United States Department of Labor
Employees' Compensation Appeals Board

R.C., Appellant	)	
	)	**Docket No. 08-1763**
and	)	**Issued: April 7, 2009**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Columbia, MO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 6, 2008 appellant filed a timely appeal from the November 20, 2007 and March 19, 2008 merit decisions of the Office of Workers' Compensation Programs which granted a schedule award for a five percent impairment of her right upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2), the Board has jurisdiction to review the merits of this case.

ISSUE

The issue is whether appellant has more than a five percent impairment of her right upper extremity.

FACTUAL HISTORY

The Office accepted that appellant sustained bilateral carpal tunnel syndrome and tenosynovitis of the middle and ring fingers of the right hand due to repetitive work as a postal clerk. On February 18, 2005 appellant underwent a right carpal tunnel release and release of right ring finger. On March 11, 2005 she underwent a left carpal tunnel release and left ring

finger. On June 30, 2005 appellant was released to return to regular duty. On March 14, 2006 she filed a claim for a schedule award.

On May 3, 2006 the Office referred appellant to Dr. Robert Conway, a Board-certified physiatrist, for a second opinion evaluation. In a report dated May 18, 2006, Dr. Conway advised that appellant did not have any ratable permanent impairment of either upper extremity.[1] On June 2, 2006 an Office medical adviser agreed with Dr. Conway that appellant had no ratable impairment of her right or left upper extremities.

By decision dated June 16, 2006, the Office denied appellant's claim for a schedule award, finding that the medical evidence did not support any permanent impairment.

On July 9, 2006 appellant requested an oral hearing which was held on March 27, 2007. In a July 20, 2006 report, Dr. Joseph D. Morris, an osteopath specializing in neurology, noted that appellant had a positive Tinel's sign in both wrists. He also found a positive Phalen's sign bilaterally at about 35 seconds. Dr. Morris obtained an electromyogram (EMG) and nerve conduction studies which showed evidence of mild carpal tunnel syndrome (CTS) on the right but were otherwise reported as normal. He noted that appellant complained of episodic numbness, tingling, pain and paresthesias of the both hand, to a lesser degree on the left side. Dr. Morris stated that the normal values implied there was not enough axonal neuronal drop-out to show delay and diagnosed status post bilateral carpal tunnel release with a history of hypothyroidism and hypertension.

In a report dated April 12, 2007, Dr. James Eckenrode, a Board-certified orthopedic surgeon specializing in surgery of the hand, advised that he treated appellant since 2003. He noted that appellant still complained of numbness and diffuse weakness with loss of coordination in her hands and wrists. Dr. Eckenrode found that, pursuant to the A.M.A., *Guides* (5th ed. 2001), appellant had five percent impairment to each upper extremity.[2] He advised that an additional five percent impairment could be added to each upper extremity due to the significant weakness manifested by her markedly abnormal grip strength bilaterally.

By decision dated June 8, 2007, an Office hearing representative affirmed the June 16, 2006 decision.

On September 26, 2007 appellant requested reconsideration. In a September 18, 2007 report, Dr. Eckenrode noted that his rating of five percent impairment to each upper extremity was based on page 495 of the A.M.A., *Guides*. He indicated that an optimal recovery time had followed surgical decompression and appellant had complaints of pain with normal sensibility

[1] Dr. Conway noted that using the American Medical Associations, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) 467, Figure 16-28, there was a zero percent impairment due to loss of extension or flexion of either wrist. He noted that pursuant to A.M.A., *Guides* 469, Figure 16-31, there was a zero percent impairment of the upper extremity due to any limitation of radial or ulnar deviation of either wrist. Dr. Conway noted no impairment due to motor loss and no evidence of atrophy. He also noted that appellant's sensory examination, although it did appear relatively reproducible, demonstrated deficits in the ulnar distribution greater than the median distribution. Dr. Conway concluded that appellant had no ratable impairment due to loss of sensation.

[2] A.M.A., *Guides* 495.

and opposition strength and some motor latency on EMG testing. Therefore, a residual carpal tunnel syndrome was still present and five percent impairment to each upper extremity was allowed. Dr. Eckenrode noted that he measured grip strength using the standard protocol for grip strength measurements as mentioned in the A.M.A., *Guides.* He had reported the average of multiple grip strength tests done in the middle position of the Jamar dynamometer.

On November 2, 2007 a second Office medical adviser reviewed the record and impairment estimate of Dr. Eckenrode. He noted that the electrodiagnostic studies obtained by Dr. Morris supported a mild residual carpal tunnel syndrome on the right, for which the A.M.A., *Guides* allowed a five percent impairment rating. However, as the diagnostic studies were reported as normal for the left side, this did not support residual impairment. Therefore, the Office medical adviser concluded that the medical evidence supported five percent impairment of appellant's right upper extremity.

By decision dated November 20, 2007, the Office granted a schedule award for five percent impairment to the right upper extremity.

On February 4, 2008 appellant requested reconsideration. In a January 16, 2008 report Dr. Roger W. Cameron, an osteopath, listed his impression as recurrent right carpal tunnel syndrome, probable recurrent left carpal tunnel syndrome, bilateral residual ring trigger ringers, bilateral thoracic outlet syndrome and hypothyroidism. He advised that appellant had five percent impairment to wrist due to residual carpal tunnel syndrome, more on the right than the left, as evidenced by sensory abnormality to light touch, positive Tinel's over the carpal tunnel and mild slowing of the right and left median motor nerves evidenced on the prior diagnostic studies. Dr. Cameron also stated that appellant had components of thoracic outlet syndrome that affected the C8 and T1 nerve roots which combined to form the ulnar nerve. He rated nine percent impairment due to the thoracic outlet syndrome and ulnar nerve findings.[3] Combining these percentages, Dr. Cameron concluded that appellant had 14 percent impairment to each arm.

On March 1, 2008 the Office medical adviser stated that Dr. Cameron had rated upper extremity impairments caused by conditions which had not been accepted by the Office as employment related. He indicated that thoracic outlet syndrome affecting the C8 and T1 nerves was a new diagnosis and that it had not accepted any condition above the level of the wrist for either upper extremity. Therefore, it was inappropriate for Dr. Cameron to provide an impairment rating utilizing Table 16-14, based on deficits of the brachial plexus.

[3] Dr. Cameron noted that the thoracic outlet syndrome affected cervical roots C8 and T1 which combined to form the ulnar nerve. For the sensory component, he concluded that appellant was a Grade 4 and assigned a 10 percent sensory deficit with a range of 1 to 25 percent. A.M.A., *Guides* 482, Table 16-10. Dr. Cameron noted that maximum sensory deficit for the ulnar nerve, lower trunk, was listed as 20 percent. A.M.A., *Guides* 490, Table 16-14. Dr. Cameron then multiplied 10 percent by the maximum sensory deficit of 20 percent to arrive at 2 percent impairment for the sensory side. In grading the motor side of the nerve, he believed appellant was Grade 4 and assigned a 10 percent motor deficit from a range of 1 to 26. A.M.A., *Guides* 484, Table 16-11. Dr. Cameron noted the maximum upper extremity impairment due to motor deficit from the lower trunk C8-T1 as 70 percent. A.M.A., *Guides* 490, Table 16-14. Dr. Cameron then multiplied 10 percent times 70 percent and gave appellant a 7 percent rating for the motor component to the ulnar nerve. Combining the sensory and motor rating, he concluded that appellant had nine percent impairment due to thoracic outlet and ulnar nerve findings.

By decision dated March 19, 2008, the Office denied modification of the previous decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing regulations[5] set 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 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* have been adopted by the implementing regulations as the appropriate standards for evaluating schedule losses.[6]

In rating impairment due to carpal tunnel syndrome, the A.M.A., *Guides*, note three possible scenarios can be present following surgical decompression:

> (1) Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTS 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 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.

ANALYSIS

Appellant's claim was accepted by the Office for carpal tunnel syndrome of both upper extremities. She underwent a right carpal tunnel release on February 18, 2005 and a left carpal tunnel release on March 11, 2005. Appellant subsequently claimed a schedule award due to residuals of her accepted condition.

Following surgery, appellant underwent a neurological evaluation by Dr. Morris, who obtained an EMG and nerve conduction studies on July 10, 2006. Dr. Morris advised that, testing showed evidence suggesting a mild residual carpal tunnel on the right, otherwise, the evaluation was described as normal. He stated that the normal values implied that there was not enough axonal drop-out to show delay. Based on this report, the Office medical adviser found

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999).

[6] *See Id; Jacqueline S. Harris*, 54 ECAB 139 (2002).

that appellant had five percent impairment of the right upper extremity under the rating criteria applicable to carpal tunnel syndrome at page 495 of the A.M.A., *Guides*, under scenario 2. As appellant did not have any abnormal electrodiagnostic testing related to her left upper extremity, the Office medical adviser found that she did not have evidence of impairment to her left upper extremity. The Board finds that the report of the Office medical adviser properly applied the criteria of the A.M.A., *Guides*, in rating appellant's impairment based upon her accepted bilateral carpal tunnel syndrome.

On appeal, appellant contends that she has greater impairment than that found by the Office. The Board notes, however, that the remainder of the medical evidence of record does not provide an impairment rating conforming to the A.M.A., *Guides*. Dr. Eckenrode provided an impairment rating of five percent to each upper extremity, indicating that he was applying the criteria at page 495. However, he did not adequately explain how he rated impairment to appellant's left upper extremity at five percent in the absence of abnormal electrodiagnostic testing, as required under scenario 2. The Board notes that Dr. Eckenrode did not obtain any new diagnostic studies but relied on those obtained by Dr. Morris on July 10, 2006. Although he stated that testing revealed "bilateral abnormal findings," his opinion is not well explained given that Dr. Morris had described testing of the left upper extremity as normal. Dr. Eckenrode also rated five percent impairment based on loss of grip strength to each upper extremity. However, this rating also fails to conform to the A.M.A., *Guides*, which provide at page 494: "In compression neuropathies, additional impairment values are not given for decreased grip strength." As the impairment rating provided by Dr. Eckenrode did not properly apply the A.M.A., *Guides*, his opinion is of reduced probative value.

Similarly, the report of Dr. Cameron is also of diminished probative value. He also relied upon the July 20, 2006 diagnostic studies of Dr. Morris in making a five percent impairment estimate for both upper extremities under the criteria at page 495. Moreover, Dr. Cameron diagnosed thoracic outlet syndrome resulting in some upper extremity numbness and tingling and contributing to weakness on grip studies. As noted, however, the Office has not accepted any condition above the level of the wrists as related to appellant's federal employment. Dr. Cameron did not provide sufficient medical rationale to attribute the diagnosed thoracic outlet syndrome as a consequence of her accepted bilateral carpal tunnel syndrome. As noted, the criteria for rating impairment due to carpal tunnel syndrome preclude the consideration of loss due to grip strength.

CONCLUSION

The Board finds that appellant has no more than five percent impairment of her right upper extremity due to her accepted carpal tunnel condition.

ORDER

IT IS HEREBY ORDERED THAT the March 19, 2008 and November 20, 2007 decisions of the Office of Workers' Compensation Programs be affirmed.

Issued: April 7, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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