that her condition was not permanent and did not warrant an impairment rating.

LEGAL PRECEDENT

An employee seeking compensation under FECA has the burden of establishing the essential elements of his or her claim, including that he or she sustained an injury in the performance of duty as alleged and that an employment injury contributed to the permanent impairment for which schedule award compensation is alleged.[3]

The schedule award provision of FECA[4] and its implementing regulations[5] 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. FECA however does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[6] For consistent results and to ensure equal justice, the Board has authorized the use of a

[3] *Bobbie F. Cowart*, 55 ECAB 476 (2004).

[4] 5 U.S.C. §§ 8101-8193.

[5] 20 C.F.R. § 10.404.

[6] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

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 the appropriate standard for evaluating schedule losses.[7] Effective May 1, 2009, OWCP adopted the sixth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[8]

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).[9] In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[12] In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories test findings, history and physical findings. 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.[13]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[14]

ANALYSIS

OWCP accepted that appellant sustained work-related bilateral carpal tunnel syndrome and tendinitis as a result of her employment duties as a financial technician. Appellant filed a claim for a schedule award.

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[7] *R.D.*, 59 ECAB 127 (2007); *Bernard Babcock, Jr.*, 52 ECAB 143 (2000); *see also* 20 C.F.R. § 10.404.

[8] Federal (FECA) Procedure Manual, Part 3 -- Claims, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[9] A.M.A., *Guides* 3, 6 (6th ed. 2008).

[10] *Id*. at 383-419.

[11] *Id.* at 411.

[12] *Id*. at 449, Table 15-23.

[13] 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. *See C.P.*, Docket No. 13-1293 (issued November 20, 2013).

[14] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

OWCP determined that a conflict in medical opinion existed between Dr. Ward, a treating physician, and Dr. Angley, a second-opinion physician regarding appellant's entitlement to a schedule award. It referred her schedule award claim to an impartial medical examiner, Dr. Rohner, to resolve the conflict in medical opinion. Dr. Rohner determined in an August 14, 2012 report that appellant did not have a ratable impairment of her upper extremities as a result of her accepted conditions. In a decision dated April 22, 2013, an OWCP hearing representative affirmed the September 20, 2012 denial of her schedule award. The Board finds that the medical evidence failed to establish that appellant sustained any permanent impairment of her upper extremities as a result of her accepted bilateral carpal tunnel syndrome and tendinitis.

The Board finds that OWCP properly relied on the August 14, 2012 report from Dr. Rohner. In his report, Dr. Rohner provided an accurate history of injury and reviewed the medical record. He opined that, based on his physical examination and review of the history and diagnostic studies in the record, there was no evidence to support the diagnosis of carpal tunnel syndrome. Dr. Rohner cited the EMG/NCV studies from 2003 and 2006, which all reported normal findings of both upper extremities. Based upon this objective evidence and his physical examination findings, he concluded that appellant had zero impairment rating for bilateral carpal tunnel syndrome. Regarding the diagnosis of left wrist tenosynovitis, Dr. Rohner reported that, according to the sixth edition of the A.M.A., *Guides*, Table 15-3 for wrist regional grid, she was a class 0. As he was selected as the impartial medical specialist to resolve the conflict regarding the extent and degree of impairment, if any, of appellant's employment-related injury and his report was sufficiently well rationalized, his report constitutes the special weight of the medical evidence.[15] The Board further notes that the medical adviser reviewed the medical record, including Dr. Rohner's August 14, 2012 report and agreed that appellant did not have any ratable impairment of the upper extremities under the sixth edition of the A.M.A., *Guides.*

On appeal, appellant alleges that multiple reports showed that appellant sustained permanent impairment as a result of her accepted carpal tunnel syndrome. A review of the record demonstrates that she did not submit sufficient medical evidence which conformed to the A.M.A., *Guides* that established a ratable impairment as a result of her accepted conditions. Because appellant has not established any ratable impairment of the upper extremities, the Board finds that she did not meet her burden of proof to establish her schedule award claim.

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 not established that she sustained any ratable impairment of both upper extremities as a result of her accepted bilateral carpal tunnel syndrome and tendinitis.

[15] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the April 22, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 23, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board