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

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| **O.L., Appellant** | ) | |
| **and** | ) | **Docket No. 08-1014** |
| | ) | **Issued: November 13, 2008** |
| **DEPARTMENT OF VETERANS AFFAIRS, W.G. HEFNER MEDICAL CENTER, Salisbury, NC, Employer** | ) | |

*Appearances:*
*Appellant, pro se*
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

### ***JURISDICTION***

On February 20, 2008 appellant filed a timely appeal from a schedule award decision of the Office of Workers' Compensation Programs dated November 28, 2007. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award.

### ***ISSUE***

The issue is whether appellant has met her burden of proof to establish that she has more than 12 percent impairment of the right upper extremity, for which she received a schedule award.

### ***FACTUAL HISTORY***

On May 30, 2000 appellant, then a 48-year-old licensed practical nurse, sustained injury to both arms, shoulders and her neck when she was twisted and pulled by a combative patient. On July 31, 2000 the Office accepted bilateral wrist strains. On September 29, 2000

Dr. Gregg E. Cregan, Board-certified in orthopedic surgery and hand surgery, performed arthroscopy of the right wrist with an open scapholunate ligament repair and reconstruction of the dorsal capsule. Appellant returned to limited duty on January 15, 2001, stopped on February 12, 2001 and did not return.

On June 21, 2001 the Office accepted bilateral shoulder and cervical strains. It noted that Dr. Cregan had advised that her carpal tunnel syndrome was not related to the May 30, 2000 employment injury. By report dated June 21, 2004, Dr. William Renfroe, Board-certified in family medicine, performed a disability evaluation and advised that appellant was significantly limited due to the inability to use her hands. On August 15, 2001 Dr. Cregan performed left carpal tunnel release. On December 14, 2001 he performed a right anterior ulnar nerve transposition and carpal tunnel release.[1]

On February 4, 2002 Dr. Edward G. Hill, Jr., an attending neurologist, diagnosed possible cervical radiculopathy. On March 21, 2001 Dr. Cregan noted that appellant was 3½ months post right upper extremity surgery and reported her complaint of mild pillar pain. He provided permanent restrictions for the right upper extremity and advised that appellant had a 20 percent permanent disability of her right hand based on the carpal tunnel release and ulnar nerve transposition and 25 percent for the scapholunate ligament injury because of the high possibility of the need for future reconstruction, instability and arthritis. Dr. Cregan found a total right upper extremity impairment of 45 percent. On April 16, 2002 appellant filed a schedule award claim.

In a May 9, 2002 report, Dr. Hill noted appellant's complaint of continued neck pain. Spurling's sign was positive on the left and Tinel's positive over the carpal tunnel on the right. Reflexes were symmetrically diminished and sensory testing was nonspecific. On June 26, 2002 Dr. Hill reported that electrodiagnostic (EMG) studies confirmed left carpal tunnel syndrome and left tardy ulnar palsy with mild findings suggestive of C7 radiculopathy. He advised that magnetic resonance imaging (MRI) scan demonstrated a small disc extrusion at C3-4 and C6-7 and disc bulging at C4-5.

On July 17, 2002 the Office referred appellant to Dr. Andrew Bush, Board-certified in orthopedic surgeon, for a second opinion evaluation. In an August 20, 2002 report, Dr. Bush noted his review of the record, appellant's medical history and her complaints of neck pain and pain and numbness in the elbows and wrists. He diagnosed neck pain and bilateral arm pain, stating that there were no objective findings other than a decreased range of motion of the right wrist. Dr. Bush advised that appellant's multiple subjective complaints were inconsistent with objective findings and that maximum medical improvement was reached on August 16, 2002. He concluded that there was no orthopedic reason why appellant could not return to work and recommended psychological evaluation. In a supplementary report dated October 24, 2002, Dr. Bush advised that, on physical examination, there was no indication or recurring carpal tunnel syndrome or any type of ulnar nerve pathology on either side.

On November 13, 2002 Dr. Cregan advised that appellant's May 30, 2000 injury was severe enough to cause a scapholunate dissociation on the right and some mild widening of the

[1] The record does not indicate that either the August 15 or December 14, 2001 procedures were authorized.

scapholunate interval on the left which produced swelling which could produce bilateral carpal tunnel syndrome. In February 2003, the Office referred appellant to Dr. James H. Carter, a Board-certified psychiatrist, for a second opinion evaluation. In a March 6, 2003 report, Dr. Carter diagnosed mood disorder due to orthopedic injury with depressed features and advised that she could not return to work due to her psychiatric condition. In a supplementary report dated April 29, 2003, he again advised that appellant was totally disabled due to her psychiatric impairment. On June 12, 2003 the Office accepted mood disorder as employment related.

On July 31, 2003 the Office referred appellant to Dr. Robert W. Elkins, Board-certified in orthopedic surgery, for a second opinion evaluation. In an October 14, 2003 report, Dr. Elkins noted the history of injury and medical treatment. Appellant complained of neck and bilateral shoulder, arm, low back, bilateral thigh, calf and foot pain. Physical findings included decreased neck range of motion and normal bilateral shoulder and wrist motion with a positive Phalen's sign on the right. Dr. Elkins noted that appellant was markedly obese with multiple medical problems. He diagnosed status post left carpal tunnel release, status post arthroscopic and open repair of disassociation scapholunate area and transposition of right ulnar nerve. Dr. Elkins commented that there was very little objective evidence to support her continuing symptomatology and that she had reached maximum medical improvement. He advised that under the fourth or fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides* hereinafter), appellant had a 5 percent rating to each hand for carpal tunnel release, 5 percent for the ulnar nerve transposition and 10 percent for the carpal dissociation.

A cervical spine MRI scan on March 2, 2004 demonstrated degenerative disc disease at multiple levels. By reports dated May 10 and 14, 2004, Dr. Hill advised that appellant continued to have problems with grip strength and pain radiating from the neck down to all fingers of the left hand with a positive Tinel's sign on the left and stocking-glove sensory loss in the distal lower extremities. He diagnosed bilateral carpal tunnel syndrome, borderline left tardy ulnar palsy and minimal evidence of left cervical radiculopathy at the C7 level. On August 10, 2005 appellant elected retirement benefits from the Office of Personnel Management. By report dated September 26, 2005, Dr. Hill noted Dr. Cregan's impairment rating and advised that appellant's continued problems of chronic neck and arm pain yielded an additional 10 percent disability rating. On April 21, 2006 appellant again filed a schedule award claim.

In a July 10, 2006 addendum to his March 21, 2002 treatment note, Dr. Cregan advised "the patient has met [maximum medical improvement]." On October 5, 2006 the Office determined that a conflict in medical evidence existed regarding whether appellant's diagnosed conditions of carpal tunnel syndrome, ulnar nerve transposition and right scapholunate tear were caused by the May 30, 2000 employment injury and whether the accepted orthopedic conditions had resolved. In a February 19, 2007 report, Dr. Cregan advised that appellant had a total permanent impairment of 45 percent of the right hand based on the A.M.A., *Guides*, with 10 percent for carpal tunnel, 10 percent for ulnar nerve transposition, 12 percent for scapholunate dissociation under Table 26 and 13 percent for a combination of weakness and loss of motion. In an October 11, 2007 report, an Office medical adviser found the date of maximum medical improvement was February 19, 2007. He disagreed with Dr. Cregan's conclusion that appellant had a 45 percent impairment. The Office medical adviser noted that neither carpal tunnel syndrome nor any ulnar nerve condition was accepted and that weakness and loss of motion was

not reported on examinations by different physicians. He concluded that the only impairment that could be verified was a 12 percent permanent impairment for the right carpal instability, as described in Table 16-25 of the A.M.A., *Guides* and that she was not entitled to schedule award for her left upper extremity.

By decision dated November 28, 2007, appellant was granted a schedule award for a 12 percent impairment of the right arm. The Office set the date of maximum medical improvement at March 21, 2002 and the schedule award ran from February 19 to November 8, 2007, for a total of 37.44 weeks.

## ***LEGAL PRECEDENT***

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulation,[3] 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 a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides*,[4] has been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5] Chapter 16 provides the framework for assessing upper extremity impairments.[6]

## ***ANALYSIS***

The Board finds that this case is not in posture for decision. The accepted conditions in this case are bilateral wrist, shoulder and cervical strains and mood disorder. The Board initially notes that Dr. Cregan's determination that appellant had 45 percent right upper extremity impairment is of diminished probative value as his rating was not based in accordance with the A.M.A., *Guides*.[7] Similarly, Dr. Hill and Dr. Elkins provided impairment ratings but did not refer to any figures or tables of the A.M.A., *Guides.* These ratings are of diminished probative value.[8]

The record also does not clearly establish a date of maximum medical improvement. The question of when maximum medical improvement has been reached is a factual one which

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

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

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

[6] A.M.A., *Guides*, *supra* note 4 at 433-521.

[7] *See Richard Niedert*, 57 ECAB 474 (2006).

[8] *Id*.

depends upon the medical findings in the record. The determination of such date is to be made in each case upon the basis of the medical evidence in that case.[9] In this case, Dr. Cregan advised that maximum medical improvement was reached on March 21, 2002, which was only three months after appellant underwent a right ulnar nerve transposition and carpal tunnel release. Section 16.8a of the fifth edition of the A.M.A., *Guides* 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.[10] Dr. Bush, who provided a second opinion evaluation for the Office in August 2002, advised that maximum medical improvement was reached on August 16, 2002. The Office medical adviser stated that maximum medical improvement was reached on February 19, 2007, the date of Dr. Cregan's most recent report. It is, however, unclear if Dr. Cregan examined appellant at that time or if he had examined her since March 2002.

The Board notes that the medical evidence does not substantiate that appellant is entitled to a schedule award under Table 16-25 of the A.M.A., *Guides*.[11] The Office medical adviser apparently relied on Dr. Cregan's finding of carpal instability to rate 12 percent right upper extremity impairment under Table 16-25. In discussing carpal instability, Section 16.7a of the A.M.A., *Guides* provides, however, that this table is to be used with measurements found in x-ray studies, as described in the table.[12] While Dr. Cregan advised beginning on February 12, 2001 that, x-ray demonstrated widening of the scapholunate interval, he did not provide any measurements, as required by Table 16-25. Furthermore, appellant underwent additional right carpal tunnel surgery on December 14, 2001. In October 2002, Dr. Bush noted that x-rays were not available for evaluation and neither Dr. Hill nor Dr. Elkins indicated that they reviewed wrist x-rays. The medical evidence of record therefore does not support the schedule award of 12 percent impairment under Table 16-25.

The Office found that a conflict in medical evidence arose regarding the cause of appellant's carpal tunnel syndrome, ulnar nerve transposition and scapholunate tear. Proceedings under the Act are not adversarial 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 to see that justice is done.[13] For these reasons, the case will be remanded to the Office. On remand, the Office should further develop the medical record to resolve the conflict regarding causal relationship and obtain an opinion

[9] *L.H.*, 58 ECAB ____ (Docket No. 06-1691, issued June 18, 2007).

[10] A.M.A., *Guides*, *supra* note 4 at 508; *Silvester DeLuca*, 53 ECAB 500 (2002).

[11] A.M.A., *Guides*, *id*. at 503.

[12] *Id*. at 502.

[13] *Phillip L. Barnes*, 55 ECAB 426 (2004).

regarding the date of maximum medical improvement and the degree of impairment in accordance with the A.M.A., *Guides*.[14]

## ***CONCLUSION***

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

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated November 28, 2007 be vacated and the case remanded to the Office for proceedings consistent with this opinion of the Board.

Issued: November 13, 2008
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[14] The Board notes that it is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related impairment, preexisting impairments are to be included. *Carl J. Cleary*, 57 ECAB 563 (2006). However, where a permanent impairment caused by the accepted occupational exposure has not been demonstrated, a claim is not ripe for consideration of any preexisting impairment. *Thomas P. Lavin*, 57 ECAB 353 (2006). Furthermore, although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under the Act for injury to the spine. In 1960, however, amendments to the Act modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Thus, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originates in the spine. *Tommy R. Martin*, 56 ECAB 273 (2005).