U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CRISTEEN FALLS and U.S. POSTAL SERVICE,
POST OFFICE, Winston Salem, NC

Docket No. 03-1665; Submitted on the Record;
Issued March 29, 2004

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant has greater than an eight percent permanent impairment of her right upper extremity, for which she has received a schedule award.

On March 19, 2001 appellant, then a 53-year-old manager of mail processing, tripped on a pallet, fell backwards and attempted to break her fall with her right hand. Appellant fractured the scaphoid bone in her right wrist as a result. The Office of Workers' Compensation Programs accepted that appellant sustained a right wrist nondisplaced scaphoid fracture. As appellant healed she developed a mild right median nerve entrapment neuropathy at the wrist. The Office accepted that appellant also developed right carpal tunnel syndrome, and surgery was authorized; appellant underwent a right carpal tunnel release on June 6, 2002 with good results.

In a report dated June 29, 2002, Dr. John Lee Graves, a Board-certified orthopedic surgeon, opined that appellant had reached maximum medical improvement and had a 5 percent permanent impairment for the carpal tunnel syndrome, a 5 percent permanent impairment for the right scaphoid fracture and a 2.5 percent permanent impairment for de Quervain's tenosynovitis, for a total right upper extremity impairment of 12.5 percent.

On September 16, 2002 appellant filed a Form CA-7 claim for a schedule award.

In support she submitted an August 29, 2002 report from Dr. Graves which noted that, in accordance with the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, appellant had a 5 percent permanent impairment of the right hand for the carpal tunnel release, 1 percent for 5 degrees lack of radial deviation compared to the opposite side, 4 percent for 20 degrees lack of extension and 3 percent for 20 degrees lack of flexion for a total of 8 percent permanent impairment to the right hand for loss of motion which would add up to a total of 13 percent permanent impairment of the right hand.

On October 1, 2002 the Office referred appellant's record to an Office medical adviser and requested that he provide an opinion as to appellant's permanent impairment rating. The Office medical adviser replied that he agreed with Dr. Graves that appellant had a five percent permanent impairment for the carpal tunnel syndrome, as it was in accord with the fifth edition of the A.M.A., *Guides*, page 495. However, the Office medical adviser noted that Dr. Graves improperly added eight percent permanent impairment due to losses in range of motion to the diagnosis-based estimate, as this loss in range of motion was not as a result of the carpal tunnel release, and had not been shown to be causally related to the carpal tunnel syndrome. The Office medical adviser recommended that appellant receive a five percent permanent impairment rating of the right upper extremity.

On October 22, 2002 the Office granted appellant a schedule award for a five percent permanent impairment of her right upper extremity for the period October 6, 2002 to January 23, 2003 for a total of 15.60 weeks of compensation.

By undated letter received by the Office on November 4, 2002, appellant requested reconsideration of the amount of the schedule award. Appellant claimed that the eight percent impairment and limited wrist motion was due to the fracture and not the carpal tunnel syndrome, and should not be discounted.

By decision dated January 13, 2003, the Office denied appellant's request for further review of her case on its merits on the grounds that she failed to submit new medical evidence or cite any new legal argument to support reopening her case for further review on its merits.

In a letter dated February 6, 2003, appellant requested reconsideration arguing that her losses in range of motion were due to her accepted fracture and not to the carpal tunnel syndrome.

The Office referred the case to the Office medical adviser indicating that appellant had pointed out that she had two accepted conditions, the scaphoid fracture and carpal tunnel syndrome, and it requested that the Office medical adviser recalculate appellant's permanent impairment considering both accepted conditions. On February 19, 2003 the Office medical adviser recalculated appellant's impairment based on the loss in range-of-motion measurements and found that appellant had an eight percent total permanent impairment of the right upper extremity.

On March 6, 2003 the Office granted appellant an additional three percent permanent impairment for a total of eight percent permanent impairment of the right upper extremity. This award was calculated and given for loss of range of motion only, as the impairment percentage for loss of motion was greater than the diagnosis-based impairment of five percent.

In an undated letter received by the Office on March 19, 2003, appellant requested reconsideration and argued that she was entitled to a 13 percent schedule award; 5 percent for the carpal tunnel syndrome and 8 percent for loss of range of motion due to the scaphoid fracture.

By decision dated March 25, 2003, the Office declined to reopen appellant's case for further review on the merits as she had failed to provide any new medical evidence or cite any new legal argument to warrant further merit reconsideration.

By informational letter dated April 8, 2003, the Office advised appellant that, according to Table 17-2 on page 526 of the A.M.A., *Guides*, fifth edition,[1] a diagnosis-based estimate cannot be combined with a range-of-motion impairment, and for that reason, the Office cannot combine the 5 percent for carpal tunnel syndrome and the 8 percent for loss of range of motion due to the scaphoid fracture to arrive at a 13 percent total permanent impairment.

In an April 28, 2003 report, Dr. Graves noted as follows:

> "The rating ultimately given by me was for 13 percent of the right hand. This was basically 8 percent for her fracture of the scaphoid determined mostly by lack of motion of the wrist if you totaled the motion up to 8 percent overall impairment rating. As a separate impairment rating, she had 5 percent for her carpal tunnel syndrome and to my understanding, this would be additive 8 percent for the fracture; 5 percent for her carpal tunnel syndrome. These two conditions were separated over time by greater than one year and as such, I believe the rating should be additive.
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> "My opinion is as it was before, that her overall rating should be 13 percent of her hand."

By letter dated May 4, 2003, appellant again requested reconsideration and she provided a letter from Dr. Graves describing her total disability.

By decision dated May 21, 2003, the Office declined to modify their prior March 4, 2003 decision, after reviewing Dr. Graves' new report on its merits. The Office found that the A.M.A., *Guides* did not provide for combining or adding a diagnosis-based estimate with impairment due to loss in range of motion. The Office therefore took the greater impairment, eight percent for loss in range of motion, and granted an award for that instead of a five percent award for a diagnosis-based estimate. The Office, however, did not add a diagnosis-based estimate impairment for carpal tunnel syndrome with a diagnosis-based estimate for a scaphoid fracture, which would be consistent with the A.M.A., *Guides*, to determine what this rating would be and whether it would be greater than the rating for loss in range of motion.

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

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulation[3] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members of the body. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[4] However, the Act does not specify the manner in which the

[1] This section, however, pertains only to evaluation of the lower extremities.

[2] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[3] 20 C.F.R. § 10.304.

[4] 5 U.S.C. § 8107(c)(19).

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 fifth edition of the A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[5]

The standards for evaluating the percentage of impairment of upper extremities can be found in Chapter 16 of the fifth edition of the A.M.A., *Guides.* In calculating an impairment rating for the upper extremities, when a given unit has more than one type of impairment (*e.g.*, abnormal motion, sensory loss, partial amputation of a finger), the various impairments are combined to determine the total impairment of the unit (*e.g.*, finger) before conversion to the next larger unit (*e.g.*, hand).[6] Similarly, multiple regional impairments, such as those of the hand, wrist, elbow and shoulder, are first expressed individually as upper extremity impairments and then combined to determine the total upper extremity impairment.[7] Section 16.1 stated that "Regional impairments resulting from the hand, wrist, elbow and shoulder regions are combined to provide the upper extremity impairment." Section 1.4 of the A.M.A., *Guides*, on the Philosophy and Use of the Combined Values Chart, states that "In general, impairment ratings within the same region are combined before combining the regional impairment rating from another region."[8] More specifically, section 16.5d of the A.M.A., *Guides*, pgs. 491-95, address entrapment and compression neuropathies, which includes carpal tunnel syndrome. Table 16-15 reveals that for each nerve affected, sensory deficit or pain is combined with motor deficit to arrive at the upper extremity impairment for the affected member. In Chapter 16.9 the A.M.A., *Guides* details the summary of steps for evaluating impairment of the upper extremity when dealing with the wrist, and notes that first the upper extremity impairment due to loss of motion (section 16.4g) is determined and then the impairment due to other disorders (section 16.7) are combined to determine upper extremity impairment related to the wrist region. Nowhere in this chapter on upper extremity impairment do the A.M.A., *Guides* address diagnosis-based estimates such as carpal tunnel syndrome when added or combined with other impairments. In example 16-78 wrist impairment factors to be rated cannot be losses due to the same pathomechanics. In this case, the pathomechanics for carpal tunnel syndrome and a fractured scaphoid are independent of each other. Finally, in the case of *Robert V. DiSalvatore,*[9] the Board indicates

[5] 20 C.F.R. § 10.404 (2002). FECA Transmittal No. 02-12 (issued August 30, 2002) explains that all permanent impairment awards determined on or after February 1, 2001, the effective dated of the A.M.A., *Guides* application, regardless of the date of the medical examination, should be based on the fifth edition of the A.M.A., *Guides*; *see also* A.M.A., *Guides*, (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB ___ (Docket No. 01-1361, issued February 4, 2002).

[6] *See* A.M.A., *Guides*, Chapter 16.1c, *Combining Impairment Ratings*, pg. 438.

[7] Paragraph 16.1c, pg. 438, A.M.A., *Guides.*

[8] A.M.A., *Guides*, pg. 9-10.

[9] 54 ECAB ___ (Docket No. 02-2256, issued January 17, 2003) the Board found that "there generally will be no ratings based on loss of motion or grip strength" in carpal tunnel schedule award cases. The decision goes on to state that impairment for carpal tunnel syndrome be rated on motor and sensory impairments only.

that the components for rating carpal tunnel syndrome include both range of motion and sensory deficits.

Therefore, by merely rating appellant on losses in range of motion due to the scaphoid fracture, she is uncompensated for sensory losses due to carpal tunnel syndrome, an independent compensable factor.

In this case, appellant had two independent impairment components from one injury resulting in her right upper extremity impairment, each of which were due to separate pathomechanics which occurred at separate times, one impairment of five percent due to carpal tunnel syndrome (for sensory losses/disturbances) of the entire right upper extremity, and a greater one of eight percent due to scaphoid fracture (motor loss), and localized to the right wrist.

However, appellant was not granted a schedule award for her entire right upper extremity impairment. Initially, she was granted an award for five percent determined by a diagnosis-based estimate of her carpal tunnel syndrome. Nothing was allowed for her scaphoid fracture or its accompanying losses in range of motion. Then, an impairment for her fracture was calculated by combining her losses in range of motion, which equaled eight percent. As eight percent (for fracture) was greater than five percent (for carpal tunnel syndrome) the Office granted appellant an award for a total of eight percent permanent impairment on the right upper extremity due to losses in ranges of motion due to her scaphoid fracture. Nothing was given for her carpal tunnel syndrome. This, therefore, still did not address appellant's total right upper extremity impairment.

Consequently, the case must be remanded to the Office for further development, including separate assessments of impairment due to appellant's carpal tunnel syndrome and impairment due to appellant's scaphoid fracture, and referral to the Office medical adviser or another physician well versed in the application of the A.M.A., *Guides,* for determination of whether the impairments for each separate accepted condition should be additive or combined, accompanied by medical rationale supporting the approach taken, to ascertain appellant's total right upper extremity impairment due to both accepted conditions.

The decisions of the Office of Workers' Compensation Programs dated May 21 and March 6, 2003 are hereby set aside and the case is remanded for further development in accordance with this decision and order of the Board.

Dated, March 29, 2004
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member