United States Department of Labor
Employees' Compensation Appeals Board

KIMBERLY M. HELD, Appellant	)	
	)	**Docket No. 05-1050**
and	)	**Issued: August 16, 2005**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Des Moines, IA, Employer	)	

Appearances:
Kimberly M. Held, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On April 11, 2005 appellant filed a timely appeal from a July 16, 2004 merit decision of the Office of Workers' Compensation Programs granting her a schedule award for a permanent impairment of the upper extremities. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than an 11 percent permanent impairment of the right upper extremity and a 6 percent permanent impairment of the left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On March 3, 2003 appellant, then a 35-year-old distribution clerk, filed an occupational disease claim alleging that she sustained bilateral wrist pain due to factors of her federal

employment.[1] She did not stop work. The Office accepted her claim for bilateral carpal tunnel syndrome and mild de Quervain's extensor tenosynovitis. The Office authorized bilateral endoscopic carpal tunnel releases.

Dr. Delwin E. Quenzer, a Board-certified orthopedic surgeon, performed a right open endoscopic carpal tunnel release on June 9, 2003. Appellant worked with restrictions following the surgery. Dr. Quenzer performed a left open endoscopic release on August 8, 2003. Appellant returned to light work on August 11, 2003 and to her regular employment in September 2003.

On February 17, 2004 appellant filed a claim for a schedule award. In an impairment evaluation dated February 11, 2004, Dr. Quenzer noted that he used a computerized system which provided "appropriate measurements of strength, sensation and range of motion…." He indicated that appellant described her pain in the hands as tenderness on the left when pressing the area and noticeable pain when performing work on the right. Dr. Quenzer stated:

> "On my examination, I confirm 20 [percent] weakness of thenar muscles on the right side and 10 [percent] weakness of thenar muscles on [the] left side, referring to Table 16-11 of the A.M.A., *Guides* [American Medical Association, *Guides to the Evaluation of Permanent Impairment*]. Sensation is normal to light touch. Repeat nerve conduction test today demonstrates that the distal motor latency of the left median nerve has improved from 6.56 msec [milliseconds] to 4.25 msec, which is at the upper limits of normal. On the right side, the same value has decreased from 7.03 to 4.15 msec., which is borderline abnormal."

He opined that appellant had reached maximum medical improvement.

By letter dated May 12, 2004, the Office referred appellant to Dr. Charles F. Denhart, a Board-certified physiatrist, for a second opinion evaluation to determine whether she had a permanent impairment due to her employment injury.

In an impairment evaluation dated June 7, 2004, Dr. Denhart listed normal findings for grip strength, "finger abduction, wrist dorsiflexion, elbow flexion and extension and shoulder abduction…." He noted that appellant complained of occasional pain on the right at the base of her thumb and wrist and "very occasional" pain on the left. Dr. Denhart stated:

> "She reports a mild Tinel's sign on the right on the palm side of the carpal tunnel and not on the left. There is no crepitus at the wrist. On sensory examination, sensation is intact to soft touch and two point discrimination with less than [five] mm [millimeter] of two point discrimination on both the median and ulnar sides of the right and left hands."

[1] On January 16, 2001 the Office accepted that appellant sustained right forearm tendinitis due to factors of her federal employment. She returned to her regular employment on March 29, 2001. The Office doubled the claim, assigned file number A11-0182615, into the current claim, assigned file number A11-2014728.

Dr. Denhart measured her range of motion and determined that she had a bilateral one percent impairment due to loss of dorsiflexion. He related:

> "She does have loss of motor strength, more pronounced on the right than the left on thumb opposition. Using Table [1]6-11 on page 484 in the A.M.A., *Guides*, these would both fall into the fourth grade and I would assign a 20 [percent] motor deficit on the right and 10 [percent] motor deficit on the left. Applying this to Table 16-14 on page 492, in which the median nerve has a maximum of 10 [percent] impairment of the upper extremity, this would represent a 1 [percent] impairment of the upper extremity on the left and a 2 [percent] impairment of the upper extremity on the right. She also has discomfort in the hands more pronounced on the right than the left. Using Table 16-10 on pages 482 in the A.M.A., *Guides*, this again falls in the fourth grade as she is able to perform all aspects of her job. I would assign this a 20 [percent] deficit on the right and a 10 [percent] deficit on the left. This includes consideration of the very occasional soreness over the extensor surface at the base of the thumb. Applying this again to Table 16-15, which has the maximum of 39 [percent] impairment of the upper extremity related to sensory deficit or pain, yields a 7.8 [percent] impairment on the right, which I will round up to 8 [percent]; and a 3.9 [percent] impairment on the left, which I will round up to 4 [percent]."

On the right side, Dr. Denhart combined the 8 percent impairment for sensory deficit, the 2 percent impairment due to loss of motor function and the 1 percent impairment due to loss of dorsiflexion to find an 11 percent impairment. On the left side, he combined the four percent impairment for sensory deficit, the one percent impairment due to loss of motor function and the one percent impairment due to loss of dorsiflexion to find a six percent impairment. Dr. Denhardt opined that appellant reached maximum medical improvement on February 11, 2004.

An Office medical adviser reviewed Dr. Denhart's report on June 16, 2004 and concluded that his findings were acceptable according to the A.M.A., *Guides*.

By decision dated July 16, 2004, the Office granted appellant a schedule award for an 11 percent permanent impairment of the right upper extremity and a 6 percent impairment of the left upper extremity. The period of the award ran for 53.04 weeks from February 11, 2004 to February 16, 2005.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[2] and its implementing federal 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 or functions of the body. However, the Act does not specify the manner in which the percentage of

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[4] The Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[5]

The fifth edition of the A.M.A., *Guides*, regarding carpal tunnel syndrome, provides:

> "If, after optimal recovery time following surgical decompression, an individual continues to complain of pain, parethesias and/or difficulties in performing certain activities, three possible scenarios can be present--
>
> > 1. Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual [carpal tunnel syndrome] 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 [electromyogram] testing of the thenar muscles: a residual [carpal tunnel syndrome] 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."[6]

The A.M.A., *Guides* further provides that, "In compression neuropathies, additional impairment values are not given for decreased grip strength."[7] Carpal tunnel syndrome is an entrapment/compression neuropathy of the median nerve.[8] Additionally, the Board has found that the fifth edition of the A.M.A., *Guides* provides that an impairment for carpal tunnel syndrome be rated on motor and sensory deficits only.[9]

ANALYSIS

The Office accepted appellant's claim for bilateral carpal tunnel syndrome and mild de Quervain's extensor tenosynovitis. She underwent a right-sided carpal tunnel release on June 9, 2003 and a left-sided carpal tunnel release on August 8, 2003. On February 17, 2004 appellant

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[4] 20 C.F.R. § 10.404(a).

[5] *See* FECA Bulletin No. 01-05, issued January 29, 2001.

[6] A.M.A., *Guides* at 495; *see also Silvester DeLuca*, 53 ECAB 500 (2002).

[7] A.M.A., *Guides* at 494; *see* also FECA Bulletin No. 01-05, issued January 29, 2001.

[8] A.M.A., *Guides* at 492.

[9] A.M.A., *Guides* at 494, *Robert V. Disalvatore*, 54 ECAB ___ (Docket No. 02-2256, issued January 17, 2003).

filed a claim for a schedule award. In support of her claim, she submitted a February 11, 2004 report from Dr. Quenzer, who noted that she complained of pain with applied pressure on the left side and pain performing work activities on the right side. He found that appellant had a 20 percent loss of strength of the thenar muscle on the right and a 10 percent loss of strength of the thenar muscle on the left. Dr. Quenzer noted that nerve conduction studies performed on that date showed normal distal motor latency of the left median nerve and borderline abnormal distal motor latency of the right median nerve. Dr. Quenzer, however, did not provide a specific impairment finding in accordance with the A.M.A., *Guides* and thus the Office properly referred appellant to Dr. Denhart for a second opinion evaluation.

In a report dated June 7, 2004, Dr. Denhart noted that appellant had a mild Tinel's sign on the right but not the left with intact sensation and two point discrimination. He measured appellant's range of motion and found that she had a one percent impairment due to loss of dorsiflexion. Dr. Denhart graded her loss of strength as 20 percent on the right and 10 percent on the left according to Table 16-11 on page 484 of the A.M.A., *Guides*. He multiplied these percentages by 10 percent, the maximum impairment of the median nerve according to Table 16-14 on page 492, to find a 1 percent impairment of the left upper extremity and a 2 percent impairment of the right upper extremity. Dr. Denhart next utilized Table 16-10 on page 482 in grading appellant's impairment due to pain as 20 percent on the right and 10 percent on the left. He multiplied the graded percentages by the maximum impairment due to sensory deficit or pain of the median nerve of 39 percent using Table 16-15 on page 492 to find a 7.8 percent impairment on the right, which he rounded to 8 percent and a 3.9 percent impairment on the left, which he rounded to 4 percent. Dr. Denhart combined the 8 percent impairment due to pain, the 2 percent impairment due to loss of strength and the 1 percent impairment due to loss of dorsiflexion to find an 11 percent impairment of the right upper extremity. He then combined the four percent impairment due to pain, the one percent impairment due to loss of strength and the one percent impairment due to loss of dorsiflexion to find a six percent impairment of the left upper extremity. He opined that appellant reached maximum medical improvement on February 11, 2004. An Office medical adviser reviewed Dr. Denhart's report and concurred with his findings.

The Board finds that Dr. Denhart and the Office medical adviser incorrectly applied the A.M.A., *Guides* in calculating appellant's impairment of the right and left wrists due to carpal tunnel syndrome. As noted above, the A.M.A., *Guides* provides a specific method for determining the permanent impairment due to carpal tunnel syndrome. An impairment for carpal tunnel syndrome is rated on motor and sensory deficits.[10] Appellant, therefore, should not have received an impairment rating for loss of range of motion of the wrist in addition to a sensory loss due to carpal tunnel syndrome.

Additionally, in assessing the impairment due to carpal tunnel syndrome following a surgical decompression, the A.M.A., *Guides* requires an optimal recovery time. If an individual continues to experience pain, parethesias or difficulty with certain activities, three scenarios can be present. If the individual has positive clinical findings of median nerve dysfunction and electrical conduction delays, the impairment due to carpal tunnel syndrome is rated according to

[10] A.M.A., *Guides* at 495; *see also Robert V. Disalvatore*, *supra* note 9.

sensory and/or motor deficits described early in Chapter 16.[11] The impairment is evaluated by multiplying the grade of severity of the sensory or motor deficit by the respective maximum upper extremity value resulting from sensory or motor deficits of each nerve structure involved. When both sensory and motor functions are involved the impairment values derived for each are combined.[12] In this case, on the right side appellant had evidence of a positive Tinel's sign and borderline abnormal nerve conduction studies obtained on February 11, 2004 the date of maximum medical improvement. Dr. Denhart thus properly rated her impairment of the right wrist using the sensory and motor deficits provided in Tables 16-10, 16-11, 16-14 and 16-15 on pages 482, 484 and 492 of the A.M.A., *Guides*. Combining the 8 percent impairment due to pain with the 2 percent impairment due to loss of strength yields a 10 percent impairment of the right upper extremity. The Board thus finds that appellant has a 10 percent impairment of the right upper extremity.

On the left side, appellant did not have evidence of positive clinical findings of median nerve dysfunction and electrical conduction delays. She further did not have findings of abnormal sensory or motor latencies or abnormal electromyogram testing of the thenar muscles.[13] The A.M.A., *Guides* provides that there is no basis for an impairment rating with "[n]ormal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies.[14] The Board, consequently, finds that appellant is not entitled to a schedule award on the left side.

On appeal, appellant notes that she has difficulty performing some work tasks due to pain. Factors, however, such as employability or limitations on daily activities do not go into the calculation of a schedule award.[15]

CONCLUSION

The Board finds that appellant has a 10 percent permanent impairment of the right upper extremity.

[11] A.M.A., *Guides* at 495.

[12] *Id*. at 494, 481.

[13] *Id*. at 495.

[14] *Id*.

[15] *James A. Castagno*, 53 ECAB 782 (2002).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 16, 2004 is affirmed, as modified.

Issued: August 16, 2005
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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