United States Department of Labor
Employees' Compensation Appeals Board

H.S., Appellant	)	
and	)	**Docket No. 16-1624**
	)	**Issued: January 13, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Hickory, NC, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 9, 2016 appellant, through counsel, filed a timely appeal from a July 12, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has established that he sustained more than three percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity, for which he received schedule awards.

FACTUAL HISTORY

OWCP accepted that on or before August 15, 2012 appellant, then a 65-year-old custodian, sustained an exacerbation of preexisting bilateral carpal tunnel syndrome related to a December 12, 2008 nonoccupational motor vehicle accident.[3]

Appellant submitted medical reports relative to the etiology of his carpal tunnel syndrome. A December 12, 2008 emergency room report noted appellant's complaints of cervical spine pain following a motor vehicle accident earlier that day. In January 29 and March 27, 2009 reports, Dr. Larry Boyles, an attending Board-certified neurologist, diagnosed bilateral carpal tunnel syndrome due to a December 12, 2008 motor vehicle accident in which appellant was struck from behind at a high rate of speed by a large vehicle. Appellant recalled gripping the steering wheel so tightly that it broke. Dr. Boyles obtained electromyography (EMG) and nerve conduction velocity (NCV) studies on February 13, 2009 showing bilateral carpal tunnel syndrome.[4] Appellant underwent bilateral median nerve releases in May 2009. He participated in postoperative occupational therapy.

In October 10 and 15, 2012 reports, Dr. Andreas Runheim, an attending Board-certified neurologist, noted a history of carpal tunnel syndrome with surgery in May 2009. He related appellant's account of bilateral hand paresthesias when performing assigned custodial duties requiring repetitive upper extremity motion, such as mowing grass, waxing floors, cleaning windows, and shoveling snow. Dr. Runheim diagnosed severe right and moderate left carpal tunnel syndrome. He opined that the condition was a "direct result of the work that he has been doing as a custodian since 1995." Dr. Runheim explained in an April 10, 2013 report that the December 2008 motor vehicle accident "initiated the carpal tunnel syndrome," exacerbated by repetitive hand motions at work. He obtained updated EMG and NCV studies showing moderate bilateral carpal tunnel syndrome, mild multilevel cervical radiculopathy, and mild peripheral polyneuropathy.[5]

[3] On August 17, 2012 appellant filed an occupational disease claim (Form CA-2). OWCP initially denied the claim by decision issued October 3, 2012. Following a February 13, 2013 hearing, it denied the claim by decision issued May 1, 2013, finding that the medical evidence of record was insufficient to establish fact of injury. Following a June 27, 2013 request for reconsideration, OWCP accepted the claim for an exacerbation of bilateral carpal tunnel syndrome.

[4] Dr. Boyles obtained a magnetic resonance imaging (MRI) scan of the cervical spine on February 3, 2009, demonstrating minimal right-sided cord compression and bilateral foraminal stenosis at C5-6, and a C4-5 disc protrusion.

[5] The electrodiagnostic report imaged into the case record on June 27, 2013 does not contain the date of the examination.

On February 27, 2014 appellant claimed a schedule award (Form CA-7). In support of his claim, he submitted a January 8, 2014 report from Dr. Runheim, opining that appellant had reached maximum medical improvement (MMI). Appellant found 10 percent impairment of each arm due to carpal tunnel syndrome. In a May 1, 2014 report, Dr. Runheim opined that appellant had 12 percent permanent impairment of each hand, according to unspecified portions of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).

On September 10, 2014 OWCP obtained a second opinion from Dr. Harrison Latimer, a Board-certified orthopedic surgeon. Dr. Latimer reviewed the medical record and statement of accepted facts. He administered a *Quick*DASH questionnaire, with a score of 50 in each upper extremity. On examination Dr. Latimer found mildly diminished grip strength bilaterally, normal objective sensation, and full motion throughout both hands, wrists, and all digits. He found that appellant had attained MMI in 2012. Referring to Table 15-23 of the sixth edition of the A.M.A., *Guides*,[6] Dr. Latimer assessed a grade 2 modifier for Functional History (GMFH), a grade 1 modifier for Physical Examination (GMPE), and grade 2 modifier for Clinical Studies (GMCS) of each hand. Applying the net adjustment formula, he calculated a net modifier of +1, shifting the default value of two percent one step to the right, equaling three percent permanent impairment of each upper extremity.

On September 27, 2014 an OWCP medical adviser reviewed Dr. Latimer's report and concurred with his impairment assessment and method of calculation. The medical adviser noted on November 19, 2014 that the correct date of MMI was January 8, 2014, the date of Dr. Runheim's examination.

By decision dated November 24, 2014, OWCP granted appellant schedule awards for three percent permanent impairment of each upper extremity, based on Dr. Latimer's opinion as the weight of the medical evidence. The period of the award, equivalent to 18.72 weeks, ran from January 8 to May 19, 2014.

In a December 10, 2014 letter, counsel requested a telephonic hearing before an OWCP hearing representative. He provided a November 5, 2014 report from Dr. Runheim, noting improved bilateral carpal tunnel syndrome. EMG and NCV studies performed on November 5, 2014 showed moderate bilateral carpal tunnel syndrome, stable multilevel cervical radiculopathy, and stable mild peripheral neuropathy. In a November 7, 2014 report, Dr. Runheim opined that appellant had nine percent impairment of each hand due to moderate carpal tunnel syndrome with "axonal loss, weakness, and constant symptoms," based on pages 448 to 450 of the A.M.A., *Guides*.

By decision dated May 8, 2015, an OWCP hearing representative remanded the case for additional development to determine whether the new reports from Dr. Runheim established a greater percentage of upper extremity impairment than that awarded.

On remand of the case, OWCP requested that Dr. Latimer review Dr. Runheim's November 5 and 7, 2014 reports, and explain whether they established that appellant sustained

[6] A.M.A., *Guides*, 449 (sixth edition) is entitled "Entrapment/Compression Neuropathy Impairment."

more than three percent impairment of each arm. Dr. Latimer responded by June 9, 2015 letter, finding that Dr. Runheim's reports did not establish a greater percentage of permanent impairment than the three percent for each upper extremity previously awarded.

By *de novo* decision dated July 23, 2015, OWCP found that the additional medical evidence submitted did not establish a greater percentage of permanent impairment than that previously awarded.

On November 2, 2015 appellant claimed a schedule award for additional impairment.

On May 9, 2016 counsel requested reconsideration. He provided an April 18, 2016 impairment rating performed by Keith L. Blankenship, a physical therapist, who found five percent impairment of the right upper extremity, and three percent impairment of the left upper extremity due to carpal tunnel syndrome.

By decision dated July 12, 2016, OWCP denied modification of the July 23, 2015 decision, finding that the additional evidence submitted was insufficient to establish a greater percentage of permanent impairment than that previously awarded.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] provide for compensation to employees sustaining impairment from loss or loss of use of specified members 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 sound discretion of OWCP. 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 a standard for evaluation of schedule losses and the Board has concurred in such adoption.[8] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*.[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, the evaluator identifies the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

[7] 5 U.S.C. § 8107.

[8] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] A.M.A., *Guides* 3 (6th ed. 2009), section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[11] A.M.A., *Guides* 494-531 (6th ed. 2009).

ANALYSIS

OWCP accepted that appellant sustained an exacerbation of bilateral carpal tunnel syndrome. Appellant claimed a schedule award on February 27, 2014. In support of his claim, he provided reports from Dr. Runheim, an attending Board-certified neurologist. On January 8, 2014 appellant found 10 percent permanent impairment of each arm and, on May 1, 2014, 12 percent permanent impairment of each arm due to carpal tunnel syndrome.

As Dr. Runheim did not provide an impairment rating or calculation referring to specific elements of the A.M.A., *Guides*,[12] OWCP obtained a second opinion from Dr. Latimer, a Board-certified orthopedic surgeon. Dr. Latimer provided a September 10, 2014 impairment rating, based on a thorough clinical examination, the medical record and a statement of accepted facts, finding three percent permanent impairment of each upper extremity due to carpal tunnel syndrome. Referring to Table 15-23 of the sixth edition of the A.M.A., *Guides*,[13] he assessed a grade 2 GMFH, a grade 1 GMPE, and grade 2 GMCS for each arm. Applying the net adjustment formula, Dr. Latimer calculated a net modifier of +1, moving the default two percent impairment rating upward to three percent. Based on this opinion, OWCP issued schedule awards for three percent permanent impairment of each arm.

Appellant subsequently submitted a November 7, 2014 report of Dr. Runheim, finding nine percent permanent impairment of each hand. This report is also of diminished probative value. While Dr. Runheim referenced pages 448 to 450 of the A.M.A., *Guides*, he did not fully explain his calculation under these pages of the A.M.A., *Guides*.[14] Dr. Latimer reviewed this rating and additional electrodiagnostic studies, and opined that they did not establish that appellant sustained greater than three percent permanent impairment of each arm. Based on this, OWCP issued a July 23, 2015 decision, finding that appellant did not have any greater impairment.

Counsel requested reconsideration on May 9, 2016. He submitted an April 18, 2016 impairment rating performed by Mr. Blankenship, a physical therapist. However, as physical therapists are not considered physicians under FECA, their opinions are of no probative medical

[12] *See Shalanya Ellison*, 56 ECAB 150, 154 (2004) (an estimate of permanent impairment is irrelevant and of diminished probative value where it is not based on the A.M.A., *Guides*).

[13] *Supra* note 6.

[14] *See J.G.*, Docket No. 09-1128 (issued December 7, 2009) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

value unless reviewed or signed by a physician.[15] The report was not signed or reviewed by a physician. Therefore, OWCP denied modification by July 12, 2016 decision, as the April 18, 2016 impairment rating was not competent medical evidence.

The Board finds that Dr. Latimer's impairment rating of appellant's upper extremities, as reviewed by OWCP's medical adviser, is entitled to the weight of the medical evidence. Dr. Latimer properly applied the appropriate portions of the A.M.A., *Guides* to his detailed clinical findings. His opinion was based on a review of the medical record, and a statement of accepted facts. There is no probative medical evidence of record establishing a greater percentage of impairment. Therefore, OWCP's July 12, 2016 decision finding that appellant had not established that he sustained more than three percent permanent impairment of each upper extremity was proper under the facts and circumstances of this case.

On appeal, counsel contends that the April 18, 2016 impairment rating performed by a physical therapist, which was not signed or reviewed by a physician, should be considered of probative medical value in the case. He cites to the Board's holding in *C.C.*[16] *CC.* found that reliable findings made by a physical therapist could be considered medical evidence if reviewed and affirmed by a competent physician. However, in the present claim, the April 18, 2016 impairment rating was not signed or reviewed by a physician. Alternatively, counsel contends that, under its procedures,[17] OWCP should have submitted the April 18, 2016 evaluation to an OWCP medical adviser for review. The Board notes that OWCP procedures only contemplate that a file be referred to a medical adviser when germane medical evidence is obtained.[18] Here, as explained, a report from a nonphysician is not considered competent medical evidence.

Appellant may request a schedule award or increased schedule award at any time 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 he sustained more than three percent permanent impairment of the right upper extremity and three percent permanent impairment of the left upper extremity, for which he received schedule awards.

[15] 5 U.S.C. § 8102(2) of FECA provides that the term physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. *See also David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006) (lay individuals such as physician assistants, nurses and physical therapists are not competent to render a medical opinion under FECA).

[16] Docket No. 10-2204 (issued June 28, 2011).

[17] Counsel cited to Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6d (October 2004). However, Chapter 2.808 was revised in February 2013.

[18] Current OWCP procedures provide that, "after obtaining all necessary medical evidence, the file should be routed to the DMA for opinion concerning the nature and percentage of impairment." Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 12, 2016 is affirmed.

Issued: January 13, 2017
Washington, DC

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board