

appellant underwent surgery for right and left carpal tunnel releases. On December 18, 2006 she submitted a claim for a schedule award.

In an impairment rating report, dated March 9, 2007, Dr. James M.T. Garrity, an attending osteopathic specialist in occupational medicine, noted that appellant had ongoing symptoms of bilateral paresthesias, numbness and weakness in her hands. He diagnosed work-related bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome and mild carpometacarpal (CMC) arthritis. Dr. Garrity provided findings on physical examination:

“OBJECTIVE: Exam[ination] today shows normal range of motion of [appellant’s] upper extremities. [She] does have decreased strength with lateral pinch at 5 pounds bilaterally and using both positions one and two a grip strength that ranges from 10 [to] 15 pounds bilaterally. [Appellant] notably has mild swelling of the carpal metacarpal joints bilaterally with tenderness and a positive groin test. She also has positive Tinel’s at the elbows over the ulnar nerves bilaterally without apparent subluxation on this examination. There is a well-healed surgical scar at the wrist with continued positive Tinel’s at the wrist, however, mild compared to the findings at the elbow. There is good capillary refill and normal radial pulse. Two-point discrimination, even with repeated testing bilaterally and throughout the hands and upper extremity, shows response of 8 [to] 15 mm [millimeters] to assess 2-point discrimination in the median nerve distribution. This range [is] based on repeated testings.”

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“DISCUSSION: I informed [appellant] that likely the reason for her additional complaints of paresthesias in the ulnar nerve distribution indicate that [she] has a separate problem, namely cubital tunnel syndrome. The tenderness at the CMC joint does contribute to [her] complaints of weakness likely is a common finding as well and I do feel [that] she has degenerative joint disease in this area based on examination. The evaluation today does show both motor and sensory loss of function. [Appellant’s] decreased sensation in the median nerve distribution would be a Grade 4 with diminished light touch sensation. I would place this in the mid range and multiply 12½ percent times [the] maximum sensory deficit at the midforearm of the median nerve of 39 percent which results in a 4.8 percent rounding [to] 5 percent impairment for sensory loss. [Appellant] does have motor deficit as evidenced by repeated testing using lateral pinch and grasp. This is placed in the mid range as well, with 12½ percent times the maximum deficit at the midforearm of 44 percent for the median nerve [which] results in a 5.5 rounding [to] 6 percent for motor loss. These motor and sensory losses are bilateral, 5 percent and 6 percent respectively. Using the [fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,¹] combining the 5 percent sensory loss with the 6 percent motor loss we would get an 11 percent impairment for [each upper extremity].”

¹ A.M.A., *Guides* (5th ed. 2001).

On April 2, 2007 Dr. Morley Slutsky, an Office medical adviser, reviewed Dr. Garrity's report. He found that appellant had six percent impairment to each upper extremity. This included five percent for sensory deficit of the median nerve, based on Table 16-10 at page 482 and Table 16-15 at page 492 of the fifth edition of the A.M.A., *Guides* and one percent for motor deficit of the median nerve, based on Table 16-11 at page 484 and Table 16-15 at page 492. Dr. Slutsky stated:

"I agree with Dr. Garrity's grading of the motor and sensory deficits of the median nerve in each upper extremity. I do not agree with the use of 44 percent UEI [upper extremity impairment] as the maximum value for median nerve motor deficit for carpal tunnel syndrome. First[,] carpal tunnel syndrome does not [originate] above the midforearm. It originates below midforearm near ... the wrist level (this is where the carpal tunnel is located and it is at this level that the median nerve becomes compressed). Secondly, [appellant] obtained relief from injections into the carpal tunnel canal at the wrist indicating that symptoms related to compression of the median nerve originated at this level.

"The maximum value for median nerve deficit below the midforearm is 10 percent UEI using Table 16-15, page 492. I used this number and multiplied [it] by Dr. Garrity's ... motor deficit (12.5 percent) to obtain the final median nerve motor impairment of 1 percent (versus Dr. Garrity's 5 percent UEI)."

On April 20, 2007 Dr. Garrity maintained that appellant's motor deficit of her upper extremities should be based on the maximum deficit of 44 percent in Table 16-15 for the area above the midforearm. He stated that it was his experience with physicians locally and in other regions of the country that typically the above midforearm motor deficit was used in determining impairment due to carpal tunnel syndrome.

On May 10, 2007 Dr. Slutsky reiterated his disagreement with Dr. Garrity's April 20, 2007 report. He stated that using the area above the midforearm for rating impairment due to carpal tunnel syndrome was inconsistent with the anatomy and diagnosis of carpal tunnel syndrome and the A.M.A., *Guides*.

On June 11, 2007 the Office granted appellant a schedule award for six percent impairment of each upper extremity or 37.44 weeks from March 9 to November 26, 2007.²

LEGAL PRECEDENT

The schedule award provision of the Act³ and its implementing regulations⁴ set forth the number of weeks of compensation payable to employees sustaining permanent impairment from

² The Federal Employees' Compensation Act provides for 312 weeks of compensation for 100 percent loss or loss of use of an upper extremity. 5 U.S.C. § 8107(c)(1). Multiplying 312 weeks by 12 percent (6 percent for each upper extremity) equals 37.44 weeks of compensation.

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404.

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 regulations as the appropriate standard for evaluating schedule losses.⁵

ANALYSIS

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

“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:

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 [in Tables 16-10a and 16-11a].
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 Board has found that the fifth edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory deficits only.⁷

In this case, Dr. Garrity found that the first scenario applied to appellant’s condition. He found that she had sensory and motor deficits in both upper extremities causally related to her accepted bilateral carpal tunnel syndrome. Using the fifth edition of the A.M.A., *Guides*, Dr. Garrity rated appellant’s sensory deficit in the mid range of Grade 4, 12½ percent, and multiplied this by the maximum median nerve sensory impairment, at the midforearm, 39 percent,⁸ which resulted in a 4.8 percent impairment, rounded to 5 percent, for sensory deficit

⁵ A.M.A., *Guides* (5th ed. 2001).

⁶ A.M.A., *Guides* 495.

⁷ *Kimberly M. Held*, 56 ECAB ___ (Docket No. 05-1050, issued August 16, 2005).

⁸ Table 16-15 provides for a maximum impairment of 39 percent for sensory deficit of the median nerve regardless of whether the area involved is below or above the midforearm. A.M.A., *Guides* 492, Table 16-15.

impairment. He rated appellant's motor deficit in the mid range of Grade 4, 12½ percent, and multiplied this by the maximum median nerve motor impairment, above the midforearm, 44 percent, which resulted in a 5.5 percent impairment, rounded to 6 percent, for motor deficit impairment. Dr. Garrity combined the 5 percent sensory deficit with the 6 percent motor deficit, resulting in an 11 percent combined impairment of each upper extremity, according to the Combined Values Chart at page 604 of the A.M.A., *Guides*.

Dr. Slutsky found that appellant had six percent impairment to each upper extremity. This included five percent for sensory deficit, based on Table 16-10 at page 482 and Table 16-15 at page 492 of the fifth edition of the A.M.A., *Guides* and one percent for motor deficit of the median nerve, based on Table 16-11 at page 484 and Table 16-15 at page 492. Dr. Slutsky stated that the 44 percent maximum median nerve motor impairment provided in Table 16-15 at page 492, and used by Dr. Garrity in his impairment rating, was not appropriate because carpal tunnel syndrome does not originate above the midforearm. He stated that compression of the median nerve occurs at the level of the wrist. Dr. Slutsky noted that appellant obtained relief from injections into the carpal tunnel canal at her wrist, showing that symptoms related to compression of the median nerve originated at her wrist. He multiplied the maximum impairment for median nerve deficit below the midforearm in Table 16-15, 10 percent, by Dr. Garrity's finding of a Grade 4 motor deficit of 12½ percent, to obtain a median nerve motor impairment of 1 percent. The A.M.A., *Guides* states at page 495 that carpal tunnel syndrome "involves the median nerve at the volar aspect of the wrist."⁹ Dr. Garrity indicated that appellant's motor deficit was evidenced by repeated testing using lateral pinch and grasp. Dr. Slutsky's use of the portion of Table 16-15 pertaining to motor deficit below the midforearm, a maximum of 10 percent, is consistent with the description of carpal tunnel syndrome in the A.M.A., *Guides*. It is also consistent with Dr. Garrity's description of appellant's motor strength deficit as involving pinching and grasping motions which would be performed primarily with the hand, wrist and fingers, the area below the midforearm. Accordingly, Dr. Slutsky's determination that appellant had a one percent impairment due to motor deficit of the median nerve is consistent with the A.M.A., *Guides* and Dr. Garrity's findings on physical examination. As noted, Dr. Slutsky concurred with Dr. Garrity's determination that appellant had a five percent impairment of each upper extremity due to sensory deficit of the median nerve. He disagreed only with Dr. Garrity's motor deficit impairment rating. Dr. Garrity did not provide sufficient medical rationale in support of his opinion that motor deficit should be rated with references to the area above the midforearm. The Board finds that the medical evidence establishes that appellant has no more than a six percent combined impairment of each upper extremity causally related to her accepted bilateral carpal tunnel syndrome.

CONCLUSION

The Board finds that appellant has no more than a six percent impairment of each upper extremity.

⁹ A.M.A., *Guides* 495, "Carpal Tunnel Syndrome"; see also The Merck Manual of Diagnosis and Therapy (18th ed. 2006) 334 (carpal tunnel syndrome involves the compression of the median nerve as it passes through the carpal tunnel in the wrist).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 11, 2007 is affirmed.

Issued: November 20, 2007
Washington, DC

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

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board