United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 14-518**
	)	**Issued: August 4, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Toledo, OH, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Acting Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 8, 2014 appellant filed a timely appeal from an October 10, 2013 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 each upper extremity for which she received schedule awards.

FACTUAL HISTORY

On March 27, 2009 appellant, then a 46-year-old letter carrier, filed an occupational disease claim alleging that she developed bilateral carpal tunnel syndrome as a result of

[1] 5 U.S.C. § 8101 *et seq.*

repetitively grasping and holding bundles of letters in her hands in the performance of duty. She worked limited duty. OWCP accepted appellant's claim for bilateral carpal tunnel syndrome.

On September 9, 2009 appellant stopped work and underwent left carpal tunnel release surgery. On December 9, 2009 she underwent right carpal tunnel release surgery. Appellant returned to work part time on March 4, 2010 and to work full time on August 10, 2010. On May 27, 2011 she underwent left carpal tunnel revision surgery. Appellant received disability compensation. On October 3, 2011 she returned to work part time with restrictions and received compensation for intermittent disability and medical appointments.

In a March 28, 2012 report, Dr. Martin C. Skie, a Board-certified orthopedic surgeon with a subspecialty in hand surgery, related that appellant had persisting symptoms of bilateral carpal tunnel syndrome. He noted that she had carpal tunnel release surgeries on the right and left hand. Upon examination, Dr. Skie observed a full range of motion of all appellant's digits and no swelling or erythema. He reported positive Tinel's percussion over the median nerve at her wrist. Dr. Skie recommended that appellant continue work with restrictions. In an attached work restrictions note, he restricted her to no lifting greater than 20 pounds, no prolonged sorting and frequent stretching of digits.

On April 9 and November 5, 2012 appellant filed schedule award claims.

By letter dated December 7, 2012, OWCP advised appellant that the evidence submitted was insufficient to establish her claim. It informed her of the medical evidence required to establish permanent impairment based on her accepted bilateral carpal tunnel syndrome.

In a March 5, 2013 report, Dr. Skie noted appellant's diagnosis of bilateral carpal tunnel syndrome and her history of carpal tunnel release surgeries. He related her complaints that her symptoms and pain had returned and worsened. Dr. Skie stated that the onset of appellant's hand symptoms was directly related to the injury. He reviewed her history and conducted an examination. Dr. Skie observed no swelling of the wrist and hand and no ecchymosis or erythema. Tinel's sign of the wrist was positive.

On May 8, 2013 OWCP referred appellant, together with the statement of accepted facts and the medical record, to Dr. Manhal Ghanma, a Board-certified orthopedic surgeon, for a second opinion examination. In a June 3, 2013 report, Dr. Ghanma reviewed her medical record and the statement of accepted facts. He described appellant's medical history and noted that a June 13, 2011 electromyography (EMG) study of the right upper extremity demonstrated evidence of mild right carpal tunnel syndrome. Dr. Ghanma reported a *Quick*DASH score of 58 of the right upper extremity and 63 of the left upper extremity. On examination, he observed full range of motion of the right wrist and good finger abduction and adduction bilaterally. Dr. Ghanma also reported a five millimeter (mm) two-point discrimination in the fingers of the right hand and five mm two-point discrimination in the fingers of the left hand. He stated that appellant's right carpal tunnel syndrome had not resolved as the June 13, 2011 diagnostic report revealed evidence of mild carpal tunnel syndrome. Dr. Ghanma reported that there was insufficient evidence to support left carpal tunnel syndrome. He noted that appellant had subjective complaints consistent with left carpal tunnel syndrome even though she underwent

carpal tunnel revision surgery. Dr. Ghanma found that she could continue to work without restrictions. He reported a date of maximum medical improvement of July 19, 2011.

Utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Ghanma opined that appellant had three percent impairment to both upper extremities. For right carpal tunnel syndrome, he determined that she had a class 1 diagnosis for carpal tunnel syndrome according to Table 15-23.[2] Dr. Ghanma noted grade modifiers 1 for test findings, history and physical examination findings. He stated that for a *Quick*DASH score of 58 the A.M.A., *Guides* recommended increasing impairment from the default setting of two to three percent right upper extremity impairment. Dr. Ghanma related that similar results were obtained when rating impairment for left carpal tunnel syndrome. He found that appellant had a default impairment of two percent. Based on the *Quick*DASH score of 63 for the left, appellant's rating increased to three percent upper extremity impairment for the left upper extremity.

On June 27, 2013 OWCP referred the medical record to Dr. Morley Slutsky, Board-certified in occupational medicine and a medical adviser for review. In a July 2, 2013 report, Dr. Slutsky agreed with Dr. Ghanma's ratings that appellant had three percent impairment of the right and left upper extremities. Utilizing Table 15-23 of the sixth edition of the A.M.A., *Guides,* for each upper extremity, he reported a grade modifier 1 for history, 1 for test findings based on nerve diagnostic testing and 0 for physical findings based on significant objective sensory and motor findings. Dr. Slutsky also noted a *Quick*DASH score of 58 and 63 percent, which was moderate. He determined that the average of the three grade modifiers rounded to the nearest integer equaled 1, which provided a default rating of two percent. Dr. Slutsky increased the rating by 1 for appellant's *Quick*DASH score for a final upper extremity impairment of three percent for each upper extremity. He noted a date of maximum medical improvement of June 3, 2013, the date of Dr. Ghanma's second opinion report.

In a September 3, 2013 report, Dr. Skie noted appellant's complaints of bilateral hand pain, cramping and spasms beginning February 20, 2009 and her history of bilateral carpal tunnel release surgery and left carpal tunnel revision surgery. He reviewed her history and conducted an examination. Dr. Skie diagnosed chronic bilateral carpal tunnel syndrome and recommended an EMG and nerve conduction velocity study (NCV) examination. He did not address permanent impairment.

In a September 13, 2013 report, Dr. Tallat Rizk, Board-certified in physical medicine and rehabilitation, reviewed appellant's history and noted her complaints of chronic bilateral carpal tunnel syndrome. He provided EMG/NCV test findings of the right and left upper extremities and opined that she had very mild carpal tunnel syndrome on both sides.

On October 10, 2013 OWCP granted appellant schedule awards for three percent impairment of the right and left upper extremities. It advised her that a schedule award was not payable concurrently with wage-loss compensation for the same injury. Because appellant received disability compensation through September 3, 2013, the starting date of her schedule award was adjusted to September 4, 2013.

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

LEGAL PRECEDENT

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.[3] 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 the appropriate standard for evaluating schedule losses.[4] 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.[5]

The sixth edition of the A.M.A., *Guides* provide a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[6] 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).[7] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[8]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[9] 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 modifiers 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.[10]

ANALYSIS

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome. On April 9 and November 5, 2013 appellant filed a claim for a schedule award. The Board finds that the

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

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

[5] Federal (FECA) Procedure Manual, Part 3 -- Claims, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 9, 2010).

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

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

[8] *Id.* at 411.

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

[10] 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).

medical evidence of record establishes no more than three percent impairment for her right and left upper extremity.

In support of her claim, appellant submitted various reports by Drs. Skie and Rizk regarding her treatment for bilateral carpal tunnel syndrome. They related her complaints of hand pain, tingling and cramping and provided findings on examination. Neither physician, however, provided any impairment rating of appellant's accepted bilateral carpal tunnel syndrome. Accordingly, these reports are insufficient to establish her schedule award claim.

OWCP referred appellant to Dr. Ghanma for a second opinion examination. In a May 8, 2013 report, Dr. Ghanma reviewed her history of injury and conducted an examination. He opined that appellant had a three percent impairment of each upper extremity. Dr. Ghanma utilized Table 15-23 of the sixth edition of the A.M.A., *Guides* to determine that she had class 1 diagnosis and grade modifiers 1 for test findings, history and physical examination for her right carpal tunnel syndrome. He noted that, for a *Quick*DASH score of 58, the A.M.A., *Guides* recommended increasing impairment from two to three percent right upper extremity impairment. Dr. Ghanma provided similar results for appellant's left carpal tunnel syndrome and noted a *Quick*DASH score of 63, which also increased her impairment rating to three percent impairment for the left upper extremity.

In a July 2, 2013 report, Dr. Slutsky, the district medical adviser, reviewed the record. He agreed with Dr. Ghanma's rating of three percent impairment to each upper extremity. Utilizing Table 15-23 of the sixth edition of the A.M.A., *Guides*, Dr. Slutsky reported a grade modifier 1 for history, 1 for test findings based on nerve diagnostic testing and 0 for physical findings based on significant objective sensory and motor findings. He also noted a *Quick*DASH score of 58 and 63 percent. Dr. Slutsky determined that the average of the three grade modifiers rounded to the nearest integer equaled 1, which provided a default rating of two percent. He increased the rating by 1 for appellant's *Quick*DASH score for a final upper extremity impairment of three percent for each upper extremity. Dr. Slutsky noted a date of maximum medical improvement of June 3, 2013, the date of Dr. Ghanma's second opinion report.

The Board finds that the medical evidence establishes that appellant has a three percent impairment of each upper extremity. The medical adviser properly applied the sixth edition of the A.M.A., *Guides* to Dr. Ghanma's clinical findings. Dr. Slutsky reviewed the medical evidence and determined that appellant had three percent impairment of each upper extremity. His rating is in accordance with the protocols pertaining to upper extremity impairment determinations and represents the weight of medical opinion. Appellant did not submit any medical evidence that establishes greater impairment.

On appeal, appellant requests that the date of her schedule award be changed to June 4, 2013, the date of maximum medical improvement, instead of September 4, 2013. The period covered by a schedule award generally commences on the date that the employee reaches maximum medical improvement from the residuals of the employment injury.[11] The Board has also noted a reluctance to find a date of maximum improvement, which is retroactive to the

[11] *Adela Hernandez-Piris*, 35 ECAB 839 (1984).

award, as retroactive awards often result in payment of less compensation benefits.[12] As OWCP explained, a schedule award is payable consecutively to but not concurrently with wage loss for the same injury.[13] Appellant received disability compensation for a medical appointment on September 3, 2013. Accordingly, the Board finds that OWCP properly commenced the schedule award as of September 4, 2013.[14]

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 more than a three percent impairment of each upper extremity.

[12] *See C.W.*, Docket No. 13-1501 (issued November 15, 2013).

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability* Claims, Chapter 2.808.4(a)(3) (February 2013).

[14] The Board also notes that the effective date of the pay rate was May 26, 2011 and the effective date of the last cost-of-living adjustment increase to the pay rate was March 1, 2013.

ORDER

IT IS HEREBY ORDERED THAT the October 10, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 4, 2014
Washington, DC

Patricia Howard Fitzgerald, Acting Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board