

FACTUAL HISTORY

This case has been before this Board before. The relevant facts are briefly set forth. On June 4, 1993 appellant, then a 33-year-old senior claims examiner, filed an occupational disease claim alleging that she suffered left and right carpal tunnel syndrome and tendinitis as a result of repetitive typing, keying and grasping movements required by her federal employment. Right carpal tunnel release was performed on May 7, 1993. The Office accepted her claim for bilateral carpal tunnel syndrome. On November 29, 1994 it issued a schedule award for 10 percent impairment of appellant's right upper extremity. In a letter dated November 9, 2006, appellant requested an increase in her schedule award. In a decision dated June 26, 2007, the Office, based on the opinion of an Office medical adviser, found that there was no basis to increase the impairment to her right upper extremity and further found that she was not entitled to a schedule award for her left upper extremity. In a January 29, 2008 decision, the Board found a conflict in medical opinion between Dr. Pedro A. Murati, an attending physiatrist, and an Office medical adviser as to the extent of impairment to appellant's right upper extremity and returned the case to the Office to resolve the conflict.¹ On May 30, 2008 based on the opinion of Dr. Robert T. Tenny, a Board-certified neurosurgeon appointed by the Office to serve as the impartial medical specialist, the Office denied appellant's request for an additional schedule award for the right upper extremity. On June 12, 2008 the Office issued a schedule award based upon five percent impairment of the left upper extremity. Appellant appealed and on August 5, 2009 the Board issued an Order Remanding Case. In this order, the Board found that the Office did not comply with its procedures in selecting Dr. Tenny as the impartial medical specialist. The Board further found that there was an unresolved conflict between appellant's attending physician, Dr. Murati, and the second opinion physician with regard to her impairment to her left upper extremity. Accordingly, the Board remanded the case for referral to a properly selected impartial medical examiner to resolve the conflict in the medical opinion evidence.²

On remand, the Office referred appellant to Dr. Joseph Huston, a Board-certified orthopedic surgeon, for an impartial medical examination. In a medical opinion dated October 6, 2009, Dr. Huston applied the sixth edition of the A.M.A., *Guides* and determined that she had four percent rating of each upper extremity secondary to carpal tunnel syndrome. In reaching this conclusion, he stated that he applied the A.M.A., *Guides* page 449, Table 15-23 and, using a Grade Modifier 2 and a mild functional scale, appellant had 4 percent impairment rating of the right upper extremity secondary to right carpal tunnel problem, which he noted was less than the 10 percent she had previously been awarded. With regard to the left upper extremity, Dr. Huston noted that electromyograph and nerve conduction study reported mild evidence of carpal tunnel syndrome. He then used a Grade Modifier 2 with a mild functional scale and concluded that appellant had an impairment of four percent of the left upper extremity due to carpal tunnel syndrome.

On November 4, 2009 the Office referred the case to the Office medical adviser for his opinion with regard to permanent impairment. In a reply dated November 14, 2009, the medical adviser concurred with the rating given by Dr. Huston, who noted that appellant complained of an intermittent numbness and tingling in the right arm after the carpal tunnel release with

¹ Docket No. 07-2097 (issued January 29, 2008).

² Docket No. 08-2134 (issued August 5, 2009).

symptoms aggravated by successive use of the hand, which was thought to be in all five digits. The Office medical adviser noted that, on the left side, there was some numbness and tingling in what was thought to be all five digits and pain on a daily basis. He indicated that appellant stated that the left sided symptoms were mainly at night and woke her up at night. The Office medical adviser also noted some locking of the right long finger at night as well as over two weeks prior to the evaluation. With regard to objective tests, he noted that neurodiagnostic studies on April 26, 2006 to May 18, 2007 showed mild left carpal tunnel syndrome. The Office medical adviser noted Dr. Huston's physical examination showed positive Tinel's sign over the median nerve bilaterally and range of motion, sensation to pinprick and strength of the hand were all described as fairly normal. The medical adviser concluded that, based on Dr. Huston's report and Table 15-23 of the A.M.A., *Guides*, he concurred with Dr. Huston's assessment of four percent impairment for each upper extremity.

By decision dated December 29, 2009, the Office denied appellant's claim for an increased schedule award for impairment to her left and right upper extremities.

LEGAL PRECEDENT

The schedule award provisions of the Federal Employees' Compensation Act³ provide compensation to employees sustaining impairment from loss or loss of use of specified member of the body. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption.⁴ Effective May 1, 2009 the Office began using the sixth edition of the A.M.A., *Guides* to calculate schedule awards.⁵

For evaluating impairment related to dysfunction of the median nerves, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) contains Appendix 15-B (Electrodiagnostic Evaluation of Entrapment Syndromes). It provides that the criteria for carpal tunnel syndrome include distal motor latency longer than 4.5 milliseconds for an 8-centimeter (cm) study; distal peak sensory latency longer than 4.0 cm for a 14-cm distance; and distal peak compound nerve latency of longer than 2.4 milliseconds for a transcarpal or midpalmar study of 8 cm. If different distances were used in testing, correction to the above-stated distances could be accomplished by assuming each 1 cm of distance required 0.2 milliseconds.⁶

³ 5 U.S.C. §§ 8101-8193.

⁴ *Bernard A. Babcock, Jr.*, 542 ECAB 143 (2000).

⁵ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims* Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

⁶ A.M.A., *Guides*, 487, Appendix 15-B.

If carpal tunnel syndrome is found under the standards of Appendix 15-B, impairment is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.⁷ In Table 15-23, grade modifiers are described for test findings, history and physical findings. A survey completed by a given claimant, known by the name *QuickDASH*, is used to further modify the grade and to choose the appropriate numerical impairment rating.⁸ If carpal tunnel syndrome is not found under the standards of Appendix 15-B, impairment due to median nerve dysfunction is evaluated under the scheme found in Table 15-21 (Peripheral Nerve Impairment: Upper Extremity Impairments).⁹ Under Table 15-21, observed conditions are placed into classes (ranging from Class 0 to Class 4) based on diagnosis and the severity of the condition. After the class is identified, the precise degree of the impairment can be modified by various factors, including functional history, physical examination and clinical studies.¹⁰

Proceedings under the Act are not adversary 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. The Office has the obligation to see that justice is done.¹¹

ANALYSIS

The Office accepted appellant's claim for carpal tunnel syndrome and granted her schedule awards for 10 percent impairment of the right upper extremity and 5 percent impairment of the left upper extremity. Appellant contends that she is entitled to a greater award. The impartial medical examiner, Dr. Huston, found that, under the sixth edition of the A.M.A., *Guides*, she was entitled to four percent impairment to each upper extremity and the Office medical adviser agreed with Dr. Huston's conclusion. Accordingly, the Office denied appellant's claim for a greater schedule award.

The Board finds that the impairment rating made by Dr. Huston and reviewed with approval by the Office medical adviser is incomplete and requires further clarification. As noted, with respect to evaluating impairment related to dysfunction of the median nerves, Appendix 15-B (Electrodiagnostic Evaluation of Entrapment Syndromes) contain criteria for evaluating whether carpal tunnel syndrome is present. If carpal tunnel syndrome is found under the standards of Appendix 15-B, impairment is evaluated under the schedule found in Table 15-23. If carpal tunnel syndrome is not found under the standards of Appendix 15-B, impairment due to median nerve dysfunction is evaluated under the scheme found in Table 15-21. There is no indication that either Dr. Huston or the Office medical adviser made reference to Appendix 15-B or sufficiently explained why they applied Table 15-23 in making their evaluation. Furthermore, Dr. Huston and the Office Medical Officer stated that under Table 15-23, using a Grade Modifier

⁷ See *id.*, at 449, Table 15-23.

⁸ *Id.* at 448.

⁹ *Id.* at 437-40, Table 15-21 (portion relating to median nerves).

¹⁰ *Id.* at 406-09.

¹¹ *Russell F. Polhemus*, 32 ECAB 1066 (1981).

2 with a mild function scale, appellant had four percent impairment. However, neither physician provided any evaluation of the grade modifiers that applied to appellant's case. As noted, grade modifiers should be considered for functional history, physical examination and clinical studies and these grade modifiers can change the extent of a given impairment rating.¹²

For these reasons, the impairment rating of Dr. Huston needs clarification.¹³ Dr. Huston should further address the medical evidence consistent with the sixth edition of the A.M.A., *Guides*. After such development as it deems necessary, the Office shall issue an appropriate decision on her claim for a schedule award.

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 December 29, 2009 is set aside. The case is remanded to the Office for proceedings consistent with this decision of the Board.

Issued: December 14, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

¹² *Id.* at 448-450.

¹³ *See R.D.*, Docket No. 10-152 (issued July 20, 2010).