United States Department of Labor
Employees' Compensation Appeals Board

J.W., Appellant	)	
and	)	**Docket No. 08-180**
	)	**Issued: May 7, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Newark, DE, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 23, 2007 appellant, through his attorney, filed a timely appeal of the Office of Workers' Compensation Programs' hearing representative's merit decision dated May 23, 2007, finding the extent of his permanent impairment for schedule award purposes. 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 12 percent impairment of the left upper extremity for which he has received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board on appeal. On January 10, 2002 appellant, then a 32-year-old letter carrier, filed an occupational disease claim, alleged that on December 4, 2001 he became aware of his diagnosed condition of carpal tunnel syndrome and attributed this condition to his federal duties. Dr. Peter F. Townsend, a Board-certified orthopedic surgeon, performed an ulnar nerve transposition and carpal tunnel release on

appellant's left upper extremity on January 31, 2002. The Office accepted that appellant had sustained left carpal tunnel syndrome and left ulnar nerve entrapment and authorized surgery on March 15, 2002. Appellant requested a schedule award and submitted a report dated September 3, 2002 from Dr. David Weiss, an osteopath and Board-certified orthopedic surgeon, who concluded that he had 20 percent impairment due to loss of grip strength, 9 percent impairment due to motor strength deficit in left thumb abduction and an additional 3 percent impairment due to pain for a total of 30 percent impairment of the left upper extremity. The Office medical adviser reviewed Dr. Weiss' report and concluded that appellant had only 12 percent permanent impairment of his left upper extremity. The Office granted appellant a schedule award for 12 percent impairment of his left upper extremity on December 18, 2003. By decision dated October 18, 2004, the hearing representative affirmed the Office's December 18, 2003 decision. The Board reviewed appellant's claim in a decision dated June 14, 2005,[1] finding that the October 18, 2004 decision must be set aside and the case remanded for further development as Dr. Weiss' report was not sufficiently detailed to allow an informed determination of appellant's permanent impairment and as the Office medical adviser did not correlate his conclusions with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] The Board directed the Office to refer appellant to an appropriate physician for evaluation of his permanent impairment and to issue an appropriate decision. The facts and circumstances of the case as set out in the Board's prior decisions are adopted herein by reference.

The Office referred appellant, a statement of accepted facts and a list of questions to Dr. Robert A. Smith, for a second opinion evaluation. Dr. Smith examined appellant on August 15, 2005 and found no muscle atrophy, normal muscle strength and normal sensation in the fingertips. He diagnosed ulnar and median nerve entrapment in the left upper extremity or carpal tunnel and cubital tunnel syndromes. Dr. Smith requested an electromyelogram (EMG). He found that appellant had reached maximum medical improvement and did not require further treatment. Appellant underwent an EMG on October 4, 2005. In a report dated October 7, 2005, Dr. Smith noted that appellant's postsurgical EMG showed mild residual carpal tunnel findings, but that he had a normal physical examination. He concluded that in accordance with the A.M.A., *Guides*, this was five percent impairment of the left upper extremity. Dr. Smith also noted that appellant's EMG demonstrated ulnar nerve entrapment at the elbow, a Grade 4 sensory deficit under the A.M.A., *Guides*. He opined that appellant had an impairment of 10 percent which he multiplied by the 7 percent sensory value of the ulnar nerve to reach 0.7 percent or 1 percent of the upper extremity. Dr. Smith concluded that appellant had six percent impairment of his left upper extremity after combining the impairment ratings in accordance with the A.M.A., *Guides*.[3] The Office medical adviser reviewed Dr. Smith's report on October 21, 2005 and agreed with his "rationale and calculation" of six percent impairment of the left upper extremity.

[1] Docket No. 05-700 (issued June 14, 2005).

[2] A.M.A., *Guides*, 5th ed. (2000).

[3] He provided detailed citations to the appropriate sections of the A.M.A., *Guides*.

By decision dated December 29, 2005, the Office denied appellant's claim for an additional schedule award. The Office found that the weight of the medical evidence rested with Dr. Smith's report establishing that appellant had no more than six percent impairment of his left upper extremity. Appellant, through his attorney, requested an oral hearing. By decision dated July 11, 2006, the hearing representative set aside the Office's December 29, 2005 decision finding that Dr. Smith did not fully describe appellant's "normal" examination findings. She noted that Dr. Smith did not provide a description of specific ranges of motion or results of motor strength testing and that the Office medical adviser did not explain why he agreed with Dr. Smith's opinion. The hearing representative remanded the case for the Office to secure a supplemental report from Dr. Smith.

The Office requested that Dr. Smith provide a supplemental report including specific ranges of motion and results of motor strength testing by letter dated September 26, 2006. Dr. Smith responded on November 20, 2006 and stated that range of motion figures were not applicable to a rating for carpal tunnel syndrome. He stated that he tested appellant's motor strength through manual motor testing and concluded that he did not have any weakness related to his carpal tunnel syndrome. Dr. Smith concluded that his application of the A.M.A., *Guides* was appropriate to appellant's findings and conditions.

The Office medical adviser reviewed the medical evidence on November 28, 2006. He agreed with Dr. Smith's findings and application of the A.M.A., *Guides*. The Office medical adviser stated that Dr. Smith provided well-reasoned opinions and utilized the appropriate sections of the A.M.A., *Guides*. He then provided an extensive review of the factual and medical evidence in the record.

By decision dated November 30, 2006, the Office determined that appellant was not entitled to an additional schedule award based on Dr. Smith's reports. Appellant, through his attorney, requested an oral hearing on December 6, 2006. His attorney appeared at the oral hearing on March 20, 2007 and alleged that Dr. Smith failed to provide the requested information in his supplemental report. She also alleged a conflict of medical opinion evidence between Dr. Smith and Dr. Weiss.

Following the oral hearing, appellant, through his attorney, submitted a form completed by him rating his level of difficulty completing specific tasks. By decision dated May 23, 2007, the hearing representative affirmed the Office's November 30, 2006 decision. She found that Dr. Smith's reports were sufficiently detailed and constituted the weight of the medical opinion evidence.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing regulations[5] 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

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999).

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.

The A.M.A., *Guides* provide that to rate a sensory or motor impairment, the physician must identify the nerve structure involved and multiply the grade of severity of the sensory or motor deficit by the respective maximum upper extremity impairment value resulting from the sensory or motor deficit of each nerve structure.[6] If more than one nerve structure is involved then the upper extremity impairment values should be combined.[7]

In evaluating 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 or difficulties in performing certain activities three possible scenarios can be present. The first situation is: "Positive clinical finding of median nerve dysfunction and electrical conduction delay(s): [t]he impairment due to residual CTS [carpal tunnel syndrome] is rated according to the sensory and/or motor deficits as described earlier."[8] In this situation, the impairment due to residual carpal tunnel syndrome is evaluated by multiplying the grade of severity of the sensory or motor deficit by the respective maximum upper extremity impairment 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.[9] In the second scenario: "Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS [carpal tunnel syndrome] is still present and an impairment rating not to exceed [five] percent of the upper extremity may be justified." In the final situation: "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."[10]

ANALYSIS

The Board previously reviewed this case and found that the medical evidence relied upon by the Office was not appropriate to determine appellant's permanent impairment for schedule award purposes. The Board remanded the claim for the Office to undertake additional development of the medical evidence in order to properly calculate appellant's permanent impairment and entitlement to a schedule award. In response to the Board's decision, the Office referred appellant to Dr. Smith, a Board-certified orthopedic surgeon, for a second opinion evaluation. Dr. Smith noted appellant's accepted conditions of carpal tunnel syndrome and

[6] A.M.A., *Guides*, 481.

[7] *Id.*

[8] *Id.* at 495.

[9] *Id*. at 494, 481.

[10] *Supra* note 8.

cubital tunnel syndrome and found that he had reached maximum medical improvement. He reviewed appellant's postsurgical EMG findings and noted that this testing revealed mild residual carpal tunnel findings. Dr. Smith performed a physical examination and concluded that appellant had normal sensation and normal muscle strength with no muscle atrophy. He properly applied the A.M.A., *Guides* and concluded that appellant had no more than five percent impairment of his left upper extremity due to carpal tunnel syndrome.[11] The Office medical adviser reviewed Dr. Smith's reports and agreed with this rating.

In regard to appellant's cubital tunnel syndrome, Dr. Smith found that he had impairment of the ulnar nerve demonstrated on EMG, with a maximum value of seven due to sensory deficit or pain.[12] He then multiplied this value by the degree of impairment, Grade 4 or "Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity," with a sensory deficit rating of 1 to 25 percent to reach his impairment rating of 1 percent. Dr. Smith opined that appellant had a sensory deficit rating of 10 percent which he multiplied by the 7 percent sensory value of the ulnar nerve to reach 0.7 percent or 1 percent impairment of the upper extremity. The Office medical adviser concurred this finding. Dr. Smith then properly combined appellant's upper extremity ratings to reach six percent impairment.

Dr. Smith's reports are detailed and comport with the A.M.A., *Guides*. Appellant submitted a form report from Dr. Weiss' office which did not provide independent physical findings and did not reference the A.M.A., *Guides*. This form, therefore, has no value in determining appellant's permanent impairment for schedule award purposes.[13] The Office properly found that Dr. Smith's reports represent the weight of the medical opinion evidence and establish that appellant has no more than 12 percent impairment of his left upper extremity for which he has received a schedule award.

CONCLUSION

The Board finds that Dr. Smith's reports establish that appellant has no more than 12 percent impairment of his left upper extremity, for which he has received a schedule award. Appellant has not established that he has any additional impairment for schedule award purposes.

[11] *Id.*

[12] A.M.A., *Guides*, 492, Table 16-15.

[13] The Board notes that, in its previous decision, it found that Dr. Weiss' reports were not appropriate to constitute the weight of the medical evidence due to lack of detail and numerous defects in the application of the A.M.A., *Guides*. For these same reasons, these reports cannot create a conflict with the detailed reports of Dr. Smith. 5 U.S.C. §§ 8101-8193, 8123.

ORDER

IT IS HEREBY ORDERED THAT the May 23, 2007 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 7, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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