United States Department of Labor
Employees' Compensation Appeals Board

D.P., Appellant	)	
	)	**Docket No. 12-1122**
and	)	**Issued: December 5, 2012**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Upper Marlboro, MD, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 30, 2012 appellant filed a timely appeal of January 19, 2012 Office of Workers' Compensation Programs' (OWCP) merit decision denying 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 to consider the merits of the case.

ISSUE

The issue is whether appellant has permanent impairment to a scheduled member entitling him to a schedule award.

FACTUAL HISTORY

On January 25, 1999 appellant, then a 34-year-old letter sorter machine operator, filed a notice of occupational disease alleging that he developed bilateral carpal tunnel syndrome due to factors of his federal employment. On April 8, 1999 OWCP accepted his claim for bilateral

[1] 5 U.S.C. § 8101 *et seq.*

carpal tunnel syndrome and authorized right carpal tunnel release. On April 16, 1999 Dr. Rida Azer, a Board-certified orthopedic surgeon, performed a right carpal tunnel release and on May 12, 2000 he performed authorized left carpal tunnel release. On October 16, 2003 appellant underwent an electromyogram (EMG) and nerve conduction velocity (NCV) tests. On March 9, 2005 Dr. Azer stated that appellant had satisfactory grip and normal sensation over the right and left median nerves. She repeated these findings on June 15, 2005.

Appellant filed a claim for compensation requesting a schedule award on October 12, 2006. He submitted a report dated February 9, 2007 from Dr. Hampton J. Jackson, Jr., a Board-certified orthopedic surgeon, who applied the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] and found that appellant had 20 percent loss of strength on the right and 20 to 25 percent loss of strength on the left. Dr. Jackson found appellant had 10 percent impairment bilaterally due to loss of grip strength. He further found that appellant had 10 percent impairment bilaterally due to loss of pinch strength. Dr. Jackson found that appellant had grade three sensory deficit and pain or 24 percent impairment of each upper extremity. He also found that appellant had Grade 4 impairment due to motor and power deficit or 2.5 motor deficit. Dr. Jackson concluded that appellant had 41 percent impairment of each upper extremity due to carpal tunnel syndrome.

OWCP referred appellant for a second opinion evaluation with Dr. Robert Smith, a Board-certified orthopedic surgeon on June 19, 2007. In a report dated July 19, 2007, Dr. Smith noted appellant's history of injury and medical history. He found no evidence of atrophy or deformity in the upper extremities and normal range of motion. Dr. Smith stated that grip, pinch and opposition strength were normal with negative Tinel's and Phalen's signs. He noted that a postoperative EMG study in 2003 showed no evidence of ongoing carpal tunnel syndrome. Dr. Smith found that appellant had no ratable impairment of his upper extremities based on the fifth edition of the A.M.A., *Guides*.

By decision dated August 29, 2007, OWCP denied appellant's claim for a schedule award finding that Dr. Smith's report established that appellant did not have a ratable impairment due to his accepted condition of bilateral carpal tunnel syndrome.

Dr. Peter S. Trent, a Board-certified orthopedic surgeon, submitted a report dated December 10, 2007 and stated that he did not agree with Dr. Smith's impairment rating. He stated, "The physical examination of the patient in the office today shows well-healed scars. There is a small degree of thenar atrophy on the right when compared to the left. The patient does have some residual tenderness over the carpal canal, but grip strength is good."

Dr. Jackson submitted a report dated August 1, 2008 and stated that grip and pinch strength testing established diminished strength. He again opined that appellant had 41 percent impairment of his upper extremities bilaterally under the fifth edition of the A.M.A., *Guides*.

Appellant requested reconsideration on August 27, 2008. By decision dated December 4, 2008, OWCP reviewed the merits of his claim and denied modification of the August 29, 2007 decision.

[2] A.M.A., *Guides*, 5th ed. (2001).

Appellant again requested reconsideration on December 20, 2008. He submitted a report dated December 12, 2008 from Dr. Jackson noting that he supplied appellant's impairment rating based on the fifth edition of the A.M.A., *Guides* using grip and pinch strength and that appellant's impairment rating remained the same. Dr. Azer examined appellant on January 14, 2009 and stated that sensation in the median nerves was normal bilaterally and that grip was satisfactory.

OWCP's medical adviser reviewed the medical evidence on March 27, 2009 and agreed that appellant had no ratable impairment under the A.M.A., *Guides*.

By decision dated April 16, 2009, OWCP denied modification of its prior decisions.

Subsequently, appellant submitted a report by Dr. Azer who examined appellant on May 22, 2009 and repeated her findings of satisfactory sensation and grip strength. Dr. Jackson recommended repeat EMG's on June 16, 2009. In a report dated October 9, 2009, Drs. Jackson and Azer reviewed appellant's findings and applied the sixth edition of the A.M.A., *Guides*.[3] The physicians stated, "It is my opinion that the ratings that we gave based on the fifth edition, remains 41 percent of the upper extremity. However, when I review the sixth edition for the same findings, his rating drops to 38 percent. That is 38 percent in each upper extremity."

Appellant requested reconsideration on October 23, 2009. In a decision dated January 4, 2010, OWCP denied modification of the April 16, 2009 decision denying his claim for a schedule award.

Dr. Daniel Ignacio, completed an EMG report on February 1, 2010 and diagnosed chronic bilateral carpal tunnel syndrome with chronic stable denervation of the right hand. He stated that the right median nerve conduction block across the right wrist was improved but continued to be slow with chronic denervation of the right hand. In a narrative report of the same date, Dr. Ignacio noted appellant's medical history and found hypoesthesia along the right thumb and index finger with limited grip strength. He also found continuing hypoesthesia and weakness along the left hand. Dr. Ignacio diagnosed chronic bilateral carpal tunnel syndrome with chronic denervations along the right hand, chronic tenosynovitis of the wrist and chronic regional pain syndrome. On February 12 and 24, 2010 Dr. Ignacio repeated his diagnoses and recommended that appellant use a wrist splint.

In a report dated March 11, 2010, Dr. Ignacio stated that appellant had multiple surgeries with scarring and associated sensorimotor defect which he believed resulted in a permanent impairment. He opined that appellant had a permanent impairment due to scarring in and around the joints and nerves with deformity and disfigurement. Dr. Ignacio also stated that appellant had sensorimotor defect. He provided an impairment rating based on the fifth edition of the A.M.A., *Guides* and awarded appellant 59 percent impairment of the right upper extremity due to sensory defect of the median nerve, loss of muscle power and motor function of 75 percent and 5 percent impairment due to contractures of the right wrist. In regard to appellant's left upper extremity, Dr. Ignacio found 50 percent impairment due to sensory deficit and 60 percent due to

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

loss of motor function and 5 percent impairment due to contractures of the left wrist for 53 percent impairment of the left upper extremity.

Appellant requested reconsideration on March 18, 2010. In a report dated January 29, 2010, Dr. Azer disagreed with Dr. Smith's evaluation. He submitted a report dated February 2, 2010 from Dr. Henry M. Daniels, a Board-certified orthopedic surgeon, noting the history of injury and medical history. Dr. Daniels noted that appellant experienced numbness and tingling in the median sensory distribution of both hands as well as dysesthesia during sleeping hours and residual grip strength weaknesses. He reviewed appellant's electrodiagnostic studies and diagnosed residual median neuropathy and de Quervain's tenosynovitis bilaterally.

By decision dated June 29, 2010, OWCP declined to reopen appellant's claim for reconsideration of the merits finding that he failed to submit new legal evidence or argument in support of his request for reconsideration.

Appellant appealed this decision to the Board, who found that appellant had submitted pertinent new and relevant evidence entitling him to a merit review and remanded the case for OWCP to review the merits of appellant's claim.[4]

Appellant submitted additional evidence into the record following OWCP's June 29, 2010 nonmerit decision. Dr. Ignacio completed a note dated July 9, 2010 listing his findings and diagnoses. Appellant underwent an MRI scan on July 14, 2010 which demonstrated intercarpal ligament partial tear between the navicular and lunate and complex tear of the base of the triangular fibrocartilage in both wrists. Dr. Ignacio completed reports dated September 16 and 30, 2010 and reported multiple scars along the right wrist and limited movement with continuing tenderness. He made similar findings in regard to the left wrist. Dr. Ignacio diagnosed chronic bilateral carpal tunnel syndrome, chronic tenosynovitis of the wrists, complex regional pain syndrome.

In a copy of the September 16, 2010 report received by OWCP on October 29, 2010, Dr. Ignacio found that appellant had permanent impairment due to multiple surgeries, disfigurement, contractures and sensory and motor defects. He determined that appellant had 59 percent impairment of the right upper extremity and 50 percent impairment of the left upper extremity in accordance with the fifth edition of the A.M.A., *Guides*. Dr. Ignacio continued to submit reports dated November 11 and 19, 2010. On November 19, 2010 he performed an infrared imaging report which demonstrated diminished infrared heat emission along the index finger, middle finger and thumb of each hand.

On February 14, 2011 Dr. Nigel M. Azer, a Board-certified orthopedic surgeon, examined appellant and found thenar atrophy in both hands, loss of grip strength and decreased sensation to pinprick and light touch in the thumb and index finger with decreased two-point discrimination bilaterally. He diagnosed chronic median nerve neuropathy of the right and left wrist and de Quervain's tenosynovitis bilaterally. Dr. Azer opined that appellant had permanent impairments due to his employment injury.

[4] Docket No. 11-36 (issued August 17, 2011).

Following the Board's decision on August 17, 2011, Dr. Azer completed a report dated January 3, 2012 and stated that appellant's residuals and permanent impairment remained the same. She opined that appellant had 38 percent impairment of the upper extremities.

By decision dated January 19, 2012, OWCP performed a merit review of the evidence submitted in support of the March 18, 2010 reconsideration request and determined that this evidence was not sufficient to establish a permanent impairment to a scheduled member. It repeatedly stated that the reports submitted failed to provide any specific references to the appropriate tables or figures in the sixth edition of the A.M.A., *Guides.*

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 for 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 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*.[7]

ANALYSIS

OWCP accepted that appellant developed bilateral carpal tunnel syndrome due to his work activities and authorized bilateral carpal tunnel releases. Appellant requested a schedule award and OWCP relied on the second opinion physician, Dr. Smith, in determining that appellant had no ratable impairment of his upper extremities entitling him to a schedule award. Dr. Smith noted that appellant had no electrodiagnostic findings in 2003. Appellant has repeatedly requested reconsideration and submitted additional medical evidence including new electrodiagnostic reports and additional impairment ratings in support of his claim for a schedule award.

In its most recent merit decision, OWCP discussed a portion of the medical evidence received since January 4, 2010 and denied appellant's request for a schedule award finding that the evidence was not sufficient to meet appellant's burden of proof as the medical evidence did not correlate to or comport with the sixth edition of the A.M.A., *Guides*.

[5] 5 U.S.C. §§ 8101-8193, 8107.

[6] 20 C.F.R. § 10.404.

[7] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award & Permanent Disability Claims*, Chapter 2.808.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

The Board finds that this case is not in posture for a decision. OWCP's procedures state that when there is a request for reconsideration in a schedule award claim and if the claimant is disputing the percentage of the award and submits new evidence, the case should be referred to the OWCP medical adviser or for further examination if needed.[8] In this case, OWCP failed to comply with its procedures as the new medical evidence submitted by appellant was not reviewed by an OWCP medical adviser nor was he referred for further examination. The claims examiner reviewed the medical evidence and dismissed the reports on the grounds that there were no citations to the sixth edition of the A.M.A., *Guides*. The Board finds that a review of the totality of the case was necessary to adequately complete a merit review and that as directed by the procedure manual, OWCP should have referred the medical evidence to an OWCP medical adviser to determine whether appellant had established a ratable permanent impairment or if further development was needed.

On remand, OWCP should refer all the medical evidence to an OWCP medical adviser to determine if appellant has a ratable impairment of his upper extremities due to his accepted condition of carpal tunnel syndrome or if an additional medical examination is necessary. After this and such other development as OWCP deems necessary, OWCP should issue a *de novo* decision on the merits of appellant's claim.

CONCLUSION

The Board finds that the case is not in posture for decision and requires referral to an OWCP medical adviser to determine if and what additional development of the medical evidence is necessary prior to issuing a *de novo* decision.

[8] Federal (FECA) Procedure Manual Part 2 -- Claims, *Reconsiderations,* Chapter 2.1602.8(b)(1) (October 2011).

ORDER

IT IS HEREBY ORDERED THAT the January 19, 2012 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further development consistent with this decision of the Board.

Issued: December 5, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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