United States Department of Labor
Employees' Compensation Appeals Board

M.P., Appellant	)	
and	)	**Docket No. 07-2437**
	)	**Issued: March 7, 2008**
U.S. POSTAL SERVICE, WEST GLEN ANNEX, Peoria, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 25, 2007 appellant filed a timely appeal from a September 7, 2007 merit decision of the Office of Workers' Compensation Programs granting her a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than a two percent permanent impairment of the right upper extremity.

FACTUAL HISTORY

On July 5, 2005 appellant, then a 56-year-old mail carrier, filed an occupational disease claim alleging that she sustained numbness of the right hand due to casing and carrying mail.

She did not stop work. The Office accepted appellant's claim for right carpal tunnel syndrome and right cubital tunnel syndrome.[1]

On August 24, 2006 appellant filed a claim for a schedule award. In a report dated October 10, 2006, Dr. David E. Connor, an attending Board-certified orthopedic surgeon, discussed appellant's history of an anterior transposition of the right ulnar nerve and endoscopic decompression of the right median nerve on December 14, 2005.[2] He opined that she had reached maximum medical improvement and had an 18 percent permanent impairment of the right upper extremity. Dr. Connor found that appellant had a loss of right hand strength and "some decreased sensation in the volar aspect of the right ring and small fingers, which will also add to her permanent disability." In a note dated October 4, 2006, an occupational therapist indicated that she had tested appellant's range of motion, grip strength and sensation on that date for Dr. Connor.

On November 17, 2006 an Office medical adviser reviewed appellant's history of a right carpal tunnel release and ulnar nerve transposition on December 14, 2005. He opined that the medical evidence was insufficient to determine the extent of her right upper extremity impairment and recommended further evaluation identifying any residual motor or sensory deficits in the median and ulnar nerves. The Office medical adviser noted that the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*) did not provide an impairment due to loss of range of motion in compression neuropathies absent evidence of complex regional pain syndrome (CRPS) or an additional impairment due to decreased grip strength.

Appellant submitted the October 4, 2006 report from the occupational therapist, who listed grip and pinch strength for the right and left hands and range of motion measurements of the wrists, forearms, elbows, shoulders, hands and fingers. The occupational therapist found that appellant had a loss of sensation in the small finger and numbness in the finger with two-point discrimination. Appellant had normal sensation of the dorsum of the hand. The occupational therapist concluded that appellant had a 22 impairment due to loss of range of motion

On February 26, 2007 an Office medical adviser reviewed the reports from the occupational therapist obtained for Dr. Connor, who noted that appellant had normal Semmes-Weinstein monofilament testing but decreased two-point discrimination by 8 to 10 millimeters in the ulnar nerve distribution. The Office medical adviser found that appellant had a Grade 4 sensory deficit for loss of sensation of the ulnar nerve which constituted a two percent impairment of the right upper extremity according to Tables 16-15 and 16-10 on pages 492 and 482 of the A.M.A., *Guides*. He determined that she was not entitled to a greater impairment due to loss of range of motion as there was no evidence of a regional pain syndrome. The Office medical adviser also found that appellant's grip strength values did not show a permanent impairment under the A.M.A., *Guides*. He concluded that she reached maximum medical improvement on March 15, 2006.

[1] A June 23, 2005 electromyogram and nerve conduction study revealed moderately severe right ulnar cubital tunnel syndrome and slight to moderate carpal tunnel syndrome.

[2] The operative report is not in the record.

By decision dated September 7, 2007, the Office granted appellant a schedule award for a two percent permanent impairment of the right upper extremity. The award ran for 6.24 weeks March 14 to April 27, 2006.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[3] and its implementing federal regulations,[4] 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 for all claimants, the Office has adopted the A.M.A., *Guides* (5th ed. 2001) as the uniform standard applicable to all claimants.[5] 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.[6]

The A.M.A., *Guides* provides, "In compression neuropathies, additional impairment values are not given for decreased grip strength. In the absence of CRPS, additional impairment values are not given for decreased motion."[7]

It is well established that the period covered by the schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury. The Board has explained that maximum medical improvement means that the physical condition of the injured member of the body has stabilized and will not improve further. The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record, and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[8]

The Board has noted a reluctance to find a date of maximum medical improvement retroactive to the award, as retroactive awards often result in payment of less compensation benefits. The Board, therefore, requires persuasive proof of maximum medical improvement for selection of a retroactive date of maximum medical improvement.[9]

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[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] 20 C.F.R. § 10.404(a).

[6] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[7] A.M.A., *Guides* at 494.

[8] *Mark A. Holloway*, 55 ECAB 321 (2004).

[9] *James E. Earle*, 51 ECAB 567 (2000).

ANALYSIS

The Office accepted that appellant sustained carpal and cubital tunnel syndrome of the right hand. She underwent an anterior transposition of the right ulnar nerve and endoscopic decompression of the right median nerve on December 14, 2005.

On October 4, 2006 an occupational therapist evaluated the extent of appellant's permanent impairment of the right upper extremity for Dr. Connor. She measured grip and pinch strength for the right and left hands and provided range of motion measurements for the upper extremities. The occupational therapist further determined that appellant had a loss of sensation in the small finger with two-point discrimination. She found that appellant had a 22 percent impairment due to loss of range of motion. The A.M.A., *Guides*, however, states that additional impairment values are not provided for decreased motion in the absence of complex regional pain syndrome.[10]

On October 10, 2006 Dr. Connor opined that appellant had reached maximum medical improvement. He indicated that she had a loss of strength of the right hand and decreased sensation in the right ring and small fingers. Dr. Connor concluded that appellant had an 18 percent permanent impairment of the right upper extremity. He did not, however, explain how he calculated the impairment percentage with reference to the tables and pages of the A.M.A., *Guides*. As Dr. Connor did not provide an impairment determination in accordance with the A.M.A. *Guides*, his opinion is of diminished probative value.[11]

An Office medical adviser reviewed the evidence and noted that appellant had decreased two-point discrimination in the ulnar nerve distribution. He found that she had a Grade 4 sensory deficit for loss of sensation of the ulnar nerve which he multiplied to find a two percent right upper extremity impairment according to Tables 16-15 and 16-10 of the A.M.A., *Guides*. The Board notes that this would comport with the A.M.A., *Guides*, as a Grade 4 sensory deficit with pain would warrant an impairment percentage of between 1 and 25 percent.[12] If the maximum sensory deficit percentage of 25 is multiplied by 7, the maximum impairment for the ulnar nerve according to Table 16-15 on page 392, the result is a 1.75 percent impairment due sensory deficit which when rounded yields a 2 percent impairment.[13] There is no medical evidence of record which provides an impairment rating of appellant's right upper extremity establishing greater impairment.

It is well established that the period of a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury. The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record and is usually considered to be the

[10] A.M.A., *Guides* 494-95.

[11] *Mary L. Henninger*, 52 ECAB 408 (2001).

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

[13] Impairment percentages are rounded to the nearest whole point. Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3b (June 2003).

date of the evaluation by the attending physician which is accepted as definitive by the Office.[14] The Board has noted a reluctance to find a date of maximum medical improvement which is retroactive to the award, as retroactive awards often result in payment of less compensation benefits.[15] The Board, therefore, requires persuasive proof of maximum medical improvement for selection of a retroactive date of maximum medical improvement.[16] Dr. Connor found that appellant reached maximum medical improvement in a report dated October 10, 2006. The Office medical adviser, however, found that appellant reached maximum medical improvement on March 15, 2006. He did not provide any rationale for his finding and thus did not present the persuasive proof necessary to support a retroactive date of maximum medical improvement.[17] The Board, therefore, finds that the period of the schedule award should commence on October 10, 2006, the date of the evaluation by Dr. Connor. The case will be remanded for the Office to determine whether the change in the date of commencement of the schedule award changes the pay rate applicable to the schedule award.

CONCLUSION

The Board finds that appellant has no more than a two percent permanent impairment of the right upper extremity. The case will be remanded to change the date the schedule award begins and to determine whether the change alters the pay rate.

[14] *Mark A. Holloway*, *supra* note 8.

[15] *James E. Earle*, *supra* note 9.

[16] *Id*.

[17] Appellant underwent a right carpal tunnel release in December 2005 and thus the date of maximum medical improvement found by the Office medical adviser is only three months after her surgery.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 7, 2007 is affirmed in part and set aside in part and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: March 7, 2008
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