United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 08-1995**
	)	**Issued: April 22, 2009**
DEPARTMENT OF THE NAVY, NAVAL AIR FACILITY, El Centro, CA, 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
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 14, 2008 appellant filed a timely appeal from a June 24, 2008 merit decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award decision.

ISSUE

The issue is whether appellant has established more than 14 percent right upper extremity impairment and more than 14 percent left upper extremity impairment for which she received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board. In a May 22, 2008 decision, the Board set aside the Office's September 5, 2007 decision, which denied appellant's claim for an increased schedule award beyond 14 percent permanent impairment previously awarded for each upper extremity.[1] The Board found that Dr. Arthur S. Harris, a Board-certified orthopedic

[1] Docket No. 08-13 (issued May 22, 2008).

surgeon and Office medical adviser, did not adequately explain how he reached his impairment rating of 9 percent impairment of the right arm and 12 percent impairment of the left arm. The Board found that he did not explain his basis for including three percent impairment for lost range of motion for the left arm. The Board also found that Dr. Harris erroneously based four percent pain impairment for each arm based on a decreased sensation to the ulnar nerve, when it should have been based on median nerve distribution in view of the findings of appellant's physician, Dr. James R. Moitoza, a Board-certified orthopedic surgeon. The Board further noted that, while Dr. Harris classified appellant's impairment of the upper extremity due to sensory deficit or pain as that of Grade 3 deficit, he applied a percentage deficit for that of a Grade 4 deficit. The Board remanded the case for the Office to request clarification from Dr. Harris. The facts and the circumstances of the case as set forth in the Board's prior decision are incorporated herein by reference.[2]

Following the Board's May 22, 2008 decision, the Office requested that Dr. Harris clarify his May 7, 2007 calculations. It noted that the pain impairment to both the left and right upper extremities should have been based on the median nerve. The Office requested that Dr. Harris recalculate the impairment of the right and left upper extremities using the correct maximum impairment value for the proper peripheral nerve (39 percent for the median nerve below the midforearm) and correlates the proper sensory deficit percentage range for the classification of the sensory deficit or pain.

Dr. Moitoza continued to submit additional reports documenting appellant's continued treatment. He noted that appellant continued to have some sort of neuropathic pain syndrome with no evidence of any neurologic deficit in either upper extremity.

In a June 9, 2008 report, Dr. Harris reviewed his May 7, 2007 finding that appellant had 9 percent impairment of the right upper extremity and 12 percent impairment of the left upper extremity as well as Dr. Moitoza's subsequent reports and advised he did not wish to change his previously expressed opinion. He stated it was obvious from Dr. Moitoza's March 22, 2007 report, as well as his subsequent reports that appellant has chronic problems with bilateral median nerve neuropathy at the wrists/carpal tunnel syndrome, bilateral cubital tunnel syndrome/ulnar neuropathy at the elbow and some residual problems from her bilateral first dorsal compartment release. With regards to impairment resulting from cubital tunnel syndrome/ulnar neuropathy, Dr. Harris felt appellant's symptoms were consistent with Grade 3 pain/decreased sensation that interferes with some activity (Table 16-10 page 482 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*) and, when multiplied by the seven percent maximum impairment value for the ulnar nerve above midforearm (Table 16-15, page 492 of the A.M.A., *Guides*), resulted in a four percent impairment of both the right and left upper extremities. He stated appellant had residual carpal tunnel symptoms status post right carpal tunnel release on May 3, 2001 and left carpal tunnel release in April 2001 and opined that, under Chapter 16 at page 495, appellant had five percent impairment for her bilateral carpal tunnel symptoms consistent with having a satisfactory result

[2] The Office accepted appellant's claim for bilateral carpal tunnel syndrome, bilateral lesion of the ulnar nerve, right wrist ganglion cyst and right radial styloid tendinitis and authorized appropriate surgeries. It paid appropriate benefits and appellant returned to full-time modified-duty work after each surgery. In its May 22, 2008 decision, the Board found that the record did not show that appellant had a right wrist ganglion cyst.

following carpal tunnel release. Dr. Harris further advised that appellant has some loss of ulnar deviation as a result of her continued problems with chronic de Quervain's tenosynovitis status post left de Quervain's/first dorsal compartment release on December 9, 2005 and had three percent impairment for loss of motion for her left upper extremity.[3] He advised that while a Grade 3 pain/decreased sensation that interferes with some activity (Table 16-10, page 482) of the median nerve/sensory function [39] would result in a 24 percent impairment of each upper extremity, he did not feel appellant was entitled to this impairment. He explained that Dr. Moitoza's subsequent evaluations documented appellant's continued chronic problems with her bilateral median nerve/median neuropathy and bilateral cubital tunnel/ulnar neuropathy and that her symptoms wax and wane with time with no evidence of any neurologic deficit in either upper extremity. Dr. Harris stated that, because appellant's symptoms wax and wane and there would be different subjective complaints as well as objective findings depending on the date that she was seen, he did not wish to change his previous opinion that appellant had 9 percent impairment in the right arm and 12 percent impairment in the left arm with a date of maximum medical improvement of December 20, 2006.

By decision dated June 24, 2008, the Office denied appellant's request for an increased award for the right and left upper extremities. Based on the Office's medical adviser's June 9, 2008 report, it found that appellant was entitled to no greater than the 14 percent right upper extremity impairment and the 14 percent left upper extremity impairment previously paid.

On appeal, appellant agreed that her condition was chronic, but disagreed with the Office's denial of her claim for an increased schedule award.

LEGAL PRECEDENT

A claim for an increased schedule award may be based on new exposure.[4] Absent any new exposure to employment factors, a claim for an increased schedule award may also be based on medical evidence indicating that the progression of an employment-related condition has resulted in a greater permanent impairment than previously calculated.[5]

In determining entitlement to a schedule award, preexisting impairment to the scheduled member should be included.[6] Any previous impairment to the member under consideration is included in calculating the percentage of loss except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.[7]

[3] In his May 7, 2007 report, Dr. Harris found that under Figure 16-31 at page 469, the A.M.A., *Guides* (5th ed. 2001), appellant had three percent impairment for loss of wrist ulnar deviation.

[4] *Linda T. Brown*, 51 ECAB 115 (1999).

[5] *Id.*

[6] *Carol A. Smart*, 57 ECAB 340 (2006); *Michael C. Milner*, 53 ECAB 446, 450 (2002).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.7(a)(2) (November 1998).

The schedule award provision of the Federal Employees' Compensation Act[8] and its implementing regulations[9] 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. The Act, however, does not specify the manner in which the percentage loss of a member 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 Office for evaluating schedule losses.[10]

The A.M.A., *Guides* note that carpal tunnel syndrome involves compression of the median nerve at the volar aspect of the wrist.[11] The A.M.A., *Guides* list the symptoms, signs and findings of carpal tunnel syndrome as pain and paresthesias in the median nerve distribution, including sensory autonomic disturbances in the radial 3.5 digits, weakness or atrophy of the thenar muscles, a positive percussion sign at the wrist, presence of Phalen's sign and motor and sensory electroneuromyographic abnormalities.[12]

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): The impairment due to residual carpal tunnel syndrome is rated according to the sensory and/or motor deficits as described earlier.[13] 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.[14]

In the second scenario: Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal electromyogram (EMG) 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. Finally, the A.M.A., *Guides* provide: Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *See id*. at § 10.404; *see also David W. Ferrall*, 56 ECAB 362 (2005).

[11] A.M.A., *Guides* 495.

[12] *Id.*

[13] *Id.*

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

testing), opposition strength and nerve conduction studies: there is no objective basis for an impairment rating.[15]

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the Office medical adviser providing rationale for the percentage of impairment specified.[16]

ANALYSIS

By decision dated May 22, 2008, the Board remanded the case for the Office to obtain clarification from its Office medical adviser, Dr. Harris, regarding appellant's entitlement to a schedule award beyond the 14 percent permanent impairment to both upper extremities previously awarded. The Board found that Dr. Harris did not adequately explain how he reached his impairment rating of 9 percent impairment of the right arm and 12 percent impairment of the left arm in his March 22, 2007 report. Specifically, the Board found that Dr. Harris did not explain his basis for including impairment based on three percent loss of range of motion for the left upper extremity and his four percent pain impairment to both the left and right upper extremities were erroneously based on a decreased sensation to the ulnar nerve and should have been based on median nerve distribution.

In his June 9, 2008 report, Dr. Harris reiterated that appellant has 9 percent impairment of the right upper extremity and 12 percent impairment of the left upper extremity with a date of maximum medical improvement of December 20, 2006 as previously found in his earlier report. The right upper extremity impairment was comprised of four percent cubital tunnel/ulnar neuropathy at the elbow and five percent carpal tunnel/median neuropathy at the wrists. The left upper extremity impairment was comprised of four percent cubital tunnel/ulnar neuropathy at the elbow, five percent carpal tunnel/median neuropathy at the wrists and three percent loss of range of motion. With regard to appellant's bilateral carpal tunnel syndrome/median neuropathy, the Board previously affirmed Dr. Harris's finding that appellant was entitled to five percent impairment under option two on page 495 of the A.M.A., *Guides* as appellant had normal sensibility and opposition strength with abnormal studies.

Regarding impairment for loss of motion, Dr. Harris stated that appellant had three percent impairment for loss of motion based on loss of ulnar deviation of the left upper extremity. He noted that Dr. Moitoza found some loss of ulnar deviation as a result of her continued problems with chronic de Quervain's tenosynovitis status post left de Quervain's/first dorsal compartment release on December 9, 2005. The Board notes that, under Figure 16-31 at page 469 of the A.M.A, *Guides*, 17 degrees of ulnar deviation, noted in Dr. Moitoza's December 22, 2006 report, equals three percent impairment.[17] Thus, Dr. Harris properly

[15] *Id.* at 495.

[16] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[17] Dr. Harris referenced the A.M.A., *Guides* in his May 7, 2007 report. *See supra* note 3.

accorded three percent impairment for loss of motion based on loss of ulnar deviation of the left upper extremity.

However, the remainder of Dr. Harris's impairment evaluation is not well rationalized. He maintained that appellant was entitled to four percent pain impairment to both the left and right upper extremities based on decreased sensation to the ulnar nerve and disagreed that she had a bilateral median nerve sensory impairment based on a Grade 3 pain/decreased sensation that interferes with some activity. Dr. Harris found that Dr. Moitoza's reports established that appellant has chronic problems with bilateral median nerve/median neuropathy and bilateral cubital tunnel/ulnar neuropathy with no evidence of any neurologic deficit in either upper extremity. Because appellant has chronic problems, Dr. Harris explained appellant's symptoms would wax and wane and there would be different subjective complaints as well as objective findings depending on when she was seen. However, he failed to adequately explain why appellant would have bilateral pain impairment rating based on a decreased sensation to the ulnar nerve as opposed to the median nerve. Dr. Moitoza specifically noted in his March 22, 2007 report, that appellant's numbness and tingling and dysesthesias and loss of sensation arose from the median nerve distribution and there were no ulnar nerve symptoms present. Thus, Dr. Harris' conclusion that appellant did not have bilateral pain impairment based on decreased sensation to the median nerve is not well reasoned upon a proper factual basis and requires further clarification. Moreover, there is no objective evidence to support Dr. Harris' impairment findings of bilateral pain impairment based on decreased sensation to the ulnar nerve while Dr. Moitoza had an opportunity to examine appellant and report findings.

Given the deficiencies in Dr. Harris's supplemental report, the Office should not have relied upon his findings in denying appellant's claim for an increased schedule award. Further medical development is needed in this matter. Thus, the Board will remand the case to the Office so that it may obtain an appropriate medical opinion regarding the extent of appellant's permanent impairment of her arms.[18] Following this and such other development as is deemed necessary, it shall issue an appropriate merit decision.

CONCLUSION

The Board finds that the case is not in posture for decision. The record is not sufficiently detailed to establish appellant's impairment rating in accordance with the applicable provisions of the A.M.A., *Guides,* and must be remanded for additional medical development.[19]

[18] *See Mae Z. Hackett*, 34 ECAB 1421 (1983) (once the Office begins medical development, it has the responsibility to obtain an evaluation which will resolve the issue involved in the case).

[19] The Board notes that appellant disputes some of the conditions which the Office accepted, such as a right wrist ganglion cyst. A review of the record does not establish that appellant had such a diagnosis. On remand, it should make sure that its accepted conditions are supported by the record.

ORDER

IT IS HEREBY ORDERED THAT the June 24, 2008 decision of the Office of Workers' Compensation Programs is set aside and remanded for further action consistent with this decision of the Board.

Issued: April 22, 2009
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