



performance of duty. On November 30, 1999 the Office accepted this claim<sup>1</sup> for right carpal tunnel syndrome and bilateral tendinitis of the hands.

In December 1999 appellant filed a series of claims alleging traumatic injuries from October 21 to November 18, 1999, injuries to her hands, wrists, elbows and both sides of her neck. On January 18, 2000 the Office accepted the occupational disease claim<sup>2</sup> for right carpal tunnel syndrome and ulnar neuropathy, left elbow.

The Office consolidated the case records under the earlier claim. On November 9, 2000 it issued a schedule award for 10 percent impairment of the right upper extremity due to the accepted right carpal tunnel syndrome and 10 percent impairment of the left upper extremity due to the accepted ulnar neuropathy, left elbow.

On August 11, 2008 appellant filed a claim for an increased schedule award. She noted that her injuries had advanced. On October 14, 2008 Dr. Richard A. Stappenbeck, a Board-certified neurologist, reported 50 percent impairment of each upper extremity due to motor deficits and 50 percent impairment of each upper extremity due to sensory deficits. He examined appellant that day and found muscle strength and muscle tone slightly reduced and not equal bilaterally. Grip strength was not equal bilaterally and she was not able to lift her left arm above her head. The sensory examination was normal. Dr. Stappenbeck diagnosed carpal tunnel syndrome in both wrists and tendinitis in the left arm.

In a decision dated October 21, 2008, the Office denied appellant's claim for an increased schedule award. It indicated that Dr. Stappenbeck's report of unequal bilateral findings seemed at odds with his assessment of an equal bilateral impairment. Further, the Office noted that he did not explain how he applied the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5<sup>th</sup> ed. 2001).<sup>3</sup>

### **LEGAL PRECEDENT**

Section 8107 of the Federal Employees' Compensation Act<sup>4</sup> authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.<sup>5</sup>

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<sup>1</sup> OWCP No. xxxxxx207.

<sup>2</sup> OWCP No. xxxxxx452.

<sup>3</sup> When asked the date of maximum medical improvement, Dr. Stappenbeck wrote "no improvement." The Office took this to mean no change in the date of maximum medical improvement and proceeded to deny any merit review of matter on the grounds there was no clear evidence of error in the November 9, 2000 schedule award.

<sup>4</sup> 5 U.S.C. § 8107.

<sup>5</sup> 20 C.F.R. § 10.404 (1999).

## ANALYSIS

Appellant states that she is confused about the references to the different parts of her limbs. She does not understand why the Office's decision denies her additional problems, including tendinitis in her right rotator cuff.

Appellant may receive a schedule award for permanent impairment to her upper extremities caused by the medical conditions the Office expressly accepted: right carpal tunnel syndrome, bilateral tendinitis of the hands and ulnar neuropathy, left elbow. She may not receive a schedule award for left carpal tunnel syndrome, right rotator cuff tendinitis or any other medical condition the Office has not accepted to be related to her federal employment, unless impairment from such conditions preexisted her employment injuries in late 1999.<sup>6</sup>

To establish her entitlement to an increased schedule award, appellant must submit a proper impairment evaluation demonstrating that she has more than 10 percent impairment of her right upper extremity due to right carpal tunnel syndrome or more than 10 percent impairment of her left upper extremity due to ulnar neuropathy, left elbow.

The physician evaluating appellant's impairment must follow the fifth edition of the A.M.A., *Guides*. According to Chapter 16.7d, page 507, titled "Tendinitis," several syndromes involving the upper extremity are variously attributed to tendinitis, fasciitis, or epicondylitis. Although these conditions may be persistent for some time, they are not given a permanent impairment rating unless there is some other factor that must be considered, such as a tendon rupture or surgical release or excision of the epicondyle, which may cause a permanent weakness of grip. For this reason, it would not appear that appellant would be entitled to any increased schedule award based on the accepted bilateral tendinitis of her hands.

Every evaluation of impairment due to carpal tunnel syndrome starts with the three scenarios listed on page 495 of the A.M.A., *Guides*. Each of these scenarios requires a comparison of clinical findings with electromyography and nerve conduction studies.<sup>7</sup> Based on this comparison, the evaluating physician will select the appropriate scenario and evaluate impairment accordingly.

Appellant's right carpal tunnel syndrome and ulnar neuropathy, left elbow, are entrapment or compression neuropathies. The A.M.A., *Guides* provides that the diagnosis of

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<sup>6</sup> It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included. *Raymond E. Gwynn*, 35 ECAB 247, 253 (1983).

<sup>7</sup> If, after optimal recovery time following surgical decompression for carpal tunnel syndrome, an individual continues to complain of pain, paresthesias 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 carpal tunnel syndrome is rated according to the sensory and motor deficits as described in Chapter 16.5b. 2. Normal sensibility and opposition strength with abnormal sensory or motor latencies or abnormal electromyogram testing of the thenar muscles. A residual carpal tunnel syndrome is still present, and an impairment rating not to exceed five 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. A.M.A., *Guides* 495.

such conditions is made not only on believable symptoms but, more important, on the presence of positive clinical findings and loss of function. Further, the diagnosis should be documented by electromyography as well as sensory and motor nerve conduction studies.<sup>8</sup> The sensory deficits or pain, and/or the motor deficits and loss of power, are evaluated according to the impairment determination method described in section 16.5b. Table 16-10, page 482, provides a grading scheme and procedure for determining impairment of the upper extremity due to sensory deficits or pain resulting from peripheral nerve disorders. Table 16-11, page 484, provides a similar grading scheme and procedure for determining impairment due to motor and loss-of-power deficits resulting from peripheral nerve disorders based on individual muscle rating.

In compression neuropathies, additional impairment values are not given for decreased grip strength and in the absence of complex regional pain syndromes, additional impairment values are not given for decreased motion.<sup>9</sup>

Appellant bears the burden to submit an impairment evaluation that comports with these provisions of the A.M.A., *Guides*. The only evaluation she submitted was the October 14, 2008 evaluation by Dr. Stappenbeck, her neurologist, who simply reported 50 percent impairment of each upper extremity due to motor deficits and 50 percent impairment of each upper extremity due to sensory deficits.<sup>10</sup> Dr. Stappenbeck made no reference to any table in the A.M.A., *Guides* and otherwise gave no indication how he came about those percentages. For this reason, the Board finds that his October 14, 2008 impairment ratings have little if any value in establishing appellant's claim for an increased schedule award.

Because Dr. Stappenbeck's October 14, 2008 impairment evaluation does not show that appellant has a greater permanent impairment of her upper extremities due to her accepted conditions, the Board will affirm the Office's October 21, 2008 decision denying an increased schedule award.<sup>11</sup>

### CONCLUSION

The Board finds that appellant has not met her burden to establish that she has more than 10 percent permanent impairment of either upper extremity causally related to her accepted employment injuries.

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<sup>8</sup> *Id.* at 493.

<sup>9</sup> *Id.* at 494.

<sup>10</sup> Those figures combine for 75 percent total impairment of each upper extremity. *Id.* at 604 (Combined Values Chart).

<sup>11</sup> The Board does not believe that Dr. Stappenbeck's "no improvement" comment raises any issue of maximum medical improvement. As it does not appear that appellant was contesting the date of maximum medical improvement in her November 9, 2000 schedule award, it was unnecessary for the Office to deny a merit review of the matter in its October 21, 2008 decision.

**ORDER**

**IT IS HEREBY ORDERED THAT** the October 21, 2008 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 18, 2009  
Washington, DC

David S. Gerson, Judge  
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge  
Employees' Compensation Appeals Board

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