United States Department of Labor
Employees' Compensation Appeals Board

STACEY M. POGORZELSKI, Appellant	)	
and	)	**Docket No. 05-1502**
	)	**Issued: October 19, 2005**
ENVIRONMENTAL PROTECTION AGENCY, REGION IX, San Francisco, CA, Employer	)	

Appearances:
Stacey M. Pogorzelski, 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 July 7, 2005 appellant filed a timely appeal from the Office of Workers' Compensation Programs' April 4, 2005 merit decision concerning her entitlement to a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2), the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than a five percent permanent impairment of her left arm and a five percent permanent impairment of her right arm, for which she received a schedule award.

FACTUAL HISTORY

On April 11, 1995 appellant, then a 40-year-old environmental protection specialist, filed an occupational disease claim alleging that she sustained upper extremity conditions due to the repetitive duties of her job, including typing and handling documents. The Office accepted that she sustained bilateral carpal tunnel syndrome, bilateral wrist and arm tendinitis, and bilateral

overuse syndrome.[1] She continued to work for the employing establishment in a limited-duty position and received compensation for periods of partial and total disability.[2]

Appellant received medical treatment from numerous physicians who periodically changed her work restrictions and the number of hours she could work per week. She continued to complain of upper extremity pain, swelling, and numbness, particularly upon activity, along with neck symptoms. In a report dated September 3, 1996, Dr. Jules Steinmetz, an attending physician Board-certified in physical medicine and rehabilitation, indicated that appellant reported experiencing pain in her neck, both triceps, and both elbows in the lateral and medial aspects as well as numbness in the fingertips. Dr. Steinmetz diagnosed repetitive strain injury with tendinitis, possible thoracic outlet syndrome, possible hypermobility syndrome predisposing her to musculoskeletal complaints, and a preexisting neck problem.

In a report dated May 11, 2000, Dr. David R. Kell, an attending physician Board-certified in physical medicine and rehabilitation, indicated that appellant continued to report neck and upper extremity symptoms especially upon activity.[3] He stated that she continued to have an employment-related bilateral overuse syndrome and recommended various work restrictions.

In December 2003, the Office requested that Dr. Kell examine appellant and provide an updated account of her upper extremity condition. In a report dated December 21, 2003, Dr. Kell stated that appellant reported experiencing pain in both elbows alternating between the lateral and medial aspects; pain and swelling in the extensor compartments of both forearms; swelling in both hands with rare tingling in digits one and two; and pain in both anterior shoulder girdles which often extended down the lateral aspects of both arms.[4] He indicated that appellant reported that she could perform all of her basic activities of daily living without difficulty unless she was in the midst of a flare-up of upper extremity symptoms. Appellant reported that driving and other activities which required elevation were limited to 30 minutes, writing was tolerated for an average of 30 minutes, and that computer work was tolerated for up to 45 minutes on mildly symptomatic days. He examined the peripheral nerves of appellant's upper extremities and found no abnormal findings in the median nerves, radial nerves, or the left ulnar nerve. Appellant's objective findings on examination included stiffness of neck extension and left-sided bending, increased tension in the left brachial plexus, bilateral grip strength weakness, multilevel cervical segmental stiffness and dysfunction, unusual tenderness of the right ulnar nerve in the notch just below the elbow, and myofascial tightness and hypertonicity in the muscles of the yoke area and the extensor compartments of the forearms, right greater than left. He diagnosed a "complex, work-related, bilateral, upper quarter repetitive strain injury" and indicated that the

[1] Appellant was involved in a nonwork-related motor vehicle accident in November 1987 which caused neck, upper back, and lower back pain. In a report dated July 17, 1995, Dr. Peter Rill, an attending Board-certified orthopedic surgeon, indicated that appellant had been diagnosed with bilateral carpal tunnel syndrome.

[2] The employing establishment made accommodations to appellant's workplace, including having an ergonomic study performed and installing a voice-activated device for her computer. She took a leave of absence from between May 1999 and May 2000 and resigned from the employing establishment in December 2000.

[3] Appellant had received medical care from Dr. Kell since December 1997.

[4] Appellant also reported experiencing cervical stiffness particularly in the upper cervical region on the left.

condition was entirely related to the injury appellant sustained while performing her work duties for the employing establishment.

On April 29, 2004 appellant filed a claim for schedule award compensation.

In October 2004, the Office referred appellant to Dr. Alan B. Kimelman, Board-certified in physical medicine and rehabilitation, to evaluate the permanent impairment of her upper extremities in accordance with the standards of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001).[5]

Dr. Kimelman carried out electromyogram (EMG) and nerve conduction studies on November 11, 2004, which revealed normal findings of both median nerves without evidence of carpal tunnel syndrome or mononeuropathy at the wrists and normal findings of both ulnar nerves with no evidence of cubital tunnel syndrome or ulnar nerve entrapment.[6] In a November 11, 2004 report, he noted that appellant reported mild pain in the hands and fingers and indicated that this pain was reported as interfering with writing and driving. Dr. Kimelman stated that appellant exhibited the following range of motion findings for each wrist: extension of 60 degrees; flexion of 70 degrees; radial deviation of 20 degrees and ulnar deviation of 30 degrees. He indicated that she exhibited the following range of motion findings for each thumb: interphalangeal joint motion of 80 degrees; metacarpophalangeal joint motion of 60 degrees; abduction of 50 degrees; adduction of 1 centimeter and opposition of 8 centimeters. Dr. Kimelman indicated that the "accepted diagnosis" was "bilateral carpal tunnel syndrome" and "bilateral mononeuritis of the upper extremity."

The Office referred the case record to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an Office medical consultant, for an evaluation of appellant's upper extremity impairment. In a report dated December 20, 2004, Dr. Harris concluded that appellant had a five percent permanent impairment of her left arm and a five percent permanent impairment of her right arm. He stated that a review of the medical record established the diagnosis of bilateral carpal tunnel syndrome. Dr. Harris indicated that appellant's residual bilateral carpal tunnel symptoms were consistent with a category 4 pain grade (or 25 percent) for pain which is forgotten with activity (Table 16-10 on page 482 of the A.M.A., *Guides*) and stated that this value multiplied by the maximum figure of 39 percent for sensory loss associated with the median nerve below the midforearm (Table 16-15 on page 492 of the A.M.A., *Guides*) yielded a finding that appellant had a 5 percent permanent impairment in each arm.

By decision dated April 4, 2004, the Office granted appellant a schedule award for a five percent permanent impairment of her left arm and a five percent permanent impairment of her right arm.

[5] The Office listed the accepted conditions as bilateral carpal tunnel syndrome and bilateral mononeuritis of the upper limbs.

[6] Part of Dr. Kimelman's report bears the date September 23, 2003, but this appears to be an error.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] and its implementing regulation[8] 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 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 regulation as the appropriate standard for evaluating schedule losses.[9]

It is well established that 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.[10]

ANALYSIS

The Office accepted that appellant sustained bilateral carpal tunnel syndrome, bilateral wrist and arm tendinitis, and bilateral overuse syndrome. By decision dated April4, 2004, the Office granted appellant a schedule award for a five percent permanent impairment of her left arm and a five percent permanent impairment of her right arm.

The Office based its schedule award on a December 20, 2004 report of Dr. Harris, a Board-certified orthopedic surgeon who served as an Office medical consultant. He calculated the permanent impairment of appellant's upper extremities after performing a review of the case record. In his report, Dr. Harris made particular reference to a December 21, 2003 report of Dr. Kell, an attending physician Board-certified in physical medicine and rehabilitation, and a November 11, 2004 report of Dr. Kimelman, a physician Board-certified in physical medicine and rehabilitation to whom the Office referred appellant.[11]

Dr. Harris determined that appellant's residual bilateral carpal tunnel symptoms were consistent with a category 4 pain grade of 25 percent[12] and stated that this value multiplied by the maximum figure of 39 percent for sensory loss associated with the median nerve below the midforearm[13] yielded a finding that appellant had a 5 percent permanent impairment in each arm.

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[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999).

[9] *Id*.

[10] *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[11] Neither Dr. Kell nor Dr. Kimelman provided a calculation of the permanent impairment of appellant's upper extremities.

[12] *See* A.M.A., *Guides* 482, Table 16-10.

[13] *Id.* at 492, Table 16-15.

The Board notes that it was appropriate for Dr. Harris to perform such an evaluation of appellant's sensory loss and that there is no evidence that he improperly determined that she falls within the upper level of the category 4 pain grade of 25 percent or that the maximum figure for sensory loss associated with the median nerve below the midforearm is 39 percent.[14]

The Board finds, however, that there is an error in Dr. Harris' calculations which led to his ultimate determination that appellant had a five percent permanent impairment of her left arm and a five percent permanent impairment of her right arm. Dr. Harris indicated that multiplying the category 4 pain grade of 25 percent times the maximum figure of 39 percent for sensory loss associated with the median nerve below the midforearm for each arm would yield such a result. The Board notes, however, that it appears that this multiplication calculation would yield a figure of 9.75 percent impairment (rather than 5 percent) based on sensory loss for each arm. Given this circumstance, the case will be remanded to the Office for further development.[15] After such development it deems necessary, the Office should issue an appropriate decision regarding appellant's entitlement to schedule award compensation due to permanent impairment of her upper extremities.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant has more than a five percent permanent impairment of her left arm and a five percent permanent impairment of her right arm. The case shall be remanded to the Office for further development to be followed by an appropriate decision.

[14] Although Dr. Kimelman's EMG and nerve conduction testing did not show carpal tunnel syndrome, the Office has clearly accepted that appellant has bilateral carpal tunnel syndrome. The Board notes that the medical evidence supports Dr. Harris' choice of the category 4 pain grade of 25 percent, *i.e.*, a pain grade meant for pain on the borderline between pain which interferes with some activity and pain which is forgotten with activity. *See* A.M.A., *Guides* 482, Table 16-10. Appellant argued that she was entitled to a higher pain grade, but she did not submit any medical evidence supporting this claim. It is further noted that the range of motion findings for both wrists and thumbs provided by Dr. Kimelman were normal and would not entitle appellant to any impairment rating. *See* A.M.A., *Guides* 454-60, 467, 469, Tables 16-8a, 16-8b, 16-9, 16-28, 16-31 and Figures 16-12, 16-15 and 16-16.

[15] *See supra* note 10 and accompanying text.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' April 4, 2005 is set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: October 19, 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