United States Department of Labor
Employees' Compensation Appeals Board

M.M., Appellant	)	
	)	**Docket No. 07-1758**
and	)	**Issued: December 27, 2007**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, Wilmington, DE, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
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 June 20, 2007 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated June 8, 2007, which granted schedule awards for eight percent permanent impairment to both the right and left upper extremities. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than an eight percent permanent impairment to both the right and left upper extremities, for which she has received schedule awards.

FACTUAL HISTORY

On May 29, 2002 appellant, then a 46-year-old program support assistant, filed an occupational disease claim alleging that she developed bilateral ganglion cysts and right wrist tendinitis as a result of performing work duties. She did not stop work. The Office accepted

appellant's claim for aggravation of bilateral ganglion cysts and expanded her claim to include right wrist tendinitis.[1]

Appellant came under the treatment of several physicians. Dr. Alfred Fletcher, a Board-certified family practitioner, diagnosed right wrist tendinitis and ganglion cysts in reports from May 14, 2002 to March 12, 2003. Dr. Peter F. Townsend, a Board-certified orthopedic surgeon, submitted reports dated March 14 and May 9, 2003 noting a volar ganglion cyst on the left wrist. He advised that she underwent a ganglionectomy of the volar aspect of her right wrist. Dr. Townsend diagnosed volar ganglion cyst on the left side and recommended conservative treatment with cortisone injections. Dr. Randeep S. Kahlon, a Board-certified orthopedic surgeon, treated appellant for bilateral volar ganglions. On May 30, 2003 he diagnosed bilateral wrist ganglions, right side more painful and recommended surgery. On November 8, 2003 Dr. Fletcher advised that appellant reached maximum medical improvement and referred her to Dr. George L. Rodriguez, a Board-certified orthopedic surgeon, for an impairment rating.

In a March 5, 2004 report, Dr. Rodriguez noted that appellant reached maximum medical improvement on May 31, 2003. He noted that physical examination of the right wrist revealed a well-healed surgical scar on the volar aspect of the radial styloid, positive Finkelstein's and Phalen's signs, normal range of motion of the wrist and fingers in all directions and some hyperesthesia. Examination of the left wrist revealed full range of motion in all directions and an elevated ganglion cyst overlying the radial styloid of the volar aspect. Dr. Rodriguez noted that sensation was absent overlying the proximal aspect of the thenar eminence on the area of the radial styloid surgical scar on the right with a positive Tinel's sign in the radial nerve overlying the right distal styloid. He further noted grip strength loss was 20 percent for the right hand and 10 percent for the left hand. Dr. Rodriguez diagnosed bilateral carpal tunnel syndrome, status post release, de Quervain's syndrome of the right wrist, status post surgery, radial neuritis of the right wrist, ganglion cyst of the left wrist, activity decrease and ratable pain. He noted that, based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[2] (A.M.A., *Guides*) that appellant would receive a 20 percent impairment on the right for grip strength deficit, 1 percent impairment for sensory abnormality of the right radial nerve, 3 percent impairment for motor abnormality of the right median nerve, 3 percent impairment for motor abnormality of the right ulnar nerve, 3 percent impairment for motor abnormality of the right radial nerve and 1 percent for pain-related impairment, for a total impairment of 29 percent for the right arm. With regard to the left arm, appellant would receive 10 percent impairment for grip strength deficit and 1 percent for pain-related impairment, for a total impairment of 11 percent for the left arm.

In a report dated April 3, 2005, an Office medical adviser noted that appellant was previously treated for bilateral carpal tunnel syndrome and recently developed ganglion cysts of both wrists and associated tendinitis. He noted that appellant underwent ganglion cyst excision

[1] Appellant filed a claim for bilateral carpal tunnel syndrome on April 2, 1985, which the Office accepted for precipitation of bilateral carpal tunnel syndrome, File No. A03-0103289. The Office authorized right carpal tunnel release which was performed on March 18, 1985 and left carpal tunnel release which was performed on April 22, 1985. These claims were consolidated.

[2] A.M.A., *Guides* (5th ed. 2001).

and bilateral carpal tunnel syndrome surgery. The medical adviser noted that appellant would be entitled to a five percent permanent impairment of the right and left arms for mild postoperative residuals[3] and an additional three percent impairment for both upper extremities for pain,[4] for a total impairment of eight percent permanent of both the right and left arms. He noted that Dr. Rodriguez found a significant sensory and motor deficit but the medical adviser stated that his examination did not support this impairment rating. The medical adviser further indicated that there was no award for grip strength deficit in a compression neuropathy under the A.M.A., *Guides*.

On April 12, 2005 appellant filed a claim for a schedule award.

In a decision dated April 15, 2005, the Office granted appellant a schedule award for eight percent impairment to both the right and left arms.

On April 17, 2005 appellant requested an oral hearing before an Office hearing representative. She asserted that the medical adviser rejected the impairment rating provided by Dr. Rodriguez without explanation. On December 8, 2005 appellant withdrew her request for an oral hearing and requested that the Office proceed with a review of the written record. She submitted an April 8, 2005 treatment note from Dr. Townsend. Also submitted was a physical therapy note dated April 11, 2005.

In a decision dated February 14, 2006, the hearing representative affirmed the April 15, 2005 decision.

On February 28, 2006 appellant appealed her claim to the Board. In an order dated September 8, 2006, the Board remanded the case to the Office to combine her File Nos. 03-2009688 and 03-0103289 and issue an appropriate merit decision on her claim for compensation.[5] In a decision dated October 13, 2006, the Office advised that File Nos. 03-2009688 and 03-0103289 were combined. The Office reissued the April 15, 2005 schedule awards. On October 17, 2006 appellant appealed her claim to the Board. In an order dated May 31, 2007, the Board determined that the Office failed to properly combine appellant's claim and remanded the case to the Office to combine her File Nos. 03-2009688 and 03-0103289 and issue an appropriate merit decision.[6]

In a decision dated June 8, 2007, the Office advised that File Nos. 03-2009688 and 03-0103289 were combined. The Office reissued the April 15, 2005 schedule awards.

[3] *See* A.M.A., *Guides* at 495, Chapter 16.5d, Entrapment/Compression Neuropathy, Carpal Tunnel Syndrome.

[4] Figure 18.1, page 574 (A.M.A., *Guides*).

[5] Docket No. 06-857 (issued September 8, 2006).

[6] Docket No. 07-190 (issued May 31, 2007).

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] and its implementing 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 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.[9]

ANALYSIS

On appeal, appellant contends that she has 29 percent permanent impairment of the right arm and an 11 percent impairment of the left arm as rated by Dr. Rodriguez. The Office accepted appellant's claim for aggravation of bilateral ganglion cysts, right wrist tendinitis and precipitation of bilateral carpal tunnel syndrome and authorized bilateral carpal tunnel releases March 18 and April 22, 1985. Appellant was paid a schedule award for eight percent impairment of both the right and left upper extremities.

The Board has carefully reviewed Dr. Rodriguez' March 5, 2004 report and find he did not rate impairment in accordance with the relevant standards of the A.M.A., *Guides*.[10]

Office procedures[11] provide that upper extremity impairment secondary to carpal tunnel syndrome and other entrapment neuropathies should be calculated using section 16.5d and Tables 16-10, 16-11 and 16-15.[12]

Regarding carpal tunnel syndrome, the A.M.A., *Guides* provide:

> "If, after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias and/or difficulties in performing certain activities, three possible scenarios can be present --
>
> > (1) Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTS [computerized

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999).

[9] *See id*.; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

[10] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

[11] *See* Federal (FECA) Procedure Manual, Part 2 -- Schedule Awards and Permanent Disability Claims, *Evaluation of Schedule Awards*, Chapter 2.808 (August 2002).

[12] A.M.A., *Guides*; *Joseph Lawrence, Jr*., 53 ECAB 331 (2002).

> tomography scan] is rated according to the sensory and/or motor deficits as described earlier.
>
> (2) Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG [electromyogram] testing of the thenar muscles: a residual CTS is still present and an impairment rating not to exceed 5 percent of the upper extremity may be justified.
>
> (3) 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."[13]

Section 16.5d of the A.M.A., *Guides* further provides that, in rating compression neuropathies, additional impairment values are not given for decreased grip strength.[14]

Dr. Rodriguez calculated one percent impairment for sensory abnormality of the right radial nerve,[15] three percent impairment for motor abnormality of the right median nerve,[16] three percent impairment for motor abnormality of the right ulnar nerve[17] and three percent impairment for motor abnormality of the right radial nerve.[18] The A.M.A., *Guides*, Table 16-10, 16-11 and 16-15, page 482, 484 and 492, set forth impairment rating for sensory and motor deficit for the peripheral nerve disorders. Although Dr. Rodriguez found sensory and motor deficit impairments of the right median, ulnar and radial nerves, there was no evidence of median, ulnar and radial nerve deficits upon physical examination. Rather, he noted that the physical examination of the right wrist revealed a well-healed surgical scar on the volar aspect of the radial styloid, positive Finkelstein's sign and normal range of motion of the wrist and fingers in all directions with some hyperesthesia. Additionally, Dr. Rodriguez did not adequately explain how he calculated the specific sensory and motor impairment values using Table 16-15, page 492 of the A.M.A., *Guides*[19] when the physical examination did not support these findings.

Dr. Rodriguez further determined that appellant sustained a 20 percent impairment of the right arm and a 10 percent impairment of the left arm for grip strength deficit.[20] However, as noted, the A.M.A., *Guides* provides that "in compression neuropathies, additional impairment

[13] *Id*. at 495.

[14] *Id.* at 494.

[15] *Id*. at 482, 492 Table 16-10, 16-15.

[16] *Id*. at 484, 492, 487, Table 16-11, 16-15, 16-47.

[17] *Id.*

[18] *Id*. at 484, 487, 492, Table 16-11, 16-15, 16-47.

[19] *Id*. at 492, Table 16-15.

[20] *Id*. at 509, Table 16-32, 16-34.

values are not given for decreased grip strength."[21] Furthermore, principles set forth in the A.M.A., *Guides,* pertaining to strength evaluation, state that loss of grip strength is considered only in rare cases when the impairing factor has not been considered adequately by other methods.[22] Dr. Rodriguez has not explained why the impairing factors in any of appellant's conditions had not been adequately considered by the other methods such that evaluation of grip strength would be proper. Further, he erroneously added a pain-related impairment under Chapter 18 of the A.M.A., *Guides*. The Board has noted that physicians should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.[23] Again, Dr. Rodriguez did not explain why the other chapters of the A.M.A., *Guides* could not adequately rate appellant's pain. The Board finds that Dr. Rodriguez did not properly follow the A.M.A., *Guides.* An attending physician's report is of diminished probative value where the A.M.A., *Guides* were not properly followed.[24]

The medical adviser utilized the findings in Dr. Rodriguez' March 5, 2004 report and correlated the provisions in the A.M.A., *Guides* to determine the impairment rating. He noted that appellant underwent ganglion cyst excision and bilateral carpal tunnel syndrome surgery. In accordance with the A.M.A., *Guides,* the medical adviser noted that appellant would be entitled to a five percent permanent impairment of the right and left arms for mild postoperative residuals.[25] He noted that Dr. Rodriguez found a significant sensory and motor deficit; however, advised that his examination did not support this impairment rating. The medical adviser also properly found, as noted above, there was no award for grip strength deficit in a compression neuropathy under the A.M.A., *Guides*. The Board notes that the medical adviser also erroneously attributed pain-related impairment under Chapter 18 of the A.M.A., *Guides*. As noted above, the Board has held that physicians should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*. The medical adviser otherwise properly applied the A.M.A., *Guides* in calculating appellant's permanent impairment.

The Board finds that appellant has no more than a five percent impairment to both the right and left upper extremities. There is no other medical evaluation to record explaining how, pursuant to the fifth edition of the A.M.A., *Guides*, appellant has impairment that for which the Office has issued a schedule award.

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[21] *See* A.M.A., *Guides,* at 494; *see also Robert V. Disalvatore*, 54 ECAB 351 (2003) (where the Board found that the Fifth Edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory impairments only).

[22] *See* A.M.A., *Guides,* at 508; *Phillip H. Conte*, 56 ECAB ___ (Docket No. 04-1524, issued December 22, 2004).

[23] *See* A.M.A., *Guides,* at 574, Figure 18.1; *see also Frantz Ghassan*, 57 ECAB ___ (Docket No. 05-1947, issued February 2, 2006); *Linda Beale*, 57 ECAB ___ (Docket No. 05-1536, issued February 15, 2006).

[24] *See Paul R. Evans, Jr.*, 44 ECAB 646 (1993); *John Constantin*, 39 ECAB 1090 (1988) (medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

[25] *See* A.M.A., *Guides,* at 495 (scenario number two provides for impairment not to exceed five percent where there is normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles where residual carpal tunnel syndrome is present).

CONCLUSION

The Board finds that appellant has five percent permanent impairment to the right and left upper extremities for which she received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the June 8, 2007 decision of the Office of Workers' Compensation Programs is affirmed as modified.

Issued: December 27, 2007
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