

**United States Department of Labor
Employees' Compensation Appeals Board**

LINDA J. MICHENER, Appellant

and

**U.S. POSTAL SERVICE, POST OFFICE,
Lancaster, PA, Employer**

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**Docket No. 04-1516
Issued: March 4, 2005**

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
MICHAEL E. GROOM, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On May 24, 2004 appellant filed a timely appeal from an Office of Workers' Compensation Programs' hearing representative's schedule award decision dated January 20, 2004. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than a 12 percent permanent impairment of her right upper extremity for which she received a schedule award.

FACTUAL HISTORY

On October 9, 1997 appellant, then a 40-year-old postmaster, filed an occupational disease claim alleging that she sustained carpal tunnel syndrome and tenosynovitis in the right hand while in the performance of duty. She did not stop work and was provided with limited duty.¹ The Office accepted her claim for right wrist tendinitis, right carpal tunnel syndrome and

¹ The record reflects that appellant stopped work on January 14, 1999, returned on May 4, 1999 to light duty and stopped on December 17, 1999. She returned again on November 6, 2000 to limited duty. On January 13, 2001 appellant accepted a rehabilitation job offer as a modified postmaster.

right radial neuropathy and authorized right radial decompression and carpal tunnel release surgeries.² She received appropriate compensation benefits.³

By letter dated October 10, 2002, appellant, through her attorney, requested a schedule award. In support of her claim, she submitted a July 23, 2002 report from Dr. David Weiss, an osteopath. He utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001) to find that appellant's pain with respect to activities of daily living was equivalent to 2 out of 10. Regarding elbow range of motion, he noted flexion-extension of 145/145 degrees, pronation of 80/80 degrees and supination of 80/80 degrees with the valgus and varus stress tests producing firm end points. Regarding the right wrist, Dr. Weiss noted that appellant had a well-healed, midpalmar surgical scar with mild thenar atrophy and some flattening. He advised that fist presentation was normal to the distal palmar crease and wrist range of motion revealed dorsiflexion of 0-75/75 degrees; palmar flexion of 0-75/75 degrees; radial deviation of 0-20/20 degrees; and ulnar deviation of 0-35/35 degrees with a positive Tinel's sign, Phalen's sign and carpal compression. Dr. Weiss indicated that the resisted thumb abduction was graded at 4/5 and the long finger extension sign produced pain into the radial tunnel. Regarding grip strength testing performed with the Jamar hand Dynamometer at Level 3, he advised that appellant had 20 kilograms of force strength involving the right hand, which he noted was abnormal for a right-hand dominant female. Dr. Weiss conducted a neurological examination and advised that a sensory examination failed to reveal any perceived sensory deficits involving the right upper extremity. He indicated that manual muscle testing of the biceps and triceps was graded at 5/5 on the right. Regarding the upper arm circumference, Dr. Weiss noted that appellant measured 39 centimeters on the right versus 37 centimeters on the left; however, he explained that the discrepancy was due to the congenital deformity. Dr. Weiss determined that appellant had a 21 percent impairment of the right upper extremity based on motor strength deficits. He referred to Table 16-11, pages 484 and Table 16-15 page 492 of the A.M.A., *Guides*, which combined allowed percentages for motor strength deficit in right thumb abduction and equated to nine percent.⁴ Dr. Weiss referred to appellant's right grip strength deficit which he determined to be 10 percent pursuant to Table 16-32 and 16-34, at page 509 and explained that, when combined they were 18 percent.⁵ In addition, he allowed three percent for related pain impairment pursuant to Figure 18-1, page 574 for a total right upper extremity impairment of 21 percent.⁶ Dr. Weiss opined that appellant reached maximum medical improvement on July 23, 2002 and that she had 21 percent impairment of her right upper extremity.

Dr. Weiss' report and the case record were referred to an Office medical adviser, who, in a report dated October 25, 2002, determined that, under the A.M.A., *Guides*, at page 494, "[i]n

² On March 13, 2000 the Office also accepted appellant's recurrence claim for a December 17, 1999 recurrence.

³ The Office issued a decision on February 22, 2002, finding that her actual earnings fairly and reasonable represented her wage-earning capacity.

⁴ A.M.A., *Guides* 484, Table 16-11; A.M.A., *Guides* 492, Table 16-15.

⁵ A.M.A., *Guides* 509, Table 16-32; A.M.A., *Guides* 509, Table 16-34.

⁶ A.M.A., *Guides* 574, Table 18-1.

compression neuropathies, additional impairment values are not given for decreased grip strength.” The Office medical adviser combined the estimates for pain of 3 percent and loss of motor strength of 9 percent to determine that appellant had a 12 percent total impairment of the right upper extremity.

On October 29, 2002 the Office granted appellant a schedule award for 12 percent impairment of the right upper extremity. The award covered a period of 37.44 weeks from July 23 to November 2, 2002.⁷

By letter dated October 30, 2002, appellant, through her attorney, requested a hearing, which was held on October 22, 2003. In a January 20, 2004 decision, the Office hearing representative affirmed the October 29, 2002 decision.

LEGAL PRECEDENT

Section 8107 of the Federal Employees’ Compensation Act⁸ sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.⁹ The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.¹⁰ The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.¹¹

ANALYSIS

In support of her claim for a schedule award, appellant submitted a report from Dr. Weiss dated July 23, 2002. The Board notes that, while he determined that appellant sustained a 21 percent impairment of the right upper extremity, this estimate did not conform with the protocols of the A.M.A., *Guides*.

⁷ The Office decision inadvertently incorrectly omitted the percentage of impairment, but the award was correctly paid for 12 percent impairment to the right arm.

⁸ 5 U.S.C. §§ 8101-8193.

⁹ 5 U.S.C. § 8107.

¹⁰ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

¹¹ A.M.A., *Guides* (5th ed. 2001); 20 C.F.R. § 10.404.

Office procedures¹² 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 16-15.¹³ 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) [p]ositive 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) [n]ormal 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 five percent of the upper extremity may be justified.

(3) [n]ormal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies: there is no objective basis for an impairment rating.”¹⁴

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.¹⁵ 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.”¹⁶

Dr. Weiss determined that appellant had a 21 percent impairment of the right upper extremity based on motor strength deficits and referred to Table 16-11, page 484 and Table 16-15 page 492 of the A.M.A., *Guides*, which combined allowed percentages for motor strength deficit in right thumb abduction and opined that this equated to nine percent.¹⁷ He also referred

¹² See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808 (August 2002) (March 1995).

¹³ A.M.A., *Guides supra* note 8; *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

¹⁴ A.M.A., *Guides, supra* note 8 at 495.

¹⁵ *Id.* at 494.

¹⁶ *Id.* at 508.

¹⁷ A.M.A., *Guides* 484, Table 16-11; A.M.A., *Guides* 492, Table 16-15.

to appellant's right grip strength deficit which he determined to be 10 percent pursuant to Table 16-32 and 16-34, at page 509 and explained that when combined they were 18 percent.¹⁸ However, as noted above, the A.M.A., *Guides* provides that "in compression neuropathies, additional impairment values are not given for decreased grip strength."¹⁹ 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.²⁰

Dr. Weiss also noted complaints of pain in the right wrist and forearm, numbness and tingling with decreased grip strength and increased pain with weather changes and post-operative scarification and determined that appellant's pain with respect to her activities of daily living was 2 out of 10. He allowed three percent for related pain impairment pursuant to Figure 18-1, page 574.²¹ However, according to section 18.3(b) of the A.M.A., *Guides*, "examiners should not use this chapter 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*."²² Office procedures provide that Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain (Chapters 13, 16 and 17).²³ He subsequently combined these ratings for a total right upper extremity impairment of 21 percent and opined that appellant reached maximum medical improvement on July 23, 2002.²⁴

The Office medical adviser utilized Dr. Weiss' report and concurred with his calculations, with the exception of grip strength. The Office medical adviser concurred with Dr. Weiss regarding the three percent impairment for pain; however, as indicated above, Office procedures provide that Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain.²⁵ The Office medical adviser explained his reason for not including the ratings for grip strength and related that the A.M.A., *Guides* do not allow using grip strength loss in cases of entrapment neuropathies.²⁶ He, therefore, determined that appellant would not be entitled to the 10 percent for the grip strength loss. He subsequently utilized the findings of Dr. Weiss which included the 9 percent for motor strength deficit and 3 percent for pain and advised that appellant was entitled to a schedule award comprised of no more than 12

¹⁸ A.M.A., *Guides* 509, Table 16-32; A.M.A., *Guides* 509, Table 16-34.

¹⁹ A.M.A., *Guides* 492, Table 16-15.

²⁰ *Robert V. Disalvatore*, 54 ECAB ____ (Docket No. 02-2256, issued January 17, 2003).

²¹ A.M.A., *Guides* at 574.

²² Section 18.3b, page 571, A.M.A., *Guides* (5th edition, 2001).

²³ See FECA Bulletin 01-05 (issued January 31, 2001): Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

²⁴ A.M.A., *Guides* 574, Table 18-1.

²⁵ See *supra* note 23.

²⁶ A.M.A., *Guides* at 494, 95; see also *Robert V. Disalvatore*, 54 ECAB ____ (Docket No. 02-2256, issued January 17, 2003).

percent to the right upper extremity. With regard to how the 9 percent for motor strength was calculated, the Office medical adviser referred to Table 16-11, page 484 and determined that appellant was entitled to a grade of 4/5 for pain or a maximum of 25 percent for her motor deficit.²⁷ He subsequently referred to Table 16-15 page 492 of the A.M.A., *Guides* and it appears that he determined that appellant would be entitled to a 35 percent motor deficit for her impairment to the upper extremity which was in the category of elbow with sparing of triceps.²⁸ Multiplying the 25 percent for the motor strength deficit by the 35 percent for her radial nerve at the elbow equated to 8.75 percent and when rounded up equated to nine percent.²⁹ The Office relied upon the Office medical adviser's opinion in awarding 12 percent impairment to appellant's right upper extremity. However, a review of the Office medical adviser's calculations for the right upper extremity reflect that appellant only had a nine percent impairment to her right upper extremity for the reasons noted above. There is no other evidence of an additional impairment as a result of any of appellant's accepted conditions.

Accordingly, the Board finds that the evidence supports that appellant has a nine percent impairment of the right upper extremity. She has not established entitlement to a schedule award greater than the 12 percent awarded by the Office.

On appeal appellant's representative alleged that the Office medical adviser's report was not sufficient to carry the weight or in the alternative, should have created a conflict. However, the Board notes that the evidence does not suggest a conflict of medical opinion.³⁰ As noted above, grip strength loss is not applicable in cases of carpal tunnel syndrome.³¹ Counsel's argument that grip strength could be used in a functional loss rating criteria is without merit. The A.M.A., *Guides*, state that loss of strength should be graded separately, only if it is based on an unrelated cause or mechanism, "otherwise, the impairment ratings based on objective anatomic findings take precedence."³² Therefore, grip strength should not be used to calculate an upper extremity impairment caused by a compression neuropathy such as carpal tunnel syndrome.

CONCLUSION

The Board finds that appellant does not have more than a 12 percent impairment of her right upper extremity.

²⁷ A.M.A., *Guides* 484, Table 16-11.

²⁸ A.M.A., *Guides* 492, Table 16-15.

²⁹ No percentage was given for sensory deficit for pain.

³⁰ The Board finds that, with the exception of concurring with the 3 percent for pain, the medical adviser properly applied the findings of Dr. Weiss to the fifth edition of the A.M.A., *Guides*. Board precedent is well settled, however, that, when an attending physician's report improperly applies the A.M.A., *Guides*, as in the present case, the Office is correct to follow the advice of its medical adviser or consultant where he or she has properly utilized the A.M.A., *Guides*. See *Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980).

³¹ See footnote 14 *supra*.

³² A.M.A., *Guides* at 508.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 30, 2003 is hereby affirmed.

Issued: March 4, 2005
Washington, DC

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member