

ISSUE

The issue is whether appellant has established a permanent impairment of either upper extremity for purposes of a schedule award.

On appeal counsel contends that OWCP's medical adviser's opinion that appellant was entitled to a schedule award constituted competent medical evidence in support of appellant's schedule award claim.

FACTUAL HISTORY

On October 16, 1998 appellant, then a 42-year-old medical clerk typist, filed an occupational disease claim (Form CA-2) alleging that she suffered from severe carpal tunnel syndrome causally related to working on a computer for 12 years. On November 18, 1998 OWCP accepted her claim for right carpal tunnel syndrome. On December 6, 2005 appellant underwent an authorized right carpal tunnel release and right median nerve block. On August 24, 2005 OWCP accepted her claim for left carpal tunnel syndrome. On November 4, 2005 appellant underwent an authorized left carpal tunnel release and left median nerve block. OWCP paid compensation and medical benefits.

In an undated note received by OWCP on November 27, 2013, Dr. Mutaz A. Tabbaa, a Board-certified neurologist, indicated that appellant was evaluated in his office for her carpal tunnel syndrome in 2011 and again in October 2013, and that from a clinical standpoint she had reached maximum medical improvement with respect to her carpal tunnel syndrome.

On June 8, 2014 Keith L. Blankenship, a physical therapist, submitted a right carpal tunnel syndrome impairment evaluation. Utilizing Table 15-23 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009) (A.M.A., *Guides*), he first found a grade modifier of 2 for test findings based on electromyogram/nerve conduction velocity (EMG/NCV) findings and an examination consistent with visible atrophy of appellant's right thenar eminence compared to her left hand. Mr. Blankenship noted that he was assuming that her initial presurgery EMG/NCV qualified her for a motor conduction block.³ He found a history grade modifier of 2 based on constant low grade aching in her right thumb, pain with heavy use, mild numbness of her fingers, right hand weakness and greater discomfort at night. Mr. Blankenship found a physical findings grade modifier of 1, noting that appellant demonstrated right thenar atrophy, a mild retrograde pain radiation with a Tinel's and negative Phalen's, reverse Phalen's, and Durkan's tests, and reasonably normal strength of the right abductor pollicis brevis and opponens pollicis muscles by manual muscle testing. He found that the average of the 3 grade modifiers was 1.7 which rounded to a grade modifier of 2. Mr. Blankenship determined that appellant's average grade modifier of 2 placed her right carpal tunnel syndrome in grade 2 pursuant to Table 15-23 of the A.M.A., *Guides*, which resulted in five percent default upper extremity impairment.

Mr. Blankenship then proceeded to evaluate appellant's impairment due to her left carpal tunnel syndrome. He determined that the EMG/NCV studies demonstrated fewer findings than

³ See A.M.A., *Guides* 449, Table 15-13.

on the right hand, so he classified her with mild left carpal tunnel syndrome, which would qualify under test findings as a conduction delay on Table 15-13, which would indicate a grade modifier of 1. With regard to the history grade modifier, Mr. Blankenship reported that appellant noted similar symptoms as with her right hand, but not as severe, including constant low grade aching, pain with heavy use, and mild numbness of the tips of fingers, which would qualify for a history grade modifier of 2. With regard to physical findings, he found that appellant's left hand did not demonstrate any thenar atrophy, Tinel's, Phalen's, Durkan's, or reverse Phalen's. Mr. Blankenship noted very mild radiation to the left thumb, normal point discrimination in all digits, and normal strength of the abductor pollicis brevis and opponens pollicis muscles by manual testing. He concluded that these results qualified for a physical findings grade modifier of 1. The average of the three grade modifiers was 1.33 which he averaged to 1. Applying the upper extremity impairment for a grade modifier of 1 pursuant to Table 15-23 of the A.M.A., *Guides*, Mr. Blankenship determined that appellant had a left upper extremity impairment of two percent.

On January 14, 2015 appellant filed a claim for a schedule award (Form CA-7).

By memorandum dated January 20, 2015, OWCP asked its medical adviser to comment on appellant's request for schedule award impairment. Dr. James Dyer, a Board-certified orthopedic surgeon and OWCP medical adviser, indicated that he was in complete agreement with Dr. Tabbaa and the evaluation of Mr. Blankenship. He noted that pursuant to Table 15-23 of the A.M.A., *Guides*, the total grade modifiers of appellant's left carpal tunnel syndrome was 4 for an average of 1, and therefore, the default impairment was two percent of the left upper extremity. Dr. Dyer noted that for the right upper extremity, the grade modifiers totaled 5 for an average of 2, and that pursuant to Table 15-23, this yielded five percent impairment of the right upper extremity. He also noted that appellant had a left carpal tunnel release on October 4, 2005 and a right carpal tunnel release on December 6, 2005, and that both of these surgeries had good results, despite some postoperative low grade aching with heavy use and numbness and weakness.

By letter dated January 27, 2015, OWCP asked appellant to have Dr. Tabbaa review the reports of Mr. Blankenship and OWCP's medical adviser and state whether he concurred with their opinions. No reply was received.

By decision dated March 4, 2015, OWCP denied appellant's claim for a schedule award because the evidence failed to include a report demonstrating a measurable permanent impairment by a physician.

On March 10, 2014 appellant, through counsel, requested an oral hearing before an OWCP hearing representative. At the hearing held on October 5, 2015, counsel argued that although Mr. Blankenship was not a physician, OWCP's medical adviser, who was a physician, made it clear that he relied upon both Dr. Tabbaa and Mr. Blankenship's statements in reaching his conclusion on impairment.

By decision dated December 15, 2015, the hearing representative affirmed the denial of appellant's claim for a schedule award. He found that appellant's treating physician failed to indicate that appellant had reached maximum medical improvement. The hearing representative

also determined that appellant's treating physician failed to provide measurements, citations, and calculations evaluating appellant under the A.M.A., *Guides*.

LEGAL PRECEDENT

The schedule award provision of FECA⁴ and its implementing regulations⁵ 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. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to insure 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* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.⁶ The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.⁷

The sixth edition requires identifying the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).⁸ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).⁹

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the medical adviser providing rationale for the percentage of impairment specified.¹⁰

ANALYSIS

The Board finds that this case is not in posture for decision.

OWCP accepted appellant's claim for left and right carpal tunnel syndrome, and authorized bilateral carpal tunnel releases. Appellant filed a claim for a schedule award. OWCP denied the claim, and the hearing representative affirmed OWCP's decision. The hearing representative found that there was no medical evidence from appellant's treating physician relating that appellant reached maximum medical improvement on rating appellant's permanent

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404.

⁶ *Id.*

⁷ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

⁸ A.M.A., *Guides* 494-531.

⁹ *Id.* at 521.

¹⁰ See *supra* note 7 at Chapter 2.808.6(f) (February 2013).

impairment pursuant to the A.M.A., *Guides*.¹¹ The Board also notes that on November 27, 2013 Dr. Tabbaa, appellant's treating Board-certified neurologist, in a note received by OWCP on November 27, 2013 that appellant found that appellant had reached maximum medical improvement with regard to her carpal tunnel syndrome.

The Board finds that appellant submitted a comprehensive report wherein Mr. Blankenship, a physical therapist, applied Table 15-23 of the A.M.A., *Guides*, and determined that appellant had five percent impairment to her right upper extremity and two percent impairment to her left upper extremity due to her bilateral carpal tunnel syndrome. However, reports of physical therapists have no independent probative value as a physical therapist is not considered a physician as defined by FECA.¹² Therefore, the reports of appellant's physical therapist do not constitute relevant and pertinent medical evidence.¹³

OWCP attempted to obtain an opinion with regard to the degree of appellant's impairment from Dr. Tabbaa, appellant's treating physician, but no response was received.

OWCP referred appellant's case record, including Dr. Tabbaa's finding that appellant had reached maximum medical improvement and Mr. Blankenship's impairment rating, to OWCP's medical adviser. OWCP's medical adviser noted that he was in complete agreement with Dr. Tabbaa and Mr. Blankenship and concluded that under Table 15-23 of the A.M.A., *Guides*, appellant had two percent impairment of her left upper extremity and five percent impairment of the right upper extremity. He found the evidence sufficient to provide an impairment rating sufficient to establish that appellant reached maximum medical improvement. Pursuant to FECA's procedures, if an appellant does not provide an impairment evaluation from his/her physician when requested, and there is an indication of permanent impairment in the medical evidence of file, the claims examiner should refer the claim for a second opinion evaluation. The claims examiner may also refer the case to the district medical adviser prior to scheduling a second opinion examination to determine if the evidence in the file is sufficient for the district medical adviser to provide an impairment rating.¹⁴

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to

¹¹ The hearing representative noted that on November 13, 2013 appellant was examined by Dr. Douglas Hein, a second opinion orthopedist, who provided an opinion that appellant had no permanent impairment as a result of the accepted employment injuries. Initially, the Board notes that there is no opinion dated November 13, 2013 by Dr. Hein of record.

¹² 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. 5 U.S.C. § 8102(2); *J.G.*, Docket No. 15-251 (issued April 13, 2015); *A.C.*, Docket No. 08-1453 (issued November 18, 2008) (records from a physical therapist do not constitute competent medical opinion in support of causal relation, as physical therapists are not considered physicians as defined under FECA).

¹³ *A.L.*, Docket No. 15-1418 (issued October 8, 2015).

¹⁴ *Supra* note 7 at Chapter 2.808.6(d) (February 2013).

see that justice is done.¹⁵ Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.¹⁶ Because Dr. Tabbaa indicated that appellant had reached maximum medical improvement, and because OWCP's medical adviser determined the evidence was sufficient to provide an impairment rating. OWCP then had the responsibility to obtain an opinion from a second opinion physician with regard to appellant's impairment.

On remand, OWCP shall refer appellant to an appropriate specialist for a medical opinion on the degree of appellant's permanent impairment due to her bilateral carpal tunnel syndrome. After such further development of the case record as OWCP deems necessary, a *de novo* decision shall be issued.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the December 15, 2015 decision of the Office of Workers' Compensation Programs is set aside, and the case remanded for further action consistent with this opinion.

Issued: June 21, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

¹⁵ See *Richard E. Simpson*, 55 ECAB 490 (2004).

¹⁶ See *M.E.*, Docket No. 16-0770 (issued July 26, 2016).