

FACTUAL HISTORY

On February 28, 2013 appellant, then a 57-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he developed carpal tunnel syndrome due to his federal employment duties. He stated that he first became aware of his condition on February 4, 2013 and first realized that it was related to his employment on February 8, 2013.

In an accompanying narrative statement, appellant related that he began a mounted route in June 2011 with a change in the mechanics of his position. He stated that he had more delivery time and increased movement of his arms, wrists, and hands. Appellant reported approximately 800 deliveries on his route. He described his duties of sorting flats of up to 920 pieces of magazine-sized mail, residential letters of 50 pieces of mail, and parcels of 30 pieces of mail. Appellant loaded his vehicle with this mail as well as an additional 2,700 letters. To deliver the mail, he had to finger each letter with his right hand to check for forwarded mail, holds, miss-sorted, and miss-spent mail. Appellant then placed the mail in the proper mailbox from his vehicle using his right hand. He noted that he delivered to locked mailboxes which required him to unlock and lock 23 boxes a day. Appellant stated that his route required work of 8 to 10 hours a day and that he also worked an additional 1 to 2 hours to perform delivery functions on a vacation route. He worked six days a week and averaged 56 hours a week. Appellant stated, "These thousands of daily fine manipulations by my hands, wrists, and arms has resulted in slowly over a period of time, numbness, tingling, swelling, and pain which has resulted in carpal tunnel in both my left and right hands and/or wrists."

In a report dated February 8, 2013, Dr. Conrad G. Hamilton, a surgeon, noted appellant's history of injury and the gradual onset of his paresthesias, numbness, and tingling. He reviewed appellant's electromyogram study and found that it demonstrated bilateral carpal tunnel syndrome worse on the right. Dr. Hamilton noted that appellant had thick muscular hands and wrists that limited his range of motion due to anatomy rather than pathology. He found no thenar or hyperthenar atrophy and noted that Tinel's sign was negative. Dr. Hamilton reported that appellant's right side two-point discrimination was in the six to seven millimeter range on the ulnar distribution and the seven to eight millimeter range on the median distribution. Appellant demonstrated eight millimeter or greater two-point discrimination on the radial and ulnar borders. On the left side he demonstrated six millimeter two-point discrimination in his small finger, six to seven millimeter discrimination on the remaining fingers with seven to eight millimeter two-point discrimination on his thumb.

By decision dated May 2, 2013, OWCP accepted appellant's claim for bilateral carpal tunnel syndrome.

Dr. Hamilton performed an open median nerve decompression at the right carpal tunnel with thenar motor branch exploration on May 28, 2013. He performed an open median nerve decompression on the left carpal tunnel on July 9, 2013. Appellant returned to full duty on August 20, 2013.

In a report dated October 18, 2013, Dr. Hamilton noted appellant's increasingly symptomatic bilateral long finger triggering. On October 28, 2013 he performed trigger digit injections. On November 21, 2013 Dr. Hamilton noted that appellant's symptoms had worsened and that the injections had not helped.

Appellant requested a schedule award on February 10, 2014. In a letter dated February 19, 2014, OWCP informed him that he was entitled to a schedule award when he reached maximum medical improvement (MMI) of his accepted condition of bilateral carpal tunnel syndrome.

Dr. Hamilton completed a report following his February 3, 2014 examination, finding that appellant had experienced complete resolution of numbness and tingling bilaterally in his wrists, hands, and digits. Appellant continued to describe global achiness and pain in his hands with long days at work as well as intermittent symptoms of the left long finger triggering. Dr. Hamilton examined appellant's wrists and found negative Tinel's sign, with no thenar atrophy, normal strength in the abductor pollicis brevis, and abductor digiti quinti minimi. He reported appellant's two-point discrimination as five millimeters on the radial and ulnar borders of all digits. Dr. Hamilton noted that no triggering was actively identified on the right long finger, but mild nodularity could be appreciated with deep palpation and tendon excursion. Appellant's left long finger demonstrated intermittent trace triggering with deep palpation and associated nodularity was appreciated in the active range. Dr. Hamilton reported that appellant's grip strength on the right side was 46 kilograms and on the left side 41 kilograms in position number two. He noted that appellant did not wish to undergo operative intervention for his left long finger trigger digit and was at MMI.

By decision dated April 24, 2014, OWCP denied appellant's claim for a schedule award finding that Dr. Hamilton did not provide an impairment rating in accordance with the A.M.A., *Guides*.

In a report dated April 29, 2014, Dr. Paul S. Darby, a physician Board-certified in occupational medicine, examined appellant to rate his permanent impairment. He noted that appellant had not regained his preinjury strength, that he complained of pain in both hands that woke him from sleep, and that his grip strength was lessened. Dr. Darby found a positive Tinel's sign at the left wrist, with no dermatomal sensory deficits in either hand. He observed, "His hands are quite massive. There is no obvious muscle atrophy of the thenar regions. He has 5/5 strength of bilateral thumb opposition.... His gross grip strength is diminished bilaterally compared to what it should be based on his massive hand size." Appellant's *QuickDASH* score was 62. Dr. Darby noted that appellant required repeat electrodiagnostic studies prior to an impairment rating.

Appellant underwent electrodiagnostic studies on May 20, 2014. These revealed that his distal motor latency on the right median nerve was 5.8 and on the left it was 5.9. Appellant's right distal motor latency had improved while his left had worsened. Dr. Kevin J. Jamison, a Board-certified neurologist, diagnosed moderate bilateral carpal tunnel syndrome and recommended repeat carpal tunnel releases.

In a report dated July 16, 2014, Dr. Darby applied the A.M.A., *Guides* to his electrodiagnostic studies and physical findings. He reported that appellant's electrodiagnostic studies showed ongoing delayed distal motor latencies of the bilateral median nerves at the wrists and bilateral mixed median sensory responses, which were borderline to slightly delayed bilaterally. Dr. Darby referenced Table 15-23² of the A.M.A., *Guides* and found that appellant's

² A.M.A., *Guides*, 449, Table 15-23.

test findings were grade modifier 1, that his constant bilateral symptoms were grade modifier 3 for history, and based on bilateral weakness appellant had grade modifier 3 for physical findings. He noted, “The sum of the modifiers is 7 and the averages is 2.33, indicating [g]rade 2 is the final rating category. The *QuickDASH* score of 62 corresponds to [g]rade [m]odifier 3 on the functional scale. Therefore, the default upper extremity impairment of five percent is raised to six percent because the functional grade modifier is one level higher than the final rating category.” Dr. Darby concluded that appellant had six percent impairment of his upper extremities bilaterally.

An OWCP medical adviser reviewed the reports of Drs. Hamilton and Darby on August 14, 2014. He agreed with Dr. Darby’s method of impairment rating, but stated that he disagreed with the grade modifier for physical examination which, he noted, affected the final rating for the right side, but not the left. The medical adviser found that, in accordance with the A.M.A., *Guides*, appellant’s grade modifier for test findings was 1, that his grade modifier for history was 3, bilaterally. He then found that, as appellant had a normal physical examination on the right, the grade modifier for physical examination was 0 on the right. On the left the medical adviser found a grade modifier 1 for physical examination based on appellant’s positive Tinel’s sign. He found a functional scale grade modifier 3 bilaterally. The medical adviser concluded that on the right appellant’s average grade modifier was 1 for an impairment rating of two percent, while on the left appellant’s average grade modifier was 2 for an impairment rating of five percent. He further explained, “Dr. Darby used a grade modifier for physical examination of 3 on both sides based on his perception of grip strength weakness, however, he reported 5/5 strength of individual muscles and no atrophy and he did not measure grip strength. Dr. Hamilton had previously documented that grip strength was 46 kilograms (101 pounds) on the right and 41 kilograms (90 pounds) left, which would be considered to be normal.” The medical adviser noted that, as the functional scale was greater on both sides than the average grade modifier, the default impairment rating was increased by one percent on both sides. Therefore, he concluded that appellant had three percent impairment of the right upper extremity for residuals of median neuropathy carpal tunnel syndrome and six percent impairment of the left upper extremity. The medical adviser used April 29, 2014 as the date of MMI based on Dr. Darby’s examination.

By decision dated September 8, 2014, OWCP granted appellant schedule awards for six percent impairment of the left upper extremity and three percent impairment of the right upper extremity. The award ran 28.08 weeks for the period April 29, 2014 MMI to November 11, 2014.

LEGAL PRECEDENT

The schedule award provision of FECA³ and its implementing regulations⁴ set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For

³ 5 U.S.C. §§ 8101-8193, 8107.

⁴ 20 C.F.R. § 10.404.

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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.⁵

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.⁶ In Table 15-23, grade modifiers 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.⁷

ANALYSIS

Appellant submitted medical evidence from Dr. Hamilton and Dr. Darby regarding the extent of his permanent impairment for his accepted bilateral carpal tunnel condition. The medical adviser reviewed these reports and generally agreed with Dr. Darby's findings and ratings. Dr. Darby applied the methodology of Table 15-23 of the A.M.A., *Guides*⁸ and reviewed appellant's electrodiagnostic studies to reach grade modifier 1 based on a sensory or motor conduction delay. The medical adviser agreed with this rating. Dr. Darby then opined that appellant had constant bilateral symptoms which resulted in grade modifier 3 for history. The medical adviser agreed. Both Dr. Darby and the medical adviser agreed that appellant's functional scale or *QuickDASH* score was grade modifier 3 and resulted in an increase in one percent of the determined impairment ratings.

The disagreement between Dr. Darby and the medical adviser was based on a difference in determination of appellant's physical findings. Dr. Darby found that appellant had a grade modifier 3 based on atrophy of weakness. In his initial report he noted that appellant's hands were massive and that his gross grip strength was diminished bilaterally compared to what it should be based on his massive hand size. However, Dr. Darby did not provide any additional grip strength measurements and noted that appellant had no obvious muscle atrophy of the thenar regions. In further defining physical findings, the A.M.A., *Guides* provide: "To qualify for class 3 by physical findings, there should be constant numbness (history), and no protective sensation.... There must also be grade 3 or less motor function, or a history of surgical tendon transfer to restore function. This is almost never seen in peripheral nerve entrapment."⁹

⁵ For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

⁶ A.M.A., *Guides* 449, Table 15-23.

⁷ A survey completed by a given claimant, known by the name *QuickDASH*, may be used to determine the function scale score. *Id.* at 448-49.

⁸ *Id.* at 449, Table 15-23.

⁹ *Id.* at 446.

The medical adviser disagreed with Dr. Darby's selection of grade modifier 3 for physical findings and explained, "Dr. Darby used a grade modifier for physical examination of 3 on both sides based on his perception of grip strength weakness, however, he reported 5/5 strength of individual muscles and no atrophy and he did not measure grip strength. Dr. Hamilton had previously documented that grip strength was 46 kilograms (101 pounds) on the right and 41 kilograms (90 pounds) left, which would be considered to be normal."

It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment and OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings of the attending physician.¹⁰ The Board finds that Dr. Darby did not provide sufficient findings or reasoning to support his selection of grade modifier 3 for physical findings under Table 15-23 of the A.M.A., *Guides*. The medical adviser offered his agreement with the majority of Dr. Darby's findings and provided a detailed explanation of why he did not believe that the physical findings grade modifier was appropriate. He concluded that appellant had grade modifier 2 for physical findings on the left based on a positive Tinel's sign and grade modifier 1 for physical findings on the right due to normal physical findings.

After averaging the grade modifiers for test findings, history, and physical findings, the medical adviser concluded that on the right appellant's average grade modifier was 1 for an impairment rating of two percent, while on the left appellant's average grade modifier was 2 for an impairment rating of five percent. He concluded that, as the functional scale was greater on both sides than the average grade modifier, the default impairment rating was increased by one percent on both sides, to three on the right and to six on the left.

The Board finds that appellant has no more than three percent impairment of his right upper extremity and no more than six percent impairment of his left upper extremity for which he received schedule awards.

On appeal, appellant alleges that as his grip strength was diminished and because of his large hand-size, he should have received six percent impairment of each upper extremity. For the reasons set forth above, the Board finds that appellant's medical evidence is insufficient to establish this greater impairment rating.

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 three percent impairment of his right upper extremity and six percent impairment of his left upper extremity for which he received schedule awards.

¹⁰ *Linda Beale, 57 ECAB 429 (2006).*

ORDER

IT IS HEREBY ORDERED THAT September 8, 2014 decision of the Office of Workers' Compensation Programs is affirmed.¹¹

Issued: March 24, 2016
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

¹¹ James A. Haynes, Alternate Judge, participated in the original decision but was no longer a member of the Board effective November 16, 2015.