United States Department of Labor
Employees' Compensation Appeals Board

JUDITH S. HOWARD-MANNING, Appellant	)	
	)	**Docket No. 04-427**
and	)	**Issued: July 6, 2004**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, Employer	)	

Appearances:
Judith S. Howard-Manning, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On December 8, 2003 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award dated November 19, 2003. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award in this case.

ISSUE

The issue is whether appellant has more than a four percent impairment of the right upper extremity and a one percent impairment of the left upper extremity for which she received schedule awards.

FACTUAL HISTORY

On January 4, 2000 appellant, then a 58-year-old clerk, filed an occupational disease claim alleging that she developed bilateral carpal tunnel syndrome as a result of keying bundles and flats at work. She became aware of her condition on December 21, 1999 and did not stop

work. The Office accepted bilateral carpal tunnel syndrome and authorized right and left carpal tunnel surgical releases.

On August 15, 2000 appellant filed a claim for a schedule award. She submitted reports from Dr. Mitchell L. Goldflies, a Board-certified orthopedist, dated September 14, 2000 to May 17, 2002. He diagnosed bilateral carpal tunnel syndrome which was worse on the right than the left and flexor tendinitis. Dr. Goldflies advised that appellant was improving with rehabilitation, however, she remained symptomatic. On May 17, 2002 he noted that her range of motion was full with end range pain in flexion and extension, bilaterally; bilateral grip strength deficit which was worse on the right; and sensory changes in the median nerve innervated portion of both hands. Dr. Goldflies concluded that, based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[1] (A.M.A., *Guides*) appellant had a 63 percent impairment of the hands and a 57 percent impairment of the upper extremity.

The medical record was referred to an Office medical adviser. In a report dated August 26, 2002, the Office medical adviser determined that the date of maximum medical improvement was May 17, 2002. He advised that based on the findings set forth in Dr. Goldflies report, appellant sustained a 13 percent impairment of the right upper extremity and a two percent impairment of the left upper extremity.

In a decision dated September 20, 2002, the Office granted appellant schedule awards for 13 percent impairment of the right upper extremity and two percent impairment of the left upper extremity. The period of the schedule awards was from May 17, 2002 to January 28, 2003.

In a letter dated October 5, 2002, appellant requested a review of the written record. In a decision dated March 10, 2003, an Office hearing representative vacated the September 20, 2002 schedule award and remanded the case for further development. The hearing representative noted that, neither Dr. Goldflies nor the medical adviser properly applied the A.M.A., *Guides* in determining appellant's impairment.

On June 17, 2003 the Office referred appellant for a second opinion evaluation to Dr. Richard H. Sidell, Jr., a Board-certified orthopedic surgeon. The Office provided him with appellant's medical records, a statement of accepted facts and a detailed description of her employment duties. In a medical report dated August 19, 2003, Dr. Sidell reviewed the record and performed a physical examination of appellant. The physician advised that in accordance with the A.M.A. *Guides*, appellant had a four percent impairment of the right upper extremity and one percent impairment of the left upper extremity.

In a letter dated September 9, 2003, the Office requested that Dr. Sidell provide an impairment rating in accordance with the fifth edition of the A.M.A., *Guides.* The Office requested that the physician provide his calculation using the tables and charts in the A.M.A., *Guides.* In an addendum report dated October 24, 2003, Dr. Sidell referred to the tables and charts in the A.M.A., *Guides* (fifth edition) and determined that appellant had a five percent impairment to the right upper extremity. He noted that there were minimal subjective complaints

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

and a negative examination of the left upper extremity and recommended a one percent impairment of the left upper extremity; however, he provided no reference to the A.M.A. *Guides* to support this determination.

Dr. Sidell's report and the case record were referred to the Office's medical adviser. In a report dated November 10, 2003, he determined that appellant sustained a five percent impairment of the right upper extremity and a zero percent impairment of the left upper extremity.

In a decision dated November 19, 2003, the Office granted appellant schedule awards for four percent impairment of the right upper extremity and a one percent impairment of the left upper extremity. The period of the schedule awards was from May 17 to September 3, 2002. It was noted that appellant was previously awarded 36.6 weeks of compensation for the period of May 17, 2002 through January 28, 2003 and that the previously paid compensation would not be declared an overpayment.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulation[3] 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.

ANALYSIS

In July 2003, the Office referred appellant for a second opinion evaluation to Dr. Sidell. The Board has carefully reviewed his reports dated August 19 and October 24, 2003 and notes that, while Dr. Sidell properly determined that appellant sustained a five percent impairment of the right upper extremity, it is not clear how he determined that appellant had a one percent impairment of the left upper extremity.

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

Office procedures[4] specifically 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.[5]

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 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."[6]

Section 16.5d of the A.M.A., *Guides* provides that in rating compression neuropathies, additional impairment values are not given for decreased grip strength.[7] Section 16.8a provides that, since maximum strength is usually not regained for at least a year after an injury or surgical procedure and impairment is evaluated when an individual has reached maximum medical improvement, "strength can only be applied as a measure when a year or more has passed since the time of injury or surgery."[8]

With respect to the right upper extremity, Dr. Sidell determined that appellant fell into the first category which allows for a rating according to sensory and motor deficits. Utilizing Table 16-10, page 482 of the A.M.A., *Guides*, was rated at Grade 4, representing a sensory deficit of between 1 and 25 percent. The physician noted that, based on appellant's minimal findings, he would find a deficit of 10 percent.[9] Utilizing Table 16-11, page 484, appellant was rated at

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[4] *See* Federal (FECA) Procedure Manual, Part 2 – Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808 (March 1995).

[5] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB ___ (Docket No. 01-1361, issued February 4, 2002).

[6] A.M.A., *Guides*, *supra* note 3 at 495

[7] *Id.* at 494.

[8] *Id.* at 508.

[9] Table 16-11, page 484 (A.M.A., *Guides*).

Grade 4, representing a motor and loss of power deficit of between 1 and 25 percent. Dr. Sidell determined that appellant sustained a 10 percent motor deficit. Table 16-15, page 492 of the A.M.A., *Guides* allows a maximum upper extremity impairment due to sensory deficit or pain of 39 percent and maximum impairment due to motor deficit of 10 percent.[10] He calculated that 10 percent of a 39 percent maximum upper extremity impairment totaled four percent upper extremity impairment for sensory deficit. For the maximum upper extremity impairment due to motor deficit, he calculated a 10 percent of a 10 percent maximum upper extremity impairment totaled a 1 percent impairment for motor deficits; for a combined total of 5 percent impairment to the right upper extremity. With respect to the left upper extremity Dr. Sidell found a one percent impairment, but he did not explain how his determination was reached in accordance with the relevant standards of the A.M.A., *Guides*.[11] He noted only, that there were minimal subjective complaints and a negative examination of the left upper extremity and recommended one percent impairment of the left upper extremity. Dr. Sidell did not provide any reference to the A.M.A., *Guides* to support this determination.

The Board has carefully reviewed the Office medical adviser's report dated November 10, 2003 and notes this report is deficient as to the rating of appellant's impairment. While the medical adviser found a five percent impairment for the right upper extremity he did not adequately explain how his determination was reached in accordance with the relevant standards of the A.M.A., *Guides*.[12] The Office medical adviser noted no muscle atrophy, bilateral range of motion of the wrist and finger joints within normal limits; negative Tinel's sign bilaterally; and minimal positive Phalen's sign bilaterally; negative wrist compression test bilaterally; two-point discrimination was five millimeters on the right in the median nerve distribution and three millimeters on the left, which was within normal limits; and no evidence of motor weakness, except very minimal decreased opposition thumb to the fifth finger on the right. The Office medical adviser indicated that the only objective finding was mild loss of strength on the right side and stated that this should be evaluated using grip strength testing and he made reference to extrapolating permanent partial impairment from page 509 of the A.M.A., *Guides.* However, as noted above, the A.M.A., *Guides* provides that, "in compression neuropathies, additional impairment values are not given for decreased grip strength."[13] Additionally, the Board has 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. The medical advisers report is speculative with regard to his impairment determination stating that "one can guess" what very minimally decrease strength means. He opined that "very minimal decrease" in strength corresponded to a "5/5 strength in the distribution of the median nerve" which represented a five percent right upper extremity impairment. There is no further explanation as to how the medical adviser determined that appellant sustained a 5 percent impairment of the right upper extremity.

[10] Table 16-15, page 492 (A.M.A., *Guides*).

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

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

[13] *See* page 494, the fifth edition of the A.M.A., *Guides; see also Robert V. Disalvatore*, 54 ECAB ___ (Docket No. 02-2256, issued January 17, 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).

The Board can only surmise that the medical adviser used Table 16-11, page 484 of the A.M.A., *Guides* to grade at 50 percent, but his narrative does not confirm this conclusion. With regard to the left upper extremity, the medical adviser indicated that there were no objective findings to support any left upper extremity impairment.

Appellant submitted a May 17, 2002 report from Dr. Goldflies who found a full range of motion with end range pain in flexion and extension, bilaterally; bilateral grip strength deficit which was worse on the right; and sensory changes in the median nerve innervated portion of both hands. The physician concluded that based on the A.M.A., *Guides*, appellant had a 63 percent impairment of the hands or 57 percent impairment of the upper extremities. However, he failed to provide his calculations in support of this determination and did not cite to applicable tables or charts of the A.M.A., *Guides* in making his impairment rating determination.[14]

In view of the disparity in the impairment ratings of the Office medical adviser, Dr. Sidell, Dr. Goldflies, and the failure of the Office medical adviser to adequately explain how his rating was reached in accordance with the relevant standards of the A.M.A., *Guides*, the Office should refer the matter to an appropriate physician to determine the extent of impairment to the right and left upper extremities and, to provide a full description of impairment which conforms to the A.M.A., *Guides*.[15]

Proceedings under the Act are not adversary in nature, nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[16] Accordingly, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.

The Board finds that this case is not in posture for decision. On remand the Office should refer appellant to an appropriate specialist for examination and opinion as to whether she has any permanent impairment of the left and right upper extremity causally related to her December 21, 1999 employment injury. Following this and any other further development as deemed necessary, the Office shall issue a *de novo* decision on appellant's schedule award claim.

CONCLUSION

The Board finds that this case is not in posture for decision.

[14] *See Paul R. Evans, Jr.*, 44 - 646 (1993) (an attending physician's report is of little probative value where the A.M.A., *Guides* were not properly followed).

[15] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (March 1995) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[16] *John W. Butler*, 39 ECAB 852 (1988).

ORDER

IT IS HEREBY ORDERED THAT the November 19, 2003 decision of the Office of Workers' Compensation Programs is set aside and remanded for further proceedings consistent with this decision of the Board.

Issued: July 6, 2004
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member