United States Department of Labor
Employees' Compensation Appeals Board

M.P., Appellant	)	
and	)	**Docket No. 17-0150**
	)	**Issued: June 21, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Federal Way, WA, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 31, 2016 appellant filed a timely appeal from a June 23, 2016 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 established that she has more than five percent permanent impairment of the left upper extremity, for which she previously received a schedule award, and whether she is entitled to a schedule award for permanent impairment of her right upper extremity due to her accepted bilateral carpal tunnel syndrome.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On January 26, 2012 appellant, then a 63-year-old mail processing clerk, filed an occupational disease claim (Form CA-2) alleging that she sustained bilateral carpal tunnel syndrome as a result of repetitively sweeping mail and pulling trays in the performance of duty. The claim form did not indicate whether she stopped work. Appellant noted that she was last exposed to the conditions alleged to have caused her condition on January 27, 2012.[2]

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome.

A December 13, 2011 electromyogram (EMG) and nerve conduction velocity (NCV) study by Dr. Larry Lamb, Board-certified in physical medicine and rehabilitation, revealed mild bilateral carpal tunnel syndrome with the left more affected than the right.

Appellant underwent left carpal tunnel release surgery on April 10, 2012 and right carpal tunnel release surgery on May 8, 2012. She stopped work and filed claims for wage-loss compensation (Form CA-7) beginning April 9, 2012. OWCP paid disability benefits.

On October 19, 2012 appellant returned to part-time limited duty.

Appellant retired from federal service on February 20, 2013.

On October 8, 2013 appellant filed a schedule award claim (Form CA-7). No evidence was received by OWCP in support of her schedule award claim.

By letter dated October 11, 2013, OWCP requested that appellant provide a medical report from her treating physician with an opinion as to whether she had reached maximum medical improvement (MMI) and whether she had a permanent impairment pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). No additional evidence was received by OWCP.

OWCP denied appellant's schedule award claim in a decision dated January 22, 2014. It found that the medical evidence of record failed to establish a permanent impairment of the bilateral upper extremities as a result of her accepted bilateral carpal tunnel syndrome.

In a November 26, 2014 impairment rating report, Dr. Stephanie Walker Stoke, Board-certified in preventive and occupational medicine, related that she examined appellant for an impairment rating as required by OWCP. She noted that she reviewed minimal records in advance of appellant's examination. Upon physical examination of appellant's hands, Dr. Walker Stoke observed multiple deformities at the metacarpophalangeal joints (MCP), proximal interphalangeal (PIP) joints, and distal interphalangeal (DIP) joints of both hands. Range of motion of both wrists was full and Tinel's and Phalen's tests were positive bilaterally. Dr. Walker Stoke also reported some weakness with grip strength and pinch strength in both

[2] Appellant has a previously accepted traumatic injury claim (File No. xxxxxx228) for right radial styloid tenosynovitis and right shoulder disorder of bursae and tendons and was awarded a schedule award for 12 percent permanent impairment of the right upper extremity due to these conditions.

hands symmetrically. Examination of appellant's left elbow revealed tenderness to palpation over the left lateral epicondyle and full flexion and extension.

Dr. Walker Stoke diagnosed bilateral carpal tunnel syndrome and left lateral epicondylitis. She reported that according to the sixth edition of the A.M.A., *Guides,* Table 15-23 on page 449, appellant had a grade modifier of 1 for test findings of conduction delay, 2 for history of significant intermittent paresthesias of the bilateral hands, and 2 for physical findings of positive Tinel's and Phalen's tests bilaterally, which resulted in an average overall grade of 2. Dr. Walker Stoke noted a *Quick*DASH score of 66, which modified appellant's rating impairment to three percent upper extremity impairment in each hand. Utilizing Table 15-11 on page 420, she calculated that appellant had two percent whole person impairment, which equaled four percent whole person impairment using the Combined Values Chart on page 604. Dr. Walker Stoke further explained that using Table 15-4 on page 399 appellant fell into a class 1 for left lateral epicondylitis. She related a functional history grade modifier of 3 for her *Quick*DASH score of 70, grade modifier of 2 for moderate palpatory findings on examination, and no clinical studies grade modifiers. Dr. Walker Stoke calculated that using the net adjustment formula, appellant had an overall grade of E, which equaled seven percent upper extremity impairment. She indicated that this resulted in four percent whole person impairment, which resulted in eight percent whole person impairment using the Combined Values Chart on page 604.

Appellant received treatment from Dr. Eric Hofmeister, a Board-certified orthopedic hand surgeon. In a January 9, 2015 report, Dr. Hofmeister noted that appellant had worked for the employing establishment for years and was now retired. He related appellant's current complaints of residual numbness, pins and needles, and aching pain in her left elbow and bilateral hands. Dr. Hofmeister indicated that appellant completed a Pain Disability Questionnaire with a score of 165 and a *Quick*DASH score of 61. Upon physical examination, he observed no varus, valgus, or instability of appellant's right elbow. Dr. Hofmeister provided range of motion findings of appellant's right elbow and wrist. Carpal compression test and Phalen's test were nonprovocative and Tinel's test was mildly positive. Dr. Hofmeister also reported full extension and flexion of appellant's digits with no intrinsic or extrinsic tightness. He diagnosed bilateral carpal tunnel syndrome, administratively accepted as related to her occupational illness, and history of right lateral epicondylitis.

Dr. Hofmeister noted that appellant had reached maximum medical improvement (MMI) by her attending surgeon on February 7, 2013. He indicated that objective examination findings included no thenar atrophy or intrinsic wasting, normal two-point discrimination, and full range of motion of the wrists and digits. Dr. Hofmeister also reported a mild Tinel's at the bilateral carpal tunnels. He opined that using the sixth edition of the A.M.A., *Guides* appellant had no permanent impairment.

In an April 2, 2015 report, Dr. L. Jean Weaver, an OWCP medical adviser, indicated that appellant's claim was accepted for bilateral carpal tunnel syndrome. He noted that although appellant had also received treatment for left lateral epicondylitis, this condition was not accepted by OWCP. Dr. Weaver also pointed out that there were many considerable and unexplainable differences in the findings, examinations, and conclusions of Dr. Hofmeister and Dr. Walker Stoke. He indicated that even if it were possible to resolve the unexplainable

differences in the examinations, a permanent impairment assessment was not possible because appellant had previously received a schedule award for the right upper extremity rotator cuff tear. Dr. Weaver recommended that appellant be referred for an examination to clarify the inconsistences in the above reports, to address appellant's lateral epicondylitis, and to provide an impairment assessment of the right upper extremity that included all right upper extremity conditions.

OWCP referred appellant, along with a statement of accepted facts (SOAF) and the record, to Dr. Aleksandar Curcin, a Board-certified orthopedic surgeon, for a second opinion examination in order to determine whether appellant sustained left lateral epicondylitis as a result of her employment and to calculate whether appellant sustained any ratable impairment of her accepted conditions of bilateral carpal tunnel syndrome, right radial styloid tenosynovitis, and disorder of bursae and tendons in the right shoulder region.

In a November 10, 2015 report, Dr. Curcin indicated that appellant's current claim was accepted for bilateral carpal tunnel syndrome and her previous claim was accepted for right radial styloid tenosynovitis and disorder of bursae and tendons in the right shoulder region. He related appellant's current complaints of numbness and paresthesias in her fingers, pain in her shoulder with any amount of lifting or overhead work, and pain in the left elbow region. Dr. Curcin discussed the reviewed medical records. He noted that a December 13, 2011 electrodiagnostic testing report showed bilateral carpal tunnel syndrome, left somewhat more affected than right. Upon physical examination, Dr. Curcin observed some discomfort upon palpation over the acromioclavicular (AC) joint of appellant's right shoulder. He reported that impingement maneuvers immediately produced painful clunking of the shoulder, so no further impingement testing was performed. Examination of appellant's elbows revealed no erythema, swelling or deformity about the left elbow, and some minimal discomfort with palpation over the lateral epicondyle and extensor mass. Dr. Curcin indicated that examination of appellant's hands showed stigmata of osteoarthritis of her interphalangeal joints diffusely. Tinel's test was positive at both carpal tunnels. Two-point discrimination was normal.

In response to OWCP's questions, Dr. Curcin explained that based upon current examination appellant had no residuals of left lateral epicondylitis. He pointed out that examination showed symmetrical range of motion and no pain with resistance testing. Regarding permanent impairment, Dr. Curcin reported that appellant had reached MMI for all her accepted conditions as of the date of this second opinion examination. Utilizing the sixth edition of the A.M.A., *Guides* he opined that appellant had no permanent impairment from any of appellant's injuries. He pointed out that examination showed symmetrical range of motion of shoulders, elbows, wrists, and normal two-point discrimination.

In a February 10, 2016 report, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and OWCP medical adviser, noted the medical records he reviewed and related that appellant's claim was accepted for bilateral carpal tunnel syndrome. He indicated that he reviewed Dr. Curcin's November 10, 2015 report and disagreed with Dr. Curcin's impairment rating. Dr. Berman explained that Dr. Curcin did not take into account appellant's positive Tinel's sign bilaterally and positive EMG studies preoperatively. He pointed out that Dr. Curcin applied the incorrect criteria as he did not use Table 15-23. Dr. Berman related that according to Table 15-23, page 449, *Entrapment Compression Neuropathy Impairment* appellant had grade

modifier of 1 due to test findings of right and left conduction delay sensory and motor, grade modifier of 2 for a history of significant intermittent symptoms, and grade modifier of 2 for decreased sensation upon physical examination. He pointed out that appellant's two-point discrimination should be four and determined that with weakness present, appellant had a default rating of three. After applying the net adjustment formula, Dr. Berman calculated an adjustment of two, which resulted in five percent impairment. He concluded that appellant had five percent permanent impairment of each upper extremity due to her accepted bilateral carpal tunnel syndrome and had reached MMI on November 10, 2015, the date of Dr. Curcin's second opinion report.

By decision issued June 23, 2016, OWCP granted a schedule award for five percent permanent impairment of the left upper extremity, based on Dr. Berman's report. The award ran from November 10, 2015 to February 27, 2016. OWCP explained that although OWCP's medical adviser advised in his February 10, 2016 report that appellant had also 5 percent right upper extremity impairment, appellant did not receive this additional impairment because she had previously received a schedule award for 12 percent right upper extremity impairment under File No. xxxxxx228.

LEGAL PRECEDENT

A claimant seeking compensation under FECA has the burden of proof to establish the essential elements of his or her claim.[3] With respect to a schedule award, it is the claimant's burden of proof to establish a permanent impairment of the scheduled member as a result of his or her employment injury.[4] A claimant may seek an increased schedule award if the evidence establishes that he or she sustained an increased impairment causally related to an employment injury.[5] The medical evidence must include a detailed description of the permanent impairment.[6]

The schedule award provision of FECA[7] and its implementing regulations 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. 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 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

[3] *John W. Montoya,* 54 ECAB 306 (2003).

[4] *Edward Spohr,* 54 ECAB 806, 810 (2003); *Tammy L. Meehan,* 53 ECAB 229 (2001).

[5] *See Rose V. Ford,* 55 ECAB 449 (2004).

[6] *See Vanessa Young,* 55 ECAB 575 (2004).

[7] 5 U.S.C. § 8107.

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*, published in 2009.[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] In addressing impairment for the upper extremities, the sixth edition of the A.M.A., *Guides* requires identifying the impairment Class of Diagnosis (CDX) for the diagnosed condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[11] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[12]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[13] In Table 15-23, grade modifiers levels (ranging from zero to four) are described for the categories of 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 based on functional scale, an assessment of impact on daily living activities (*Quick*DASH).[14]

ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome in the performance of duty. Appellant also had previously accepted conditions of right radial styloid tenosynovitis and disorder of bursae and tendons of the right shoulder region under a separate claim, for which she had received a schedule award for 12 percent permanent impairment of the right upper extremity. She underwent left and right carpal tunnel release surgeries and stopped work. On October 8, 2013 appellant filed a claim for a schedule award due to her accepted bilateral carpal tunnel syndrome.

In support of her schedule award claim, appellant submitted a November 26, 2014 report by Dr. Walker Stoke. She provided physical examination findings and noted diagnoses of bilateral carpal tunnel syndrome and left lateral epicondylitis. Referring to Table 15-23 of the A.M.A., *Guides*, Dr. Walker Stoke determined that appellant had three percent impairment of

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

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

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

[11] A.M.A., *Guides* 385-419; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[12] *Id.* at 411.

[13] *Id.* at 449.

[14] *Id.* at 448-49.

each upper extremity due to her accepted bilateral carpal tunnel syndrome. She further calculated that according to Table 15-11, appellant had two percent whole person impairment, which equaled four percent whole person impairment using the Combined Values Chart on page 604. FECA, however, does not authorize schedule awards for permanent impairment of the whole person.[15] Dr. Walker Stoke also referenced Table 15-4 of the A.M.A., *Guides* and calculated that appellant had seven percent left upper extremity impairment due to left lateral epicondylitis. However, OWCP has not accepted a left elbow condition as being work related, and accordingly, it cannot grant a schedule award for an unaccepted condition.[16] The Board finds, therefore, that Dr. Walker Stoke's November 26, 2014 report does not support a finding that appellant has more than five percent bilateral permanent impairment of the upper extremities due to her accepted bilateral carpal tunnel syndrome.

OWCP referred appellant's claim to Dr. Curcin for a second opinion examination to determine whether appellant had permanent impairment for her accepted conditions. In a November 10, 2015 report, Dr. Curcin opined that physical examination findings, specifically appellant's symmetrical range of motion of both shoulders, wrists, elbows, and normal two-point discrimination, demonstrated that appellant had no ratable permanent impairment due to her accepted conditions.

In a February 10, 2016 report, Dr. Berman, an OWCP medical adviser, reviewed appellant's medical record, including Dr. Curcin's November 10, 2015 report, and disagreed with his findings. The Board has carefully reviewed the opinion of Dr. Berman and finds that his February 10, 2016 report was sufficiently well rationalized to establish that appellant had five percent impairment of each upper extremity. Dr. Berman's opinion was based on a proper factual and medical history, which he reviewed, and on the proper tables and procedures in the A.M.A., *Guides.* He properly referenced Table 15-23, page 449, for Entrapment/Compression Neuropathy Impairment based on the accepted condition of bilateral carpal tunnel syndrome and determined that appellant had a default rating of three due to weakness and four-point discrimination testing. Dr. Berman assigned grade modifiers of one due to test findings of right and left conduction delay sensory and motor; two for a history of significant intermittent symptoms; and two for decreased sensation upon physical examination. He applied the net adjustment formula for a net adjustment of two, which resulted in five percent permanent impairment of each upper extremity.

The Board finds that OWCP properly relied on the report of Dr. Berman to find that appellant did not establish more than five percent permanent impairment of the upper extremities due to her accepted bilateral carpal tunnel syndrome. Dr. Berman based his report on the medical evidence in the record, was based on an accurate application of the A.M.A., *Guides,* and provided medical rationale for his impairment rating. As appellant has not provided a rationalized medical opinion to dispute Dr. Berman's impairment rating or create a conflict in medical opinion, the Board finds that she has not established more than five percent permanent impairment of the bilateral upper extremities due to her accepted condition of bilateral carpal tunnel syndrome.

[15] *D.J.*, 59 ECAB 620 (2008); *N.D.*, 59 ECAB 344 (2008).

[16] *M.B.*, Docket No. 15-0230 (issued October 6, 2016).

On appeal appellant alleges that she is also entitled to a schedule award for her right wrist/arm carpal tunnel syndrome. The Board finds that the previous schedule award for permanent impairment of appellant's right upper extremity was granted for her accepted right shoulder condition, not her accepted carpal tunnel syndrome of the right wrist. OWCP regulations provide that an employee's schedule award benefits will be reduced by compensation paid under the schedule award for an earlier injury if the impairment is of the same body part or function or different parts of the same part or function; and compensation payable for the later impairment in whole or in part would duplicate the earlier payment.[17] It did not explain how appellant's previous award for permanent impairment of her right shoulder would be duplicated by an award for carpal tunnel syndrome.[18] As OWCP's district medical adviser found that appellant was entitled to a schedule award of five percent for each upper extremity due to the accepted condition of bilateral carpal tunnel syndrome, the Board finds that the previous award for permanent impairment of appellant's right shoulder would not duplicate the carpal tunnel award. Therefore the Board finds that appellant is entitled to an additional schedule award for five percent permanent impairment of the right upper extremity due to the accepted carpal tunnel condition.

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 the evidence of record establishes that appellant has five percent permanent impairment of her bilateral upper extremities due to the accepted condition of bilateral carpal tunnel syndrome.

[17] *See* 20 C.F.R. § 10.404(d)(1)(2).

[18] *See V.T.*, Docket No. 14-0296 (issued May 5, 2014).

ORDER

IT IS HEREBY ORDERED THAT the June 23, 2016 decision of the Office of Workers' Compensation Programs is affirmed in part and remanded in part for payment of an additional schedule award.

Issued: June 21, 2017
Washington, DC

Christopher J. Godfrey, 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