United States Department of Labor
Employees' Compensation Appeals Board

E.H., Appellant	)	
	)	
and	)	**Docket No. 17-1843**
	)	**Issued: July 24, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Indianapolis, IN, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 29, 2017 appellant, through counsel, filed a timely appeal from a June 16, 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 the claim.[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] The record provided to the Board includes evidence received after OWCP issued its June 16, 2017 decision. The Board's jurisdiction is limited to the evidence that was before OWCP at the time of its final decision. Therefore, the Board is precluded from reviewing this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

ISSUE

The issue is whether appellant met his burden of proof to establish greater than two percent permanent impairment of the right upper extremity and greater than two percent permanent impairment of the left upper extremity, for which he previously received a scheduled award.

FACTUAL HISTORY

On June 9, 1992 appellant, then a 39-year-old machine clerk, filed an occupational disease claim (Form CA-2) alleging that he developed bilateral carpal tunnel syndrome due to repetitive motion of keying and lifting trays while at work. He did not stop work. OWCP accepted appellant's claim for bilateral carpal tunnel syndrome.[4] Appellant underwent an accepted right carpal tunnel release on June 8, 1993.[5]

Appellant filed a schedule award claim (Form CA-7) on March 7, 2016. In a December 16, 2015 report, Dr. Daniel Overcast, a Board-certified internist, indicated that appellant had reached maximum medical improvement (MMI).

By development letter dated March 9, 2016, OWCP informed appellant that additional medical evidence was necessary to establish his schedule award claim. It requested medical evidence describing appellant's permanent impairment as a result of his accepted employment injuries, whether MMI had been reached, and an impairment rating according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[6] OWCP afforded appellant 30 days to submit the necessary evidence.

In a March 4, 2016 report, Dr. Martin Fritzhand, a specialist in occupational medicine, noted appellant's history of injury and that his musculoskeletal distress had persisted over the years. He reported diminished range of motion (ROM) of appellant's wrists and diminished muscle strength over the palmar flexors of the right wrist. Both hands had sensory loss and reduced grasp strength bilaterally. Dr. Fritzhand noted that appellant continued to work, but had pain and discomfort involving his hands which were exacerbated by his job requirements. Appellant also found it difficult to perform various household chores and noted musculoskeletal complaints involving his hands when performing various activities.

Dr. Fritzhand opined that appellant had reached MMI on December 16, 2015. Under Table 15-23 of the A.M.A., *Guides*, he opined that appellant had six percent permanent impairment of the right upper extremity and six percent permanent impairment of the left upper extremity. For both hands, Dr. Fritzhand indicated that the grade modifiers for test findings were 1; history were 3; and for physical findings were 3. He added the grade modifiers (7) and divided by 3 to find the appropriate overall grade modifier level of 2, which indicated the default rating value of 5. Due to appellant's level 3 *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) score of 68,

[4] Appellant underwent electromyogram (EMG) and nerve conduction velocity (NCV) studies on April 8, 1992 which demonstrated the existence of bilateral carpal tunnel syndrome.

[5] Dr. William B. Kleinman, a Board-certified orthopedic surgeon, performed right carpal tunnel release.

[6] (6th ed. 2009).

Dr. Fritzhand found that appellant had the final six percent impairment rating of both upper extremities. A copy of the *Quick*DASH questionnaire was provided.

Dr. Morley Slutsky, a Board-certified occupational medicine specialist and OWCP medical adviser, reviewed Dr. Fritzhand's report on April 25, 2016. He opined that appellant achieved MMI on March 4, 2016, the date of Dr. Fritzhand's impairment evaluation. Dr. Slutsky calculated appellant's right upper extremity permanent impairment as two percent and also his left upper extremity permanent impairment as two percent.

Dr. Slutsky noted that both he and Dr. Fritzhand had rated impairment for the diagnosis of bilateral carpal tunnel syndrome as the EMG/NCV testing met the A.M.A., *Guides* criteria to rate both median nerves at the wrists under the compression neuropathy Table 15-23. Regarding the testing grade criteria, he concurred with Dr. Fritzhand's modifier of 1. However, Dr. Slutsky disagreed with the history and physical examination grade modifiers, finding that each modifier should be 1. For the history grade modifier, he indicated that there was no documentation that appellant was unable to perform at least one activity of daily living (ADL) and that someone consistently did the activity for him. Dr. Slutsky further stated that constant symptoms meant that pain or numbness was constantly present and that a conduction block or axon loss must be present on electrodiagnostic testing to substantiate the symptom severity. In support of his opinion, he referenced page 433 of the A.M.A., *Guides*.

In support of a physical examination modifier of 1, Dr. Slutsky indicated that the two-point discrimination test was not performed and grip strength was nonspecific as more than one nerve was involved. He disagreed that flattening of the thenar and hypothenar areas constituted atrophy related to peripheral nerve compression. Dr. Slutsky also noted that weakness in all of the tendons involved in palmar flexion may be due to the median nerve, but it depended on which palmar tendons were involved. In support of his opinion, he referenced page 446 of the A.M.A., *Guides*.

Dr. Slutsky also found that the *Quick*DASH score showing severe findings was unreliable because the testing may be influenced by other diagnoses. He referenced page 445 of the A.M.A., *Guides* in support of his opinion. Dr. Slutsky averaged the three grade modifiers and found that the appropriate overall grade modifier of 1 had a default upper extremity impairment value of two percent. As the functional scale was unreliable, he concluded that the final bilateral upper extremity impairment equaled two percent.

By decision dated September 27, 2016, OWCP granted appellant a schedule award for two percent permanent impairment of each upper extremity due to his bilateral carpal tunnel syndrome. The weight of the medical evidence was accorded to Dr. Slutsky, the medical adviser.

On October 6, 2016 counsel requested an oral hearing before an OWCP hearing representative. A telephonic hearing was held on April 25, 2017. Counsel contended that Dr. Slutsky's report was unreliable and that all of his upper extremity impairment ratings were inherently suspicious because of findings in Board decisions. He cited to *T.H.*, Docket No. 14-0943 (issued November 25, 2016) to support his argument that the Board had found Dr. Slutsky's upper extremity impairment ratings to be unreliable because he used an outdated version of the A.M.A., *Guides* and that he might have done so again in this case. Counsel argued that Dr. Slutsky had a pattern of reducing impairment ratings and that in this case the disagreement was with regard

to examination findings. He contended that Dr. Slutsky's opinion was unreliable as he did not perform a physical examination. Counsel cited to *J.R.*, Docket No. 15-1847 (issued March 4, 2015), in support of his argument that Dr. Slutsky used stale evidence instead of more recent examination findings.

Following the hearing, the record was held open for 30 days to allow for the submission of additional evidence. No further evidence was received.

By decision dated June 16, 2017, an OWCP hearing representative affirmed the September 27, 2016 decision. The hearing representative noted that appellant had not presented any medical rebuttal evidence and determined that it was proper for OWCP to find that the medical adviser's report constituted the weight of the medical opinion evidence.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and its implementing regulations[8] 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*.[9]

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 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 value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[11]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] 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).

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

[11] 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.

of impairment in accordance with the A.M.A., *Guides* with the medical adviser providing rationale for the percentage of impairment specified.[12]

ANALYSIS

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome and authorized a right carpal tunnel release surgery, which appellant underwent. It subsequently issued appellant a schedule award for two percent permanent impairment of the right upper extremity and two percent permanent impairment of the left upper extremity.

Both Dr. Fritzhand and the medical adviser used the compression neuropathy Table 15-23, based on the diagnosis of bilateral carpal tunnel syndrome to rate appellant's impairment. While Dr. Fritzhand opined appellant had six percent bilateral upper extremity permanent impairment, the medical adviser rated appellant's impairment as two percent permanent bilateral upper extremity impairment. Regarding the testing grade criteria, the medical adviser concurred with Dr. Fritzhand's modifier of 1. However, he disagreed with the history and physical examination modifiers, finding that each modifier was properly only a 1. The medical adviser opined that Dr. Fritzhand incorrectly applied the A.M.A., *Guides* as he used history and physical examination modifiers for more severe impairments without supporting medical documentation. He properly cited to various sections of the A.M.A., *Guides* to support his opinion and provided rationale for his modifier choices.

For the history grade modifier, the medical adviser indicated that there was no documentation that appellant was unable to perform at least one ADL and that someone else consistently performed the activity for him. He correctly referenced page 433 of the A.M.A., *Guides* which sets forth how an examiner would validate the stated inability to do at least one ADL.

For the physical examination modifier, the medical adviser cited to page 446 of the A.M.A., *Guides.* He noted that the two-point discrimination test had not been performed and grip strength was nonspecific as more than one nerve was involved. The medical adviser also disagreed that flattening of the thenar and hypothenar areas constituted atrophy related to peripheral nerve compression.

The medical adviser also found that the *Quick*DASH score showing severe findings was unreliable because the testing may be influenced by other diagnoses. He supported his opinion by referencing page 445 of the A.M.A., *Guides*, a paragraph entitled "Functional Score."

The medical adviser averaged the three grade modifiers (3 divided by 3 equaled 1) and found that the appropriate overall grade modifier of 1 had a default upper extremity impairment value of two percent. As the functional scale was unreliable, he properly concluded that the final bilateral upper extremity impairment equaled two percent.

[12] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (March 2017).

The Board finds that OWCP's medical adviser properly utilized the A.M.A., *Guides* and his rating represents the weight of the medical opinion evidence. The medical adviser explained his impairment rating calculations with citations to the A.M.A., *Guides,* and explained why his rating of two percent bilateral upper extremity permanent impairment differed from the rating of Dr. Fritzhand.[13] Appellant has not submitted any additional medical evidence indicating that he currently has a greater impairment under the A.M.A., *Guides.* There is also no evidence to refute the medical adviser's application of the A.M.A., *Guides.*

On appeal counsel again questioned OWCP's reliance on the medical adviser's opinion, arguing that the hearing representative ignored the case of *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

In *T.H.*, the Board concluded that OWCP physicians were at odds over the proper methodology for rating upper extremity impairment and district medical advisers used both diagnosis-based impairment (DBI) and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board observed that physicians had interchangeably cited to language in the first printing or the second printing when justifying use of either ROM or DBI methodology.[14] However, this case is distinguishable from *T.H.* as neither Dr. Fritzhand nor the medical adviser based impairment on ROM methodology. Carpal tunnel syndrome is properly rated under Table 23 for entrapment/compression neuropathy, not based upon ROM.[15]

Contrary to counsel's argument, there is also no evidence that the medical adviser may have relied on a prior version of the A.M.A., *Guides* in this case. The burden rests with appellant to demonstrate her entitlement to a schedule award.[16]

Therefore, the Board finds that appellant has no more than two percent permanent impairment of his right upper extremity and no more than two percent permanent impairment of his left upper extremity, for which he previously received schedule awards.

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

Appellant has not established that he has greater than two percent permanent impairment of the right upper extremity and greater than two percent permanent impairment of the left upper extremity, for which he previously received a schedule award.

[13] *See M.M.*, Docket No. 16-0388 (issued April 18, 2016).

[14] *T.H.*, Docket No. 14-0943 (issued November 25, 2016); *see* FECA Bulletin No. 17-06 (issued May 8, 2017).

[15] *Supra* note 9; *see M.C.*, Docket No. 16-1645 (issued May 3, 2018).

[16] *See Veronica Williams*, 56 ECAB 367, 370 (2005), *Tammy L. Meehan*, 53 ECAB 229 (2001).

ORDER

IT IS HEREBY ORDERED THAT the June 16, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 24, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy 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