United States Department of Labor
Employees' Compensation Appeals Board

ALICE OLIVER, Appellant	)	
	)	**Docket No. 05-1230**
and	)	**Issued: September 15, 2005**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, 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:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On May 13, 2005 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated December 6, 2004. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether the Office properly denied appellant's claim for a schedule award.

FACTUAL HISTORY

On August 21, 1999 appellant, then a 58-year-old flat sorting machine clerk, filed an occupational disease claim alleging that she developed bilateral carpal tunnel syndrome as a result of performing her clerk duties. Appellant did not stop work and retired in 1999. The Office accepted her claim for bilateral carpal tunnel syndrome and authorized bilateral carpal tunnel releases which were performed on February 8 and March 21, 2000 respectively.

Appellant came under the treatment of Dr. David S. Zelouf, a Board-certified orthopedic surgeon, who diagnosed bilateral carpal tunnel syndrome and recommended surgical

intervention. He noted performing a right carpal tunnel release on February 8, 2000 and a left carpal tunnel release on March 21, 2000. In a report dated April 20, 2000, the physician noted that appellant was progressing well postsurgery and recommended that she continue with physical therapy for three weeks prior to returning to work. On May 31, 2000 appellant reached maximum medical improvement and Dr. Zelouf returned her to full-time work without restrictions.

On May 26, 2001 appellant filed a claim for a schedule award. She submitted a March 19, 2001 report from Dr. David Weiss, an osteopath, who noted that appellant reached maximum medical improvement on March 15, 2001. He found that physical examination of the right wrist revealed a well-healed transverse mid palmer surgical scar, a distal palmar surgical scar, negative Tinel's sign, negative Phalen's sign, range of motion for dorsiflexion of 75 degrees, palmer flexion of 75 degrees, radial deviation of 20 degrees, ulnar deviation of 35 degrees and thumb abduction of 5/5. Examination of the left wrist revealed a well-healed transverse mid palmer surgical scar, a distal palmar surgical scar, negative Tinel's sign, negative Phalen's sign, range of motion for dorsiflexion of 75 degrees, palmer flexion of 75 degrees, radial deviation of 20 degrees, ulnar deviation of 35 degrees and thumb abduction of 5/5. Dr. Weiss listed grip strength testing on the right via Jamar Hand Dynamometer at Level 3 revealed six kilograms (kg) of force strength versus seven kg of force strength on the left. Dr. Weiss noted that sensory examination failed to reveal abnormalities over the median or ulnar nerves. He diagnosed cumulative and repetitive trauma disorder, bilateral carpal tunnel syndrome and status postbilateral carpal tunnel syndrome release. He noted that based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[1] (A.M.A., *Guides*) that appellant would receive a 30 percent impairment on the right for grip strength deficit[2] and 30 percent impairment on the left for grip strength impairment.[3]

In a report dated August 16, 2001, an Office medical adviser determined that appellant was not entitled to a schedule award for the upper extremities based on the report of Dr. Weiss. The medical adviser indicated that carpal tunnel syndrome was a compression neuropathy and that Dr. Weiss found no specific motor or sensory deficit and only noted a decreased grip strength deficit. The medical adviser indicated that there was no award for grip strength deficit in a compression neuropathy under the A.M.A., *Guides* and the FECA Bulletin 01-05.[4]

In a decision dated October 5, 2001, the Office denied appellant's claim for a schedule award.

In a letter dated October 12, 2001, appellant requested an oral hearing before an Office hearing representative. The hearing was held on July 29, 2003.

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

[2] *Id*. at 509, Table 16-32, 16-34.

[3] *Id.*

[4] *See also* A.M.A., *Guides* at 494.

In a decision dated October 24, 2003, the hearing representative vacated the October 5, 2001 decision and remanded the case for further medical development of the issue of permanent impairment of the upper extremities.

Appellant submitted a report from Dr. Weiss dated February 22, 2003. He reviewed the physical examination performed in March 2001 and noted that appellant did not have a sensory deficit or range of motion deficit of the wrists, rather she exhibited decreased grip strength which was directly related to her carpal tunnel syndrome. He stated that decreased grip strength was the only impairment which objectively described appellant's limitations from carpal tunnel syndrome.

On November 19, 2003 the Office referred appellant for a second opinion evaluation to Dr. Anthony W. Salem, a Board-certified orthopedic surgeon. The Office provided Dr. Salem with appellant's medical records, a statement of accepted facts as well as a detailed description of her employment duties. In a medical report dated December 30, 2003, Dr. Salem reviewed the records and performed a physical examination. He noted that appellant had undergone right and left carpal tunnel release surgeries on February and March 2000 and advised that the surgical procedures provided excellent results from which she had completely recovered. He noted findings upon physical examination of no sensory loss in her hands to pinprick, no atrophy of the thenar or hypothenar muscles, negative hyperflexion test, negative Tinel's sign at the wrists and elbows bilaterally and significant pain upon palpation of the carpometacarpal junction of both hands. Dr. Salem observed that radial and ulnar deviation of both wrists was normal, there was no sensory or motor impairment and no instability. He opined that to a reasonable degree of medical certainty appellant had no impairment as a result of the diagnosed conditions and bilateral carpal tunnel release surgeries.

In a report dated January 28, 2004, an Office medical adviser determined that, in accordance with the A.M.A., *Guides,* appellant did not sustain any permanent impairment of the upper extremities. The medical adviser advised that Dr. Salem specifically noted that there was no loss of range of motion and no motor or sensory impairment due to median neuropathy. The medical adviser determined that in accordance with the A.M.A., *Guides* appellant sustained a zero percent impairment of the right and left upper extremity.

In a decision dated February 3, 2004, the Office denied appellant's claim for a schedule award based on the reports of Dr. Salem and the Office medical adviser.

By a letter dated February 5, 2004, appellant requested an oral hearing before an Office hearing representative. The hearing was held on September 28, 2004.

In a decision dated December 6, 2004, the hearing representative affirmed the February 3, 2004 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulation[6] sets 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

The Office referred appellant for a second opinion evaluation to Dr. Salem. In a report dated December 30, 2003, the physician stated that appellant's physical examination revealed no sensory loss in her hands to pinprick, no atrophy of the thenar or hypothenar muscles, negative hyperflexion test, negative Tinel's sign at the wrists and elbows bilaterally and significant pain upon palpation of the carpometacarpal junction of both hands. Dr. Salem opined that radial and ulnar deviation of the wrists was normal and there was no sensory or motor impairment and no instability. Appellant had successfully undergone right and left carpal tunnel release surgeries from which she had completely recovered. He opined that appellant had no disability as a result of the accepted bilateral carpal tunnel syndrome and release surgeries.

The Board finds that the opinion of Dr. Salem is sufficiently well rationalized and based upon a proper factual background such that it establishes that appellant did not sustain any work-related impairment of the upper extremities. Dr. Salem opined that to a reasonable degree of medical certainty appellant has no disability as a result of the diagnosed condition of bilateral carpal tunnel syndrome and bilateral carpal tunnel releases.

The Board has carefully reviewed Dr. Weiss' reports dated March 19, 2001 and February 22, 2003, which determined that appellant sustained a 30 percent permanent impairment of the right and left upper extremities. However Dr. Weiss did not make this impairment estimate in accordance with the relevant standards of the A.M.A., *Guides*.[7] The Office procedures[8] provide that upper extremity impairment secondary to carpal tunnel syndrome and other entrapment neuropathies is to be calculated using section 16.5d and Tables 16-10, 16-11 and 16-15.[9]

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[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999).

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

[8] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808 (August 2002).

[9] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr*., 53 ECAB 331 (2002).

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."[10]

Section 16.5d of the A.M.A., *Guides* further provides that in rating compression neuropathies, additional impairment values are not given for decreased grip strength.[11]

With respect to the right and left upper extremity, Dr. Weiss noted range of motion for dorsiflexion of 75 degrees for a 0 percent impairment,[12] palmer flexion of 75 degrees for a 0 percent impairment,[13] radial deviation of 20 degrees for a 0 percent impairment,[14] ulnar deviation of 35 degrees for a 0 percent impairment[15] and thumb abduction of 5/5 for a 0 percent impairment.[16] Dr. Weiss also noted results of grip strength testing. However, as noted above, the A.M.A., *Guides* provides that "in compression neuropathies, additional impairment values are not given for decreased grip strength."[17] The Board has noted that the fifth edition of the

[10] A.M.A., *Guides* at 495.

[11] *Id.* at 494.

[12] *Id*. at 467, Figure 16-28.

[13] *Id.*

[14] *Id*. at 469, Figure 16-31.

[15] *Id.*

[16] *Id*. at 459, Table 16-8a.

[17] *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).

A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated only on motor and sensory impairments.[18]

The Board finds that Dr. Salem's opinion constitutes the weight of the medical evidence and establishes that appellant did not sustain any permanent impairment of the upper extremities due to her bilateral carpal tunnel syndrome. The Office medical adviser properly applied the A.M.A., *Guides* to the information provided in Dr. Salem's December 30, 2003 report and determined that appellant had no impairment. This evaluation conforms to the A.M.A., *Guides* and establishes that appellant has no permanent partial impairment of the upper extremities causally related to her accepted condition.

CONCLUSION

The Board therefore finds that the weight of the evidence rests with the determination of the second opinion physician. Appellant is therefore not entitled to a schedule award for the upper extremities.

ORDER

IT IS HEREBY ORDERED THAT the December 6, 2004 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 15, 2005
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

[18] *See Robert V. Disalvatore, supra* note 17.