United States Department of Labor
Employees' Compensation Appeals Board

E.D., Appellant	)	
and	)	**Docket No. 14-1167**
	)	**Issued: October 23, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Oakland, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 23, 2014 appellant filed a timely appeal from a January 31, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied her claim for a schedule award. 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 case.

ISSUE

The issue is whether OWCP properly denied appellant's claim for a schedule award from an alleged work injury to both upper extremities.

FACTUAL HISTORY

This is the second appeal of this matter considered by the Board in the present case. In a decision dated January 30, 2014, the Board affirmed a January 30, 2013 decision, which found that the position of information clerk reflected appellant's wage-earning capacity effective

[1] 5 U.S.C. § 8101 *et seq.*

January 30, 2013.[2] The facts and circumstances of the case up to that point are set forth in the Board's prior decision and incorporated herein by reference.

There was previously evidence submitted which is relevant to the current appeal. Appellant was treated by Dr. Richard A. Nolan, a Board-certified orthopedic surgeon, from October 7, 2009 to June 16, 2010. Dr. Nolan diagnosed bilateral trigger thumb and bilateral carpal tunnel syndrome. On August 27, 2010 he performed an authorized exploration of the flexor pollicis longus tendon at sesamoids with release of the fibrous pulley and inspection of the flexor pollicis longus tendon and diagnosed right trigger thumb. On February 11, 2011 Dr. Nolan performed an authorized exploration of the trigger thumb left side, release of the pulley and inspection of the flexor pollicis longus tendon and diagnosed left trigger thumb and status post release of the right trigger thumb. A December 23, 2009 electromyogram (EMG) revealed no abnormalities, no evidence of carpal tunnel syndrome, cervical radiculopathy or peripheral neuropathy.

On April 10, 2013 appellant filed a claim for a schedule award. She submitted an April 24, 2013 report from Dr. Nolan who noted findings of a visible scar from a procedure on her right thumb, tenderness to palpation with prominence of sesamoids and tenderness of the left thumb to palpation in the volar aspect radiating to the thenar eminence. Examination of the right and left wrist revealed negative Finkelstein and carpal tunnel testing. Dr. Nolan released appellant to work modified duty.

In a letter dated May 28, 2013, OWCP requested that appellant submit a rating of permanent impairment pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

Appellant submitted reports from Dr. Nolan, dated May 22 to October 28, 2013, who treated her for trigger finger. On October 28, 2013 Dr. Nolan noted findings of right-side inflammation of the sesamoids and intermittent bilateral paresthesia with fine motor activities. He noted a positive carpal Tinel's sign on the right wrist and a negative carpal and cubital Tinel's sign on the left wrist. Dr. Nolan diagnosed trigger finger acquired, status post trigger thumb release bilaterally and carpal tunnel syndrome bilaterally. He opined that the triggering of the thumbs resolved but appellant had tenderness over the sesamoids on the right and persistent carpal tunnel symptoms on the right.

On November 6, 2013 OWCP referred appellant for a second opinion to Dr. Bruce E. Thompson, a Board-certified physiatrist, to determine whether she had permanent impairment due to her work-related condition. In a December 13, 2013 report, Dr. Thompson diagnosed status post successful operative trigger thumb repair of the right and left thumbs. Examination findings included a negative Tinel's sign at the cubital and carpal tunnel and Guyon's canal,

[2] Docket No. 13-1232 (issued January 30, 2014). On or before September 15, 2009 appellant, then a 55-year-old mail processing clerk, developed bilateral finger and hand symptoms as a result of performing repetitive duties at work. OWCP accepted the claim for bilateral trigger finger and bilateral carpal tunnel syndrome and authorized bilateral trigger thumb releases which were performed on August 27, 2010 and February 11, 2011.

[3] The A.M.A., *Guides* (6th ed. 2009).

negative Finkelstein's bilaterally and no evidence of atrophy, weakness or decreased sensibility in the upper extremities. Appellant had well-healed surgical scars at the base of both thumbs on the palmar surface consistent with trigger thumb release. Manual motor testing of the elbow and wrist was 5/5 bilaterally, there was no triggering of the fingers or thumbs on passive and active motion and no numbness. Dr. Thompson noted good capillary refill in the nail beds, normal distribution, size, bulk and movement of the musculature of the forearm, wrist, hands, thumbs and fingers. He noted range of motion of the wrists for flexion was 70 degrees bilaterally, ulnar deviation was 30 degrees bilaterally, radial abduction was 50 degrees bilaterally and adduction of the thumb was eight centimeters bilaterally. Dr. Thompson noted range of motion of the fingers was 90 degrees of flexion, 0 degrees on extension and the distal interphalangeal joint and proximal interphalangeal joint were normal. Appellant's bilateral trigger thumb repair was successful and there was no evidence of carpal tunnel syndrome and the prior EMG was normal. Dr. Thompson noted that appellant was permanent and stationary six months after the second surgery and that there was no significant change since August 1, 2011. He noted her symptoms of direct light tenderness over the right palmar area of the prior surgery and adjacent fibrosis and small postoperative stable fasciitis but advised that these symptoms were not a ratable condition. Appellant had no interference with her activities of daily living and she could perform the duties of her prior job. Dr. Thompson provided prophylactic restrictions to avoid aggravating the postsurgical status of appellant's trigger thumb. He noted that she required no further treatment. Dr. Thompson noted permanent impairment could be rated as appellant was permanent and stationary since June 2011. Under the A.M.A., *Guides* he opined that she had no permanent impairment of the arms due to her work-related bilateral carpal tunnel syndrome and bilateral trigger thumb. Relying on Table 15-2 of the A.M.A., *Guides*, Digital Regional Grid 2, the table utilized to rate upper extremity digital impairments, Dr. Thompson stated that appellant's bilateral trigger thumb was rated as zero percent impairment of the digits and zero percent impairment of each upper extremity. In an accompanying December 13, 2013 worksheet, pursuant to Table 15-2, Dr. Thompson noted that appellant had no residual or objective findings of bilateral trigger thumbs and was a class zero, for zero percent hand-thumb impairment and zero percent impairment of the upper extremities.

Appellant submitted reports from Dr. Nolan dated December 11, 2013. Dr. Nolan had treated her for carpal tunnel syndrome and bilateral trigger thumbs. He noted findings of the thumbs as a slight prominence in the volar aspect of the sesamoid on the left, moderate fibrosis from scarring on the right, tenderness bilaterally and no triggering on active flexion and extension. Dr. Nolan opined that the bilateral thumb trigger release surgery resolved the triggering but appellant still had pain at the base of the thumbs with repetitive use and thickness over the sesamoids on the right with no crepitation or sensory loss. He diagnosed bilateral trigger finger acquired and bilateral carpal tunnel syndrome. Dr. Nolan noted that appellant's bilateral carpal tunnel symptoms were aggravated with repetitive activities. On January 22, 2014 he noted examination of the wrists revealed no deformity, effusion or tenderness, negative Finkelstein's testing and negative Phalen's test. Range of motion for flexion was 80 degrees bilaterally, ulnar deviation was 60 degrees on the right and 50 degrees on the left and radial deviation was 15 degrees on the right and 10 degrees on the left. With regard to the thumbs there was fullness at the volar aspect of the thumb carpometacarpal joints at the sesamoids that was moderate on the right and slight on the left, no triggering on active flexion and extension and the right thumb interphalangeal joint lacked 20 degrees of full extension. Dr. Nolan noted the carpal tunnel symptoms persisted with paresthesia and weakness in the right hand. He diagnosed

bilateral trigger finger acquired and bilateral carpal tunnel syndrome. No rating was provided in his report of December 11, 2013.

On January 2, 2014 OWCP asked its medical adviser to address whether appellant had impairment of the bilateral upper extremities. In a January 27, 2014 report, an OWCP medical adviser noted reviewing Dr. Thompson's report and advised that maximum medical improvement occurred on December 13, 2013. The medical adviser noted that, under the A.M.A., *Guides*, Dr. Thompson's examination findings resulted in zero percent impairment to the bilateral upper extremities. She noted that, with regard to impairment due to bilateral digital stenosing tenosynovitis (trigger finger), he noted no triggering with normal motion. The medical adviser noted that, pursuant to Table 15.2, Digit Regional Grid, page 392, appellant had zero percent impairment per digit bilaterally.[4] She further noted that this also resulted in no arm impairment. The medical adviser concluded that appellant had no ratable impairment in either arm.

In a decision dated January 31, 2014, OWCP denied appellant's claim for a schedule award.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing regulations[6] 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*,[7] has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8] 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.[9]

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).[10] Under the sixth edition, for upper extremity impairments the evaluator

[4] The medical adviser noted that appellant had no triggering with normal motion for a class 1; however, this appears to be a typographical error as these findings are consistent with a class zero.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

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

[8] *See supra* note 6.

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

[10] The A.M.A., *Guides*, *supra* note 3 at 3, section 1.3, The ICF, Disability and Health: A Contemporary Model of Disablement.

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). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[12]

ANALYSIS

OWCP accepted appellant's claim for bilateral trigger finger and bilateral carpal tunnel syndrome and authorized bilateral trigger thumb releases which were performed on August 27, 2010 and February 11, 2011. Appellant sought a schedule award for the upper extremities based on impairment from bilateral trigger finger and bilateral carpal tunnel syndrome and bilateral trigger thumb releases. OWCP referred appellant to Dr. Thompson to determine if she had residuals of her work-related conditions. In his December 13, 2013 report, Dr. Thompson opined that appellant sustained zero percent impairment based on Table 15.2, Digit Regional Grid: Digit Impairments, under the sixth edition of the A.M.A., *Guides*.

Dr. Thompson reported findings, noting that, manual motor testing of the elbow and wrist was 5/5 bilaterally, there was no triggering of the fingers or thumbs on passive and active motion and no numbness. He noted range of motion of the fingers for flexion was 90 degrees, extension was 0 degrees and the distal interphalangeal joint and proximal interphalangeal joint were normal. Dr. Thompson noted that there was no evidence of carpal tunnel syndrome and the prior EMG was within normal limits. He noted that the bilateral trigger thumb repair was successful. Dr. Thompson noted appellant's symptoms consist of direct light tenderness over the right palmar area of the prior surgery and adjacent fibrosis and small postoperative stable fasciitis was not ratable. Appellant had no interference with her activities of daily living. Dr. Thompson found that appellant's diagnosis of digital stenosing tenosynovitis, bilateral trigger thumb status post successful trigger thumb repair was a class zero impairment under Table 15-2 of the A.M.A., *Guides*. Pursuant to the A.M.A., *Guides* he opined that appellant had no permanent impairment of the upper extremities due to her work-related conditions.

The medical adviser concurred with Dr. Thompson's findings that appellant had no ratable impairment for the accepted conditions. As this finding was rendered in accordance with the applicable tables and protocols in the A.M.A., *Guides* for rating the bilateral upper extremities impairments based on digital impairments, the Board finds that he and the medical adviser properly determined that she had no permanent ratable impairment of the bilateral upper extremities.

[11] *Id.* at 411.

[12] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

Appellant submitted reports from Dr. Nolan dated December 11, 2013 and January 22, 2014 who treated appellant for carpal tunnel syndrome and bilateral trigger thumbs. He noted findings and opined that the trigger release of the bilateral thumbs resolved the triggering but appellant still had pain at the base of the thumbs with repetitive use and thickness over the sesamoids on the right. Dr. Nolan stated that carpal tunnel symptoms persisted with paresthesia and weakness in the right hand that was greater than the left hand. Dr. Nolan diagnosed bilateral trigger finger acquired and bilateral carpal tunnel syndrome. However, Dr. Nolan did not provide an impairment rating in accordance with the relevant standards of the A.M.A., *Guides*. The Board has held that an attending physician's report is of little probative value where the A.M.A., *Guides* were not properly followed.[13] As Dr. Nolan did not correlate his findings with the A.M.A., *Guides*, his report is insufficient to establish any permanent impairment.

The Board finds that the record supports that appellant has no ratable impairment for the bilateral upper extremities for the accepted bilateral trigger finger and bilateral carpal tunnel syndrome. The medical adviser concurred with Dr. Thompson's assessment. OWCP properly found in its January 31, 2014 decision that appellant had zero percent permanent impairment of the bilateral upper extremities.

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 failed to establish that she is entitled to a schedule award.

[13] *See Paul R. Evans, Jr.*, 44 ECAB 646 (1993); *John Constantin*, 39 ECAB 1090 (1988) (medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

ORDER

IT IS HEREBY ORDERED THAT the January 31, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 23, 2014
Washington, DC

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

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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