United States Department of Labor
Employees' Compensation Appeals Board

K.E., Appellant	)	
	)	**Docket No. 17-0863**
and	)	**Issued: October 5, 2017**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Springfield, IL, 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:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 10, 2017 appellant, through counsel, filed a timely appeal from a February 8, 2017 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 to consider the merits of the case.

ISSUE

The issue is whether appellant has met his burden of proof to establish an increased schedule award for his bilateral upper extremities.

[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.*

FACTUAL HISTORY

On September 17, 2010 appellant, then a 48-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that he developed bilateral carpal tunnel syndrome due to repetitive motion and heavy lifting at work. He retired on May 1, 2009.

Appellant underwent electromyogram (EMG) and nerve conduction velocity (NCV) studies on December 17, 2009 which demonstrated moderately-severe bilateral carpal tunnel syndrome. He underwent an authorized right carpal tunnel release on January 29, 2010 and left carpal tunnel release on March 5, 2010.

On December 1, 2010 OWCP accepted appellant's claim for bilateral carpal tunnel syndrome.

Appellant filed a schedule award claim (Form CA-7) on March 16, 2011. He underwent a right-hand magnetic resonance imaging (MRI) scan on November 12, 2010 which demonstrated mild degenerative osteoarthritis and no significant carpal tunnel abnormalities. A left-hand MRI scan on November 12, 2010 demonstrated a small ganglion cyst, tendinitis of the extensor tendon, and no significant carpal tunnel abnormalities.

In a letter dated March 23, 2011, OWCP requested medical evidence describing appellant's permanent impairment as a result of his accepted employment injuries. It afforded him 30 days for a response. Appellant requested a second opinion evaluation on April 2, 2011.

On May 10, 2011 OWCP referred appellant for a second opinion evaluation with Dr. Richard T. Katz, a Board-certified physiatrist. In a report dated May 23, 2011, Dr. Katz examined appellant and diagnosed bilateral carpal tunnel syndrome based on EMG/NCV studies. He reported that appellant had normal strength, normal two-point discrimination and normal range of motion. Dr. Katz opined that appellant had no evidence of impairment of his upper extremities based on carpal tunnel syndrome. He concluded that appellant had reached maximum medical improvement on May 5, 2010.

OWCP's medical adviser reviewed Dr. Katz' report on October 3, 2011 and agreed that given appellant's lack of complaints of numbness and tingling and his normal physical examination, there was no objective basis for a schedule award.

Dr. Edward Trudeau, a Board-certified physiatrist, examined appellant on September 29, 2012. Appellant reported burning pain at his scars, weaker grip, and pain in his fingers and thumbs following his carpal tunnel surgeries. Dr. Trudeau performed NCV studies which showed bilateral prolongations of the median motor and sensory latencies. He diagnosed moderately-severe bilateral carpal tunnel syndrome, greater on the right.

Dr. Theresa Hegge, a plastic surgeon, examined appellant on October 11, 2012 and diagnosed bilateral carpal tunnel syndrome. She recommended repeated surgeries. Appellant underwent a second right carpal tunnel release on January 22, 2013. He underwent a second left carpal tunnel release on March 12, 2013. OWCP authorized both surgeries.

Dr. Michael W. Neumeister, a Board-certified hand surgeon of professorial rank, examined appellant on July 15, 2013 and reviewed his history of injury. He noted that appellant had increased sensitivity at his incision on the left following surgery which was treated with Botox resulting in dramatic improvement. Dr. Neumeister found that appellant's grip strength was good bilaterally.

In a letter dated March 5, 2014, Dr. Neumeister opined that appellant had reached maximum medical improvement on July 15, 2013. He noted that appellant was "doing extremely well" on July 15, 2013.

Appellant filed a schedule award claim (Form CA-7) on June 24, 2014. In a letter dated July 28, 2014, OWCP requested additional medical evidence in support of his claim for employment-related permanent impairment.

In a report dated July 16, 2014, Dr. Neil Allen, a Board-certified neurologist, examined appellant and found that he had reached maximum medical improvement. He noted that appellant reported bilateral hand pain with intermittent numbness and tingling. Dr. Allen performed a physical examination and found that appellant had negative Phalen's test and Tinel's sign bilaterally. He reviewed appellant's clinical studies. Dr. Allen applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,*[3] (A.M.A., *Guides*) specifically the entrapment/compression neuropathy impairment table,[4] and found that appellant had nine percent bilateral upper extremity permanent impairment. He reported bilaterally: test findings, grade modifier 3 due to axon loss; history grade modifier 3 due to constant symptoms; and physical findings grade modifier 3 due to weakness. Dr. Allen also listed appellant's functional scale of grade modifier 3, severe due to a *Quick*DASH score of 64.

OWCP's medical adviser reviewed Dr. Allen's report on September 22, 2014 and disagreed with his impairment rating, finding Dr. Allen's rating was inconsistent with Dr. Neumeister's assessment of appellant's progress. The medical adviser determined that appellant had three percent permanent impairment of each arm due to his bilateral carpal tunnel syndrome.

By decision dated December 5, 2014, OWCP granted appellant schedule awards for three percent permanent impairment of each arm. Counsel requested an oral hearing from OWCP's Branch of Hearings and Review on December 11, 2014.

In a decision dated May 21, 2015, an OWCP hearing representative determined that the case was not in posture for a decision and remanded the case for additional development of the medical evidence, including referral to a second opinion physician for a determination of appellant's permanent impairment for schedule award purposes.

[3] 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); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[4] A.M.A., *Guides* 449, Table 15-23.

On July 9, 2015 OWCP referred appellant for a second opinion evaluation with Dr. James B. Stiehl, a Board-certified orthopedic surgeon. In his July 27, 2015 report, Dr. Stiehl reviewed appellant's history of injury and medical history. He noted that appellant continued to have chronic numbness in both hands, greater on the right. Appellant was capable of lifting and grabbing with both hands without difficulty. Dr. Stiehl determined that appellant's *Quick*DASH score was 68. Phalen's test was negative with moderate discomfort to palpation over the right transverse carpal ligament. Sensation was normal to two-point discrimination testing except for the right thumb. Semmes Weinstein test was normal in all fingers except the right thumb and index finger. Dr. Stiehl reported that grip strength and pinch were normal with no evidence of abductor pollicis atrophy. He reviewed appellant's EMG studies and found that these did not establish carpal tunnel syndrome on the left. Dr. Stiehl applied the A.M.A., *Guides* and found that under Table 15-23 appellant's left wrist was normal with normal physical findings. He noted, "I would state that the conflicting evidence of peripheral neuropathy aggravated by diabetes, hypothyroidism, and other issues in addition to the documented double crush syndrome negate the presence of chronic occupational left carpal tunnel syndrome. The impairment would be zero." Dr. Stiehl applied the A.M.A., *Guides* to appellant's right upper extremity and found a motor conduction block, grade modifier 2, based on the presence of fibrillation and positive waves in the abductor pollicis brevis muscle and evidence of conduction delays seen with motor and sensory latency studies. He found significant intermittent symptoms of the right hand and a demonstration of decreased sensation with both two-point discrimination and Semmes Weinstein test. Dr. Stiehl listed appellant's physical findings as grade modifier 1, functional score as grade modifier 3, and concluded that appellant had five percent permanent impairment of the right arm.

In an August 12, 2015 supplemental report, Dr. Stiehl found that, due to appellant's level 3 *Quick*DASH score of 68, appellant had six percent permanent impairment of the right arm.

Appellant underwent additional EMG/NCV studies on August 31, 2015. These electrodiagnostic studies showed prolonged distal latency in the left and right median motor nerves. These studies demonstrated severe right distal median neuropathy consistent with severe right carpal tunnel syndrome and milder left distal median neuropathy consistent with mild left carpal tunnel syndrome.

On October 10, 2015 OWCP requested an additional supplemental report from Dr. Stiehl and supplied him the report from OWCP's medical adviser. He responded on October 28, 2015 and opined that he had correctly applied the A.M.A., *Guides* in his July 27, and August 12, 2015 reports.

Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, and OWCP medical adviser, reviewed Dr. Stiehl's reports on January 4, 2016. He agreed with the impairment ratings of six percent permanent impairment of the right upper extremity and no ratable impairment of the left upper extremity.

Dr. Neumeister completed a note on March 29, 2016 and opined that it was unclear whether appellant's conditions of diabetes, hypothyroidism, and chronic obesity caused or aggravated his bilateral carpal tunnel syndrome.

In a decision dated April 28, 2016, OWCP found that appellant had six percent permanent impairment of his right arm and no ratable impairment of his left arm for which he had received schedule award compensation.[5] Counsel requested an oral hearing from this decision on May 9, 2016.

Appellant testified at the oral hearing before an OWCP hearing representative on December 22, 2016. Counsel contended that appellant's most recent electrodiagnostic studies supported Dr. Allen's report and requested that OWCP provide Dr. Stiehl with those studies.

By decision dated February 8, 2017, OWCP's hearing representative found that appellant had no more than six percent impairment of his bilateral upper extremities for which he had received schedule awards.

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing regulations[7] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for 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 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*.[8]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[9] In Table 15-23, grade modifier 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

[5] OWCP noted that appellant previously received a schedule award for three percent impairment of each arm. It advised that, as the current medical evidence supported six percent permanent impairment of the right arm and no impairment of the left arm, no additional payment was warranted. To the extent that OWCP purported to combine impairment for the right and left arm into an award for bilateral impairment, the Board notes that there is no provision for bilateral arm impairment under 5 U.S.C. § 8107. Each arm impairment is considered separately under FECA. *R.C.*, Docket No. 07-0254 (issued August 23, 2007); *Cf. Carl J. Cleary*, 57 ECAB 563 (2006) (each leg impairment is considered separately under FECA; there is no provision for bilateral leg impairment).

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *See supra* note 3.

[9] A.M.A., *Guides* 449, Table 15-23.

value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[10]

ANALYSIS

The Board finds this case not in posture for a decision.

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome and authorized repeated surgeries. Dr. Allen provided his findings and opined that appellant had nine percent impairment of each upper extremity under Table 15-23, page 449, of the A.M.A., *Guides*. The Board notes that applying the compression neuropathy rating process to his grade modifiers results in an average grade modifier of 3 which corresponds to a default upper extremity impairment of eight percent bilaterally.[11] The functional scale modifier of 64 is also grade modifier 3, such that the default value of eight percent is appropriate.

Dr. Stiehl, OWCP's second opinion physician, examined appellant and reviewed his diagnostic studies. He found that appellant's EMG/NCV studies dated September 29, 2012 did not establish carpal tunnel syndrome on the left. The A.M.A., *Guides* provide that the diagnosis of a neuropathy syndrome must be documented by sensory and motor nerve conduction studies or EMG to be ratable as impairment.[12] As did Dr. Stiehl did not find appellant's left carpal tunnel syndrome documented by NCV or EMG, he declined to rate this impairment in keeping with the A.M.A., *Guides*. Dr. Stiehl applied the A.M.A., *Guides* to appellant's right upper extremity and found a motor conduction block, test findings grade modifier 2, physical findings as grade modifier 1, functional scale as grade modifier 3, averaging these grade modifiers results in a final rating category of 2 with a default value of 5. Dr. Stiehl found that appellant had a *Quick*DASH score of 68, corresponding to a functional scale grade modifier of 3, which would increase appellant's impairment rating of the right upper extremity to six percent permanent impairment.

Both Dr. Allen and Dr. Stiehl provided impairment ratings under the A.M.A., *Guides*. Due to the disagreement between these physicians on the evaluation of whether appellant had EMG/NCV studies documenting left carpal tunnel syndrome and the variance in the grade modifiers, the Board finds that there is a conflict of medical opinion evidence requiring further development by OWCP. When there are opposing reports of virtually equal weight and rationale, the case will be referred to an impartial medical specialist pursuant to section 8123(a) of FECA which provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination and resolve the conflict of medical evidence.[13]

[10] A survey completed by a given claimant, known by the name *Quick*DASH, may be used to determine the functional scale score. A.M.A., *Guides* 448-49.

[11] A.M.A., *Guides*, 448-449.

[12] *Id.* at 445.

[13] 5 U.S.C. § 8123(a); *B.C.*, 58 ECAB 111 (2006); *M.S.*, 58 ECAB 328 (2007).

This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[14]

On remand OWCP should refer appellant, a statement of accepted facts, and a list of specific questions to an appropriate Board-certified physician to determine the extent and degree of any ratable permanent impairment of both upper extremities. After this and such other development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for a decision due to an unresolved conflict of medical opinion evidence.

ORDER

IT IS HEREBY ORDERED THAT the February 8, 2017 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this opinion of the Board.

Issued: October 5, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[14] *R.C.*, 58 ECAB 238 (2006).