U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of EDUARDO W. GONZALES and DEPARTMENT OF THE NAVY, MARE ISLAND NAVAL SHIPYARD, Vallejo, CA

Docket No. 00-665; Submitted on the Record;
Issued May 3, 2001

DECISION and ORDER

Before WILLIE T.C. THOMAS, MICHAEL E. GROOM, BRADLEY T. KNOTT

The issue is whether appellant has greater than a 46 percent permanent impairment of his right and left upper extremities, for which he has received schedule awards.

On October 30, 1993 appellant, then a 44-year-old engineering technician, sustained bilateral carpal tunnel syndrome, with a left carpal tunnel release in June 1994 and a right open carpal tunnel release in August 1994. The Office of Workers' Compensation Programs also accepted that appellant had a trigger finger on the left, for which he underwent a release in 1995 and consequential bilateral ulnar nerve syndrome at the wrists. Appellant underwent a second left carpal tunnel release, ulnar tunnel decompression and median nerve neurolysis on September 16, 1997.

On August 28, 1995 appellant requested a schedule award for bilateral upper extremity impairment.

On October 9, 1995 the record was reviewed by Dr. Arthur S. Harris, an Office medical consultant, to determine a schedule award entitlement. By report of that date, he reviewed the reports of record, noted that established diagnoses included bilateral chronic carpal tunnel syndromes, bilateral trigger thumbs (stenosing tenosynovitis), left greater than right and status post open left trigger thumb release, March 16, 1995, status post open right carpal tunnel release, August 22, 1994 and status post open left carpal tunnel release, June 13, 1994. Dr. Harris opined, according to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[1] that appellant had no impairment for loss of either digit or wrist motion and that, as a result of his residual right carpal tunnel symptoms, he had a 20 percent impairment of his right upper extremity, a 10 percent impairment of the right upper extremity for his 25 percent grip strength loss and an 8 percent impairment of the right upper extremity for residual mild trigger thumb symptoms. Dr. Harris reported that he utilized the Combined Values Chart, these

[1] A.M.A., *Guides*, (4th ed.) (1993).

impairments combined to result in a 34 percent total impairment of the right upper extremity. Dr. Harris also found that, as a result of his residual left carpal tunnel symptoms, appellant had a 20 percent impairment of his left upper extremity, a 10 percent impairment of the left upper extremity for his 25 percent grip strength loss and an 8 percent impairment of the left upper extremity for residual mild trigger thumb symptoms. He noted that utilizing the Combined Values Chart, these impairments combined to result in a 34 percent total impairment of the left upper extremity.

On December 15, 1995 the Office granted appellant a schedule award for a 34 percent permanent impairment of the left upper extremity and a 34 percent permanent impairment of the right upper extremity for the period June 6, 1995 to June 30, 1999 for a total award of 212.16 weeks of compensation.

By letter dated September 17, 1996 and again on September 27, 1996, appellant requested reconsideration claiming that his awards should be increased to the maximum amount allowed under the schedule award provisions. In support of his request, appellant submitted further medical reports from Dr. Noah D. Weiss, a Board-certified orthopedic surgeon, which identified the possibility of worsening median nerve damage, *i.e*. recurrent carpal tunnel syndrome. Further, electrodiagnostic testing conducted on August 30, 1996 revealed evidence of severe bilateral carpal tunnel syndrome, left worse than right. On September 16, 1996 after a review of the electrodiagnostic study results, Dr. Weiss diagnosed bilateral carpal tunnel syndrome and possible ulnar tunnel syndrome and he recommended further surgery.

On November 5, 1996 the Office referred appellant's case record to an Office medical adviser for determination of whether appellant was entitled to an increased schedule award.

By report dated November 13, 1996, Dr. Ellen Pichey, an Office medical adviser, reviewed the medical evidence and noted that current impairment due to entrapment neuropathy of the median nerve at the wrist was severe and was rated as 40 percent as per Table 16, page 57 of the A.M.A., *Guides*. Dr. Pichey further noted that present impairment due to entrapment neuropathy of the ulnar nerve at the wrist was mild and was rated as 10 percent as per Table 16, page 57 of the A.M.A., *Guides*. Using the Combined Values Chart, page 322, she opined that the total impairment of the left and the right extremities were 46 percent respectively. Dr. Pichey indicated that this represented an additional 12 percent impairment for each upper extremity, with the date of maximum medical improvement noted as September 16, 1996.

By report dated December 9, 1996, Dr. Weiss recommended further median nerve and ulnar nerve decompression surgery.

On December 24, 1996 and January 13, 1997, the Office granted appellant an increased schedule award for an additional 12 percent permanent impairment of each upper extremity for a total permanent impairment of each upper extremity of 46 percent.

By letter dated December 31, 1996, appellant requested an additional schedule award for his trigger thumb.

In support he submitted a February 12, 1997 report from Dr. Weiss regarding permanent impairment of his right thumb. He noted that appellant had undergone a right trigger thumb release in the late 1980s, that he did well until October 1994 when he noticed bilateral thumb catching problems and that he was diagnosed as having bilateral thumb stenosing flexor tenosynovitis (trigger thumb), left greater than right. Dr. Weiss noted that appellant had some significant, unresolved problems that were related to his carpal tunnel syndrome more than his trigger finger. He characterized appellant's thumb complaints as "slight" in intensity and "occasional" in frequency. Range of thumb motion measurements were provided and no obvious catching or triggering was noted. Dr. Weiss noted that two-point discrimination and grip strength were markedly reduced but he opined that this was a consequence of appellant's carpal tunnel syndrome. Dr. Weiss opined that this was not stationary but that further treatment was anticipated.

On March 13, 1997 the Office requested that the Office medical adviser opine as to whether the medical records supported any greater schedule award for permanent impairment of the right thumb. By reply dated March 17, 1997, Dr. Pichey opined: "The original award from Dr. Harris included eight percent upper extremity impairment based on the thumb. These records do not support [an] additional award. It also appears that repeat [computerized tomography surgery] is impending."

By letter dated March 19, 1997, the Office advised appellant that the additional medical reports did not support any additional award.

Appellant underwent a left open carpal tunnel release with left ulnar tunnel decompression on September 16, 1997 without complications.

By report dated November 19, 1997, Dr. Weiss noted that appellant complained of a lot of pain, diffuse numbness and tingling, the inability to close his hand or make a fist and the incapacity to flex his fingers. He noted, however, that appellant's wounds were healing nicely and that Dr. Weiss could easily get full passive flexion of every digit; he opined that he did not believe that appellant's complaints of stiffness was anatomic. Dr. Weiss noted that, upon testing, appellant's grip strength was about five pounds in both hands, but that upon questioning, he discovered that appellant was driving and doing many other activities of daily living without problems, such that Dr. Weiss considered appellant's grip strength testing measurements to be totally unreliable and not anywhere near a substantial effort. He opined that, no doubt appellant was having some pain, discomfort or other problems with his hands, but that the examination at that time was not in any way indicative of appellant's true function or symptoms. Dr. Weiss opined that there was nothing more he could do for appellant at that time and that he was really unable to assess any type of disability because of inconsistencies in the examination.

By letter dated December 22, 1997, appellant requested reconsideration of the December 24, 1996 determination alleging that based on Dr. Harris' report and the findings of 25 percent grip strength loss, he felt that the percentage assigned to the grip strength loss should be higher than a 10 percent impairment bilaterally.

By decision dated January 7, 1998, the Office denied modification of the December 24, 1996 decision, finding that the evidence submitted in support was insufficient to warrant

modification. The Office found that Dr. Weiss' report indicated that appellant was misrepresenting his true grip strength by not exerting substantial effort and that since it was dependent upon voluntary effort, it could be unreliable.

By undated letter, appellant requested reconsideration based upon a new report by Dr. Weiss. He claimed that after Dr. Weiss' surgery, his loss of grip strength had increased tremendously and he also requested examination by another physician.

In support, appellant submitted a March 19, 1998 report from Dr. Weiss, which noted that appellant had complaints of left hand pain, diffuse over the palm and difficulties making a fist, but that appellant's subjective complaints outweighed the objective findings. He noted that appellant reported subjective decreased sensation but manifested intact sensation to two point discrimination. Dr. Weiss noted no losses in range of motion of appellant's digits and that he tested at five pounds of grip strength bilaterally, but noted that he did not believe these were accurate testing results, as appellant was able to drive and to perform many other activities of daily living. Dr. Weiss opined that the grip strength measurements were unreliable, noted that there was no atrophy, but opined that appellant had lost approximately one-third to one-half of his anticipated grip strength. He found that appellant was permanent and stationary on November 19, 1997.

On April 20, 1998 the Office requested that an Office medical adviser review the recent medical report. On May 21, 1998 Dr. Pichey reviewed the report and opined that appellant's permanent impairment remained unchanged based on the new report. She noted that as Dr. Weiss opined that appellant had lost 33 to 50 percent of his grip strength, this equated with a 20 percent permanent impairment of the upper extremity as per Table 34, page 65 of the A.M.A., *Guides*. Dr. Pichey further calculated that appellant had a 27 percent impairment due to sensory deficit or pain, based upon Dr. Weiss' finding that appellant's subjective complaints of pain outweighed the objective findings and that there was intact two-point discrimination and according to the sensory deficit calculations contained in the A.M.A., *Guides*, (Table 11, page 48). Using the Combined Values Chart she calculated that appellant had a 42 percent permanent impairment of his left upper extremity.[2] Dr. Pichey noted that the right upper extremity impairment was unchanged.

By undated letter, appellant alleged that his 46 percent bilateral schedule award had been calculated prior to Dr. Weiss' most recent surgery and that following the surgery the impairment should be greater. Appellant requested examination by another physician.

By letter dated July 1, 1998, appellant requested reevaluation and argued that Dr. Pichey's report of May 21, 1998 demonstrated that his grip strength loss had increased from 25 percent to 33 to 50 percent and that it did not include impairment due to trigger thumb and he argued that total permanent impairment of the upper extremity bilaterally could, therefore, not remain unchanged.

[2] The Board notes that this impairment determination is less than the impairment for which appellant has already received a schedule award.

The Office referred appellant's letter to the Office medical adviser, who replied on July 23, 1998: "The impairment determination of 1996, which increased the entrapment neuropathy to 'severe' 40 percent and considered the ulnar entrapment at 10 percent bilaterally includes in using this table (Table 16, page 57 of the A.M.A., *Guides*), the consideration of grip strength loss -- it is not considered separately."

By decision dated August 5, 1998, the Office denied modification of the prior decisions, finding that the evidence submitted in support is insufficient to warrant modification. The Office indicated that appellant's arguments were not relevant as grip strength loss was not considered separately in the prior determinations of his bilateral permanent impairments.

By letter dated February 4, 1999, appellant requested a change in treating physicians as he felt he was getting worse.

By response dated February 17, 1999, the Office refused authorization to change treating physicians as appellant was under the care of a specialist and it appeared that his treatment had been appropriate. The Office advised, however, that appellant could make an appointment at his own cost with another physician and after a subsequent report was provided, his request could be considered.

By letter dated August 2, 1999, appellant requested reconsideration of the August 5, 1998 decision and in support he submitted a report from Dr. Kris Andrues, a chiropractor.

In a report dated July 17, 1999, Dr. Andrues reviewed appellant's history, conducted an upper extremity examination and grip strength testing and opined that appellant's condition was deteriorating. No spinal examination was conducted, no x-rays were obtained and no spinal subluxation as demonstrated by x-ray to exist was diagnosed.

By letter dated August 11, 1999, the Office responded to appellant's request to change physicians, noting that chiropractors were deemed to be physicians only to the extent that their reimbursable services were limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist. The Office defined what a subluxation was, noted that appellant's accepted conditions were limited to his upper extremities and advised that as chiropractors could only treat subluxations of the spine, authorization for change of physicians could not be granted.

By decision dated August 13, 1999, the Office denied modification of the August 5, 1998 decision, finding that the evidence submitted was insufficient to warrant modification. The Office advised that evidence from a chiropractor did not constitute probative medical evidence in support of appellant's claims regarding his upper extremity impairments.

The Board finds that appellant has no greater than a 46 percent permanent impairment of his right and left upper extremities, for which he has received schedule awards.

Under section 8107 of the Federal Employees' Compensation Act[3] and section 10.404 of the implementing federal regulation,[4] schedule awards are payable for the permanent impairment of specified bodily members, function, or organs. However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[5]

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*.[6] However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment. Chapter 3.1 of the A.M.A., *Guides* provides grading schemes and procedures for determining permanent impairment of the hand and upper extremity. In the instant case, the Office medical advisers properly utilized the A.M.A., *Guides* in determining appellant's total permanent impairment for his bilateral carpal tunnel syndrome, ulnar nerve syndrome and trigger thumbs and their sequelae.

In his October 9, 1995 report, Dr. Harris reviewed the preceding medical reports of record and determined that, according to the A.M.A., *Guides*, at that time appellant had 34 percent impairments of his right and left upper extremities. Appellant was granted schedule awards for these impairments, however, he requested reconsideration claiming that his awards should be increased to the maximum amount allowable under the schedule award provisions.[7]

After further electrodiagnostic testing, which demonstrated severe bilateral carpal tunnel syndrome, worse on the left and after review of Dr. Weiss' most recent report, the Office medical adviser referred to the A.M.A., *Guides*, Table 16, page 57, which addressed upper extremity impairment due to entrapment neuropathy and calculated, on the basis of appellant's median nerve neuropathy being categorized as "severe,"[8] that this was a 40 percent permanent impairment. The Office medical adviser further calculated, based upon the electrodiagnostic

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *See, e.g., Francis John Kilcoyne*, 38 ECAB 168 (1987).

[6] *William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

[7] The Board notes that the maximum amount allowable under the schedule awards provisions would be for a 100 percent permanent impairment of both upper extremities, which would equate with total amputation of both extremities. As appellant has the demonstrated ability to drive and to use his upper extremities to conduct activities of daily living, he does not have upper extremity impairment equivalent to total amputation of both upper extremities and so would not be eligible for the maximum amount of award allowable under the Act.

[8] The Board notes that the rating for "severe" neuropathy is the highest rating provided by the A.M.A., *Guides*.

evaluation of appellant's ulnar nerve entrapment and based upon Dr. Weiss' assessment of this ulnar tunnel syndrome, that appellant had a mild ulnar nerve impairment, for which he was entitled to a 10 percent permanent impairment rating. Correctly, utilizing the Combined Values Chart, the Office medical adviser then combined these impairment values and determined that appellant had an additional 12 percent permanent impairment of each of his upper extremities.

Thereafter, appellant received additional schedule awards for 46 percent impairment of each of his upper extremities.

Appellant, however, requested an additional schedule award for his trigger thumb. In support, he submitted a February 12, 1997 report from Dr. Weiss, which noted that appellant's bilateral stenosing flexor tenosynovitis was worse on the left, that it was slight in degree and occasional in frequency and was without obvious catching or triggering noted upon examination. Thereafter, the Office medical adviser reviewed Dr. Weiss' report and noted that an eight percent impairment rating for bilateral trigger thumb was included in Dr. Harris' original schedule award calculation and hence was previously considered and compensated. The Office medical adviser concluded that, therefore, no additional award was due. The Board agrees with this conclusion, as no claimant is entitled to dual awards for the same injury.[9]

Appellant thereafter underwent further carpal tunnel surgery without complications.

Following this most recent surgery appellant requested an additional schedule award claiming that his condition could not remain the same after having undergone further surgery. In support he submitted a November 19, 1997 report from Dr. Weiss, which noted that appellant's subjective symptoms were in excess of the objective findings, that he did not provide consistent or valid grip strength testing results and that his complaints and examination results were not indicative of his true functional level, as he could successfully drive and perform many other activities of daily living.

On January 7, 1998 the Office denied modification of the prior decision, finding that the evidence submitted did not support any additional schedule award. The Board concurs with this determination.

Thereafter, the Office medical adviser, at the Office's request, recalculated appellant's schedule award entitlement using a different method, as opposed to the method used by Dr. Harris and by herself in the calculation of appellant's original award of 46 percent, which was based upon specific consideration measurement of grip strength and sensory deficit. The Office medical adviser found, using this alternative method of impairment calculation, that appellant had a 20 percent impairment due to grip strength deficit and a 27 percent impairment due to sensory deficit, which, when combined, amounted to a 42 percent permanent impairment of each upper extremity, which was less than what appellant had already received. As Dr. Harris and her original method of impairment calculation resulted in appellant receiving a 46 percent impairment rating and the Office medical adviser's alternative method of impairment calculation resulted in a 42 percent impairment rating, the method used initially by Dr. Harris and herself

[9] *See Sherry A, Hunt*, 49 ECAB 467 (1998).

was more beneficial to appellant. The Office medical adviser also noted that, when she calculated appellant's additional impairment rating including the 40 percent impairment for median nerve involvement and 10 percent impairment for ulnar nerve involvement using Table 16, page 57 of the A.M.A., *Guides*, grip strength loss was not to be considered separately.

Consequently, the Office found that using the grip strength testing results method was less advantageous to appellant and, therefore, did not support any impairment award additional to that already received. The Board finds that this determination is correct.

Again appellant requested reconsideration and in support he submitted a report from Dr. Andrues, a chiropractor. In response the Office properly found that this evidence had no probative value in this case, as a chiropractor was not considered to be a physician in this case.

The Board has frequently explained that section 8101(2) of the Act provides that the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.[10] Therefore, as appellant was not diagnosed as having a spinal subluxation, as no x-rays were taken, nor was any spinal manipulation to correct any subluxation as demonstrated by x-ray to exist conducted, Dr. Andrues cannot be considered to be a physician in this case and his report has no probative value.

The Board has reviewed the entirety of the evidence submitted by appellant and concludes that he has not submitted any probative medical evidence that supports that he has any greater than a 46 percent permanent impairment of each of his upper extremities and, therefore, finds that he is not entitled to any greater schedule award.

[10] 5 U.S.C. § 8101(2); *see also Linda Holbrook*, 38 ECAB 229 (1986).

Accordingly, the August 13, 1999 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC
May 3, 2001

Willie T.C. Thomas
Member

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member