

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

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In the Matter of MICHAEL D. NIELSEN and U.S. POSTAL SERVICE,  
POST OFFICE, Bakersfield, Calif.

*Docket No. 96-1613; Submitted on the Record;  
Issued April 7, 1998*

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DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,  
WILLIE T.C. THOMAS

The issue is whether appellant has established more than a 10 percent impairment of his right wrist, for which he received a schedule award.

On March 17, 1994 appellant, then a 44-year-old air conditioning equipment mechanic, filed a claim for wrist pain he noticed on that date. Nerve conduction studies performed on May 2, 1994 revealed a carpal tunnel syndrome of the right wrist. The Office of Workers' Compensation Programs accepted appellant's claim for carpal tunnel syndrome and authorized a carpal tunnel release. Appellant stopped work on June 14, 1994 for the carpal tunnel release performed on that date by Dr. Gerard J. Voelkers, a Board-certified neurosurgeon. Upon his return to work on August 8, 1994, he underwent physical therapy for one month.

Appellant continued to have right wrist symptoms and in the spring 1995 he requested a schedule award. He submitted a report by Dr. Voelkers who noted appellant's complaints of pain in the distal and mid-forearm and pain when flexing any digit of the right hand against resistance, together with diminished grip strength and hypalgesia on the palmar surface. Repeat nerve conduction studies performed on April 27, 1995 showed a persistent mild conduction block at the wrist, with a notation that the distal motor latency had returned to normal but the distal sensory latency remained unchanged from the testing performed before the surgery. Dr. Voelkers referred appellant to Dr. Martin Berry, a Board-certified rheumatologist, who ordered a magnetic resonance imaging (MRI) scan of the wrist and reported the lack of arthritis of the wrist. Because of appellant's primary complaint of pain and wrist stiffness, as opposed to parasthesia. Dr. Voelkers provided appellant with a wrist splint. In response to an Office request for specific findings on pain or sensory deficit, loss of range of motion and muscle weakness or atrophy, Dr. Voelkers indicated that he was not in a position to provide the measurements, at least with respect to grip strength.

The Office referred appellant to Dr. Marshall Lewis, a Board-certified orthopedic surgeon, for a permanent impairment evaluation. By report dated September 12, 1995,

Dr. Lewis diagnosed right carpal tunnel syndrome and flexor tenosynovitis of the right wrist. Dr. Lewis rated appellant's pain at a minimal to mild level and noted that with activities such as grasping or continuous range of motion during the day, the pain level increased to a moderate level. The pain subsided and returned to the mild level upon resting for 5 or 10 minutes, with the same effect produced at times when appellant shook his hand. Based on dynamometry readings which he felt were a little inflated, he adjusted the estimated loss of strength to 25 percent loss of the right hand. With respect to range of motion measurements, he reported 75 degrees on volarflexion, 65 degrees on dorsiflexion, 15 degrees on radial deviation and 30 degrees on ulnar deviation.

On November 9, 1995 an Office medical adviser, Board-certified in family practice, reviewed the medical evidence and indicated that pursuant to correlated mild median nerve entrapment of the wrist to a 10 percent impairment under Table 16 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.<sup>1</sup>

By letter dated November 12, 1995, appellant objected to the manner in which Dr. Lewis performed the evaluation and objected to the assessment of degree of pain and grip strength measurements. The Office requested pay rate information from appellant through the submission of the claim for compensation on account of traumatic injury or occupational disease (Form CA-7) which the Office verified. By decision dated February 23, 1996, the Office awarded appellant a schedule award for 10 percent impairment of the right upper extremity.

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

The schedule award provision of the Federal Employees' Compensation Act<sup>2</sup> and its implementing regulation<sup>3</sup> set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss of use of specified members or functions of the body. However, the Act does not specify the manner in which the percentage of 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

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<sup>1</sup> A.M.A., *Guides* (4<sup>th</sup> ed. 1993).

<sup>2</sup> 5 U.S.C. § 8107.

<sup>3</sup> 20 C.F.R. § 10.304.

uniform standards applicable to all claimants. The Office has adopted the A.M.A., *Guides* and the Board has concurred in such adoption as an appropriate standard for evaluating schedule losses.<sup>4</sup>

Impairment due to carpal tunnel syndrome may be evaluated by two separate methods under the A.M.A., *Guides* including the method used by the Office medical adviser to correlate impairment under Table 16, “Upper Extremity Impairment Due to Entrapment Neuropathy.”<sup>5</sup> The Office procedures addressing use of Table 16 note that “[i]n ambiguous cases the choice between mild and moderate impairment may depend on EMG [electromyogram] results and/or an assessment of daily living, which in turn depends on the availability of clinical information.”<sup>6</sup> Under Table 16, a mild entrapment of the median nerve at the wrist correlates to a 10 percent impairment of the right arm.<sup>7</sup> While the assessment of mild nerve entrapment correlates to the findings on the April 27, 1995 nerve conduction studies, the Board notes that the Office medical adviser did not address the specific findings, provided by Dr. Lewis, to support the use of Table 16 over the other alternate method of grading the nerve root impairment by identifying the nerve and evaluating the degree of pain and loss of strength.<sup>8</sup> Office procedures provide that “[w]here more than one method of calculation may be used, the D[istrict] M[edical] A[dviser] should use the same one as the examining physician” assuming that examining physician correctly correlated his or her findings with the A.M.A., *Guides*.<sup>9</sup> Because the Office medical adviser failed to provide an explanation for her use of Table 16, which differed from the examining Office referral physician’s method of evaluation, the Board finds that the case must be remanded to the Office for further clarification or recalculation if necessary.

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<sup>4</sup> See *Danniel C. Goings*, 37 ECAB 781 (1986). The Board notes that the guidelines were prepared to establish reference tables and evaluation protocols, which if followed, may allow the clinical findings of the physician to be “compared directly with the impairment criteria and related to impairment percentages.” A.M.A., *Guides* 3<sup>d</sup> ed. While the medical opinion of the treating physician may be accorded some weight, his or her clinical date can be readily extrapolated and evaluated within the tables and guidelines as presented. *Charles Dionne*, 38 ECAB 306 (1986).

<sup>5</sup> A.M.A., *Guides* 57, Table 16.

<sup>6</sup> FECA Bulletin 96-17 (September 20, 1996).

<sup>7</sup> A.M.A., *Guides* 57, Table 16.

<sup>8</sup> Under this alternate method, the maximum amount of impairment for the nerve root affected listed in Table 15, is multiplied by the degree of impairment on the grading scheme in Table 11 for pain and Table 12 for loss of strength. A.M.A., *Guides* 48, 49, 54, Tables 11, 12, 15. This amount is “combined” through the Combined Values Chart with any loss of range of motion, or other impairment such as atrophy. Impairment due to loss of range of motion of the wrist is derived by correlating the measurements provided on examination to Figures 26 and 29. A.M.A., *Guides* 36, 38, Figures 26 and 29. Using both Figures 26 and 29, while appellant’s measurement of the right wrist differed from that of the left wrist only in dorsiflexion, the measurement of 65 degrees correlates to a 0 percent of impairment. However the measurement of 15 degrees of radial deviation, which was the same as the left wrist, correlates to a 1 percent impairment of the right wrist.

<sup>9</sup> See FECA Bulletin No. 95-17 (March 23, 1995).

The decision of the Office of Workers' Compensation Programs dated February 23, 1996 is hereby set aside and remanded for further proceedings consistent with this decision of the Board.

Dated, Washington, D.C.  
April 7, 1998

Michael J. Walsh  
Chairman

David S. Gerson  
Member

Willie T.C. Thomas  
Alternate Member