United States Department of Labor
Employees' Compensation Appeals Board

D.P., Appellant	)	
and	)	**Docket No. 18-0776**
	)	**Issued: November 9, 2018**
DEPARTMENT OF HOMELAND SECURITY, FEDERAL AVIATION ADMINISTRATION, Durango, CO, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 28, 2018 appellant, through counsel, filed a timely appeal from a January 26, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the 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 met her burden of proof to establish more than 13 percent permanent impairment of her right upper extremity for which she previously received schedule award compensation.

FACTUAL HISTORY

On June 10, 2013 appellant, then a 57-year-old transportation security officer supervisor, filed an occupational disease claim (Form CA-2) alleging that she sustained an aggravation of her preexisting carpal tunnel syndrome of the right hand and wrist while in the performance of her federal employment duties. OWCP assigned the present claim, OWCP File No. xxxxxx116. On September 27, 2013 it accepted the claim for carpal tunnel syndrome of the right hand.[3]

On May 23, 2013 appellant underwent nerve conduction velocity (NCV) testing which demonstrated that the right median motor distal latency was at the slow end of normal, indicating mild residual effective from her previous carpal tunnel surgery.

In a note dated July 24, 2013, Dr. Ryan Naffziger, a Board-certified plastic surgeon, recommended additional right carpal tunnel surgical intervention. On September 5, 2013 he performed the right carpal tunnel open release and right median nerve decompression of appellant's forearm or pronator release. Dr. Naffziger found compression of the median nerve at the leading edge of the flexor aponeurosis.

Appellant underwent additional NCV studies on June 30, 2014 which continued to demonstrate mild sensory median neuropathy at the right wrist and chronic inactive denervation of the promator teres muscle which was due to prior median entrapment.

On June 7, 2016 appellant filed a schedule award claim (Form CA-7). In a development letter dated July 5, 2016, OWCP requested that she submit additional medical evidence establishing her schedule award claim. It afforded appellant 30 days for a response.

Dr. Jack L. Rook, a Board-certified physiatrist, examined appellant on July 20, 2016. He reviewed her medical history including her previous diagnosis of bilateral carpal tunnel syndrome, and resulting surgeries in 2007. Dr. Rook reported appellant's increasing right wrist pain and diagnosis of aggravation of right carpal tunnel syndrome in 2013 as well as her 2013 surgery. He performed a physical examination and found no muscle atrophy on the thenar eminence, but significant weakness of the right hand intrinsic musculature. Dr. Rook reported muscle strength of 4/5 in the abductor pollicis brevis, in pinch strength, and grip strength. He found a positive

[3]Appellant had prior claim before OWCP. On February 5, 2007 appellant filed an occupational disease claim (Form CA-2) alleging that she developed carpal tunnel syndrome on the right due to factors of her federal employment as a security screener including lifting, inspecting, and carrying bags averaging 40 pounds. OWCP assigned that claim, File No. xxxxxx025. Appellant underwent bilateral carpal tunnel release surgeries on March 27, 2007. OWCP accepted the claim for right carpal tunnel syndrome on April 26, 2007. On May 31, 2007 it expanded acceptance of appellant's claim to include left carpal tunnel syndrome. By decision dated December 2, 2008, OWCP granted her a schedule award for 13 percent permanent impairment of her right upper extremity. OWCP File Nos. xxxxxx025 and xxxxxx116 have been administratively combined, with the latter designated the master file.

Tinel's sign on the right transverse carpal ligament, positive pronator compression sign, and diminished pinprick sensation in the right hand in the median nerve distribution, but no evidence of allodynia. Dr. Rook diagnosed right carpal tunnel syndrome and right pronator syndrome. He indicated that he was providing an impairment rating for median nerve compression at the level of the pronator mass in accordance with the sixth edition of the A.M.A., *Guides*. Dr. Rook found that appellant had mild motor and sensory defects.[4] He determined that she had five percent permanent impairment of the median nerve above midforearm in accordance with the diagnosis-based impairment (DBI) methodology.[5] Dr. Rook then related that appellant had a functional history grade modifier of 4, based on her *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) score of 82, and clinical studies grade modifier of 1, he applied the net adjustment formula of the A.M.A., *Guides* and reached an impairment rating of grade E or 10 percent impairment of the right upper extremity. He repeated this process for her mild motor deficit, to reach an additional 12 percent permanent impairment of the right upper extremity. Dr. Rook combined appellant's previous award for 13 percent permanent impairment due to carpal tunnel syndrome, with his two impairment ratings for pronator syndrome of 21 percent permanent impairment to reach a total right upper extremity permanent impairment of 31 percent.

OWCP's medical adviser reviewed Dr. Rook's report on February 19, 2017 and found it problematic for several reasons. He noted that Dr. Rook had inappropriately used a functional history grade modifier of 4 in conjunction with other modifiers of 1. Further, that Dr. Rook's impairment rating did not comport with the requirements of the A.M.A., *Guides* as he failed to use Table 15-23 of the A.M.A., *Guides* which addresses entrapment/compression neuropathy impairment.[6] The medical adviser recommended a second opinion evaluation.

On March 2, 2017 OWCP referred appellant, a statement of accepted facts, and a list of questions, for a second opinion evaluation with Dr. Thomas P. Moore, a Board-certified orthopedic surgeon.

Dr. Moore completed a report on March 30, 2017. He reviewed appellant's history of injury and medical treatment including two right carpal tunnel releases, one left carpal tunnel release, and right elbow surgery. On physical examination Dr. Moore found right-sided atrophy of the thenar eminence, and thumb index webspace musculature. He also noted appellant's report on pain with palpation on the thenar eminences, carpal, and volar radiocarpal regions. Appellant exhibited negative Tinel's sign and Phalen's test. She also demonstrated decreased grip strength and decreased strength in the intrinsic muscles of her right hand. Appellant's neurological examination was normal. Dr. Moore diagnosed right carpal tunnel syndrome and attributed this condition to her original 2007 employment injury. He found that appellant had reached maximum medical improvement on March 4, 2015 and concluded that she could not return to work in her date-of-injury position due to objective findings of weakness and atrophy.

[4] A.M.A., *Guides* 425, Table 15-14.

[5] *Id.* at 437, Table 15-21.

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

Dr. Moore provided an impairment rating utilizing Table 15-23, Entrapment/Compression neuropathy of the A.M.A., *Guides*.[7] He noted that appellant's NCV study on February 8, 2007 demonstrated both sensory and motor decreased conduction. Dr. Moore concluded that this test result was a grade modifier of 1.[8] He noted that appellant had constant symptoms which resulted in a grade modifier of 3 under history. Dr. Moore found that her physical findings of atrophy and weakness also resulted in a grade modifier of three. He averaged these grade modifiers and found that the appropriate grade modifier was 2 with a default value of five percent permanent impairment of the right upper extremity. Dr. Moore then proceeded to modify the default impairment for grade 2 based on the functional scale grade. He found that appellant's *Quick*DASH score was 88.6, severe. Dr. Moore then determined that she had a total of six percent permanent impairment of the right upper extremity.

OWCP referred Dr. Moore's report to an OWCP medical adviser on May 10, 2017. In his May 11, 2017 memorandum, OWCP's medical adviser found that Dr. Moore's findings comported with the A.M.A., *Guides* and that appellant had no more than six percent permanent impairment of her right upper extremity. He further noted that she had previously received a schedule award for 13 percent permanent impairment of her right upper extremity due to right carpal tunnel syndrome and was not, therefore, entitled to an additional schedule award.

By decision dated May 17, 2017, OWCP denied appellant's claim for an additional schedule award based on the reports of Dr. Moore and OWCP's medical adviser. On May 24, 2017 counsel requested an oral hearing before an OWCP hearing representative.

At the oral hearing on November 14, 2017, counsel contended that there was an unresolved conflict of medical evidence.

By decision dated January 26, 2018, OWCP's hearing representative found that appellant had no more than 13 percent permanent impairment of her right upper extremity for which she had previously received schedule award compensation. She found that Dr. Moore and OWCP's medical adviser applied the appropriate version of the A.M.A., *Guides* and determined that appellant did not have more than 13 percent permanent impairment of her right upper extremity and that she was not entitled to an additional schedule award.

LEGAL PRECEDENT

The schedule award provision of FECA[9] and its implementing regulations[10] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of 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

[7] *Id.*

[8] *Id.*

[9] *Supra* note 2.

[10] 20 C.F.R. § 10.404.

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,* published in 2009.[11] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[12] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related impairment, preexisting impairments are to be included.[13]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[14] 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.[15]

In some instances, OWCP's medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides*. In this instance, a detailed opinion by OWCP's medical adviser may constitute the weight of the medical evidence. As long as OWCP's medical adviser explains his or her opinion, shows values and computation of impairment based on the A.M.A., *Guides,* and considers each of the reported findings of impairment, his or her opinion may constitute the weight. If the attending physician misapplied the A.M.A., *Guides,* no conflict would exist because the attending physician's report would have diminished probative value and the opinion of OWCP's medical adviser would constitute the weight of medical opinion.[16]

[11] 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 2.808.5 (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards,* Chapter 3.700, Exhibit 1 (January 2010).

[12] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[13] *P.R., id.; Carol A. Smart,* 57 ECAB 340 (2006).

[14] A.M.A., *Guides* 449, Table 15-23; 448.

[15] *Id.*

[16] *Supra* note 11 at Part 2 -- Claims, *Developing and Evaluating Medical Evidence,* Chapter 2.810.8j (September 2010); *A.W.*, Docket No. 17-0587 (issued August 7, 2018).

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than 13 percent permanent impairment of her right upper extremity for which she previously received schedule award compensation.

The Board finds that Dr. Moore and OWCP's medical adviser properly determined that appellant had no more than 13 percent permanent impairment of her right upper extremity for which she had received a schedule award. The physicians based their reports on the appropriate tables and standards of the sixth edition of the A.M.A., *Guides*. Both Dr. Moore and OWCP's medical adviser utilizing Table 15-23 on page 449 of the sixth edition of the A.M.A., *Guides* that appellant had six percent permanent impairment of her right upper extremity due to right median nerve entrapment at her wrist resulting from carpal tunnel syndrome.

While appellant's physician Dr. Rook reached a greater impairment rating based on his diagnoses of right carpal tunnel syndrome, and right pronator syndrome, he determined his ratings in accordance with the DBI methodology, rather than the appropriate section of the A.M.A., *Guides*.[17] The A.M.A., *Guides* provide that multiple, concurrent, focal nerve compromise syndromes should be rated only in accordance with Table 15-23.[18] Therefore, Dr. Rook's impairment rating was not in keeping with the A.M.A., *Guides*. As his permanent impairment rating was of limited probative value, the opinion of OWCP's medical adviser constituted the weight of the medical opinion evidence.[19]

The Board thus finds that appellant has not established greater than 13 percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation.

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 not met her burden of proof to establish more than 13 percent permanent impairment of her right upper extremity for which she previously received schedule award compensation.

[17] *Id.* at 437, Table 15-21.

[18] *Id.* at 448.

[19] *Supra* note 16.

ORDER

IT IS HEREBY ORDERED THAT the January 26, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 9, 2018
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