

(A.M.A., *Guides*) (5th ed. 2001).² The facts of this case as set forth in the Board's prior decision are hereby incorporated by reference.

On remand, the Office referred appellant, together with the case record and a statement of accepted facts, to Dr. V.G. Raghavan, a Board-certified orthopedic surgeon. On December 3, 2003 Dr. Raghavan reported that appellant reached maximum medical improvement on February 2, 2002. He offered his evaluation of impairment:

“Clinical examination of the right hand shows that he still has some abnormal sensation in the affected right hand, but two-point discrimination is still within normal limits for the median nerve. No evidence of thenar atrophy but still has evidence on EMG [electromyogram] of sensory delay of the median nerve on the right. Using the A.M.A., [*Guides*] (5th [ed.]), the examinee is given five percent for the upper extremity for the abnormal sensory latencies on the EMG done on the right hand.

“Regarding the left wrist and hand, since I did not see any definite objective evidence on physical examination with negative Phalen, negative reverse Phalen and negative Tinel's signs, but still there is abnormal sensory latencies as noted on EMG and examinee is entitled to five percent left upper extremity for the allowed claim of carpal tunnel syndrome on the left.”

On January 29, 2004 Dr. Raghavan clarified that he evaluated impairment using the second of three scenarios described on page 495 of the A.M.A., *Guides*: “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.”

In a decision dated February 9, 2004, the Office denied additional schedule award compensation. The Office found that Dr. Raghavan's opinion was fully explained with specific references to the criteria used in the A.M.A., *Guides* and established that appellant had a five percent impairment of each upper extremity due to the accepted CTS. As appellant previously received a schedule award for 10 percent impairment of both arms, the Office found that he was not entitled to further schedule award compensation.

On March 23, 2005 Dr. John N. Harker, the attending orthopedic surgeon, reported that electrodiagnostic testing showed appellant's CTS “is certainly progressing and electrically he is deteriorating.” He completed Office forms indicating that appellant had a five percent impairment of each upper extremity due to decreased strength and a five percent impairment of each upper extremity due to sensory deficit, pain or discomfort. On March 30, 2005 appellant filed a claim for an increased schedule award.

² On August 1, 2001 appellant, then a 53-year-old city carrier, filed a claim alleging that he developed CTS in the performance of duty: “Repetitive motion of both hands by: A. Lifting trays of mail (approximately 10 pounds). B. Lifting tubs of flats (approximately 15 pounds). C. Casing mail twisting both hands (five [to] six hours). D. Driving postal vehicle (five days per week).” The Office accepted his claim for bilateral CTS and appellant filed a claim for a schedule award.

In a decision dated November 29, 2005, the Office denied appellant's claim for an increased schedule award. The Office found that the evidence failed to demonstrate an increased impairment.

On September 7, 2006 Dr. David J. Kaler, appellant's new orthopedic surgeon, completed the Office's impairment rating forms. He indicated that appellant had a 30 percent impairment of his right upper extremity and a 28 percent impairment of his left upper extremity due to sensory deficit, pain or discomfort. Appellant filed another claim for a schedule award.

On September 27, 2006 the Office medical adviser reviewed Dr. Kaler's rating and found no basis for an increase in appellant's schedule award. He noted that the nerve conduction studies obtained on August 16, 2006 were essentially the same as those obtained on July 9, 2001 and March 15 and 23, 2005. Further, the medical adviser noted that the August 16, 2006 studies revealed subtle evidence suggestive of a right C6-7 radiculopathy, which innervates the same area of the hand as the median nerve. The medical adviser concluded that the rating of 30 percent was not scientifically documented and that appellant's rating should stand at 5 percent for each upper extremity, as per scenario two, page 495 of the A.M.A., *Guides*.

In a decision dated October 20, 2006, the Office denied modification of its prior decision. The Office found that the evidence clearly demonstrated that appellant had not additional impairment of the right or left upper extremities due to work-related factors.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body.³ Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.⁴

To support a schedule award, the file must contain competent medical evidence that describes the impairment in sufficient detail for the adjudicator to visualize the character and degree of disability.⁵ The report of the examination must always include a detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

⁵ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.b(2) (August 2002).

strength or disturbance of sensation or other pertinent description of the impairment.⁶ The Office should advise any physician evaluating permanent impairment to use the fifth edition of the A.M.A., *Guides* and to report findings in accordance with those guidelines.⁷

A claimant seeking compensation under the Act has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence.⁸

ANALYSIS

The impairment rating forms that appellant's orthopedists completed on March 23, 2005 and September 7, 2006 do not explain how the physicians evaluated the impairment using the A.M.A., *Guides*. There is no reference to the procedure or criterion or tables used to calculate the ratings reported. This makes the ratings impossible for the Office or the Board to review. This is the same problem the Board found on the prior appeal, when appellant's initial orthopedist, Dr. Harker, earlier completed the same impairment rating forms. Dr. Harker did not specifically identify which criteria of the A.M.A., *Guides* applied to appellant's impairment and he provided no rationale for the ratings he reported.

The Board remanded the case for a fully explained medical opinion on appellant's impairment, with specific references to the criteria on page 495 of the A.M.A., *Guides*. Dr. Raghavan provided such an opinion on December 3, 2003 and January 29, 2004. He explained that appellant's findings fell within the second of three scenarios listed on page 495, thus indicating that a residual CTS was still present. Under this scenario impairment rating "not to exceed 5 percent of the upper extremity" may be justified.

Dr. Harker's March 23, 2005 impairment rating forms and the September 7, 2006 impairment rating forms of Dr. Kaler, appellant's second orthopedist, are of little probative or evidentiary value in showing that appellant has a greater impairment under the standards of the A.M.A., *Guides*. They do not establish that a greater impairment than the maximum impairment rating allowed under scenario two, page 495.

Dr. Harker reported on March 23, 2005 that EMG and nerve conduction studies showed that appellant's CTS was "certainly progressing and electrically he is deteriorating." But this is no basis for an increased schedule award. The A.M.A., *Guides* directly addresses this on page 493: "The severity of conduction slowing has no correlation with the severity of clinical symptoms." The A.M.A., *Guides* further states:

"Only individuals with an objectively verifiable diagnosis should qualify for a permanent impairment rating. The diagnosis is made not only on believable symptoms but, more important, on the presence of positive clinical findings and loss of function. The diagnosis should be documented by electromyography as well as sensory and motor nerve conduction studies. However, it is critical to

⁶ *Id.* at Chapter 2.808.6.c(1).

⁷ *Id.* at Chapter 2.808.6.a (noting exceptions).

⁸ *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

understand that there is no correlation between the severity of conduction delay on nerve conduction velocity testing and the severity of either symptoms or, more important, impairment rating.”⁹

The weight of the medical evidence rests with the opinion of Dr. Raghavan and establishes that appellant has no more than a five percent permanent impairment of each upper extremity causally related to his employment-related bilateral CTS. The Board will affirm the Office’s decisions denying an increased award.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he has more than a five percent permanent impairment of each upper extremity as a result of his employment-related bilateral CTS.

ORDER

IT IS HEREBY ORDERED THAT the October 20, 2006 and November 29, 2005 decisions of the Office of Workers’ Compensation Programs are affirmed.

Issued: April 26, 2007
Washington, DC

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

David S. Gerson, Judge
Employees’ Compensation Appeals Board

James A. Haynes, Alternate Judge
Employee’ Compensation Appeals Board

⁹ A.M.A., *Guides* 493.