U.S. DEPARTMENT OF LABOR

# Employees' Compensation Appeals Board

---

In the Matter of BONNIE F. ADAMS and DEPARTMENT OF THE ARMY, BLUEGRASS ARMY DEPOT, Lexington, Ky.

*Docket No. 96-1905; Submitted on the Record;*
*Issued July 1, 1998*

---

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
A. PETER KANJORSKI

The issue is whether has more than a 15 percent permanent impairment of the left upper extremity or more than a 10 percent permanent impairment of the right upper extremity.

Appellant, a supply clerk (typing), filed claims stating that she developed possible carpal tunnel syndrome as a result of her federal employment. The Office of Workers' Compensation Programs accepted her claims for bilateral carpal tunnel syndrome.

On March 16, 1993 Dr. Charles Robert Combs, appellant's attending physician, reported that appellant had a 13 percent permanent impairment of the left upper extremity secondary to median nerve dysfunction. On April 13, 1993 a medical adviser to the Office reviewed the medical evidence and determined that appellant had a five percent impairment of the left upper extremity due to discomfort and pain and a five percent impairment due to weakness or atrophy.[1] The medical adviser also found a two percent impairment due to loss of palmar flexion and a three percent loss due to loss of ulnar deviation.[2] Adding these estimates, the medical adviser reported that appellant had a 15 percent permanent impairment of the left upper extremity, which the Office awarded on April 27, 1993.

On August 23, 1994 Dr. Frank A. Burke, a Board-certified orthopedic surgeon and Office referral physician, reported that appellant had a mild bilateral carpal tunnel syndrome with persistent symptoms. He gave an impairment rating of eight percent "to the whole person,"[3] including a three percent impairment for loss of motion of her digits. An Office medical adviser

---

[1] The medical adviser did not indicate on what clinical findings he based these estimates or how he calculated the percentages reported.

[2] These estimates appear to derive from clinical findings made on March 25, 1991, although more recent clinical findings were available.

[3] The Federal Employees' Compensation Act does not authorize the payment of schedule awards for the permanent impairment of "the whole person." *Ernest P. Govednick*, 27 ECAB 77 (1975). Payment is authorized only for the permanent impairment of specified members, organs or functions of the body. 5 U.S.C. § 8107.

reviewed the medical record and determined, based on Table 16, page 57, of the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, that appellant had a 10 percent permanent impairment of the right upper extremity, which the Office awarded on October 4, 1994.

In a report dated February 21, 1995, Dr. Burke related appellant's history, findings on physical examination and impression, all of which were nearly identical to what he had reported on August 23, 1994. He reported an impression of mild bilateral carpal tunnel syndrome. With respect to rating her impairment, Dr. Burke stated that appellant's bilateral carpal tunnel syndrome with persistent symptoms gave her a rating of 6 percent for the left wrist and 5 percent for the right wrist, for a total of 11 percent, and an additional 3 percent resulting from a significant loss of motion in her digits, for a total of 14 percent "to the whole person."[4] He stated: "[Appellant] has a significant permanent impairment for both of these lesion[s] with persistent symptoms in the median nerve as well as the loss of range of motion in the forearm on the left and the fingers on the right." Dr. Burke noted that appellant had a rheumatoid or rheumatoid variant or similar contributing problem involving the upper extremities with loss of motion, particularly in the right hand and left forearm.

An Office medical adviser reviewed Dr. Burke's February 21, 1995 report and noted that Dr. Burke had found some impairment of the fingers due to nonrelated rheumatoid or rheumatoid variant.

In decisions dated April 17, 1995 and February 15, 1996, the Office denied an additional schedule award.

The Board finds that the medical evidence fails to establish that appellant has more than a 15 percent permanent impairment of the left upper extremity or more than a 10 percent permanent impairment of the right upper extremity.

The fourth edition of the A.M.A., *Guides*[5] provides that permanent impairment of the hand and upper extremity secondary to entrapment neuropathy may be derived by following the grading schemes and procedures provided in Table 11, page 48, and Table 12, page 49, for determining impairment due to sensory or motor deficits.[6] The A.M.A., *Guides* emphasizes that characteristic deformities and manifestations resulting from peripheral nerve lesions, such as

[4] *See supra* note 3.

[5] FECA Bulletin No. 94-4 (issued November 1, 1993) indicates that the Office began using the fourth edition of the A.M.A., *Guides* effective November 1, 1993. This bulletin states that awards calculated according to any previous edition should be evaluated according to the edition originally used, but any recalculations of previous awards which result from hearings, reconsiderations or appeals should be based on the fourth edition.

[6] A.M.A., *Guides* 56.

restricted motion, atrophy, and vasomotor, trophic and reflex changes, have been taken into consideration in preparing the estimated impairment percents derived from these tables:

> "If an impairment results strictly from a peripheral nerve lesion, the physician should not apply impairment percents from [the range of motion sections] and this section, because a duplication and an unwarranted increase in the impairment percent would result."[7]

If restricted motion cannot be attributed to a peripheral nerve lesion, however, motion impairment may be evaluated according to the range of motion sections and combined with the peripheral nerve system impairment percent.[8]

The fourth edition of the A.M.A., *Guides* provides an alternative, diagnosis based method for deriving the impairment of the hand and upper extremity secondary to entrapment neuropathy.[9] Rather than measure the sensory and motor deficits, and under certain conditions restricted motion, the evaluator may use Table 16, page 57, wherein impairment is estimated according to the severity of involvement of each major nerve at each entrapment site. The A.M.A., *Guides* explains that the evaluator should not use both methods.[10]

The Office previously issued schedule awards for a 15 percent permanent impairment of the left upper extremity and a 10 percent permanent impairment of the right upper extremity. Dr. Burke then reported on February 21, 1995 that appellant had a six percent impairment of the left wrist and five percent impairment of the right, and an additional three percent for loss of motion of her digits. This evidence does not support that appellant has more than the 15 and 10 percent ratings for which the Office previously compensated appellant.

First, because the wrist functional unit represents 60 percent of the upper extremity's function,[11] a 6 percent impairment of the left wrist represents a 3.6 percent impairment of the left upper extremity, and a 5 percent impairment of the right wrist represents a 3 percent impairment of the right upper extremity, both of which are far less than 15 and 10 percent ratings used for

---

[7] *Id*. at 46 (original emphasis).

[8] *Id.* Any impairment resulting from decreased range of motion must, nonetheless, be causally related to the accepted employment injury; *see Philip N.G. Barr*, 33 ECAB 948 (1982) (indicating that schedule awards are payable for a permanent impairment resulting from an employment injury).

[9] FECA Bulletin No. 95-17 (issued March 23, 1995) states:

> "If more than one method of calculation can be used, it is not necessary to perform a second calculation for purposes of comparison. That is, if the examining physician has provided a complete evaluation using one of the allowable methods, that calculation may be used without investigating whether a greater percentage of impairment would have resulted from using another calculation."

[10] A.M.A., *Guides* at 56; *see Denise D. Cason*, 48 ECAB ___ (issued June 2, 1997) (finding that the Office properly followed the diagnosis-based estimate given by its medical consultant where the treating physician did not explain the basis of his rating and where the use of examination criteria would not compensate the claimant for what appeared to be her most prominent residual: ligament laxity).

[11] A.M.A., *Guides* at 35.

appellant's schedule awards.[12] Second, although Dr. Burke's impression of "mild" bilateral carpal tunnel syndrome supports up to a 10 percent impairment of each upper extremity -- using the alternative method provided in Table 16, page 57, of the fourth edition of the A.M.A., *Guides* -- it does not support more than a 15 percent permanent impairment of the left upper extremity or more than a 10 percent permanent impairment of the right upper extremity. Third, because the findings Dr. Burke reported on February 21, 1995 are nearly word for word the same findings he reported on August 23, 1994, his later report demonstrates no increase in the injury-related impairment to appellant's upper extremities. The Office properly issued a schedule award for a 10 percent permanent impairment of the right upper extremity based on Dr. Burke's earlier report. His later report and nearly identical findings support the same rating.

For these reasons, the Board finds that the Office properly denied an increase in the schedule awards previously given to appellant.

The February 15, 1996 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, D.C.
July 1, 1998

Michael J. Walsh
Chairman

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member

[12] Dr. Burke appeared to attribute the loss of motion in the right hand and left forearm to a rheumatoid or rheumatoid variant or similar contributing problem, the employment relationship of which is neither established by his report nor accepted by the Office. The Office medical adviser correctly indicated that such impairment should not be included in appellant's rating; *see Philip N.G. Barr*, *supra* note 8.