United States Department of Labor
Employees' Compensation Appeals Board

M.L., Appellant	)	
and	)	**Docket No. 18-0547**
	)	**Issued: November 7, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Aurora, 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:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On January 22, 2018 appellant, through counsel, filed a timely appeal from a November 13, 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 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 more than two percent permanent impairment of the bilateral upper extremities, for which she previously received schedule award compensation.

FACTUAL HISTORY

On April 7, 2012 appellant, then a 44-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that she developed bilateral carpal tunnel syndrome causally related to repetitive upper extremity motions while sorting and delivering mail. She indicated on the claim form that she first became aware of her claimed condition on January 30, 2006 and of its relation to her federal employment on March 30, 2012. Appellant remained exposed to the identified work factors until she stopped work on March 30, 2012.

In a report dated May 2, 2012, Dr. Chris Huang, an attending Board-certified orthopedic surgeon, noted that he began treating appellant on April 13, 2012. Appellant presented with numbness and tingling in the thumb and index and long fingers of each hand. An April 4, 2012 electromyography (EMG) and nerve conduction velocity (NCV) study demonstrated moderate bilateral carpal tunnel syndrome. Dr. Huang attributed the condition to repetitive wrist flexion while delivering mail. He performed a left carpal tunnel release on April 19, 2012.

On May 21, 2012 OWCP accepted that appellant sustained bilateral carpal tunnel syndrome. It paid her wage-loss compensation for temporary total disability for the period May 8 to December 14, 2012.

On July 2, 2012 Dr. Huang performed an authorized right carpal tunnel release.[3] In a report dated August 2, 2012, he opined that appellant's numbness and tingling in both hands had resolved after the bilateral carpal tunnel releases. Appellant participated in physical therapy to mobilize and strengthen both wrists. In an August 10, 2012 report, Dr. Huang noted that she had developed bilateral cubital tunnel syndrome in both elbows. On September 14 and October 12, 2012 he diagnosed bilateral triangular fibrocartilage complex (TFCC) tears at the radial attachment. Dr. Huang noted that he "could not say for certain" whether the TFCC tears were occupationally related. He released appellant from care on October 12, 2012.

On December 3, 2012 appellant accepted a limited-duty job for one hour a day, casing and pulling down a mail route. She returned to this work on December 4, 2012. OWCP paid appellant compensation for the remaining seven hours a day commencing December 15, 2012.

In an April 2, 2013 report, Dr. Huang noted that appellant wore bilateral wrist braces. On examination he found well-healed surgical scars, positive compression tests bilaterally, tenderness to palpation over the TFCC in both wrists, symmetric range of motion, positive Tinel's sign over the cubital tunnel bilaterally, sensation intact to light touch throughout both hands, no thenar or

[3] In a July 11, 2012 report, Dr. Donald D. Higgins, Jr., an attending osteopath, opined that appellant had bilateral carpal tunnel syndrome, however, noted that he would not comment on whether or not the condition was related to her federal employment.

interossei atrophy, full extension, and full composite grasp of all digits. Dr. Huang diagnosed status post bilateral carpal tunnel releases, with residual numbness and tingling, ulnar-sided bilateral wrist pain secondary to TFCC tears.

In a June 4, 2013 letter, Dr. Huang opined that appellant had reached maximum medical improvement (MMI) and had completed all necessary treatment.

On August 6, 2013 appellant filed a claim for a schedule award (Form CA-7) based on a partial loss of use of her bilateral upper extremities.

In support of her claim, appellant provided a September 7, 2013 impairment rating based on an August 27, 2013 examination by Dr. Neil Allen, a Board-certified internist and neurologist. Dr. Allen reviewed medical records, electrodiagnostic test results, and opined that appellant had attained MMI. He related appellant's account of mild interference with travel; moderate interference with activities of daily living including self-care, personal hygiene, communication, and sleep; and severe interference with physical activity. Dr. Allen administered a *Quick*DASH questionnaire which yielded a score of 66. On examination of the right wrist, he found a well-healed surgical scar, minimal hypothenar atrophy, a normal sensory examination, tenderness to palpation over the carpal tunnel, and negative Phalen's and reverse Phalen's tests. Dr. Allen observed 60 degrees flexion, 55 degrees extension, 20 degrees radial deviation, 35 degrees ulnar deviation, and 50 degrees abduction. On examination of the left wrist, he noted no atrophy, a normal sensory examination, and tenderness to palpation over the carpal tunnel. Dr. Allen observed 25 degrees flexion, 65 degrees extension, 25 degrees radial deviation, 25 degrees ulnar deviation, and 50 degrees abduction. Referring to Table 15-23,[4] he assessed six percent impairment of the right upper extremity, a grade 1 modifier for clinical studies (GMCS) of 1 for conduction delay, a grade modifier for functional history (GMFH) of 3 for constant symptoms, and a physical examination (GMPE) of 1 for normal findings with a *Quick*DASH score of 66. Dr. Allen made an identical assessment for the left wrist using the same criteria, finding six percent permanent impairment of the left upper extremity.

On September 16, 2013 OWCP obtained a second opinion from Dr. Theodore J. Suchy, a Board-certified orthopedic surgeon. Dr. Suchy reviewed the medical record, a statement of accepted facts, and a list of questions regarding appellant's physical condition and ability to return to work. He related appellant's complaints of numbness and tingling throughout both hands in a nondermatomal pattern, and bilateral elbow pain radiating to both forearms which awakened her from sleep. On examination of both wrists, Dr. Suchy found well-healed surgical scars, dorsal bosses at the dorsoradial aspect, full range of wrist and finger motion, negative Tinel's sign, positive Phalen's sign, and symmetric two-point discrimination at six millimeters (mm). He opined that appellant had attained MMI. Dr. Suchy noted that her subjective symptoms exceeded her objective physical findings on examination. He found appellant able to perform full-time light-

[4] Table 15-23, page 449 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) is titled "Entrapment/Compression Neuropathy Impairment."

duty work with lifting up to 20 pounds and no more than two hours a day of repetitive upper extremity tasks.

In a June 2, 2014 report, Dr. David H. Garelick, an OWCP district medical adviser, reviewed the medical record and Dr. Suchy's report. He found that appellant had attained MMI on October 12, 2012 when Dr. Huang discharged her from care. Dr. Garelick noted that, according to Dr. Suchy, there was no evidence of muscle atrophy, subjective paresthesias in both hands, and "nearly normal" two-point discrimination at six mm. He opined that, according to Table 15-23, appellant had two percent permanent impairment of each upper extremity.

By decision dated May 29, 2015, OWCP granted appellant a schedule award for two percent permanent impairment of her left upper extremity and two percent permanent impairment of her right upper extremity. The award ran for 12.48 weeks, covering the period April 23 to July 19, 2013. OWCP based this award on Dr. Suchy's September 16, 2013 physical findings as reviewed by Dr. Garelick.

On June 8, 2015 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative. At the hearing, held on February 17, 2016, counsel contended that there was a conflict of medical opinion between Dr. Allen, for appellant, and Dr. Suchy, for the government, regarding the appropriate percentage of permanent impairment. He requested that OWCP select an impartial medical specialist to resolve the conflict.

By decision dated May 2, 2016, OWCP's hearing representative vacated OWCP's May 29, 2015 schedule award determination, finding that the medical adviser had not considered Dr. Allen's September 7, 2013 clinical findings in determining the percentage of permanent impairment. She remanded the case to OWCP to obtain a supplemental opinion from OWCP's medical adviser for review and consideration of Dr. Allen's findings, to be followed by a *de novo* decision.

In a June 5, 2016 report, Dr. Morley Slutsky, an OWCP district medical adviser, compared Dr. Allen's September 17, 2013 impairment rating to Dr. Suchy's findings as reviewed by OWCP's medical adviser on June 2, 2015. He noted that Dr. Allen assessed a GMFH of 3, whereas the medical adviser found a GMFH of 1. Also, Dr. Allen found that the *Quick*DASH score of 66 demonstrated a severe impairment, whereas the medical adviser found it invalid or unreliable. Dr. Slutsky assessed a GMFH of 1 as according to Dr. Allen and Dr. Suchy appellant did not require assistance with activities of daily living, and there was no electrodiagnostic evidence of conduction block or axonal involvement. He found a GMPE for local nerve compression of zero as appellant had two-point discrimination within normal limits, with no atrophy or muscle loss attributable to median nerve involvement. Dr. Slutsky assessed a GMCS of 1 for electrodiagnostic studies. He found that the *Quick*DASH score of 66 as obtained by Dr. Allen was unreliable as appellant had no physical findings and only mild symptoms. Dr. Slutsky averaged the GMCS of 1, GMPE of 0, and GMFH of 1 to equal .67, rounded upward to 1.0, leaving the default class of diagnosis (CDX) of 2 percent unchanged. He therefore

concurred with Dr. Garelick's finding of two percent permanent impairment of each upper extremity.

By decision dated August 30, 2016, OWCP denied appellant's claim for an additional schedule award. It found that she had not established more than two percent permanent impairment of her left upper extremity and two percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation.

On September 12, 2016 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative. During the hearing, held on September 12, 2017, counsel contended that Dr. Allen's report should be accorded the weight of the medical evidence as he was a Board-certified neurologist and properly applied the A.M.A., *Guides* to assess the appropriate percentage of permanent impairment. Alternatively, he alleged a conflict of medical opinion between Dr. Allen and Dr. Suchy, or Dr. Allen and Dr. Slutsky, requiring resolution by an impartial medical specialist. Counsel submitted additional medical evidence.

In a report dated October 18, 2017, Dr. Allen disagreed with Dr. Slutsky's invalidation of the *Quick*DASH score of 66. He indicated that all patient histories were inherently subjective and that it was a physician's duty to record the history as "reported by the patient, not out interpretation of symptoms based upon available diagnostic testing." Dr. Allen contended that, as symptom frequency was "subjective in nature, it [was] not ethical to alter this information." He affirmed his September 17, 2013 calculation of six percent permanent impairment of each upper extremity.

By decision dated November 13, 2017, an OWCP hearing representative affirmed the denial of appellant's claim for an additional schedule award. He found that she had not established more than two percent permanent impairment of her left upper extremity and two percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation. The hearing representative found that Dr. Slutsky fully considered Dr. Allen's impairment rating and applied the appropriate portions of the A.M.A., *Guides* to his clinical findings. He further found that there was no conflict of medical opinion as Dr. Slutsky provided a thorough, detailed explanation of the appropriate ratings criteria, and how Dr. Allen had misapplied the A.M.A., *Guides*.

LEGAL PRECEDENT

The schedule award provisions 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

evaluating schedule losses.[7] The claimant has the burden of proof to prove that the condition for which a schedule award is sought is causally related to her employment.[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] Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment of the class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[12] In Table 15-23, grade modifiers 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.[13]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[14]

ANALYSIS

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

[7] *Id.*

[8] *Veronica Williams*, 56 ECAB 367, 370 (2005).

[9] A.M.A., *Guides*, *supra* note 4 at 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[10] *Id.* at 385-419.

[11] *Id*. at 411.

[12] *Id*. at 449.

[13] *Id.* at 448-50. *See also M.C.*, Docket No. 16-1645 (issued May 3, 2018).

[14] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

The Board has held that an impairment rating that is not based on reasonably current examination findings is of little probative value.[15] The physical findings on which the November 13, 2017 decision relies were reported by Dr. Suchy approximately four years prior on September 16, 2013. It was improper for OWCP to have relied on his findings in its November 13, 2017 schedule award determination as they were no longer sufficiently current.[16]

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[17] While the claimant has the burden of proof to establish entitlement to schedule award compensation, OWCP shares the responsibility in the development of the evidence to see that justice is done.[18] As it undertook development of the evidence by referring appellant for a second opinion examination, it had the duty to secure an appropriate impairment rating based upon reasonably current physical findings as opposed to relying on stale medical evidence.[19] The case will therefore be remanded to OWCP for additional development. On remand of the case, OWCP shall refer appellant for a new second opinion examination in accordance with its procedures to obtain current physical findings.[20] After such further development, as it deems necessary, it should issue an appropriate *de novo* decision.

CONCLUSION

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

[15] *T.M.*, Docket No. 16-0429 (issued August 11, 2016) (whether the Board held that an OWCP medical adviser's impairment rating based on stale medical evidence was of little probative value in determining the appropriate percentage of permanent impairment); *see W.M.*, Docket No. 12-0773 (issued March 29, 2013) (where a physician sought in June 2011 to update a prior impairment rating, but the Board found that the May 2004 findings which served as the basis for he updated rating constituted stale medical evidence); *P.S.*, Docket No. 12-0649 (issued February 14, 2013) (the Board found that a physician's January 2010 impairment rating was of reduced probative value because the physician relied upon October 2007 findings as the basis for this update impairment rating).

[16] *A.W.*, Docket No. 14-0199 (issued September 1, 2017) (where the Board held that medical opinions predicated on stale medical evidence lack probative value as to the extent of permanent impairment); *T.M.*, *id*.

[17] *Id.*

[18] *Id.*

[19] *Id.*

[20] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Second Opinion Examinations*, Chapter 3.500.c(3)(b) (June 2015).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated November 13, 2017 is set aside and the case remanded to OWCP for additional development consistent with this decision of the Board.

Issued: November 7, 2018
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board