United States Department of Labor
Employees' Compensation Appeals Board

J.T., Appellant	)	
and	)	**Docket No. 17-1465**
	)	**Issued: September 25, 2019**
DEPARTMENT OF DEFENSE, DEFENSE COMMISSARY AGENCY, SCOTT AIR FORCE BASE, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 1, 2017 appellant, through counsel, filed a timely appeal from a March 2, 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 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 established greater than two percent permanent impairment of the right upper extremity for which he previously received a schedule award.

FACTUAL HISTORY

On October 18, 2013 appellant, then a 62-year-old store associate, filed an occupational disease claim (Form CA-2) alleging that his duties as a cashier caused his bilateral carpal tunnel condition after he returned to work following his December 4, 2009 back, neck, and shoulder injury. He stopped work on October 18, 2013.[3] OWCP accepted the claim for bilateral carpal tunnel syndrome and. It subsequently expanded the acceptance of the claim to include right index trigger finger (acquired). OWCP authorized surgery for right carpal tunnel release and right trigger finger release, which was performed on April 16, 2014.

On November 6, 2014 appellant filed a claim for a schedule award (Form CA-7).

In support of his schedule award claim, appellant submitted a November 20, 2014 report from Dr. Neil Allen, a Board-certified internist and neurologist. Dr. Allen briefly noted appellant's medical and employment history and diagnosed bilateral carpal tunnel syndrome and right acquired trigger finger. A physical examination revealed: no atrophy in either wrist; right tenderness in distal carpal row and carpal tunnel region; left tenderness on the distal row palmar surface; and negative Phalen's and Tinel's signs bilaterally. Regarding muscle strength, Dr. Allen related that appellant was rated 5/5 for flexion, extension, radial deviation and ulnar deviation. Grip and opposition strength was 4/5. A February 14, 2011 electromyography (EMG) study showed no evidence of cervical radiculopathy or brachial plexopathy, mild bilateral focal median wrist neuropathy, and no bilateral focal ulnar neuropathy. Dr. Allen opined that, according to Table15-23 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] appellant had six percent permanent impairment of each upper extremity due to his accepted bilateral carpal tunnel syndrome. He explained that the rating was based on a *Quick*DASH disability score of 71 percent, a grade modifier of 1 for test findings of conduction delay, a grade modifier of 1 for history of mild intermittent symptoms, and a grade modifier of 3 for physical findings of weakness.

On March 20, 2015 Dr. Michael Hellman, an orthopedic surgeon serving as an OWCP district medical adviser (DMA) reviewed Dr. Allen's impairment rating and opined that it was "too high" and inconsistent with previous findings of record. He recommended that appellant be

[3] Appellant has a prior traumatic injury claim under OWCP File No. xxxxxx238 which OWCP accepted for cervical radiculitis, thoracic sprain, lumbar sprain, and shoulder pain. He was receiving wage-loss compensation for intermittent disability on the supplemental rolls under OWCP File No. xxxxxx238 when the present occupational disease claim was filed. On November 25, 2013 OWCP granted appellant a schedule award under that claim for two percent permanent impairment of the left upper extremity. By decision dated December 27, 2017, the Board affirmed the hearing representative's decision which affirmed the left upper extremity schedule award. Docket No. 17-1116 (issued December 27, 2017). Appellant's claims have not been administratively combined by OWCP.

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

referred for a second opinion evaluation. The DMA determined the date of maximum medical improvement to be November 20, 2014.

On December 8, 2015 OWCP referred appellant, along with a statement of accepted facts (SOAF) and the medical record, to Dr. James Stiehl, a Board-certified orthopedic surgeon, for a second opinion evaluation in order to determine whether he sustained permanent impairment of his accepted bilateral carpal tunnel syndrome and right trigger finger condition in accordance with the A.M.A., *Guides*.

In an impairment evaluation dated January 20, 2016, Dr. Stiehl reviewed appellant's history of injury, and the medical evidence including the February 14, 2011 EMG study. He noted that the February 14, 2011 EMG study showed a motor nerve conduction latency of 4.5 minutes in the left median nerve and 4.2 minutes sensory delay in the right wrist. Physical examination findings included negative bilateral Phalen's and Tinel's signs and normal bilateral wrist and fingers range of motion. Using Table 15-23, page 449 of the sixth edition of the A.M.A., *Guides* Dr. Stiehl placed appellant in grade modifier 1, with mild symptoms, which carries a default value of two percent permanent impairment of each upper extremity. He opined that appellant reached maximum medical improvement on July 17, 2014.

On May 3, 2016 Dr. Morley Slutsky, a Board-certified occupational medicine specialist, acting as an OWCP DMA, reviewed the impairment ratings by both Dr. Allen and Dr. Stiehl. He found that the EMG test findings met the A.M.A., *Guides* criteria for compression neuropathy under Table 15-23, page 449. The DMA found the date of maximum medical improvement to be January 20, 2016, the date of Dr. Stiehl's examination. Using Table 15-23 at page 449, he rated appellant's right carpal tunnel syndrome. The DMA found the three grade modifiers of history, physical findings, and test results resulted in an average grade modifier of 1. He concluded that appellant had two percent permanent impairment of the right upper extremity. For the left upper extremity, the DMA found a history grade modifier of 1, a grade modifier for physical findings of 0, a grade modifier for test findings of 1, which resulted in an average grade modifier of -1 or zero impairment. He determined the date of maximum medical improvement to be January 20, 2016, the date of Dr. Stiehl's examination. The DMA explained that his evaluation of appellant's left wrist permanent impairment differed from Dr. Stiehl's because Dr. Stiehl had not documented more than one motion per joint, which was not consistent with the validation criteria in section 15.7 of the A.M.A., *Guides*, page 464. Therefore appellant was assigned a zero grade modifier for physical examination findings.

By decision dated June 22, 2016, OWCP granted appellant a schedule award for two percent permanent impairment of the right upper extremity.

On June 30, 2016 counsel requested a telephonic hearing before an OWCP hearing representative, which was held on January 25, 2017.

By decision dated March 2, 2017, the hearing representative affirmed the June 22, 2016 decision.

LEGAL PRECEDENT

Under section 8107 of FECA[5] and section 10.404 of the implementing federal regulations,[6] schedule awards are payable for permanent impairment of specified body members, functions or organs. FECA, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for all claimants, good administrative practice necessitates 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 the implementing regulations as the appropriate standard for evaluating schedule losses.[7]

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).[8] Under the sixth edition, the evaluator identifies 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).[10]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[11] In Table 15-23, grade modifier levels (ranging from zero to four) 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.[12]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[13]

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[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *D.J.*, 59 ECAB 620 (2008); *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[8] A.M.A., *Guides* (6th ed., 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[9] *Id*. at 383-419.

[10] *Id.* at 411.

[11] *Id.* at 449.

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

[13] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013). *See C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

ANALYSIS

The Board finds that appellant has not established greater than two percent permanent impairment of the right upper extremity, for which he previously received a schedule award.

Dr. Allen, an examining Board-certified internist and neurologist determined that appellant had a six percent impairment of each upper extremity due to his accepted bilateral carpal tunnel syndrome. He assigned a grade modifier of 1 for test findings of conduction delay, a grade modifier of 1 for mild intermittent symptoms, and a grade modifier of 3 for physical findings of weakness. On March 20, 2015 the DMA reviewed Dr. Allen's report and determined that it was of limited probative value as it was inconsistent with previous medical findings. The Board notes that, while Dr. Allen assigned a grade modifier of 3 for weakness of both wrists, he did not document significant weakness. Dr. Allen related that regarding muscle strength appellant was 5/5 for flexion, extension, radial and ulnar deviation, and 4/5 for grip and opposition strength. To be of probative value, the medical evidence must describe the impairment in sufficient detail so that it can be visualized on review and utilized to compute the percentage of impairment in accordance with the A.M.A., *Guides*.[14] Dr. Allen failed to adequately explain how the A.M.A., *Guides* supported his findings of a greater impairment.[15] Since Dr. Allen did not explain how appellant's examination findings would warrant a grade 3 modifier, his opinion is of limited probative value.

OWCP properly referred appellant for a second opinion evaluation as Dr. Allen's report was of limited probative value. Dr. Stiehl, the second opinion physician determined that appellant had two percent permanent impairment of each upper extremity due to his accepted bilateral carpal tunnel syndrome. He noted that appellant's motor conduction delay which would place him in grade modifier 1 of Table 15-23 of the A.M.A., *Guides*. Appellant's history of mild symptoms, with normal physical examination findings, would result in the default rating of two percent. Therefore he concluded that pursuant to Table 15-23 appellant had two percent permanent impairment of each upper extremity.

The DMA determined that appellant had only two percent permanent impairment of the right upper extremity. OWCP determined that the weight of the evidence was represented by the opinion of the DMA.

The DMA properly applied Table 15-23, which pertains to entrapment/compression neuropathy to evaluation of appellant's right wrist permanent impairment. He explained that appellant's right wrist conduction delay and mild intermittent symptoms, with normal physical findings placed appellant in grade 1 of this Table. The DMA concurred with Dr. Stiehl that application of the formula for grade modifiers resulted in a total impairment value of two percent permanent impairment of the right wrist. The Board finds that the DMA properly reviewed the EMG/NCV testing and explained his findings with regard to history and physical examination by reviewing the medical findings in the record and applying them to the criteria set forth in the A.M.A., *Guides*.

[14] *See G.D.*, Docket No. 16-1712 (issued August 11, 2017).

[15] *Id.*

The Board thus finds that well-rationalized opinions of the second opinion physician and the DMA represent the weight of the medical evidence regarding permanent impairment of appellant's right wrist.[16]

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 established greater than two percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the March 2, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 25, 2019
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

[16] *Id.*