United States Department of Labor
Employees' Compensation Appeals Board

M.V., Appellant	)	
and	)	**Docket No. 09-401**
	)	**Issued: October 2, 2009**
U.S. POSTAL SERVICE, POST OFFICE, New Orleans, LA, 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
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On November 25, 2008 appellant filed a timely appeal from an August 20, 2008 merit decision of the Office of Workers' Compensation Programs denying his claim for a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant sustained permanent impairment of his upper or lower extremities.

FACTUAL HISTORY

On October 7, 1995 appellant, then a 44-year-old city letter carrier, filed a claim alleging that he sustained an injury to his left ankle on that date in the performance of duty. The Office accepted the claim, assigned file number xxxxxx402, for a left ankle sprain, bilateral carpal

tunnel syndrome and bilateral tenosynovitis of the foot and ankle.[1] Appellant underwent a right carpal tunnel release in 1998 and a left carpal tunnel release in 1999.

On January 30, 2006 appellant filed a claim for a schedule award. In an impairment evaluation dated June 27, 2005, Dr. Sofjan Lamid, a Board-certified physiatrist, diagnosed right carpal tunnel syndrome postsurgery with continued complaints of pain and numbness in the hand and fingers. On examination he found a positive Tinel's sign and Phalen's test. Citing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*), Dr. Lamid found that, for the right upper extremity, appellant had a 20 percent impairment due to loss of grip strength[2] and a 15 percent impairment due to a sensory deficit of the right median nerve below the mid-forearm.[3] He further generally determined that appellant had a 10 percent impairment of the whole person due to loss of range of motion of the right upper extremity. Dr. Lamid concluded that appellant had a 28 percent whole person impairment.

In an impairment evaluation dated July 5, 2005, Dr. Lamid diagnosed left ankle synovitis and a talocalcaneal ligament injury. Citing the A.M.A., *Guides*, he found a 15 percent left lower extremity impairment from plantar flexion weakness, a 10 percent impairment from dorsiflexion weakness, a 5 percent impairment from inversion weakness and a 5 percent impairment from eversion weakness.[4] Dr. Lamid further determined that appellant had a seven percent whole person impairment due to a mild abnormal gait.[5] He additionally found a six percent whole person impairment due to loss of left ankle plantar flexion and a six percent whole person impairment due to loss of left ankle dorsiflexion.[6] Dr. Lamid concluded that appellant had a 29 percent whole person impairment.

On January 22, 2007 an Office medical adviser reviewed Dr. Lamid's June 27, 2005 report. He found that the physician did not adequately describe the impairment and recommended a second opinion examination.

On February 9, 2007 the Office referred appellant to Dr. Christopher E. Cenac, a Board-certified orthopedic surgeon. In a March 1, 2007 examination, Dr. Cenac found a mild Tinel's sign on the right and a negative Tinel's sign on the left. He found no atrophy or sensory deficits of the upper extremities and normal range of motion and dexterity. Dr. Cenac related that grip strength testing showed "flat line deficits in all three settings which is inconsistent." He determined that appellant had normal range of motion of the ankle with "minimal crepitation on the right as compared to the left ankle." Dr. Cenac found no swelling of either ankle or atrophy of the calves and feet. He measured normal motion of the ankles and interpreted x-rays as

[1] The Office also accepted that appellant sustained right carpal tunnel syndrome under file number xxxxxx030.

[2] A.M.A., *Guides* 439, Table 16-3.

[3] *Id*. at 492-93, Tables 16-15, 16-3.

[4] *Id*. at 527, 532, Tables 17-3, 17-8.

[5] *Id*. at 529, Table 17-5.

[6] *Id*. at 537, Table 17-11.

revealing normal joint spaces of the ankle and mid tarsal joints with mild calcifications in the syndesmosis of the right distal tibia and fibula. Dr. Cenac concluded that appellant had no "orthopedic mechanical dysfunction or neurological deficits and/or residual causally related to the October 7, 1995 injury and conditions of left ankle sprain, bilateral carpal tunnel syndrome [and] tenosynovitis of both feet and ankles."

An Office medical adviser reviewed Dr. Cenac's report on March 14, 2007 and concurred with his finding that appellant had no right or left upper or lower extremity impairment. He listed the date of maximum medical improvement as March 1, 2007.

By decision dated March 16, 2007, the Office denied appellant's claim for a schedule award on the grounds that the weight of the medical evidence established that he had no ratable permanent impairment due to his employment injury.

On March 10, 2008 appellant requested reconsideration. In a report dated December 5, 2007, Dr. Bernard Manale, a Board-certified orthopedic surgeon, discussed appellant's complaints of pain and numbness in the right and left hands and wrists and pain, locking and clicking in the right and left ankles. On examination, Dr. Manale found a positive Phalen's sign bilaterally and decreased bulk thenar muscles on the right. He measured range of motion and grip strength for the wrists. On examination of the ankles, Dr. Manale found tenderness of the bilateral ankles and medial and lateral subtalar joints. He found 50 percent range of motion for dorsiflexion and plantar flexion due to pain and 5 to 10 degrees of inversion and eversion with marked pain. Dr. Manale noted "audible snapping tendons on the right with circular motion…." He diagnosed bilateral carpal tunnel syndrome, traumatic arthropathy of the ankle and foot, congenital pes planus, ankle sprain/strain and bilateral sinus tarsi syndrome. Dr. Manale estimated that appellant had a 10 percent impairment of each upper and lower extremity.

On August 13, 2008 an Office medical adviser reviewed Dr. Manale's December 5, 2007 report. He stated that limitations in range of motion due to pain were not utilized in determining impairment and that loss of grip strength was not relevant in rating impairments due to carpal tunnel syndrome. The Office medical adviser concluded that Dr. Manale's report was "not adequate to determine [the] impairment in this case."

By decision dated August 20, 2008, the Office denied modification of its March 16, 2007 decision. It found that the medical evidence was not sufficient to show that appellant had a permanent impairment of a scheduled member.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] and its implementing federal regulations,[8] 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

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

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* as the uniform standard applicable to all claimants.[9] 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.[10]

Page 495 of the A.M.A., *Guides* states that after an optimal recovery time following surgical decompression of carpal tunnel syndrome, three scenarios are possible: if positive clinical findings of median nerve dysfunction are present, impairment is rated according to sensory or motor deficits; with normal sensibility and opposition strength or abnormal sensory or motor latencies or abnormal electromyogram (EMG) testing, an impairment rating not to exceed five percent may be justified; finally, with normal sensibility, opposition strength and nerve conduction studies, there is no objective basis for an impairment rating.[11]

ANALYSIS

The Office accepted that appellant sustained bilateral carpal tunnel syndrome, left ankle sprain and bilateral tenosynovitis of the foot and ankle. Appellant had a right carpal tunnel release in 1998 and a left carpal tunnel release in 1999.

On January 30, 2006 appellant requested a schedule award. On July 5, 2005 Dr. Lamid diagnosed left ankle synovitis and an injury to the talocalcaneal ligament. He determined that appellant had impairments due to weakness in plantar flexion, dorsiflexion, inversion and eversion according to Table 17-8 on page 532. The A.M.A., *Guides* provide, however, that strength measurements are functional tests influenced by subjective factors that are difficult to control; consequently, the A.M.A., *Guides* does not assign a large role to such measurements.[12] Section 17.2e on page 531 of the A.M.A., *Guides* states, "Measurements can be made by one or two observers. If the measurements are made by one examiner, they should be consistent on different occasions." Dr. Lamid did not provide the specific measurements he obtained during manual muscle testing to find the impairment due to weakness and did not indicate that the measurements were consistent on different occasions; consequently, his finding is not in accordance with the A.M.A., *Guides*. He also found that appellant had a whole person impairment due to loss of range of motion in plantar flexion and dorsiflexion and a whole person impairment resulting from an abnormal gait. The Act, however, does not provide for impairment of the whole person.[13] As Dr. Lamid's opinion does not conform to the A.M.A., *Guides*, it is of diminished probative value.[14]

[9] *Id*. at § 10.404(a).

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

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

[12] *Id*. at 507.

[13] *Tania R. Keka*, 55 ECAB 354 (2004).

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

In a report dated December 5, 2007, Dr. Manale determined that appellant had an impairment due to loss of range of motion in dorsiflexion, plantar flexion, inversion and eversion due to pain. He found audible snapping of the right tendons with circular motion and tenderness of the ankles and joints. Dr. Manale concluded that appellant had a 10 percent impairment of each lower extremity. He did not, however, reference any specific tables and pages of the A.M.A., *Guides* utilized in rating impairment. As Dr. Manale did not explain the protocols used in making the impairment determination, his opinion is insufficient to establish permanent impairment.[15]

On March 1, 2007 Dr. Cenac performed a second opinion examination. He found that appellant had normal range of motion of the ankle with no atrophy or swelling and normal joint spaces of the ankle and mid tarsal joints by x-ray. Dr. Cenac determined that appellant had no impairment of the lower extremities. An Office medical adviser reviewed Dr. Cenac's report and concurred with his conclusion. As there is no probative medical evidence in accordance with the A.M.A., *Guides* showing that appellant has a lower extremity impairment, the Board finds that the Office properly denied his claim.

In support of his claim for an upper extremity impairment, appellant submitted a June 27, 2005 impairment evaluation from Dr. Lamid, who diagnosed right carpal tunnel syndrome postsurgery. Dr. Lamid found a right positive Tinel's sign and Phalen's test on examination. He determined that appellant had a 20 percent right upper extremity impairment due to loss of grip strength, a 15 percent right upper extremity impairment due to a sensory deficit of the right median nerve and a 10 percent whole person impairment due to loss of range of motion of the right hand. Dr. Lamid concluded that appellant had a 28 percent whole person impairment. In evaluating carpal tunnel syndrome, however, an impairment is determined not by measuring range of motion or grip strength but by the criteria set forth on page 495 of the A.M.A., *Guides*. Page 495 of the A.M.A., *Guides* states that after an optimal recovery time following surgical decompression of carpal tunnel syndrome, three scenarios are possible: if positive clinical findings of median nerve dysfunction are present, impairment is rated according to sensory or motor deficits; with normal sensibility and opposition strength or abnormal sensory or motor latencies or abnormal EMG testing, an impairment rating not to exceed five percent may be justified; finally, with normal sensibility, opposition strength and nerve conduction studies, there is no objective basis for an impairment rating.[16] The A.M.A., *Guides* thus provides a specific method for determining the permanent impairment due to carpal tunnel syndrome. It is not proper to rate residuals of carpal tunnel syndrome on loss of grip strength.[17] Additionally, as

[15] *See Carl J. Cleary*, 57 ECAB 563 (2006) (an opinion which is not based upon the standards adopted by the Office and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's impairment).

[16] *Supra* note 11.

[17] A.M.A., *Guides* 494-95; *see also Kimberly M. Held*, 56 ECAB 670 (2005); *David D. Cumings*, 55 ECAB 285 (2004).

previously noted, the Act does not provide for impairment of the whole person.[18] As Dr. Lamid's report is not in accordance with the A.M.A., *Guides*, it is of little probative value.[19]

In a report dated December 5, 2007, Dr. Manale measured range of motion and grip strength for the wrists. He found that appellant had a 10 percent impairment of each upper extremity. Dr. Manale did not evaluate his impairment due to carpal tunnel syndrome by rating his motor or sensory deficits as provided in the A.M.A., *Guides*.[20] Consequently, his opinion is of little probative value.[21]

In a report dated March 1, 2007, Dr. Cenac listed findings of a mildly positive Tinel's sign on the right and a negative Tinel's sign on the left. He found no atrophy or sensory deficits of the upper extremities and a normal range of motion and dexterity. Dr. Cenac concluded that appellant had no impairment of the upper extremities. As noted, the A.M.A., *Guides* provides a specific method for determining the permanent impairment due to carpal tunnel syndrome. The A.M.A., *Guides* on page 495 states that following surgical decompression, if there remains positive clinical findings of median nerve dysfunction, the impairment should be rated according to sensory and motor deficits. Dr. Cenac properly determined that appellant had no impairment of the left upper extremity as he had found no positive clinical findings. On the right side, however, he found a mild Tinel's sign. Consequently, as Dr. Cenac found positive clinical findings of median nerve dysfunction, he should have evaluated appellant's impairment of the right upper extremity according to the procedures for rating sensory and motor deficits set forth in the A.M.A., *Guides*.[22] The Board, therefore, finds that the case must be remanded for further development of the issue of whether appellant has a permanent impairment of the right upper extremity, to be followed by a *de novo* decision.

CONCLUSION

The Board finds that the Office properly found that appellant was not entitled to a schedule award for the left upper extremities and lower extremities. The Board finds that the case is not in posture for decision on the issue of the extent of impairment to appellant's right upper extremity.

[18] *Supra* note 13.

[19] *Richard A. Neidert*, 57 ECAB 474 (2006).

[20] *Supra* note 11; *Kimberly M. Held*, *supra* note 17.

[21] *See Richard A. Neidert*, *supra* note 19.

[22] *Supra* note 11; *see also Michelle L. Collins*, 56 ECAB 552 (2005).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 20, 2008 is affirmed, in part, and set aside, in part. The case is remanded for further proceedings consistent with this opinion of the Board.

Issued: October 2, 2009
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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