United States Department of Labor
Employees' Compensation Appeals Board

M.F., Appellant	)	
and	)	**Docket No. 23-0881**
	)	**Issued: December 6, 2023**
U.S. POSTAL SERVICE, BALTIMORE POST OFFICE, Baltimore, MD, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 12, 2023 appellant filed a timely appeal from a May 18, 2023 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. § § 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than five percent permanent impairment of her left upper extremity or five percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On September 3, 1997 appellant, then a 44-year-old clerk, filed an occupational disease claim (Form CA-2) alleging that she developed pain, tingling, and stiffness in her fingers, hands,

[1] 5 U.S.C. § 8101 *et seq*.

and wrists due to repetitive factors of her federal employment. She noted that she first became aware of her condition on May 8, 1997, and realized its relation to her federal employment on May 22, 1997. OWCP accepted the claim for bilateral carpal tunnel syndrome (CTS). On June 8, 2006 appellant underwent OWCP-authorized left carpal tunnel release surgery. On June 17, 2009 she underwent OWCP-authorized right carpal tunnel release surgery. OWCP initially paid appellant wage-loss compensation on the supplemental rolls commencing June 8, 2006, and then on the periodic rolls commencing May 13, 2007.

On April 19, 2022 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In an April 19, 2022 report, Dr. Kenneth R. Lippman, an orthopedic surgeon, examined appellant's wrists and hands and found well-healed carpal tunnel incisions. He related that her hands were tender bilaterally and her grip was very weak and dysfunctional bilaterally. On examination, appellant experienced discomfort with Tinel's testing and Phalen's testing bilaterally; her sensory testing revealed shooting pains that radiated through the fingers; and she reported tingling, numbness, and inability to hold or get a good grip. Dr. Lippman diagnosed entrapment/compression neuropathy and opined that this condition interfered with appellant's functional use of both hands and limited her vocational and activities of daily living abilities. He referred to "the AMA Guidelines" and opined that his diagnosis resulted in 35 percent impairment of the right upper extremity and 35 percent impairment of the left upper extremity.

In a December 29, 2022 report, Dr. Nathan Hammel, a Board-certified orthopedic surgeon and district medical adviser (DMA), reviewed Dr. Lippman's report. He noted the accepted condition of bilateral carpal tunnel syndrome and referred to the sixth edition of the A.M.A., *Guides*[2] and noted that entrapment neuropathy is rated using Table 15-23, Entrapment/ Compression Neuropathy Impairment (at page 449). Dr. Hammel noted that the grade modifier for test findings/clinical studies (GMCS) was 1 for conduction delay, the grade modifier for functional history (GMFH) was 2 for significant intermediate symptoms, and the grade modifier for physical examination (GMPE) was 2 for decreased sensation. He explained that the average of the grade modifiers was 2, which resulted in 5 percent bilateral upper extremity impairment, according to Table 15-23. In response to the request that he comment on Dr. Lippman's report, Dr. Hammel indicated that it was "completely unclear" how Dr. Lippman opined that appellant had 35 percent bilateral upper extremity impairment, given that Table 15-23 only allows a maximum impairment rating of 9 percent. He opined that appellant reached maximum medical improvement (MMI) on April 19, 2022, the date of Dr. Lippman's report.

In a February 7, 2023 report, Dr. Lippman noted that appellant agreed with his impairment rating of 35 percent and that appellant suggested that "we get a book to calculate the award." He indicated that due to the discrepancy in the rating, it would be reasonable to obtain an independent third-party rating.

[2] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009).

On February 28, 2023 OWCP referred appellant for a second opinion examination with Dr. Brian Lumsden, a Board-certified orthopedic surgeon.

In a March 24, 2023 report, Dr. Lumsden noted appellant's history of injury, medical course, and the diagnosis of bilateral carpal tunnel syndrome. He examined her and related that her shoulder, biceps, triceps, elbow, forearm, wrist, hand, grip, and manual dexterity motion were normal. Dr. Lumsden also noted appropriate composite fist flexors and extensors, grip was poor effort to 3+/5, and sensory was diminished to the thumb index and middle, moderately on the right and mildly on the left, with no cubital tunnel involvement. He noted that MMI was reached on April 19, 2022, per the DMA's report. Dr. Lumsden referred to the A.M.A., *Guides*, Table 15-23, at pages 448-49, for entrapment compression neuropathy impairment. He assessed GMFH of 3, and GMPE of 3, based on appellant's constant symptoms and the objective examination findings of some thenar atrophy and weakness, and complaints of sensation. Dr. Lumsden noted that his assignment of 3 for GMFH and 3 for GMPE were a grade above what the DMA assessed. He did not provide a grade modifier for test findings, explaining that there were no updated clinical studies. Dr. Lumsden explained that his grade modifiers of 3 for GMFH and 3 for GMPE resulted in an average grade modifier of 3. He noted that in Table 15-23, the grade modifier of 3 corresponds with an impairment range of seven to nine percent, with eight percent being the default value; however, he opined that, "realistically this claimant actually falls to a seven percent impairment relative to the hands bilaterally."

On April 10, 2023 OWCP requested that the DMA provide an addendum to his December 29, 2022 report.

In an April 18, 2023 report, Dr. Hammel noted that the range of motion (ROM) methodology provided no impairment, as the ROM was full. With regard to the diagnosis-based impairment (DBI) methodology, the DMA noted that carpal tunnel syndrome is rated using Table 15-23, page 499 of the A.M.A., *Guides*, for Entrapment/Compression Neuropathy Impairment. Dr. Hammel assigned a GMFH of 3, based on a history of functional limitations, and a GMPE of 3 for physical findings, based on atrophy and decreased sensation. The DMA also assigned a GMCS of 1 for test findings, based on the preoperative nerve conduction study, and noted that averaging the three grade modifiers yielded 2, which resulted in five percent bilateral upper extremity impairment.

On April 25 and May 3, 2023 OWCP requested that the DMA, Dr. Hammel, clarify his April 18, 2013 report.

In a May 12, 2023 report, Dr. Hammel indicated that he reviewed Dr. Lumsden's report and opined that Dr. Lumsden did not apply the A.M.A., *Guides* correctly. He explained that Dr. Lumsden did not utilize the preoperative nerve conduction velocity study and did not provide a GMCS, which should have been 1. Dr. Hammel further explained excluding the GMCS elevated the impairment rating. He explained that the A.M.A., *Guides* mandate use of a GMCS, which results in an average grade modifier of 2 and corresponds to five percent permanent impairment of the bilateral upper extremities, according to Table 15-23. Dr. Hammel concurred that MMI was reached on April 19, 2022.

By decision dated May 18, 2023, OWCP granted appellant a schedule award for five percent permanent impairment of her right upper extremity (right arm) and five percent permanent impairment of her left upper extremity (left arm). The period of the award ran for 31.2 weeks from January 1 to August 7, 2023.

LEGAL PRECEDENT

The schedule award provisions of FECA[3] and its implementing regulations[4] 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. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such adoption.[5] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[6]

In determining impairment under the sixth edition of the A.M.A., *Guides*, an evaluator must identify the impairment class of diagnosis (CDX), which is then adjusted by GMFH, GMPE, and GMCS.[7] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[8] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids, and calculations of modifier scores.[9]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23, Entrapment/Compression Neuropathy Impairment, and the accompanying relevant text.[10] In Table 15-23, grade modifiers levels (ranging from 0 to 4) are described for the categories clinical studies, functional history, and physical examination findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.* at § 10.404(a); *see R.M.*, Docket No. 20-1278 (issued May 4, 2022); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5.a (March 2017); *id.* at Part 3 -- Medical, *Schedule Awards,* Chapter 3.700.2 and Exhibit 1 (January 2010).

[7] A.M.A., *Guides* 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[8] *Id.* at 411.

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

[10] A.M.A., *Guides* 448-49; *see J.L.*, Docket No. 22-1299 (issued May 17, 2023); *S.B.*, Docket No. 22-0148 (issued March 24, 2023).

value. The default rating value is modified up or down based on the Functional Scale section of Table 15-23, using a *Quick*DASH score as an assessment of impact on daily living activities.[11]

ANALYSIS

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

OWCP referred appellant for a second opinion examination with Dr. Lumsden and in a March 24, 2023 report, he also applied Table 15-23 of the A.M.A., *Guides* for entrapment compression neuropathy impairment. Dr. Lumsden calculated an average grade modifier of 3, using grade modifiers of 3 for GMFH and GMPE, based on constant symptoms, atrophy, and weakness, and noting that he did not include a GMCS because there were no recent clinical studies. He computed an average grade modifier of 3, and opined that appellant had seven percent bilateral upper extremity impairment. Dr. Lumsden noted that the grade modifier of 3 corresponded to an impairment rating range of seven to nine percent, with a default value of 8, and explained that he chose seven percent because, "realistically this claimant actually falls to a [seven percent] impairment relative to the hands bilaterally." However, the Board notes that A.M.A., *Guides* at page 448 provide that preoperative clinical studies should be used unless postoperative studies were performed for failure to improve with surgery and the postoperative studies clearly show a worsening of the condition. Dr. Lumsden also did not discuss the Functional Scale section of Table 15-23 and did not provide a *Quick*DASH score. As such, the Board finds that his report fails to comply with the A.M.A., *Guides* and lacks probative value.[12]

It is well established that proceedings under FECA are not adversarial in nature, and while the employee has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[13] Once OWCP undertook development of the evidence by referring appellant's case file to a second opinion physician and an OWCP medical adviser, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.[14]

This case must, therefore, be remanded to OWCP for referral of the case record and a SOAF to Dr. Lumsden, the second opinion physician, to address appellant's bilateral upper extremity permanent impairment rating based on all of appellant's findings, including her preoperative clinical studies, the Functional Scale and *Quick*Dash score. After this and such other further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.

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

[12] *Id*.

[13] *See B.W.*, Docket No. 20-1441 (issued July 30, 2021); *see W.W.*, Docket No. 18-0093 (issued October 9, 2018); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[14] *See G.M.*, Docket No. 19-1931 (issued May 28, 2020); *Peter C. Belkind*, 56 ECAB 580 (2005); *Ayanle A. Hashi*, 56 ECAB 234 (2004).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the May 18, 2023 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: December 6, 2023
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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