United States Department of Labor
Employees' Compensation Appeals Board

L.W., Appellant	)	
and	)	**Docket No. 09-574**
	)	**Issued: June 4, 2009**
U.S. GOVERNMENT PRINTING OFFICE, Washington, DC, Employer	)	

Appearances:
Linda L. Harper, for the appellant
No appearance, for the Director

Oral Argument April 8, 2009

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 5, 2009 appellant, through his representative, filed a timely appeal of the April 17 and November 21, 2008 merit decisions of the Office of Workers' Compensation Programs finding three percent impairment of the right upper extremity. 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 three percent impairment of the right upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On November 2, 2004 appellant, then a 51-year-old head pressman, filed a traumatic injury claim alleging that on October 26, 2004 he sustained a lump on his right wrist as a result of pressing down on a wrench. By letter dated December 30, 2004, the Office accepted his claim for a ganglion cyst of the right wrist and authorized surgery to remove the cyst, which was

performed on March 3, 2005 by Dr. German H. Nader, an attending Board-certified orthopedic surgeon.

On March 21, 2006 appellant filed a claim for a schedule award. In a March 17, 2006 medical report, Dr. Nader stated that appellant sustained a three percent impairment of the right upper extremity for loss of volar flexion. He advised that the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001) were silent on rating impairment for appellant's wrist surgery and scar. Dr. Nader determined that appellant had an additional three percent impairment resulting in a six percent impairment of the right upper extremity.

In a July 31, 2006 report, Dr. Nader stated that appellant had reached maximum medical improvement. He found that appellant had lost 12 percent of volar flexion of the right wrist and had no atrophy. Dr. Nader further found that appellant's subjective complaint of paresthesia from the right wrist to the shoulder was not substantiated by examination. He reiterated his opinion that appellant sustained a six percent impairment of the right upper extremity. Dr. Nader related that he had not used the A.M.A., *Guides*.

In a January 9, 2007 report, Dr. Eric G. Dawson, an attending orthopedic surgeon, reviewed a history of appellant's October 26, 2004 employment injury and medical treatment. On physical examination, he reported no signs of cervical discopathy or cervical radiculopathy as the motor units were tested bilaterally of the upper extremities without deficit. Dr. Dawson stated that appellant demonstrated signs of a healed z-plasty, which was used either for a tenosynovectomy and/or removal of ganglion cysts. There was some atrophy locally, but not enough for circumferential changes. There was some thinning of the skin and slight loss of integumentary structures consistent with local complex regional pain syndrome (CRPS). There was "local soft, as well as pinpoint discrepancy loss in the distribution of the posterior antibrachial cutaneous nerve." Dr. Dawson reported 44 degrees of flexion, which constituted a three percent impairment and 42 degrees of extension, which constituted a four percent impairment (A.M.A., *Guides* 467, Figure 16-28). He also reported 15 degrees of radial deviation, which represented a one percent impairment and 36 degrees of ulnar deviation, which represented a zero percent impairment (A.M.A., *Guides* 469, Figure 16-31).

Dr. Dawson determined that appellant sustained a Grade 4 sensory loss of the posterior antibrachial cutaneous nerve (A.M.A., *Guides* 482, Table 16-10a), which constituted a four percent impairment even though the sensory deficit percentage would be higher under Figure 16-48 on page 488 of the A.M.A., *Guides*. He stated that his CRPS findings were demonstrated by soft touch neurosensory deficit, which was indicated by atrophy of dermal and integumentary structures with local pain and fatigue-ability. Dr. Dawson stated that power loss due to local structural concerns constituted a 5 percent impairment and added to the 12 percent impairment for loss of range of motion, resulting in a 17 percent impairment of the right upper extremity. He related that this impairment rating was conservative noting, that many times the figures were double and above for CRPS related to carpal tunnel syndrome.

On March 7, 2007 Dr. Willie E. Thompson, an Office medical adviser, reviewed appellant's October 26, 2004 employment injury and medical treatment. He determined that 12 degrees of volar flexion represented 50 degrees of flexion, which resulted in a two percent

impairment of the right upper extremity (A.M.A., *Guides* 467, Figure 16-48). Dr. Thompson stated that Dr. Nader's July 31, 2006 statement that he did not use the A.M.A., *Guides* and had never done so in determining impairment ratings for the Office was clearly not consistent with the Office's policy. He opined that appellant reached maximum medical improvement on March 3, 2006. Dr. Thompson stated that Dr. Dawson's January 9, 2007 finding that appellant sustained a 17 percent impairment of the left upper extremity was based on a diagnosis of CRPS which had not been accepted by the Office.[1] He noted that Dr. Dawson attempted to rate appellant for some type of neurological impairment or impingement which was not an accepted condition. Dr. Thompson related that Dr. Dawson's January 9, 2007 report was inconsistent with the accepted condition and it did not relate to the accepted October 26, 2004 employment injury. He concluded that appellant sustained a two percent impairment of the right upper extremity. Dr. Thompson further concluded that appellant reached maximum medical improvement on March 3, 2006.

By decision dated May 23, 2007, the Office granted appellant a schedule award for a two percent impairment of the right upper extremity.[2] On June 5, 2007 it amended the May 23, 2007 decision to reflect the finding that Dr. Thompson's March 7, 2007 opinion constituted the weight of the medical evidence.

On June 6, 2007 appellant requested an oral hearing before an Office hearing representative.

By decision dated November 1, 2007, an Office hearing representative set aside the June 5, 2007 decision and remanded the case to the Office. The hearing representative instructed the Office to further develop the medical evidence to determine whether appellant developed CRPS as a result of the October 26, 2004 employment injury and the extent of any permanent impairment based on the A.M.A., *Guides* due to this condition.

By letter dated November 5, 2007, the Office requested that Dr. Nader address whether appellant developed CRPS as a result of his accepted employment injury and/or effects of the March 3, 2005 surgery. Dr. Nader did not respond.

By letter dated February 22, 2008, the Office referred appellant, together with a statement of accepted facts, the case record and a list of questions to be addressed, to Dr. Robert A. Smith, a Board-certified orthopedic surgeon, for a second opinion medical examination.

In a March 5, 2008 report, Dr. Smith reviewed a history of appellant's accepted employment injury and medical treatment.[3] On physical examination of the right hand, he reported a well-healed, z-type incision on the dorsum of the hand where the ganglion cyst had

[1] The Board notes that it appears that Dr. Thompson inadvertently stated that Dr. Dawson found that appellant sustained a 17 percent impairment of the left extremity rather than the right extremity as Dr. Dawson's January 9, 2007 report only addressed impairment of appellant's right upper extremity.

[2] The Board notes that the Office's May 23, 2007 decision is not contained in the case record.

[3] Dr. Smith noted that the date of injury was November 2, 2004, the date appellant filed his traumatic injury claim rather than October 26, 2004, the actual date of his injury.

been removed. Dr. Smith stated that sensation in the adjacent skin distally was normal. He found no evidence of atrophy in either the forearm or hand. There was also no evidence of any skin or integument defect as found by Dr. Dawson and no abnormal sweating. Dr. Smith stated that appellant exhibited normal hair growth and nails on his hand. He reported 60 degrees of dorsiflexion, 30 degrees of ulnar deviation and 20 degrees of radial deviation which each constituted a zero percent impairment and 40 degrees of volar flexion constituted a three percent impairment (A.M.A., *Guides* 467, 469, Figures 16-28 and 16-31). Dr. Smith further reported normal grip, pinch and opposition strength. He advised that, based on the A.M.A., *Guides*, appellant sustained a three percent impairment of the right upper extremity causally related to the accepted employment-related injury. Dr. Smith found no evidence of a work-related nerve injury or sympathetic remediated condition such as CRPS or reflex sympathetic dystrophy. He concluded that appellant reached maximum medical improvement on March 3, 2006.

In an April 17, 2008 decision, the Office granted appellant a schedule award for an additional one percent impairment, for a total three percent impairment of the right upper extremity. On May 16, 2008 appellant requested an oral hearing before an Office hearing representative.

At the September 16, 2008 hearing, appellant's representative argued that the Office failed to obtain sufficient medical evidence regarding appellant's CRPS condition as directed by the hearing representative. She further argued that Dr. Smith failed to provide a clear opinion addressing the cause of appellant's carpal tunnel syndrome as demonstrated by the July 2008 electromyogram and nerve conduction velocity (EMG/NCV) study results.[4] The representative noted that appellant had filed an occupational disease claim for his carpal tunnel syndrome and that it was currently under development. She stated that he was seeking a schedule award that included his carpal tunnel syndrome.

Following the hearing, appellant submitted Dr. Dawson's June 12, 2008 report. Dr. Dawson stated that appellant continued to experience weakness in the hand and wrist, which caused significant pain and discomfort and "giving way" of the hand and wrist. He reported atrophy that was measurable on the right versus the left. In a March 30, 2007 report, Dr. Dawson stated that appellant had nerve impingement in the right hand based on history and findings on examination. In reports dated July 10 and 31, August 27 and October 17, 2008, he stated that a June 25, 2008 EMG/NCV study demonstrated right carpal tunnel syndrome. Dr. Dawson advised that appellant's repetitive work duties aggravated and exacerbated this condition. The June 25, 2008 EMG/NCV study was performed by Dr. Rashid Khan, a Board-certified physiatrist which found electrodiagnostic evidence of moderate right median sensorimotor neuropathy axonal and demyelinating consistent with right carpal tunnel syndrome. Dr. Khan also found no electrodiagnostic evidence of right cervical radiculopathy.

By decision dated November 21, 2008, an Office hearing representative affirmed the April 17, 2008 decision. The hearing representative found that the evidence submitted by appellant was insufficient to establish that he had more than a three percent impairment of the right upper extremity. The hearing representative found that Dr. Dawson's reports failed to

[4] The Board notes that the July 2008 EMG/NCV study results are not contained in the case record.

provide a rationalized medical opinion establishing that appellant's carpal tunnel syndrome was causally related to his October 26, 2004 employment-related injury. The hearing representative noted that the physician's reports were supportive of appellant's claim file number xxxxxx848 for right carpal tunnel syndrome, which was still under development.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulations[6] set forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[7] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[8]

ANALYSIS

The Office granted appellant a schedule award for a three percent impairment of the right upper extremity. On appeal, appellant contends that he has greater impairment. The Board finds that the case is not in posture for decision.

Appellant's schedule award was based on his accepted employment-related ganglion cyst of the right wrist. At the September 16, 2008 hearing and as noted by the hearing representative in the November 21, 2008 decision, appellant filed an occupational disease claim file number xxxxxx848 for carpal tunnel syndrome of the right wrist due to the accepted employment-related injury and his work duties. The claim was under development by the Office. At oral argument before the Board, appellant contends that the claim was accepted for this condition. Dr. Dawson's July 31 and October 17, 2008 reports stated that appellant's carpal tunnel syndrome was aggravated and exacerbated by his repetitive work duties. The Board notes, however, that the record on appeal does not indicate whether the Office accepted appellant's occupational disease claim for carpal tunnel syndrome of the right wrist. In order to properly determine the degree of permanent impairment to the right upper extremity causally related to employment, the issue of whether appellant's additional right wrist condition is employment related must properly be resolved. Once that issue is resolved, an appropriate determination can be made as to entitlement to a schedule award. The Board will remand the case to the Office.

On remand the Office should combine appellant's claim file number xxxxxx848 for carpal tunnel syndrome of the right wrist with the current claim file number xxxxxx148 for the accepted employment-related ganglion cyst of the right wrist for proper consideration of his

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[5] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[6] 20 C.F.R. § 10.404.

[7] 5 U.S.C. § 8107(c)(19).

[8] *Supra* note 6.

claim for a schedule award. If appellant's claim has been accepted for carpal tunnel syndrome, then the Office should prepare an amended statement of accepted facts and submit the medical record to an appropriate medical specialist to determine the extent of permanent impairment under the A.M.A., *Guides*. After such development as deemed necessary, the Office should issue an appropriate merit decision.

CONCLUSION

The Board finds that the case is not in posture for decision as to whether appellant has more than a three percent impairment of the right upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the November 21 and April 17, 2008 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further consideration consistent with this decision.

Issued: June 4, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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