U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOYCE M. HOLLIS and U.S. POSTAL SERVICE,
POST OFFICE, Tulsa, OK

Docket No. 02-963; Submitted on the Record;
Issued December 12, 2002

DECISION and ORDER

Before ALEC J. KOROMILAS, COLLEEN DUFFY KIKO,
WILLIE T.C. THOMAS

The issue is whether appellant has more than a five percent impairment of her left upper extremity, for which she received a schedule award.

Under section 8107 of the Federal Employees' Compensation Act[1] and section 10.404 of the implementing federal regulation,[2] schedule awards are payable for permanent impairment of specified body members, functions or organs. However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment*[3] (hereinafter A.M.A., *Guides*) has been adopted by the Office of Workers' Compensation Programs, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[4] Effective February 1, 2001, the fifth edition of the A.M.A., *Guides* is utilized to calculate any awards.[5]

On May 17, 1995 appellant, then a 50-year-old automated markup clerk, filed an occupational disease claim, alleging that factors of employment caused carpal tunnel syndrome. By letter dated November 15, 1995, the Office accepted that appellant sustained employment-

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[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999).

[3] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB ___ (Docket No. 01-1361, issued February 4, 2002).

[4] *See Joseph Lawrence, Jr., supra* note 3; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[5] FECA Bulletin No. 01-05 (issued January 29, 2001).

related right carpal tunnel syndrome. On February 9, 1996 she underwent right carpal tunnel release. On March 17, 1997 appellant filed an occupational disease claim for employment-related right trigger thumb and left carpal tunnel syndrome. In a decision dated October 17, 1997, the Office awarded appellant a schedule award for a 30 percent permanent impairment of her right upper extremity. On November 21, 1997 the Office also accepted appellant's claim for right trigger thumb and left carpal tunnel syndrome. On February 3 and 21, 1998 appellant underwent left carpal tunnel release with release of the ulnar nerve at the wrist. On June 9, 1998 appellant filed an occupational disease claim for employment-related left elbow tendinitis. By letter dated July 14, 1998, the Office accepted appellant's claim for left lateral epicondylitis. On August 11, 1998 appellant underwent left elbow fasciotomy with partial ostectomy and lengthening of extensor tendons.

On July 28, 1999 appellant filed a claim for a schedule award. In support of her claim, appellant submitted an October 9, 1999 report from her treating physician, Dr. Perry D. Inhofe, a Board-certified orthopedic surgeon, who concluded that appellant had a 12 percent permanent impairment of her left upper extremity due to her employment-related conditions, but while he referenced the relevant portions of the A.M.A., *Guides*, he provided none of the degrees of motion upon which he based his conclusion. At the request of the Office, an Office medical adviser reviewed Dr. Inhofe's report and concluded that it contained insufficient information to determine appellant's entitlement to a schedule award.

By letter dated March 24, 2000, the Office referred appellant, along with the medical record, a set of questions and a statement of accepted facts, to Dr. Varsha Sikka for a second opinion. Dr. Sikka submitted a report dated April 14, 2000, but failed to respond to the Office's several attempts to obtain clarification of his opinion. Therefore, by letter dated July 5, 2001, the Office referred appellant, along with the medical record, a set of questions and a statement of accepted facts, to Dr. Ellis P. Couch, a Board-certified orthopedic surgeon. In a decision dated November 8, 2001, the Office found that appellant was entitled to a schedule award for a five percent permanent impairment of her left upper extremity. The Office based its decision on the October 30, 2001 opinion of the Office medical adviser who applied the standards of the fifth edition of the A.M.A., *Guides* to Dr. Couch's findings.[6] The instant appeal follows.

The Office's procedures specifically provide that upper extremity impairment secondary to carpal tunnel syndrome and other entrapment neuropathies should be calculated using section 16.5d and Tables 16-10, 16-11 and 16-15.[7]

[6] As stated above, Office procedures direct the use of the fifth edition of the A.M.A., *Guides* for schedule awards determined on and after February 1, 2001. *Joseph Lawrence, Jr., supra* note 3.

[7] FECA Bulletin No. 01-05, *supra* note 5.

Regarding carpal tunnel syndrome, the A.M.A., *Guides* provide:

> "If, after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias, and/or difficulties in performing certain activities, three possible scenarios can be present:
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> "1. Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTS is rated according to the sensory and/or motor deficits as described earlier.
>
> "2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS is still present, and an impairment rating not to exceed five percent of the upper extremity may be justified.
>
> "3. Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength, and nerve conduction studies: there is no objective basis for an impairment rating."[8]

Section 16.5d of the A.M.A., *Guides* further provides that in compression neuropathies, additional impairment values are not given for decreased grip strength.[9]

In a November 2, 1999 report, Dr. Couch discussed all of appellant's employment-related injuries and associated surgical procedures, and noted her complaints of pain in her low back, mid back, upper back and neck, radiating into her extremities, as well as her complaints of pain in her left and right hands, wrists and shoulders. With respect to her upper extremities, the doctor found range of motion of the shoulders to be normal, with no trigger points or spasm. The physician noted that examination of the left upper extremity revealed a well-healed surgical scar over the lateral condyle, approximately two inches in length, with no muscle atrophy, and a well-healed surgical incision in the left wrist. Range of motion of the left wrist was measured and noted to approach full. Two-point discrimination was five millimeters or less in all fingers, and there was no loss of sensation to light touch. Range of motion of the metacarpal and phalangeal joints of the left hand were noted by Dr. Couch to be normal. Examination of the right hand revealed a well-healed and nontender carpal tunnel release scar over the hyperthenar eminence. There was no evidence of synovitis or arthritis on gross examination. Range of motion of the right wrist approached full and range of motion of the fingers of the right hand was full. Two-point discrimination of the right upper extremity was noted to be normal and less than five millimeters. The deep tendon reflexes in the upper extremities were full and symmetrical and there was no evidence of muscle wasting or weakness. Dr. Couch noted a slight preponderance in right grip strength over the left, but no more than three pounds, and lateral pinch was equal bilaterally. He diagnosed bilateral carpal tunnel syndrome, released surgically, lateral epicondylitis, left elbow, released surgically, and cervical disc disease, C5-6, status

[8] A.M.A., *Guides*, *supra* note 3 at 495.

[9] *Id.* at 494.

postdiscectomy and fusion. Dr. Couch noted that maximum medical improvement had been reached on January 1, 1999, and stated:

> "According to the A.M.A., *Guides to the Evaluation of Permanent Impairment,* [f]ifth [e]dition, I note no loss of sensation as measured by two-point discrimination in either the right or left hand. Similarly, range of motion of the wrist and fingers approach normal with only minimal changes, which can be ascribed to the patient's preexisting degenerative osteoarthritis.
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> "According to Table 16-10, [p]age 482 of the [A.M.A.,] *Guides*, it is my opinion that [appellant] has a [G]rade IV sensory deficit of a mild degree, which can be extrapolated to a five percent sensory deficit of each upper extremity. Since there is a significant change in the fifth [e]dition of the [A.M.A.,] *Guides* regarding strength loss from upper extremities due to entrapment syndromes, grip strength cannot be utilized to add additional impairment."

In an October 30, 2001 report, an Office medical adviser applied the fifth edition of the A.M.A., *Guides* to Dr. Couch's findings and concurred with the physician's conclusions that a bilateral Grade IV sensory deficit of the median nerve, below midforearm, equated to a five percent permanent impairment of each upper extremity, pursuant to Tables 16-10 and 16-15, pages 482 and 492 of the A.M.A., *Guides*.

As stated above, the fifth edition of the A.M.A., *Guides* provides three scenarios for interpreting carpal tunnel syndrome.[10] The findings in the instant case fall into the second scenario which indicates that an impairment rating is not to exceed five percent.[11] The Board therefore finds that, with respect to appellant's accepted carpal tunnel syndrome, as both Dr. Couch and the Office medical adviser provided an explanation regarding the application of the values found in the A.M.A., *Guides*, appellant has not established that she has more than a five percent impairment of her left upper extremity. With respect to the issue of whether appellant has any additional impairment of her left upper extremity due to her accepted left lateral epicondylitis with associated surgery, the Board finds that this case is not in posture for a decision. While Dr. Couch clearly noted in his report that appellant's left lateral epicondylitis with associated surgery was accepted by the Office, Dr. Couch did not note whether appellant has any range of motion deficit due to her left lateral epicondylitis. Proceedings under the Act are not adversarial in nature and while the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[12] In addition, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[13] In this case, the Office did not fulfill its responsibility in the development of the medical evidence because it did not seek clarification from Dr. Couch as to whether his impairment rating included all of appellant's accepted conditions. Therefore, this

[10] FECA Bulletin No. 01-05, s*upra* note 5.

[11] A.M.A., *Guides, supra* note 3 at 495.

[12] *Shirley A. Temple*, 48 ECAB 404 (1997); *Mary A. Wright*, 48 ECAB 240 (1996).

[13] *Robert F. Hart*, 36 ECAB 186 (1984).

case must be remanded for further medical development on the issue of whether appellant has any additional impairment due to her accepted left elbow epicondylitis.

Accordingly, the decision of the Office of Workers' Compensation Programs dated November 11, 2001 is affirmed in part, and this case is remanded for further development consistent with this opinion.

Dated, Washington, DC
December 12, 2002

Alec J. Koromilas
Member

Colleen Duffy Kiko
Member

Willie T.C. Thomas
Alternate Member