

of the right wrist. The Office accepted appellant's claim for right carpal tunnel syndrome on August 10, 2000.

Appellant underwent electrodiagnostic testing on August 30, 2000 which demonstrated moderate to severe slowing of the right median nerve at the wrist. On September 13, 2000 Dr. Knight performed a surgical right carpal tunnel release. In a note dated February 1, 2001, Dr. Knight requested an electromyogram (EMG) and stated that appellant continued to complain of wrist pain. On February 19, 2001 Dr. Knight stated that the Office did not provide approval for the EMG and stated that appellant had reached maximum medical improvement with 10 percent permanent impairment of her right upper extremity.

In a note dated April 6, 2001, Dr. Knight stated that appellant had reached maximum medical improvement. By letter of that date, the Office requested additional evidence regarding appellant's permanent impairment from Dr. Knight. Appellant requested a schedule award on April 3, 2001. In a report dated April 9, 2001, the Office medical adviser stated that additional medical evidence was necessary to establish the extent of appellant's permanent impairment. The Office requested this evidence from Dr. Knight by letter dated May 17, 2001.

Dr. Knight completed a report on June 14, 2001 and found that appellant had 10 percent permanent impairment of her right upper extremity based on her subjective complaints of pain and discomfort. He recommended an EMG. The Office authorized an EMG and a functional capacity evaluation on July 6, 2001. On August 6, 2001 Dr. Knight reviewed the July 18, 2001 functional capacity evaluation and found that appellant used submaximal effort. He again concluded that she had 10 percent permanent impairment.

In an undated letter, appellant requested to change physicians to Dr. Rommel Childress, a Board-certified orthopedic surgeon. The Office granted appellant's change of physicians on September 18, 2001.

Dr. Childress completed a note on April 23, 2002 and found that appellant's April 19, 2002 EMG was suggestive of recurrence carpal tunnel syndrome. He recommended surgery and performed a second right carpal tunnel release on June 28, 2002.

The Office entered appellant on the periodic rolls on July 16, 2002. Dr. Childress released appellant to return to light duty on August 26, 2002. By decision dated August 7, 2003, the Office reduced appellant's compensation benefits to zero based on her actual earnings as a modified mail handler finding that she held this position for 60 days.¹

Dr. Childress completed a report on January 5, 2004 and found that appellant had reached maximum medical improvement. He determined that appellant was entitled to 10 percent impairment due to her initial surgery and 10 percent due to residual weakness, a tendency to fatigue and paraesthesias. Dr. Childress combined these impairments to reach 19 percent permanent impairment of the right upper extremity.

¹ Appellant did not request review of this decision on appeal. As there is no evidence that appellant disagreed with the findings of this decision, the Board will not address this decision on appeal. 20 C.F.R. § 501.2(c).

The Office medical adviser reviewed the medical evidence on February 5, 2004 and determined that, in accordance with page 495 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,² appellant's impairment due to carpal tunnel syndrome was based on preoperative electrodiagnostic studies only, the second category. He found that a two percent rating was appropriate.

By decision dated March 4, 2004, the Office granted appellant a schedule award for two percent permanent impairment of her right upper extremity to run for 6.24 weeks from October 31 to December 13, 2003.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act³ and its implementing regulation⁴ 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.⁵

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, paraesthesias 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 CTS [carpal tunnel syndrome] is rated according to the sensory and/or motor deficits as described earlier."⁶ 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.⁷ In the second scenario: "Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS [carpal tunnel syndrome] is still present, and an impairment rating not to exceed 5 percent of the upper extremity may be justified." In the final situation: "Normal sensibility (two-point discrimination

² A.M.A., *Guides*, (5th ed. 2001)

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404.

⁵ *Id.*

⁶ A.M.A., *Guides*, 495.

⁷ *Id.* at 494, 481.

and Semmes-Weinstein monofilament testing), opposition strength, and nerve conduction studies: there is no objective basis for an impairment rating.”⁸

To accurately evaluate sensory impairment clinically and reduce the subjective nature of these findings,⁹ the A.M.A., *Guides* recommend either the two-point test for fine discrimination, the monofilament touch-pressure threshold test or the pinprick test.¹⁰

Before the A.M.A., *Guides* can be utilized, a description of appellant’s impairment must be obtained from appellant’s physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.¹¹ However, carpal tunnel syndrome is an entrapment/compression of the median nerve.¹² In compression neuropathies, additional impairment values are not given for decreased grip strength.¹³

ANALYSIS

In this case, the Office accepted appellant’s claim for right carpal tunnel syndrome and authorized surgeries on September 13, 2000 and June 28, 2002. Appellant’s attending physician, Dr. Childress, a Board-certified orthopedic surgeon, found that, following her second surgery and resultant maximum medical improvement, appellant continued to experience weakness, fatigue and paraesthesias. He concluded that she had 10 percent impairment due to her initial surgery and 10 percent due to continuing conditions.

As noted previously, the A.M.A., *Guides* provide a specific method for determining permanent impairment due to carpal tunnel syndrome. The A.M.A., *Guides* specifically require that, after a claimant had reached maximum medical improvement, additional electrodiagnostic studies and physical findings are necessary to determine the extent of the permanent impairment. In this case, Dr. Childress did not provide the results of EMG or other appropriate testing following maximum medical improvement, he did not provide his findings on physical examination through two point discrimination, monofilament testing or pinprick testing and he did not demonstrate familiarity with the appropriate section of the A.M.A., *Guides*. Therefore his report did not contain sufficient detailed findings so that the claims examiner and others

⁸ *Id.* at 495.

⁹ *Id.* at 446.

¹⁰ *Id.* at 445.

¹¹ *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

¹² A.M.A., *Guides*, 492.

¹³ *Id.* at 494; *Robert V. Disalvatore*, 54 ECAB ____ (Docket No. 02-2256, issued January 17, 2003).

reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations. Therefore his report is not sufficient to constitute the weight of the medical opinion evidence.

The Office medical adviser reviewed Dr. Childress' reports on February 5, 2004 and attempted to apply the appropriate provision of the A.M.A., *Guides*. The Office medical adviser noted that electrodiagnostic studies were necessary to determine the extent of the permanent impairment, but improperly relied on the preoperative studies in the record. The A.M.A., *Guides* specifically note that prior to determining a permanent impairment due to carpal tunnel syndrome an optimal recovery time following surgical decompression must be allowed. The A.M.A., *Guides* then require positive clinical findings of median nerve dysfunction and electrical conduction delay. Evidence of electrical conduction delay predating maximum medical improvement cannot be utilized to determine the extent of permanent impairment in keeping with the A.M.A., *Guides*.

Proceedings before the Office are not adversarial in nature and the Office is not a disinterested arbiter; in a case where the Office "proceeds to develop the evidence and to procure medical evidence, it must do so in a fair and impartial manner."¹⁴ In this case, the Office referred appellant's medical evidence to the Office medical adviser to determine the extent of her permanent impairment due to her bilateral carpal tunnel syndrome and other accepted conditions. The Office medical adviser did not require the necessary medical findings and test results prior to reaching a decision on appellant's permanent impairment.

On remand, the Office should refer appellant to an appropriate physician and authorize the necessary electrodiagnostic testing to determine the extent of her permanent impairment due to her accepted bilateral carpal tunnel syndrome. After this and such other development as the Office deems necessary the Office should issue an appropriate decision.

CONCLUSION

The Board finds that the case requires additional development of the medical evidence to determine the extent of appellant's permanent impairment due to her accepted condition of right carpal tunnel syndrome.

¹⁴ *Walter A. Fundinger, Jr.*, 37 ECAB 200, 204 (1985).

ORDER

IT IS HEREBY ORDERED THAT the March 4, 2004 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this decision of the Board.

Issued: August 20, 2004
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member