

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

G.R., Appellant

and

**U.S. POSTAL SERVICE, POST OFFICE,
Kearny, NJ, Employer**

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**Docket No. 07-2071
Issued: April 16, 2008**

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, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 6, 2007 appellant filed a timely appeal from the October 12, 2006 schedule award of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the appeal.

ISSUE

The issue is whether appellant has more than 10 percent impairment to her left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On May 9, 2000 appellant, then a 54-year-old mail clerk, filed a claim for left carpal tunnel syndrome which she attributed to her federal employment. She noted prior surgery for carpal tunnel on her right hand, following which she used her left hand for heavy lifting. Appellant's claim was accepted by the Office for left carpal tunnel syndrome. She underwent surgical decompression on November 16, 2000. Appellant received appropriate benefits for intermittent disability and subsequently filed a claim for a schedule award.

On June 9, 2005 Dr. Howard L. Blank, an attending orthopedic surgeon, reported that appellant had complaints of intermittent tingling and numbness in the second and third fingers of the left hand, occasionally going to the thumb. Sometimes appellant's symptoms extended from the wrist to the elbow. She had no complaints of weakness. Dr. Blank reviewed a February 26, 2005 nerve conduction study which revealed no denervation in the thenar muscles which correlated with his findings on physical examination of no thenar weakness or atrophy. He described appellant's symptoms as sensory, not motor, and secondary to residual carpal tunnel syndrome due to scarring around the median nerve. Dr. Blank advised that appellant was capable of performing light repetitive activities and she was not a candidate for further surgery.

An Office medical adviser reviewed the report of Dr. Blank, noting that appellant experienced sensory changes following her surgery in 2000 with no motor deficit. He utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th edition) to rate impairment. Under Table 16-10, Dr. Blank found that appellant's sensory impairment would be classified as Grade 4 for distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations of pain that is forgotten during activity.¹ The medical adviser allowed 25 percent sensory deficit based on Dr. Blank's clinical description of appellant's symptoms. Under Table 16-15, he noted that the maximum upper extremity impairment allowed for sensory loss of the median nerve below the forearm was 39 percent.² The Office medical adviser multiplied the sensory deficit (25 percent) by the maximum impairment value (39 percent) to find that appellant had 10 percent impairment of her left upper extremity.³ He advised that appellant had reached maximum medical improvement as of June 9, 2005, the date of Dr. Blank's examination.

In support of her claim, appellant submitted the September 1, 2005 report of Dr. Nicholas Diamond, an osteopath. Examination of the left wrist revealed a three centimeter scar from surgery with palmar aspect tenderness. Dr. Diamond described left hand thenar atrophy and provided range of motion findings for the fingers. Grip strength testing revealed equal forces of strength for the right and left hands. Dr. Diamond stated that appellant had residual sensory neuropathy due to her bilateral carpal tunnel syndrome. He advised that she had complaints of daily left hand pain which waxed and waned. Dr. Diamond described diminished light touch and two-point discrimination at three millimeters. He advised that appellant had 31 percent impairment to her left upper extremity, indicating that her sensory deficit was Grade 2 for the left median nerve.

On July 27, 2006 an Office medical adviser reviewed the medical evidence and disagreed with the impairment rating by Dr. Diamond. He stated that Dr. Diamond incorrectly rated the median nerve deficit as Grade 2 as his physical examination revealed normal two-point discrimination measured at three millimeters. The medical adviser stated that two-point discrimination at six millimeters or less was equivalent to zero percent impairment of the nerve

¹ A.M.A., *Guides* 482.

² *Id.* at 492.

³ The total of 9.75 percent was properly rounded to 10 percent pursuant with Office standards in schedule award claims. See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3(b) (October 1990).

as recorded in the medical literature. He agreed with the prior impairment rating of 10 percent impairment based on a Grade 4 sensory deficit. The medical adviser concluded that appellant did not have greater than 10 percent impairment to her left arm.

On August 17, 2006 the Office granted appellant a schedule award for 10 percent impairment of the left upper extremity. The period of the award ran for 31.2 weeks of compensation from November 11, 2000 to June 22, 2001. On October 12, 2006 the Office modified the schedule award determination to reflect that period covered was June 9, 2005 to January 13, 2006.

Appellant, through counsel, requested a hearing before an Office hearing representative which was held on December 12, 2006. In a February 23, 2007 decision, the Office hearing representative found that appellant had no more than 10 percent impairment to her left arm.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act and its implementing federal regulations set forth the number of weeks of compensation payable to employees who sustain permanent impairment from the loss, or loss of use, of schedule members or functions of the body.⁴ The Act, however, does not specify the manner in which the percentage loss of a member 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 Office has adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* for evaluation of scheduled losses.⁵

If, after an optimal recovery time following surgical decompression, an individual continues to experience pain, paresthesias or difficulties performing certain activities and there are positive clinical findings of median nerve dysfunction and electrical conduction delays, the impairment due to residual carpal tunnel syndrome is rated according to sensory or motor deficits.⁶ Table 16-10 of the A.M.A., *Guides* set forth a grading scheme and procedure for determining impairment of the upper extremity due to sensory deficit or pain resulting from peripheral nerve disorders.⁷

ANALYSIS

Appellant's claim was accepted for left carpal tunnel syndrome for which she underwent surgery on November 16, 2000. Dr. Blank, an attending physician, noted on examination that appellant had symptoms of intermittent tingling and numbness of several fingers of her left hand.

⁴ 5 U.S.C. § 8107; 20 C.F.R. § 10.404. See *Michelle L. Collins*, 56 ECAB 552 (2005).

⁵ 20 C.F.R. § 10.404. Effective February 1, 2001 the Office began using the fifth edition of the A.M.A., *Guides*. See *David W. Ferrall*, 56 ECAB 362 (2005).

⁶ A.M.A., *Guides* 495.

⁷ *Id.* at 482.

He advised that she had no complaints of weakness or atrophy and that a February 26, 2005 nerve conduction study was consistent with residual left carpal tunnel syndrome. Dr. Blank found that appellant's residual symptoms were sensory in nature, not motor, due to scarring around the median nerve. However, he did not provide an impairment rating.

Based on this report, an Office medical adviser found that appellant had reached maximum medical improvement as of Dr. Blank's June 9, 2005 evaluation. He rated appellant as having 10 percent permanent impairment to her left arm due to sensory loss or pain. The medical adviser noted that, under the A.M.A., *Guides*, appellant's symptoms as described by Dr. Blank warranted a Grade 4 deficit under Table 16-10, which provides a range of 1 to 25 percent for sensory deficit or pain. The medical adviser allowed 25 percent under Grade 4 and, in application of Table 16-15, noted that the maximum impairment allowed for sensory loss of the median nerve below the forearm was 39 percent. Based on these Tables, he found 10 percent impairment of the left upper extremity. The Board finds that this was a proper application of the A.M.A., *Guides* by the medical adviser based on the clinical findings of Dr. Blank.⁸

Dr. Diamond rated appellant as having 31 percent impairment of her left arm. The basis of his higher impairment rating under Table 16-15 was his determination that appellant's residual sensory loss was Grade 2 under Table 16-10. Grade 2 is described as decreased superficial cutaneous pain and tactile sensibility (decreased protective sensibility), with abnormal sensations or moderate pain that may prevent activities. This grade allows for 61 to 80 percent sensory deficit. It is readily apparent that Dr. Diamond allowed appellant 80 percent sensory deficit under Table 16-10 to arrive at the 31 percent impairment under Table 16-15. However, the grading selected by Dr. Diamond is not supported by his clinical findings.

The second Office medical adviser did not accept grading of appellant's residual sensory loss as Grade 4. He noted that Dr. Diamond found two-point discrimination at three millimeters. The A.M.A., *Guides*, provide commentary for the medical examiner in estimating the values for each severity grade appearing at Table 16-10. It cautions that "[t]he maximum value for each grade is not applied automatically."⁹ The commentary provides that in interpretation of Table 16-10, a Grade 2 sensory deficit is possible with "a gross appreciation of two-point discrimination (11 to 15 millimeters) at this level."¹⁰ Dr. Diamond did not provide any explanation for why he automatically allowed the maximum value for Grade 2 sensory deficit (80 percent). His report noted some difficulties described by appellant in performing various activities, but he did not state that her abnormal sensations or pain prevented any activity, a factor which supports Grade 2 deficit. As the Office medical adviser noted, Dr. Diamond's finding on two-point discrimination were not characteristic of the Grade 2 classification he selected. For these reasons, his impairment rating is of diminished probative value. The medical

⁸ Under accepted Office procedures, after obtaining all necessary medical evidence, the file may be routed to an Office medical adviser for an opinion concerning the percentage of permanent impairment. See *Tommy R. Martin*, 56 ECAB 273 (2005).

⁹ A.M.A., *Guides* 482.

¹⁰ *Id.* at 483.

evidence of record does not establish that appellant has greater than 10 percent impairment of her left arm. The Board will affirm the schedule award granted in this case.

CONCLUSION

The Board finds that appellant has no more than 10 percent impairment of her left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the February 23, 2007 and October 12, 2006 decisions of the Office of Workers' Compensation Programs be affirmed.

Issued: April 16, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board