United States Department of Labor
Employees' Compensation Appeals Board

P.A., Appellant	)	
and	)	**Docket No. 19-1057**
	)	**Issued: March 18, 2021**
U.S. POSTAL SERVICE, O'HARE AIR MAIL CENTER, Chicago, 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:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 12, 2019 appellant, through counsel, filed a timely appeal from a February 25, 2019 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 met her burden of proof to establish greater than one percent permanent impairment of each upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On January 15, 1998 appellant, then a 34-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that she had developed bilateral carpal tunnel syndrome due to factors of her federal employment including repetitive duties. On January 16, 1999 she underwent electrodiagnostic studies including an electromyogram and nerve conduction velocity (EMG/NCV) studies of the upper extremities. These tests demonstrated bilateral median nerve findings. OWCP assigned the claim File No. xxxxxx810 and, on March 17, 1999, accepted it for bilateral carpal tunnel syndrome.[3]

On February 5, 2000 appellant filed an occupational disease claim (Form CA-2) alleging that she developed pain and stiffness in her neck, shoulder, and middle back area on her left side due to factors of her federal employment including repetitive movements. OWCP assigned that claim File No. xxxxxx757 and, on February 23, 2000, accepted it for cervical and left trapezius strains.

On December 29, 2000 OWCP administratively combined OWCP File No. xxxxxx810 and OWCP File No. xxxxxx757. OWCP File No. xxxxxx810 was designated as the master file.

On May 8, 2002 appellant filed a schedule award claim (Form CA-7). She alleged that she had reached maximum medical improvement (MMI) for her accepted bilateral carpal tunnel syndrome. By decision dated February 24, 2004, OWCP denied the schedule award claim.

On November 19, 2012 appellant again filed a schedule award claim (Form CA-7).

In a December 4, 2012 development letter, OWCP noted the deficiencies in the schedule award claim and requested medical evidence supporting permanent impairment. It afforded appellant 30 days to respond.

In a December 7, 2012 report, Dr. Neil Allen, a Board-certified neurologist, opined that appellant had reached MMI and listed her ongoing symptoms of bilateral hand numbness, pain, tingling, weakness, and locking of the digits. On physical examination he found mild thenar atrophy on the left, loss of muscle strength in extension, and loss of grip strength. For the right upper extremity Dr. Allen reported mild thenar atrophy, loss of muscle strength in extension and in grip strength, and a positive Tinel's sign and Phalen's test. He applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A.,

[3] On April 16, 1999 appellant underwent a right carpal tunnel surgical release. On October 18, 2000 she underwent a left carpal tunnel surgical release.

Guides)[4] and rated appellant's right upper extremity impairment in accordance with Table 15-23, page 449, Entrapment/Compression Neuropathy Impairment. Dr. Allen referenced appellant's January 18, 1999 EMG and found a grade modifier for test findings of 1. He then applied a grade modifier of 3 for history, due to constant symptoms; a grade modifier of 3 for physical findings, due to atrophy or weakness, based on appellant's mild thenar atrophy, and mild reductions in grip and pincher strength; and functional scale, grade modifier 3, based on a *Quick*DASH score of 80. Dr. Allen reached six percent permanent impairment of each of appellant's upper extremities.

On November 4, 2013 OWCP's district medical adviser (DMA), Dr. David H. Garelick, Board-certified in orthopedic sports medicine, reviewed Dr. Allen's December 7, 2012 report. He disagreed with Dr. Allen's reliance on the 1999 preoperative EMG, as well as his findings of weakness and atrophy, and concluded that appellant had no permanent impairment of her upper extremities.

By decision dated February 26, 2015, OWCP denied appellant's schedule award claim, finding that Dr. Garelick's November 4, 2013 report was entitled to the weight of the medical evidence.

On March 5, 2015 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated January 15, 2016, OWCP's hearing representative vacated the February 26, 2015 decision and remanded the case for further development, including a second opinion evaluation.

On September 30, 3016 OWCP referred appellant, a statement of accepted facts (SOAF), and a list of questions to Dr. Allen Brecher, a Board-certified orthopedic surgeon, for a second opinion evaluation of her permanent impairment for schedule award purposes.

In his October 21, 2016 report, Dr. Brecher reviewed the SOAF and noted appellant's accepted carpal tunnel syndrome, history of back fusion and herniated cervical disc. On physical examination he found positive Tinel's sign and Phalen's test, which were reduced with distraction, which he determined indicated an exaggeration of symptoms. Dr. Brecher disagreed with Dr. Allen's findings of loss of strength and loss of range of motion, and noted questionable positive Tinel's sign and Phalen's test. He applied Table 15-23, page 449 of the A.M.A., *Guides*, and listed a grade modifier for functional history (GMFH) of 1, due to mild impairment; a grade modifier for physical examination (GMPE) of 1, as she had no atrophy or numbness; a grade modifier for clinical studies (GMCS) of 1, as she had a prior abnormal EMG/NCV studies. Dr. Brecher found a final upper extremity impairment rating of two percent permanent impairment of each upper extremity due to carpal tunnel syndrome. He further found that appellant's accepted cervical sprain had resolved with no impairment of the upper extremities due to normal sensory and motor findings.

On December 23, 2016 OWCP's DMA, Dr. William Tontz, a Board-certified orthopedic surgeon, reviewed Dr. Brecher's report and concluded that appellant had one percent permanent

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

impairment of each of her upper extremities in accordance with page 449 of the A.M.A., *Guides*. He found that appellant had reached MMI on October 21, 2016.

By decision dated January 19, 2017, OWCP granted appellant a schedule award for one percent permanent impairment of each upper extremity. On January 24, 2017 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

In a May 11, 2017 addendum to his December 7, 2012 report, Dr. Allen asserted that Dr. Tontz inappropriately applied postoperative electrodiagnostic studies to determine the test findings grade modifier of Table 15-23, page 449, of the A.M.A., *Guides*. He further asserted that Dr. Tontz did not explain how he reached his one percent permanent impairment rating. Dr. Allen concluded that his initial December 7, 2012 impairment rating was correct.

By decision dated September 26, 2017, OWCP's hearing representative vacated the January 19, 2017 OWCP decision and remanded for a DMA to consider Dr. Allen's May 11, 2017 addendum.

In an October 16, 2017 report, Dr. Michael M. Katz, a Board-certified internist and DMA, reviewed the medical evidence and found a conflict in the physical findings from Drs. Allen and Brecher. He requested an impartial medical examination to resolve this issue.

On February 14, 2018 OWCP declared a conflict in the medical evidence and referred appellant, along with a SOAF and list of questions to Dr. Hytham Shadid, a Board-certified orthopedic surgeon, for an impartial medical examination.

In his April 12, 2018 report, Dr. Shadid reviewed the SOAF and medical records, and performed a physical examination. He noted that appellant reported bilateral hand pain. Dr. Shadid found full range of motion and strength in muscle testing in appellant's bilateral upper extremities. He also noted normal sensory findings in the medial nerve distribution confirmed by two point discrimination. Dr. Shadid noted normal Phalen's testing and Tinel's signs bilaterally. He reviewed appellant's January 16, 1999 EMG which included findings of abnormal sensory action potentials, bilaterally. Dr. Shadid applied the nerve entrapment evaluation method of the A.M.A., *Guides* found in Table 15-23, page 449 of the A.M.A., *Guides*. He determined that the grade modifier test findings was one based on the preoperative 1999 electrodiagnostic testing. Dr. Shadid found that the grade modifier physical findings was also one due normal appearance, strength, and sensory examinations. He determined that the grade modifier history was one due to subjective complaints. Dr. Shadid determined that appellant had one percent permanent impairment of each of her upper extremities.

Dr. Shadid explained his disagreement with Dr. Allen's impairment rating asserting that Dr. Allen had "over relied on subjective factors" such as the *Quick*DASH score. He opined that this score was based on exaggerated subjective complaints as appellant currently reported that she was capable of performing all her activities of daily living as well as performing light-duty work independently. Dr. Shadid also found no evidence for loss of range of motion, thenar atrophy, or radicular pain on his physical examination and noted that these findings were supported by appellant's negative electrodiagnostic studies. He found that appellant had reached MMI.

On April 19, 2018 Dr. Arthur S. Harris, a Board-certified orthopedic surgeon and DMA, reviewed the medical evidence of record and found that appellant had one percent right upper extremity permanent impairment due to carpal tunnel syndrome and one percent left upper extremity permanent impairment due to carpal tunnel syndrome.

By decision dated May 10, 2018, OWCP denied appellant's claim for an additional schedule award. On May 16, 2018 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated February 25, 2019, OWCP's hearing representative found that appellant had no more than one percent permanent impairment of her upper extremities for which she had previously received a schedule award, noting that the special weight of the medical evidence rested with Dr. Shadid.

LEGAL PRECEDENT

The schedule award provisions of FECA,[5] and its implementing federal regulations,[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. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a 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*, published in 2009.[7] 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.[8]

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).[9] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[10]

[5] *Supra* note 2.

[6] 20 C.F.R. § 10.404.

[7] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

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

[9] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, ICF: A Contemporary Model of Disablement.

[10] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

Permanent impairment due to carpal tunnel syndrome is evaluated under the procedures found in Table 15-23, page 449, Entrapment/Compression Neuropathy Impairment, and accompanying relevant text.[11] 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.[12]

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

FECA provides that if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[14] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[15]

ANALYSIS

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

OWCP had determined that there was a conflict in the medical opinion evidence between Dr. Allen an attending physician, and Dr. Brecher, an OWCP referral physician, on the issue of the extent of appellant's upper extremity permanent impairment due to her accepted condition. In order to resolve the conflict, it properly referred appellant, pursuant to section 8123(a) of FECA,[16] to Dr. Shadid, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on permanent impairment.

In an April 12, 2018 report, Dr. Shadid reviewed the medical record and the SOAF and provided examination findings. Based on his examination findings, he applied Table 15-23, page 449 of the A.M.A., *Guides* and determined that the grade modifier for test findings was 1 based on the preoperative 1999 electrodiagnostic testing. Dr. Shadid found that the grade modifier for physical findings was also one due normal strength and sensory examinations. He determined that the grade modifier for history was one due to subjective complaints. Dr. Shadid then determined

[11] A.M.A., *Guides* 449, Table 15-23; *C.M.*, Docket No. 19-0125 (issued August 16, 2019).

[12] A survey completed by a given claimant, known by the name *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand), may be used to determine the function scale score. A.M.A., *Guides* 448-49.

[13] *Supra* note 7 at Chapter 2.808.6(f) (August 2002).

[14] 5 U.S.C. § 8123(a); *A.G.*, Docket No. 18-0815 (issued January 24, 2019).

[15] *A.I.*, Docket No. 19-0193 (issued May 1, 2019).

[16] *Supra* note 14.

that appellant had one percent permanent impairment of each of her upper extremities. He found that appellant had reached MMI.

On April 19, 2018 a DMA reviewed Dr. Shadid's April 12, 2018 report and concurred in his rationale and determination.

The Board finds that Dr. Shadid and the DMA improperly utilized Table 15-23. The rating process found in Table 15-23 requires an average of the three grade modifiers to reach the grade of the final rating category. In applying the average of Dr. Shadid's grade modifiers, the grade is one, which has a default impairment value of two in accordance with page 448 and Table 15-23, page 449 of the A.M.A., *Guides*. This default value is then to be modified up or down based on the functional scale grade which is based on *Quick*DASH score. As neither Dr. Shadid, nor the DMA applied the appropriate formula or explained why appellant's permanent impairment rating should be reduced to one from the default value two, the Board finds that the case is not in posture for a decision.

When OWCP secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, it has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report.[17] OWCP's procedures further provide that, while an OWCP medical adviser may review the opinion of an impartial medical specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility and not that of OWCP's medical adviser. The medical adviser should not resolve the conflict of medical opinion or attempt to clarify or expand the opinion of the medical referee. If clarification is necessary, a supplemental report should be obtained from the referee specialist.[18]

The case shall therefore be remanded for OWCP to request a supplemental report from Dr. Shadid applying the formula as described on page 448 of the A.M.A., *Guides* to the grade modifiers that he found. It shall also request that he provide an accurate *Quick*DASH score, and apply this score to modify the default value for the grade found, if necessary. After this and other 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.

[17] *Supra* note 7 at *OWCP Directed Medical Examinations*, Chapter 3.500.4.g(3)(b) (July 2011) (If clarification or additional information is necessary, the claims examiner should write to the specialist to obtain it.) *K.S.*, Docket No. 17-1663 (issued March 28, 2018); *P.O.*, Docket No. 15-1631 (issued June 2, 2016); *K.C.*, Docket No. 14-0791 (issued August 8, 2014); *Guiseppe Aversa*, 55 ECAB 164 (2003).

[18] *Supra* note 7 at Chapter 2.808.6(g)(1) and (2) (March 2017).

ORDER

IT IS HEREBY ORDERED THAT the February 25, 2019 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: March 18, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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