United States Department of Labor
Employees' Compensation Appeals Board

V.G., Appellant	)	
and	)	**Docket No. 17-1341**
	)	**Issued: July 16, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, 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.[3]

[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.*

[3] Appellant submitted new evidence with her appeal following the February 10, 2017 decision. However, the Board's jurisdiction is limited to the evidence that was before OWCP at the time it issued its final decision. Therefore, the Board is precluded from considering this evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c)(1); *Sandra D. Pruitt*, 57 ECAB 126 (2005).

ISSUE

The issue is whether appellant met her burden of proof to establish permanent impairment of a scheduled member due to her accepted right carpal tunnel syndrome.

FACTUAL HISTORY

This case has previously been before the Board.[4] The facts and circumstances of the case as presented in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On August 29, 2001 appellant, then a 51-year-old distribution clerk, filed an occupational disease claim (Form CA-2) alleging that she sustained a back injury as a result of heavy lifting, pushing, and pulling equipment, and repetitive motion. She noted that she first became aware of her claimed condition and its relationship to her federal employment on October 21, 1997.[5] Appellant did not stop work.

OWCP accepted appellant's claim for right carpal tunnel syndrome on December 10, 2001.[6]

Appellant continued to receive medical treatment.

By letter dated December 8, 2014, counsel indicated that he was submitting a July 1, 2014 report, updated December 5, 2014, by Dr. Nicholas Diamond, an osteopath specializing in family medicine, in support of appellant's request for a schedule award. He explained that he was in the process of submitting a claim for a schedule award (Form CA-7) through appellant's employing establishment.

On December 15, 2014 OWCP received a July 1, 2014 permanent impairment evaluation report from Dr. Diamond, who indicated that appellant suffered a work-related injury and described the medical treatment that she had received for various bilateral upper extremity conditions. Dr. Diamond noted that an August 17, 2010 electromyography (EMG) study of the bilateral upper extremities showed right brachial plexus level nerve compromise, moderate left ulnar nerve compromise at the medial elbow level, and mild right radial/posterior interosseous nerve compromise at the radial tunnel level. He related appellant's complaints of bilateral hand pain and stiffness on a daily and constant basis with occasional swelling, numbness, and tingling. Dr. Diamond noted a *Quick*DASH score of 68 percent involving the right upper extremity. He

[4] Docket No. 11-1556 (issued January 13, 2012).

[5] OWCP assigned the claim File No. xxxxxx692. The record reveals that appellant previously filed claims before OWCP. Under File No. xxxxxx106, OWCP accepted her claim for left foot contusion on November 6, 1999. Under File No. xxxxxx430, it accepted appellant's February 14, 2000 claim for a left foot injury. Under File No. xxxxxx245, OWCP accepted her July 19, 2000 claim for left carpal tunnel syndrome, left shoulder tendinitis, and cervical strain. These claims have not been administratively combined.

[6] Although appellant filed an occupational disease claim citing a back injury, she submitted various medical reports regarding medical treatment for left shoulder bursitis, left brachial plexopathy, left carpal and cubital tunnel syndrome, right carpal tunnel syndrome, cervicothoracic strain, and lumbar pain.

provided physical examination findings pertaining to appellant's cervical spine, right elbow, bilateral shoulders, and bilateral ankles and feet.

Dr. Diamond conducted an examination of appellant's right wrist, which revealed palmar and dorsal tenderness. He reported positive Tinel's, Phalen's, and carpal compression tests. Range of motion demonstrated dorsiflexion of 0 to 50/745 degrees, palmar-flexion of 0 to 55/75 degrees, radial deviation of 0 to 10/20 degrees, and ulnar deviation of 0 to 20/35 degrees. Dr. Diamond indicated that sensory examination of the bilateral upper extremities showed decreased sensation over the median and radial aspects of both the left and right. Deep tendon reflexes were +2. Dr. Diamond diagnosed cumulative and repetitive trauma disorder, bilateral brachial plexopathy, left greater than right, EMG positive, left median and ulnar nerve neuropathy, bilateral radial tunnel syndrome, left greater than right, acromioclavicular (AC) arthropathy with impingement to the left shoulder and chronic supraspinatus tendinitis to the left shoulder, cumulative and repetitive trauma disorder with diffuse degenerative joint disease of the metatarsal phalangeal joints, and left foot and bilateral tarsal tunnel syndrome, EMG/nerve conduction velocity (NCV) positive, 2002. He opined that the work-related injury sustained by appellant was the competent producing factor for appellant's subjective and objective findings upon examination.

Dr. Diamond noted a date of maximum medical improvement of July 1, 2014 and provided impairment calculations under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[7] With regard to appellant's left shoulder condition, he determined that she had a total of 19 percent left upper extremity permanent impairment due to range of motion deficit, sensory deficit of the left brachial plexus, and entrapment neuropathy of the left ulnar nerve at the elbow. Regarding appellant's right upper extremity, Dr. Diamond reported that appellant had 13 percent permanent impairment under Table 15-7 for sensory deficit of the right brachial plexus, 7 percent permanent impairment under Table 15-34 for range of motion deficit of the right shoulder, and 1 percent permanent impairment under Table 15-21 for class 1 sensory deficit of the right radial nerve below the elbow for a combined total of 20 percent right upper extremity permanent impairment.

In a June 2, 2015 report, Dr. Arnold Berman, a Board-certified orthopedic surgeon and OWCP medical adviser, noted appellant's accepted condition for right carpal tunnel syndrome under the present claim and previously accepted conditions of left foot injury, left carpal tunnel syndrome, neck sprain, left shoulder injury, and left foot contusion. He related that Dr. Diamond had opined in a July 1, 2014 report that appellant had a final combined right upper extremity impairment of 20 percent permanent impairment, but he indicated that Dr. Diamond's report was not provided in the medical records. Dr. Berman opined that Dr. Diamond's opinion did not carry the weight of medical evidence because he was not an orthopedic surgeon and his conclusions and recommendations for a schedule award were not consistent with medical science. He noted specifically that none of the EMG studies dated October 7, 2006, July 19, 2007, or August 7, 2013 demonstrated median nerve compression or carpal tunnel syndrome. Dr. Berman related that the medical evidence of record demonstrated that appellant no longer had right wrist symptoms or diagnoses related to her work injury. He opined that, according to Table 15-23 of the A.M.A., *Guides,* appellant had grade modifier of zero for normal test findings, normal physical examination

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

findings, and negative history of carpal tunnel syndrome. Dr. Berman concluded that appellant had zero percent permanent impairment of her right upper extremity and zero percent permanent impairment of her left upper extremity due to her accepted right carpal tunnel syndrome.

On November 6, 2015 appellant filed a claim for a schedule award (Form CA-7).

By letter dated November 23, 2015, OWCP advised appellant that the evidence submitted was insufficient to establish her schedule award claim. It noted that an OWCP medical adviser had reviewed Dr. Diamond's July 1, 2014 permanent impairment rating report and disagreed with his findings. OWCP requested that appellant provide a medical report from her treating physician with an opinion on whether she had reached maximum medical improvement (MMI) and whether, based on a recent examination, she had permanent impairment of a scheduled member utilizing the A.M.A., *Guides*. Appellant was afforded 30 days to submit additional evidence.

In a letter dated December 4, 2015, counsel informed OWCP that Dr. Diamond could not comment on the medical adviser's report as he had not been provided a copy of the report. He requested a copy of the report and an additional 30-day period to submit additional medical evidence.

OWCP denied appellant's schedule award claim by decision dated March 10, 2016. It found that the medical evidence of record failed to establish permanent impairment of a scheduled member as a result of her accepted right carpal tunnel syndrome.

On March 21, 2016 appellant, through counsel, requested a hearing before an OWCP hearing representative. By letter dated July 7, 2016, counsel requested a review of the written record in lieu of a hearing.

In a July 11, 2016 report, Dr. Scott M. Fried, a hand surgeon and appellant's treating physician, related appellant's complaints of worsening right upper extremity pain due to continued gripping, grasping, and pinching activities at work. He reviewed appellant's history and conducted an examination. Dr. Fried reported tenderness of the bilateral wrists and pain in the right wrist with Phalen's testing. He noted positive Tinel's testing of the median nerve at the bilateral wrists and tenderness down through the bilateral radial tunnel. Dr. Fried diagnosed left shoulder capsulitis, bilateral radial neuropathy, bilateral brachial plexopathy, and bilateral carpal tunnel syndrome. He recommended updated EMG/NCV studies to evaluate appellant's continued and significant nerve symptoms.

By decision dated August 8, 2016, an OWCP hearing representative affirmed the March 10, 2016 schedule award decision. He found that appellant had not submitted probative medical evidence to rebut the June 2, 2015 report of Dr. Berman, an OWCP medical adviser, who determined that appellant had no permanent impairment causally related to her accepted right carpal tunnel syndrome.

On November 14, 2016 appellant, through counsel, requested reconsideration. Counsel indicated that appellant was submitting an August 10, 2016 EMG/NCV study report in support of the reconsideration request. He argued that the testing clearly showed that appellant still suffered

from right-sided carpal tunnel syndrome and asserted that she had established permanent impairment warranting a schedule award.

Appellant submitted an August 10, 2016 EMG/NCV study by Richard Read, a physical therapist. Mr. Read noted mild, bilateral median nerve motor component impairments at the wrist levels, right slightly more compromised than the left, moderate, left ulnar nerve impairment, and mild, sensory component of the left lower brachial plexus. He concluded that the examination results showed abnormal test results.

In a January 13, 2017 report, Dr. Diamond indicated that he had reviewed Dr. Berman's June 2, 2015 report and the August 10, 2016 EMG/NCV study. He noted his disagreement with Dr. Berman that appellant had no symptoms of carpal tunnel syndrome and indicated that appellant's accepted conditions included bilateral carpal tunnel syndrome. Dr. Diamond related that his July 1, 2014 examination showed positive Tinel's sign and carpal compression in appellant's bilateral wrists. He also reported that the August 10, 2016 EMG/NCV study revealed bilateral median nerve impairment at the wrists. Dr. Diamond determined that, according to Table 15-23, page 449 of the A.M.A., *Guides*, appellant had six percent left upper extremity permanent impairment due to left wrist median nerve entrapment neuropathy and seven percent left upper extremity impairment due to deficit of left shoulder range of motion, for a final combined total of 13 percent permanent impairment of the left upper extremity. He further opined that, according to Table 15-23, page 449 of the A.M.A., *Guides*, appellant had six percent permanent impairment of the right upper extremity due to right wrist median nerve entrapment neuropathy. By decision dated February 10, 2017, OWCP denied modification of its August 8, 2016 decision. It found that Dr. Diamond's January 13, 2017 report was of insufficient probative value to establish that appellant had permanent impairment of a scheduled member causally related to her work-related right carpal tunnel syndrome.

LEGAL PRECEDENT

A claimant seeking compensation under FECA[8] has the burden of proof to establish the essential elements of his or her claim.[9] With respect to a schedule award, it is the claimant's burden of proof to establish permanent impairment of the scheduled member as a result of his or her employment injury.[10] A claimant may seek an increased schedule award if the evidence establishes that he or she sustained an increased permanent impairment causally related to an employment injury.[11] The medical evidence must include a detailed description of the permanent impairment.[12]

[8] *Supra* note 2.

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

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

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

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

The schedule award provisions of FECA[13] and its implementing regulations[14] 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 the Board has concurred in such adoption.[15] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[16]

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).[17] 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).[18] The net adjustment formula is (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX).[19]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[20] 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).[21]

Section 8123(a) of FECA provides that if there is a disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appointment a third physician

[13] 5 U.S.C. § 8107.

[14] 20 C.F.R. § 10.404

[15] *Id.*; *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[16] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.806.6.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); A.M.A., *Guides* (6th ed. 2009).

[17] A.M.A., *Guides*, Chapter 1, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement (6th ed. 2009).

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

[19] *Id.* at 411.

[20] *Id.* at 449.

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

(known as a referee physician or impartial medical specialist) who shall make an examination.[22] 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.[23] For a conflict to arise, the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[24] Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well reasoned and based upon a proper factual background, must be given special weight.[25]

ANALYSIS

OWCP accepted that appellant sustained right carpal tunnel syndrome due to factors of her federal employment. On November 6, 2015 appellant, through counsel, filed a claim for a schedule award. In a July 1, 2014 report, Dr. Diamond determined that, under the A.M.A., *Guides*, appellant had a total of 19 percent permanent impairment of her left upper extremity and 20 percent permanent impairment of her right upper extremity due to her accepted right carpal tunnel syndrome. In a June 2, 2015 report, Dr. Berman, an OWCP medical adviser, contended that Dr. Diamond could not carry the weight of the medical evidence because he was not an orthopedic surgeon, and that appellant had no permanent impairment of her right or left upper extremities causally related to the accepted right carpal tunnel syndrome. OWCP denied appellant's schedule award claim based on Dr. Berman's June 2, 2015 report. Appellant, through counsel, requested reconsideration, and submitted evidence of greater impairment. In a January 13, 2017 report, Dr. Diamond disagreed with Dr. Berman's impairment rating and opined that appellant had 13 percent permanent impairment of her left upper extremity and 6 percent permanent impairment of the right upper extremity.

The Board finds that this case is not in posture for decision as there remains an unresolved conflict in medical opinion regarding whether appellant has a permanent impairment for purposes of a schedule award.

In his July 1, 2014 impairment rating report, Dr. Diamond related that examination findings of appellant's right wrist revealed palmar and dorsal tenderness. He reported positive Tinel's, Phalen's, and carpal compression tests. Range of motion demonstrated dorsiflexion of 0 to 50/745 degrees, palmar-flexion of 0 to 55/75 degrees, radial deviation of 0 to 10/20 degrees, and ulnar deviation of 0 to 20/35 degrees. Dr. Diamond noted that an August 17, 2010 EMG study of the bilateral upper extremities showed right brachial plexus level nerve compromise, moderate left ulnar nerve compromise at the medial elbow level, and mild right radial/posterior interosseous nerve compromise at the radial tunnel level. He provided physical examination findings and noted a date of MMI of July 1, 2014. Dr. Diamond referenced Table 15-7, Table 15-34, and Table 15-

[22] 5 U.S.C. § 8123(a); 20 C.F.R. § 10.321(b). *See R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009) (the district medical adviser (DMA), acting on behalf of OWCP, may create a conflict in medical opinion).

[23] 20 C.F.R. § 10.321.

[24] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[25] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

21 of the A.M.A., *Guides*, and opined that appellant had a total of 20 percent right upper extremity permanent impairment due to sensory deficit of the right brachial plexus, range of motion deficit of the right shoulder, and sensory deficit of the right radial nerve below the elbow.

OWCP referred Dr. Diamond's July 1, 2014 report to Dr. Berman, an OWCP medical adviser, who disagreed with Dr. Diamond's impairment rating. Dr. Berman explained that none of the EMG/NCV studies in the record showed medial nerve compression or carpal tunnel syndrome. He further noted that the medical evidence of record also indicated that appellant no longer had right wrist symptoms or diagnoses related to her work injury. Accordingly, Dr. Berman concluded that appellant had no permanent impairment of the right upper extremity.

In an updated January 13, 2017 report, Dr. Diamond indicated that he had reviewed Dr. Berman's June 2, 2015 report and a recent August 10, 2016 abnormal EMG/NCV study. He opined that, according to Table-23, appellant had six percent right upper extremity impairment due to her accepted right carpal tunnel syndrome.

The Board, therefore, finds that there remains an unresolved conflict in the medical evidence between Dr. Diamond, appellant's treating physician, and Dr. Berman, OWCP's medical adviser, regarding whether appellant has established permanent impairment of her right upper extremity as a result of her accepted right carpal tunnel syndrome. As noted above, if there is disagreement between an employee's physician and OWCP's referral physician, OWCP shall appoint a referee physician or impartial medical specialist who shall make an examination.[26] As there is an unresolved conflict in the medical evidence regarding whether appellant has established permanent impairment of her right upper extremity as a result of her accepted right carpal tunnel syndrome, the case must be remanded to OWCP for referral to an impartial medical specialist for resolution of the conflict in the medical opinion evidence in accordance with 5 U.S.C. § 8123(a).[27] After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

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

[26] *Supra* note 20.

[27] *See G.W.*, Docket No. 17-0957 (issued June 19, 2017).

ORDER

IT IS HEREBY ORDERED THAT the February 10, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision of the Board.

Issued: July 16, 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