United States Department of Labor
Employees' Compensation Appeals Board

S.S., Appellant	)	
and	)	**Docket No. 17-1361**
	)	**Issued: January 8, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Pittsburgh, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 2, 2017 appellant, through counsel, filed a timely appeal from a February 10, 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 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 more than five percent permanent impairment of his left upper extremity and three percent permanent impairment of his right upper extremity, for which he previously received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows:

On November 13, 2014 appellant, then a 56-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that he developed bilateral carpal tunnel syndrome due to factors of his federal employment. OWCP accepted the claim for bilateral carpal tunnel syndrome, tenosynovitis of the right hand and wrist, and synovitis and tenosynovitis of the left hand.

An electromyogram (EMG) and nerve conduction velocity (NCV) study performed on September 10, 2014 revealed moderately severe bilateral carpal tunnel syndrome especially on the right side. An October 22, 2014 EMG study revealed moderate bilateral carpal tunnel syndrome.

On April 23, 2015 appellant underwent authorized left carpal tunnel release and flexor tenosynovectomy and on June 25, 2015 he underwent authorized right carpal tunnel release and flexor tenosynovectomy.

In an impairment evaluation dated December 17, 2015, Dr. Michael Platto, a Board-certified physiatrist, measured range of motion of appellant's wrists and found decreased two-point discrimination of the left thumb, middle, and index fingers. Referencing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] he opined that appellant had three percent impairment due to tenosynovitis as a result of bilateral loss of wrist range of motion according to Table 15-32 on page 473. For the right side, using Table 15-23 on page 473, Dr. Platto applied a grade modifier of three due to test findings of axon loss, a grade modifier of one for normal physical findings with intermittent symptoms, and a grade modifier of one for physical examination, which rounded to a grade modifier of two. He found a grade modifier of zero based on a *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) score of 15.9. For the left side, Dr. Platto advised that he performed an NCV study due to appellant's complaints of continued numbness, which revealed axon loss with "decreased motor median amplitude of less than [five]" and a delay in median sensory peak latency, for a grade modifier of three for test results. He applied a grade modifier of one for a history of mild intermittent symptoms and a grade modifier of two for physical findings of decreased two-point discrimination, for an average grade modifier of two, or four percent

[3] Docket No. 16-1101 (issued November 4, 2016).

[4] A.M.A. *Guides* (6th ed. 2009).

impairment. Dr. Platto opined that appellant had three percent permanent impairment of each upper extremity due to tenosynovitis and four percent permanent impairment of each upper extremity due to carpal tunnel syndrome, for seven percent combined permanent impairment of each arm.

Appellant, on January 8, 2016, filed a claim for a schedule award (Form CA-7).

On January 20, 2016 OWCP referred appellant to Dr. Shaka Walker, a Board-certified orthopedic surgeon, for a second opinion examination regarding the extent of any permanent impairment due to the accepted work injury. In an impairment evaluation dated February 1, 2016, Dr. Walker reviewed his history of hand numbness and pain treated with carpal tunnel releases and flexor tenosynovectomies. On examination, he found no atrophy and a negative Tinel's sign and Phalen's test. Dr. Walker measured range of motion of the wrists and performed pinch and grip strength testing. He measured normal wrist motion, for a grade modifier of zero. Dr. Walker found no impairment due to tenosynovitis as a result of reduced motion. Referencing Table 15-23 on page 449 of the A.M.A., *Guides*, for the right side he found that EMG findings in the September 10, 2014 study showed axonal loss, for a grade three modifier. Dr. Walker applied a grade modifier of zero for functional history and physical examination. He declined to use the *Quick*DASH score due to reliability issues. Dr. Walker found an average modifier of one and a final right arm impairment rating of one percent. For the left wrist, he determined that a postoperative EMG showed median motor amplitude of less than five, or axonal loss, for a grade three modifier. Dr. Walker applied a grade two modifier for decreased sensation and a grade modifier of three for history. He found an average grade modifier of three and a resulting seven percent permanent impairment of the left arm.

An OWCP medical adviser reviewed the medical records on March 21, 2016. He advised that diagnostic testing performed September 10, 2014 did not show axonal loss and that grip and pinch strength were nonspecific findings. The medical adviser concurred with Dr. Walker's finding of no impairment due to tenosynovitis. Using Table 15-23, he applied a grade modifier of one bilaterally due to electrodiagnostic testing. The medical adviser further applied a grade modifier of zero on the right and two on the left for physical findings of loss of two-point discrimination of the left hand and a grade modifier of zero for history on the right and one on the left. He found that the functional history was not applicable because of the unreliable *Quick*DASH score. The medical adviser opined that appellant had two percent permanent impairment of each upper extremity due to carpal tunnel syndrome.

By decision dated March 23, 2016, OWCP granted appellant schedule awards for two percent permanent impairment of each upper extremity. The period of the award ran for 12.48 weeks from February 1 to April 28, 2016.

Appellant appealed to the Board. By decision dated November 4, 2016, the Board set aside the March 23, 2016 decision after finding a conflict in medical opinion between Dr. Platto and Dr. Walker regarding the extent of appellant's permanent impairment of the upper extremities. It remanded the case for OWCP to refer appellant to an impartial medical examiner for resolution of the conflict.

On December 17, 2016 OWCP referred appellant to Dr. Victoria Langa, a Board-certified orthopedic surgeon, for an impartial medical examination. In a report dated January 23, 2017, Dr. Langa reviewed the history of injury and the results of diagnostic testing. She discussed appellant's complaints of numbness and tingling intermittently more on the left side and loss of strength bilaterally. On examination, Dr. Langa found no tenderness of the wrist or hands and a negative Tinel's sign and Phalen's test bilaterally. She measured range of motion of the wrists as symmetrical bilaterally with 44 degrees of palmar-flexion, 55 degrees of dorsiflexion, 30 degrees of ulnar deviation, and 20 degrees of radical deviation. Dr. Langa found no crepitation, thenar atrophy, or weakness, normal two-point discrimination on the right and borderline two-point discrimination on the left, and full range of motion of the digits without triggering. She diagnosed status post left and right carpal tunnel releases with flexor tenosynovectomies and opined that appellant had reached maximum medical improvement. Dr. Langa found no evidence of residual digital flexor tenosynovitis and thus no impairment. She attributed appellant's minimal loss of motion at the wrists to early arthritis rather than carpal tunnel syndrome.

Referencing Table 15-23 on page 449 of the A.M.A., *Guides*, Dr. Langa found, for the right side, that he had a grade two modifier for preoperative test findings based on his motor conduction block, a grade one modifier for history due to mild intermittent symptoms, and a grade one modifier for physical findings of normal two-point discrimination and no atrophy or weakness, for a total of four. She divided the four by three as set forth on page 448 on the A.M.A., *Guides* to find a category one impairment, which she modified to three percent impairment based on the *Quick*DASH score of 50. For the left side, Dr. Langa applied a grade three modifier for test results showing axon loss, a grade modifier of one for history, and a grade modifier of two for altered sensation, which she added and divided by three to find category two impairment. She found no adjustment based on the *Quick*DASH score as the rating was already in category two, and concluded that appellant had five percent left upper extremity impairment.

In a report dated January 24, 2017, Dr. Platto provided findings on examination and determined that appellant had a *Quick*DASH score of 34. He concluded that appellant had three percent permanent impairment of each upper extremity due to tenosynovitis of the wrists, and four percent permanent impairment of each upper extremity for carpal tunnel syndrome, for a combined seven percent permanent impairment of each upper extremity.

By decision dated February 10, 2017, OWCP granted appellant a schedule award for an additional three percent left upper extremity permanent impairment and an additional one percent right upper extremity permanent impairment. It noted that he had previously received a schedule award for two percent permanent impairment of each upper extremity. The period of the award ran for 12.48 weeks from May 1 to July 27, 2016.

On appeal counsel contends that Dr. Langa did not adequately document her range of motion measurements, in contrast to the detailed findings by Dr. Platto. He notes that she attributed the motion loss to a condition other than carpal tunnel syndrome and asserts that preexisting and subsequently-acquired conditions are included in schedule awards. Counsel questions why Dr. Langa used the test results on the right side that were obtained prior to surgery and failed to rate the conditions of tenosynovitis and synovitis.

LEGAL PRECEDENT

The schedule award provisions of FECA,[5] and its implementing federal regulation,[6] 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. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

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).[9] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[10] In Table 15-23, grade modifier levels (ranging from zero to four) are described for the categories of test findings, history, and physical findings. The grade modifiers are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value.

When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[11]

ANALYSIS

On prior appeal, the Board found a conflict in medical opinion between Dr. Platto and Dr. Walker regarding the extent of appellant's permanent impairment of the upper extremities. On remand OWCP referred him to Dr. Langa, a Board-certified orthopedic surgeon, for an impartial medical examination.

---

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

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

[9] A.M.A., *Guides* 494-531.

[10] *Id.* at 449, Table 15-23.

[11] *David W. Pickett*, 54 ECAB 272 (2002); *Barry Neutuch*, 54 ECAB 313 (2003).

Where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical examiner for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[12] On January 23, 2017 Dr. Langa discussed the history of injury and considered the results of diagnostic testing. She found no wrist tenderness, crepitation, thenar atrophy, or weakness, a negative Tinel's sign and Phalen's test bilaterally, and no triggering or loss of motion of the digits. Dr. Langa measured minimal loss of wrist motion bilaterally with the loss of only five degrees of dorsiflexion, which she attributed to early arthritis. She found no evidence of tenosynovitis based on appellant's finger range of motion and lack of triggering, and thus no ratable impairment. Regarding impairment due to carpal tunnel syndrome, Dr. Langa applied the provisions Table 15-23 on page 449 of the A.M.A., *Guides*. For the right side, she applied a modifier of two due to a motor conduction block, a grade modifier of one for a history of mild intermittent symptoms and a grade modifier of one for physical findings of normal two-point discrimination with no atrophy or weakness, for a class one impairment and an impairment range of one to three percent. Dr. Langa found three percent right arm impairment based on appellant's *Quick*DASH score of 50. For the left side, she applied a grade modifier of three for test results showing axon loss, a grade modifier of one based on his history, and a grade modifier of two for physical findings of altered sensation, which yielded class 2 impairment under Table 15-23 and an impairment range of four to six percent. Dr. Langa found five percent permanent impairment due to the *Quick*DASH score of 50.

The Board has carefully reviewed Dr. Langa's report and finds that it is based on a proper factual background and supported by rationale. Dr. Langa further explained how her impairment rating comported with the standards of the sixth edition of the A.M.A., *Guides*. Consequently, her report is entitled to the special weight of the evidence as the impartial medical specialist and establishes that appellant has no more than five percent permanent impairment of the left upper extremity and three percent permanent impairment of the right upper extremity.[13]

In a report dated January 24, 2017, Dr. Platto opined that appellant had three percent permanent impairment of each upper extremity due to tenosynovitis of the wrists, and four percent permanent impairment of each upper extremity for carpal tunnel syndrome, for a combined seven percent permanent impairment of each upper extremity. He, however, was on one side of the conflict resolved by Dr. Langa. A medical report from a physician on one side of a conflict resolved by an impartial medical examiner is generally insufficient to overcome the special weight accorded the report of an impartial medical examiner or to create a new conflict.[14] Dr. Platto's report is thus insufficient to overcome the special weight accorded to Dr. Langa's opinion or to create a new conflict in medical opinion.[15]

[12] *See N.D.*, Docket No. 15-1392 (issued December 9, 2015); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[13] *See G.W.*, Docket No. 16-0525 (issued August 2, 2017).

[14] *See Jaja K. Asaramo*, 55 ECAB 200 (2004); *Michael Hughes*, 52 ECAB 387 (2001).

[15] *See K.R.*, Docket No. 16-0542 (issued December 21, 2016).

On appeal counsel asserts that Dr. Langa did not sufficiently describe her measurements for range of motion and attributed motion loss to a nonemployment-related condition. He maintains that preexisting and subsequently acquired conditions were included in calculating a schedule award. Dr. Langa, however, found minimal motion loss of the wrists, which she related to mild arthritis. She properly rated appellant's wrist impairment using the provisions of Table 15-23, applicable to rating entrapment/compression neuropathy, the accepted condition. The A.M.A., *Guides*, provide that entrapment neuropathy is determined using the standards set forth in section 15.4f, which includes Table 15-23, and that additional impairment is "not permitted for decreased grip strength, loss of motion, or pain."[16]

Counsel questions why Dr. Langa used the test results on the right side that were obtained prior to surgery and failed to rate the conditions of tenosynovitis and synovitis. Dr. Langa specifically found, however, no impairment due to tenosynovitis and provided appellant with a grade two modifier for his preoperative motor conduction block for test findings. As discussed, her report is detailed and reasoned and thus entitled to the special weight of the evidence.[17]

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 no more than five percent permanent impairment of his left upper extremity and three percent permanent impairment of his right upper extremity impairment, for which he received schedule awards.

[16] A.M.A., *Guides* 433.

[17] Furthermore, the A.M.A., *Guides*, advise that in most situations preoperative electrodiagnostic testing should be used in impairment ratings under Table 15-23. *Id.* at 448.

ORDER

IT IS HEREBY ORDERED THAT the February 10, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 8, 2018
Washington, DC

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

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

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