United States Department of Labor
Employees' Compensation Appeals Board

C.G., Appellant	)	
and	)	**Docket No. 11-1612**
	)	**Issued: February 27, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 30, 2011 appellant filed a timely appeal of a June 15, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied her claim for a schedule award. 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 established that she has more than 20 percent impairment of the right arm for which she received a schedule award.

FACTUAL HISTORY

On October 25, 2004 appellant, then 32-year-old city carrier, filed an occupational disease claim alleging that she sustained carpal tunnel syndrome in the performance of her duties. OWCP accepted her claim for right carpal tunnel syndrome, cervical sprain, effusion of

[1] 5 U.S.C. § 8101 *et seq.*

joint forearm on the right and a sprain of the wrist. Appellant received appropriate compensation benefits.[2]

On October 22, 2010 and April 1, 2011 appellant filed a Form CA-7 and requested a schedule award.

In a report dated October 20, 2010, Dr. Jacob Soloman, a surgeon, noted appellant's history of injury and treatment which included right carpal tunnel surgery in 2005. On examination, appellant had persistent pain and numbness in her hand to the point that she was unable to sleep at night. Dr. Soloman noted that she developed allodynia, a severe sensory tolerance, had a history of coldness in her hands with swelling and edema and chronic pain to include complex regional pain syndrome (CRPS) type 2, manifested by sympathetic mediated pain components such as allodynia, hyperpathia, hyperalgesia and dysesthesia. He advised that appellant reached maximum medical improvement on September 2, 2007 with permanent restrictions. Dr. Soloman referred to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009) and referred to Table 15-21 to evaluate the carpal tunnel condition.[3] He noted that she had decreased sensation to pinprick and 2-point discrimination being greater than 1.7 centimeter in the right hand. Dr. Soloman determined that appellant had decreased grip strength and pinch strength on the right hand as compared to the left. He advised that the chronic pain and numbness kept her awake at night and she had difficulties with activities of daily living such as getting dressed, buttoning clothes, handling small objects and opening jars. Dr. Soloman explained that the combination of decreased activities of daily living would result in a functional history grade modifier 2 and the physical examination due to decreased sensation and grip strength warranted a grade modifier adjustment 2 and clinical studies with an electromyography (EMG) scan revealed decreased sensation in the right median nerve along the thenar component, which resulted in a grade modifier C. He applied the net adjustment formula and determined that appellant had a final impairment of 17 percent for the carpal tunnel diagnosis-based impairment. As for the CRPS component, type 2, Dr. Soloman used Table 15-26 on page 454. Using four points of discrimination such as allodynia, vasomotor coldness of appellant's hand, swelling and edema of the hand and pain, results in class 2 impairment with a grade modifier adjustment of functional history 1, physical examination 2, clinical studies 1. Dr. Soloman advised that it resulted in a net adjustment of grade E or 25 percent. He combined the 17 percent deficit related to the carpal tunnel component and 25 percent deficit related to complex regional pain syndrome and advised that it resulted in a combined right upper extremity impairment of 42 percent. An October 19, 2010 impairment evaluation worksheet accompanied Dr. Soloman's report.

On January 4, 2011 an OWCP medical adviser reviewed the report of Dr. Solomon under the A.M.A., *Guides* and disagreed with his rating. He explained that for carpal tunnel syndrome,

[2] On May 14, 2007 OWCP reduced appellant's compensation to zero finding that her actual earnings fairly and reasonably represented her wage-earning capacity. Thereafter, appellant claimed a schedule award and submitted supporting evidence. OWCP developed the matter and, on March 5, 2010, denied her claim for a schedule award finding that the medical evidence did not establish permanent impairment of the right arm.

[3] A.M.A., *Guides* 438.

Table 15-23 should be utilized.[4] The medical adviser noted that the maximum rating would equate to a nine percent permanent impairment. He noted that the carpal tunnel symptoms of decreased pinprick, decreased grip strength and EMG loss of median nerve function, corresponded to an eight percent impairment rating. Additionally, the medical adviser noted that the symptoms of CRPS including allodynia, vasomotor symptoms, swelling, edema and pain corresponded to a grade E class 1 deficit of 13 percent. He opined that appellant had a 20 percent permanent impairment of the right upper extremity.

On June 15, 2011 OWCP granted appellant a schedule award for 20 percent permanent impairment of the right upper extremity. The award covered a period of 62.43 weeks.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing 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. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to 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. For decisions issued after May 1, 2009, the A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[7]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[8] In Table 15-23, grade modifiers 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.[9]

ANALYSIS

Appellant's claim was accepted by OWCP for right carpal tunnel syndrome, cervical sprain, effusion of joint forearm on the right and a sprain of the wrist. The Board finds that the medical evidence of record establishes no more than 20 percent impairment to her right arm.

[4] *Id*. at 449.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] FECA Bulletin No. 09-03 (issued March 15, 2009). A.M.A., *Guides* (6th ed. 2008).

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

[9] A survey completed by a given claimant, known by the name *Quick*DASH, may be used to determine the function scale score. *Id*. at 448-49.

In an October 20, 2010 report, Dr. Soloman, a treating physician, utilized the A.M.A., *Guides* and referred to Table 15-21 to evaluate the carpal tunnel condition.[10] He determined that appellant had an impairment of 17 percent for the carpal tunnel diagnosis-based impairment. However, the Board notes that Dr. Soloman did not refer to Table 15-23, as noted above, for rating carpal tunnel syndrome or explain why it did not apply.[11] Furthermore, the maximum impairment rating for carpal tunnel syndrome equates to nine percent impairment. Regarding CRPS, Dr. Soloman referred to Table 15-26.[12] His findings included four points of discrimination such as allodynia, vasomotor coldness of her hand, swelling and edema of the hand and pain, which he explained, results in class 2 impairment with a grade modifier adjustment of functional history 1, physical examination 2, clinical studies 1. Dr. Soloman advised that it resulted in a net adjustment of grade E or 25 percent. However, the Board notes that the objective findings correspond to class 1 impairment, as they add up to 4 and the maximum impairment for the CRSP would equate to 13 percent. Furthermore, the language of the A.M.A, *Guides* cautions against use of Table 15-26, noting the "extreme rarity" of CRPS and sets forth four conditions on page 451 that must be met before the condition may be rated. The A.M.A., *Guides* point out that a rating for CRPS is a stand-alone rating and that no other impairment for the same extremity may be combined.[13] The Board notes that Dr. Solomon did not clearly explain his reasoning for combining a rating for CRPS with another rating or why a rating for CRPS was warranted. The Board precedent is well settled that when an attending physician's report gives an estimate of impairment but does not address how the estimate is based upon the A.M.A., *Guides*, OWCP may follow the advice of its medical adviser or consultant.[14]

OWCP's medical adviser properly began his January 4, 2011 evaluation by referring to Table 15-23.[15] He utilized Dr. Soloman's findings, chose grade modifiers for the various relevant categories and determined that appellant fell under grade modifier 3 which had a maximum default value equaling a nine percent impairment rating. As noted, this is the maximum for carpal tunnel syndrome. The medical adviser explained that appellant's symptoms and testing warranted eight percent impairment due to carpal tunnel syndrome. Regarding the CRPS symptoms, he referred to Dr. Soloman's findings and Table 15-26 and explained why the maximum impairment value for this diagnosis would be 13 percent.[16] However, like Dr. Solomon, the medical adviser did not explain why a diagnosis of CRPS was warranted in light of the cautionary language of the A.M.A., *Guides* and he also did not explain why, even if justified, a rating for CRPS should be combined with a rating for carpal tunnel syndrome in view

[10] *Supra* note 3.

[11] *See supra* note 8.

[12] A.M.A., *Guides* 454.

[13] *Id.* at 452.

[14] *J.Q.*, 59 ECAB 366 (2008); *Laura Heyen*, 57 ECAB 435 (2006).

[15] *Supra* note 8 (6th ed. 2009).

[16] *Supra* note 12.

of the prohibition of such a combination in the A.M.A., *Guides*.[17] The Board finds that the medical adviser's report does not support any greater impairment than that which OWCP awarded appellant.[18]

CONCLUSION

The Board finds that appellant has not established that she has more than 20 percent impairment of the right arm for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the June 15, 2011 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: February 27, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[17] *See supra* note 13 and accompanying text.

[18] Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.