

On July 11, 2001 appellant, then a 34-year-old lead case technician, filed a Form CA-1, traumatic injury claim, alleging that she injured her right upper extremity and neck that day. She stopped work and on December 10, 2001, the Office accepted that she sustained employment-

related right carpal tunnel syndrome.<sup>1</sup> On April 1, 2002 Dr. Gary N. Goldstein, a Board-certified orthopedic surgeon, performed decompression of the median and ulnar nerve of the right wrist and decompression and anterior subcutaneous transposition of the ulnar nerve at the right elbow. Pre and postoperative diagnoses were right carpal tunnel and cubital tunnel syndromes.

On May 1, 2002 appellant filed a recurrence claim, noting that she stopped work on April 1, 2002 to undergo surgery. She received appropriate compensation. On June 21, 2002 the Office referred appellant to Dr. Jatinkumar D. Gandhi, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a July 11, 2002 report, Dr. Gandhi noted his review of the medical record, the history of injury and that appellant was recovering from carpal tunnel surgery. Physical examination demonstrated mild scar tenderness, no upper extremity neurological symptoms or atrophy, negative Tinel's and Phalen's tests and no evidence of brachial plexus tenderness. Dr. Gandhi diagnosed ulnar nerve neuropathy, right elbow, cubital tunnel syndrome and carpal tunnel syndrome on the right. He advised that the carpal tunnel syndrome was employment related and the surgical release was appropriate but that it was difficult to correlate the ulnar nerve neuropathy with work factors as there were no records to back this up. Dr. Gandhi concluded that she could return to work within two or three weeks with no limitations. Appellant returned to full duty for four hours daily on July 22, 2002, six hours daily on August 16, 2002 and to full duty on August 19, 2002.<sup>2</sup>

In 2006 appellant moved to Greensboro, North Carolina.<sup>3</sup> On January 3, 2007 she filed a schedule award claim and submitted a July 6, 2004 report in which Dr. David Weiss, an osteopath, noted the history of injury and appellant's continued complaints of right elbow and hand pain, stiffness and numbness. Dr. Weiss stated that appellant's activities of daily living were restricted with difficulties in cooking and personal care, in grasping, pulling, pushing and fine dexterity with her right hand. He advised that her pain level was 4-7/10 in her right elbow and 5-8/10 in her right wrist. Examination of the right elbow demonstrated normal flexion-extension, pronation and supination with a positive Tinel's sign at the cubital tunnel. Examination of the right wrist showed no atrophy. Range of motion was normal for dorsiflexion, palmar flexion, radial deviation, ulnar deviation and resisted thumb abduction. Tinel's, Phalen's and carpal compression tests were positive. Grip strength testing was read as 50 percent on the right and pinch at 5 kilograms (kg) on the right compared with 9 kg on the left. Neurological examination showed no deficits. Dr. Weiss diagnosed post-traumatic right cubital tunnel syndrome, post-traumatic right ulnar neuropathy at Guyon's canal, post-traumatic right carpal tunnel syndrome, status post decompression of median and ulnar nerve of the right wrist and status post decompression and anterior subcutaneous transposition of the ulnar nerve at the right elbow. He opined that, in accordance with the fifth edition of the American Medical

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<sup>1</sup> The instant claim was adjudicated by the Office under file number 03-2001916. It is unclear from the record when appellant returned to work following the July 11, 2001 employment injury.

<sup>2</sup> In a claim adjudicated by the Office under file number 03-2010422, it accepted that on August 23, 2002 appellant sustained a cervical strain. She stopped work that day. On that claim, by decision dated April 12, 2006, Docket No. 06-373, the Board affirmed an Office decision that terminated appellant's compensation benefits, effective October 9, 2003.

<sup>3</sup> Although it is unclear from the record, appellant apparently continues to work for the employing establishment.

Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),<sup>4</sup> under Table 16-34 appellant had a 20 percent right upper extremity impairment due to right lateral pinch deficit and, under Table 18-1, a 3 percent pain-related impairment, for a total 23 percent right upper extremity impairment.

On January 5, 2007 the Office referred the medical record, including Dr. Weiss' report to an Office medical adviser. By report dated January 15, 2007, the Office medical adviser noted his review of the medical record including Dr. Weiss' July 6, 2004 report. He recommended that the accepted condition be expanded to include right cubital tunnel ulnar nerve compression and advised that maximum medical improvement had been reached on July 6, 2004. The Office medical adviser noted that, under the A.M.A., *Guides*, Dr. Weiss' reliance on lateral pinch deficit and a pain deficit were not appropriate. He determined that under Table 16-15 appellant had a below midforearm median nerve sensory impairment and advised that, pursuant to Table 16-10, she had a Grade 4 sensory impairment of 25 percent which, when multiplied by the maximum sensory impairment of 39 percent found in Table 16-15, yielded a below midforearm right upper extremity sensory impairment rating of 9.75 percent or rounded up, a 10 percent impairment. The Office medical adviser advised that, under Table 16-15, appellant's above midforearm peripheral nerve deficit was 7 percent and found that under Table 16-10 she had a Grade 4 sensory impairment of 25 percent which, when multiplied by the maximum sensory impairment of 7 found in Table 16-15, yielded a 1.75 percent above midforearm right upper extremity impairment which he rounded up to a 2 percent impairment. He then utilized the Combined Values Chart of the A.M.A., *Guides* to find that a 10 percent impairment combined with a 2 percent impairment equaled a 12 percent right upper extremity impairment.

By decision dated February 13, 2007, appellant was granted a schedule award for a 12 percent right upper extremity impairment, to run for 37.44 weeks from July 6, 2004 to March 25, 2005. On February 23, 2007 she, through her attorney, requested a hearing that was held on June 12, 2007. Appellant did not appear at the hearing. Her attorney requested that cubital tunnel syndrome be accepted as employment related and argued that it was unreasonable not to use pinch strength in finding impairment or, at the very least, a conflict in medical evidence had been created. Appellant submitted a March 11, 2005 report in which Dr. Alan D. Carr, a Board-certified osteopath specializing in anesthesiology, noted that she had right elbow and cervical pain with a positive Tinel's test on examination. Dr. Carr recommended a rehabilitation program. In a statement dated June 10, 2007, appellant reported that she continued to experience pain in her wrist, hand, elbow, shoulder and neck areas while performing daily work and home activities and that the grip and pinch strength in her right hand was considerably weaker than on the left.

In an August 8, 2007 decision, an Office hearing representative affirmed the February 13, 2007 schedule award decision.

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<sup>4</sup> A.M.A., *Guides* (5<sup>th</sup> ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

## **LEGAL PRECEDENT**

Under section 8107 of the Federal Employees' Compensation Act<sup>5</sup> and section 10.404 of the implementing federal regulations,<sup>6</sup> schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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*<sup>7</sup> has been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.<sup>8</sup>

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.<sup>9</sup> Office procedures provide that to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred ("date of maximum medical improvement"), describes the impairment in sufficient detail to include, 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 strength or disturbance of sensation or other pertinent description of the impairment and the percentage of impairment should be computed in accordance with the fifth edition of the A.M.A., *Guides*. The procedures further provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for opinion concerning the nature and percentage of impairment and the Office medical adviser should provide rationale for the percentage of impairment specified.<sup>10</sup>

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.<sup>11</sup> Regarding carpal tunnel syndrome, the A.M.A., *Guides* provide that:

"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 --

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<sup>5</sup> 5 U.S.C. § 8107.

<sup>6</sup> 20 C.F.R. § 10.404.

<sup>7</sup> A.M.A., *Guides*, *supra* note 4.

<sup>8</sup> See *Joseph Lawrence, Jr.*, *supra* note 4; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

<sup>9</sup> *Tammy L. Meehan*, 53 ECAB 229 (2001).

<sup>10</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(d) (August 2002).

<sup>11</sup> A.M.A., *Guides*, *supra* note 4 at 433-521.

(1) Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTSE is rated according to the sensory and/or motor deficits as described earlier.<sup>12</sup>

(2) Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG [electromyogram] testing of the thenar muscles: a residual CTSS is still present and an impairment rating not to exceed 5 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.”<sup>13</sup>

Section 16.5d of the A.M.A., *Guides* provide that, in compression neuropathies, additional impairment values are not given for decreased grip strength. Carpal tunnel syndrome is an entrapment/compression neuropathy of the median nerve and the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory deficits only and that in the absence of a complex regional pain syndrome, additional impairment values are not given for decreased motion.<sup>14</sup>

Section 16.8a provides that, in a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods, the loss of strength may be rated separately. An example of such situation would be loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated.<sup>15</sup> Section 16.4 provides that in evaluating abnormal motion both active and passive motion measurements are necessary to evaluate the joint motion under the appropriate charts and these should be added to obtain the total motion impairment.<sup>16</sup> Section 16.8b states that pinch strength measurements are done with a pinch gauge and should be repeated three times. These are averaged and compared with the opposite extremity, if normal but if both

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<sup>12</sup> Section 16.5b of the A.M.A., *Guides* describes the methods for evaluating upper extremity impairments due to peripheral nerve disorders and provides that the severity of the sensory or pain deficit and motor deficit should be classified according to Tables 16-10a and 16-11a respectively. 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. *Id.* at 481; *Kimberly M. Held*, 56 ECAB 670 (2005).

<sup>13</sup> A.M.A., *Guides*, *supra* note 4 at 495.

<sup>14</sup> *Id.* at 494; *Kimberly M. Held*, *supra* note 12.

<sup>15</sup> *Id.* at 508; see *Cerita J. Slusher*, 56 ECAB 532 (2005).

<sup>16</sup> A.M.A., *Guides*, *supra* note 4 at 451-52.

extremities are involved, the strength measurements are compared to the average normal strengths listed in Tables 16-31 through 16-33.<sup>17</sup>

Section 18.3b provides that pain-related impairment should not be used if the condition can be adequately rated under another section of the A.M.A., *Guides*. Office procedures provide that, if the conventional impairment adequately encompasses the burden produced by pain, the formal impairment rating is determined by the appropriate section of the A.M.A., *Guides*.<sup>18</sup> Section 18.3d provides guidance on how a pain-related impairment should be rated, noting that an award of up to three percent whole person impairment may be granted if pain increases the burden of the employee's condition.<sup>19</sup> While the A.M.A., *Guides*, provides for impairment to the individual member and to the whole person, the Act does not provide for permanent impairment for the whole person.<sup>20</sup>

### ANALYSIS

The Board finds that appellant has a 12 percent impairment of the right upper extremity. As stated above, section 16.5d of the A.M.A., *Guides* provides three scenarios for assessing impairment due to carpal tunnel syndrome following a surgical decompression<sup>21</sup> and if, as in this case, on examination a physician finds positive clinical findings of median nerve dysfunction, the impairment due to residual carpal tunnel syndrome is to be rated according to the sensory and/or motor deficits described in section 16.5b of the A.M.A., *Guides*.<sup>22</sup> The Office medical adviser utilized Dr. Weiss' findings of a sensory deficit to determine that appellant had a below midforearm median nerve sensory impairment and properly found that, under Table 16-15, the maximum upper extremity impairment was 39 percent.<sup>23</sup> He then utilized Table 16-10 and determined that appellant had a Grade 4 impairment, which he rated at 25 percent and properly multiplied this value with the maximum 39 percent sensory impairment to find that she had a below midforearm right upper extremity sensory impairment of 9.75 percent or, rounded up, a 10 percent impairment.

The Office medical adviser then properly graded appellant's impairment above the midforearm and found that, under Table 16-15, the maximum upper extremity impairment was seven percent.<sup>24</sup> He then utilized Table 16-10 and determined that appellant had a Grade 4 impairment, which he rated at 25 percent and properly multiplied this value with the maximum

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<sup>17</sup> *Id.* at 508.

<sup>18</sup> FECA Bulletin No. 01-01 (issued January 29, 2001).

<sup>19</sup> See *Richard B. Myles*, 54 ECAB 379 (2003); A.M.A., *Guides*, *supra* note 4 at 573, 588.

<sup>20</sup> See *Janae J. Triplette*, 54 ECAB 792 (2003).

<sup>21</sup> A.M.A., *Guides*, *supra* note 4 at 495.

<sup>22</sup> *Supra* note 7.

<sup>23</sup> A.M.A., *Guides*, *supra* note 4 at 492.

<sup>24</sup> *Id.* at 492.

7 percent sensory impairment to find that she had an above midforearm right upper extremity sensory impairment of 1.75 percent or, rounded up, a 2 percent above midforearm impairment. The Office medical adviser then properly utilized the Combined Values Chart of the A.M.A., *Guides* to find that 10 percent combined with 2 percent equaled a 12 percent right upper extremity impairment.<sup>25</sup>

While Dr. Weiss opined that under Table 16-34 appellant had a right lateral pinch deficit of 20 percent and a 3 percent impairment for pain under Table 18-1, the A.M.A., *Guides* provides that strength testing is not to be used in cases with compression neuropathy.<sup>26</sup> Furthermore, the A.M.A., *Guides* warns that examiners should not use Chapter 18 to rate pain-related impairment for any condition that can be adequately rated on the basis of the body and organ impairment rating systems given in the other chapters<sup>27</sup> and pain is encompassed in the impairment ratings described in Table 16-15 which was used by the Office medical adviser in this case.<sup>28</sup>

### **CONCLUSION**

The Board finds that appellant has not established that she is entitled to a schedule award greater than the 12 percent previously awarded for her right upper extremity impairment.

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<sup>25</sup> *Id.* at 604.

<sup>26</sup> *Id.* at 494.

<sup>27</sup> *Id.* at 571.

<sup>28</sup> *Id.* at 492.

**ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs' hearing representative dated August 8, 2007 is affirmed

Issued: August 11, 2008  
Washington, DC

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

Colleen Duffy Kiko, Judge  
Employees' Compensation Appeals Board

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