United States Department of Labor
Employees' Compensation Appeals Board

CEMILLE P. PARKER, Appellant	)	
and	)	**Docket No. 04-1720**
	)	**Issued: January 27, 2005**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On June 29, 2004 appellant filed a timely appeal from a February 3, 2004 decision in which a hearing representative of the Office of Workers' Compensation Programs affirmed a May 6, 2003 decision, finding that she had no permanent impairment that would entitle her to a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish that she has a permanent impairment of her upper extremities that would entitle her to a schedule award. On appeal, appellant contends that a conflict in medical opinion evidence exists between Dr. Anthony Salem, who performed a second opinion evaluation for the Office and Dr. David Weiss, an attending physician.

FACTUAL HISTORY

On September 15, 1995 the Office accepted that appellant, then a 46-year-old postal clerk, sustained an employment-related bilateral carpal tunnel syndrome. She underwent left carpal tunnel release on May 7, 1997 and right release on December 10, 1997.[1] Appellant returned to limited duty on April 26, 1998 and full duty on May 6, 1998.

On January 24, 2002 she filed a claim for a schedule award and submitted the October 15, 2001 report of Dr. Weiss, an attending Board-certified osteopath specializing in orthopedic surgery.[2] He noted appellant's subjective complaints of bilateral wrist and hand pain and stiffness. Dr. Weiss described bilateral range of motion findings of 75 degrees dorsal and palmar flexion, 20 degrees of radial deviation and 35 degrees of ulnar deviation. Tinel's sign was positive on the left with resistive thumb abduction of 4/5 on the left and 3+/5 on the right. He found lower arm circumference to be 25 centimeters on the right and 25.5 centimeters on the left. Dr. Weiss noted no perceived sensory deficits over the median or ulnar nerve distribution on either side. He stated that grip strength testing was performed with the Jamar Hand Dynamometer at Level 3 and revealed 8 kilograms of force strength on the right and 10 kilograms on the left. Dr. Weiss referenced the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*)[3] to find that appellant had a 30 percent left upper extremity impairment, noting that, under Tables 16-32 and 16-34, she had a grip strength deficit of 20 percent, that, under Tables 16-15 and 16-11, she had a motor strength deficit for left thumb abduction of 9 percent, for a combined total of 27 percent and that under Figure 18-1 she was entitled to an additional 3 percent impairment for pain. Regarding the right upper extremity, he stated that appellant's right grip strength deficit was 20 percent, her motor strength right thumb abduction equaled an 18 percent deficit which combined to equal a 34 percent right upper extremity deficit to which he added a 3 percent pain-related deficit to total 37 percent.

By report dated February 14, 2002, an Office medical adviser reviewed the record and advised that appellant had a good result following her carpal tunnel release in 1997, but subsequently had a fall at work on January 31, 2000 after which she complained about wrist discomfort. The Office medical adviser stated any schedule award should be adjudicated under the January 31, 2000 claim, file number 030249243, rather than the instant claim, file 030207386.[4] The Office medical adviser attached a copy of a September 5, 2000 report, in

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[1] On October 15, 1997 appellant underwent left thumb ganglionectomy for a condition that was not employment related.

[2] The medical record also contains reports from Dr. R. Michael McClellan, an attending Board-certified plastic surgeon, who performed appellant's bilateral carpal tunnel releases and a February 10, 1998 report from Dr. Noubar Didizian, a Board-certified orthopedic surgeon, who performed a second opinion evaluation for the Office. These reports, however, do not contain an impairment rating.

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

[4] In a September 16, 2004 Docket No. 04-920, the Board affirmed a January 29, 2004 Office decision terminating appellant's benefits regarding the January 31, 2000 employment injury.

which Dr. Steven D. Grossinger, an osteopath specializing in neurology, advised that appellant reported a history of bilateral hand discomfort that began when she fell on January 31, 2000. He noted that appellant stated that she had no hand discomfort between 1997 and the fall of January 31, 2000. Also attached was a September 5, 2000 electromyography (EMG) and nerve conduction study (NCS), in which Dr. Grossinger advised that the study was abnormal, indicating bilateral carpal tunnel syndrome with denervation.

In a decision dated March 22, 2002, the Office found that appellant was not entitled to a schedule award under file number 030207386. On April 22, 2002 appellant, through counsel, requested a hearing that was held on November 25, 2002. At the hearing appellant testified that she continued to have pain and numbness in her hands following the 1997 surgery. She noted that in January 2000 she slipped on ice and tried to break the fall with her hands, but that her primary injury at that time was to the low back.

In an October 31, 2001 report, Dr. Bruce H. Grossinger, an osteopath specializing in neurology and Dr. Steven Grossinger's partner, advised that appellant continued to note pain and numbness in her hands due to "cumulative activities" at the employing establishment which were present both before and after the fall of January 31, 2000. He diagnosed, bilateral carpal tunnel syndrome. In a November 20, 2002 report, Dr. Robert A. Smith, an attending family practitioner, noted that appellant continued to have pain, numbness and decreased function in both wrists and hands as a result of bilateral carpal tunnel syndrome.

By decision dated March 3, 2003, an Office hearing representative remanded the case to the Office to obtain a second opinion evaluation on whether appellant had any permanent impairment causally related to the accepted bilateral carpal tunnel syndrome.

On March 21, 2003 the Office referred appellant, together with the medical record, a set of questions and a statement of accepted facts, to Dr. Anthony W. Salem, Board-certified in orthopedic surgery. In an April 24, 2003 report, he noted the history of injury, his review of the medical record and findings on physical examination. Dr. Salem stated:

> "On examination, [appellant] would not extend her fingers on any hand or her thumbs. She would not flex them into a fist and just held them in a curled-up position. When attempting to get [appellant] to extend, abduct the fingers or test her for any strength, there was absolutely no effort made on [her] part, but she definitely had no evidence of interosseous atrophy, thenar or hypothenar atrophy, muscle spasm or sensory loss. Her deep tendon reflexes were normal in the upper extremities and she had full range of motion of her cervical spine. [Appellant] would not abduct her thumb or fingers. She had a negative Tinel's for the median and ulnar nerves. I could not even see the scars from her surgeries. The hand was soft, nontender, with normal sensation. [Appellant] had full range of motion of her shoulders, wrists and fingers. She had a negative hyperflexion test, although she complained that the dorsum of her wrist hurt when I bent her wrist into flexion."

Dr. Salem advised that appellant had a "very normal" physical examination of her wrists, elbows, shoulders, neck and hands with no evidence of neurological disease in the upper

extremities. He noted that, although appellant would not move her fingers she had full passive range of motion of the metacarpophalangeal and intercarpophalangeal joints of the hand with no atrophy or contracture and that all tendons were intact. Dr. Salem's measurements of the brachium and forearms bilaterally were normal and symmetric. The physician stated that appellant questioned why he did not perform grip strength using the dynamometer so he used it, noting that she gripped 0 on the right and 20 on the left. He stated, however, "personally I feel that this test is meaningless because it only reflects what the patient wants to do." Dr. Salem concluded:

> "The range of motion of [appellant's] wrists in flexion, extension, radial and ulnar deviation was normal. Her complaints of discomfort were so vague and they changed repeatedly during my examination. There really was not a painful response to my examination. There was no motor or sensory impairment that was obvious and no significant pain. There was also no nerve involvement. [Appellant] would not move her fingers and it was a blatant example of illness behavior [and] symptom magnification.... There is no instability of any of the fingers or the wrists. There is no evidence of arthritis and no other factor that would contribute to her disability or impairment. In fact, I do not feel that [appellant] has any impairment."

By decision dated May 6, 2003, the Office denied appellant's claim for a schedule award.

On May 7, 2003 appellant, through counsel, requested a hearing that was held on November 14, 2003. Counsel contended that Dr. Weiss' report should stand unchallenged. A July 2, 2003 report was submitted in which Dr. Michael Martin Cohen, a Board-certified neurologist, noted appellant's complaints of pain, stiffness, numbness and paresthesias in her bilateral upper extremities. He noted the history of carpal tunnel release in 1997. Physical examination revealed strength at 5/5 except 4/5 for grip, interossei and opponens pollicis bilaterally. Tinel's and Phalen's signs were negative. Sensory examination revealed hypoesthesia over the median dermatome bilaterally. He advised that bilateral EMG/NCS was "essentially normal" and diagnosed carpal tunnel syndrome, residual bilaterally, despite surgical release, which he opined was permanent and due to her employment injury.

By decision dated February 3, 2004, an Office hearing representative affirmed the May 6, 2003decision, finding that the weight of the evidence rested with the opinion of Dr. Salem.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[5] and section 10.404 of the implementing federal regulation,[6] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for all claimants, good administrative practice necessitates the use of

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

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 Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[7] Chapter 16 provides the framework for assessing upper extremity impairments.[8]

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 carpal tunnel syndrome 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 testing of the thenar muscles: a residual carpal tunnel syndrome is still present and an impairment rating not to exceed five 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."[9]

Section 16.5d of the fifth edition of the A.M.A., *Guides*, provides that, in compression neuropathies, additional impairment values are not given for decreased grip strength.[10]

ANALYSIS

The Office found that appellant was not entitled to a schedule award for an upper extremity impairment based on the evaluation of Dr. Salem, a referral physician. Appellant submitted a medical report dated October 15, 2001 from Dr. Weiss. The Board finds, however, that the report of Dr. Weiss is diminished probative value as his impairment rating was not made in conformance with the A.M.A., *Guides* and he included an impairment estimate for grip strength whereas section 16.5d of the A.M.A., *Guides* precludes such use.[11] Although he also included a three percent pain-related deficit for each upper extremity under Table 18-1 of the A.M.A., *Guides*, the Board notes that Office procedures preclude the use of Table 18-1 in a case such as this where appellant's carpal tunnel syndrome is to be evaluated under the procedures

[7] *See Joseph Lawrence, Jr., supra* note 3; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[8] A.M.A., *Guides*, *supra* note 3 at 433-521.

[9] *Id.* at 495.

[10] *Id.* at 494; *Silvester DeLuca*, 53 ECAB ___ (Docket No. 01-1904, issued April 12, 2002).

[11] A.M.A., *Guides*, *supra* note 3 at 494.

provided in section 16.5d of the A.M.A., *Guides*.[12] Dr. Weiss also advised that appellant was entitled to motor strength deficits for thumb abduction of 9 percent on the left and 18 percent on the right.

The Board finds that the weight of the medical evidence rests with the opinion of Dr. Salem, an Office referral physician who provided a comprehensive report which noted that appellant was not cooperative with his physical examination. He advised that deep tendon reflexes were normal with full range of motion of the cervical spine and a negative Tinel's sign for both median and ulnar nerves. Dr. Salem noted that appellant's hands were nontender with normal sensation and that she had full range of motion of the shoulders, wrists and fingers. He stated that her complaints of discomfort were vague and changed repeatedly during his examination. Dr. Salem found no painful response or evidence of motor or sensory impairment. He concluded that appellant had a "very normal" physical examination of her wrists, elbows, shoulders, neck and hands with no evidence of neurological disease in the upper extremities and no upper extremity impairment. The Board notes that the EMG/NCS performed under the auspices of Dr. Cohen was reported as essentially normal.

The Board finds that as Dr. Salem provided a thorough examination finding no permanent impairment, appellant is not entitled a schedule award for either upper extremity.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she is entitled to a schedule award for either upper extremity.

[12] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 3, 2004 be affirmed.

Issued: January 27, 2005
Washington, DC

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member