U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ROBERT A. FULLER and U.S. POSTAL SERVICE,
POST OFFICE, Southeastern, PA

Docket No. 03-173; Submitted on the Record;
Issued January 12, 2004

DECISION and ORDER

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

The issue is whether appellant has more than a 19 percent permanent impairment of his right upper extremity, for which he has received a schedule award.

On June 18, 1999 appellant, then a 41-year-old mail handler, filed an occupational disease claim alleging that he sustained bilateral carpal tunnel syndrome which he attributed to factors of his federal employment. On September 7, 1999 the Office of Workers' Compensation Programs accepted that he sustained bilateral carpal tunnel syndrome.[1] Appellant underwent a right carpal tunnel release with neurolysis on October 5, 1999 and a left carpal tunnel release with neurolysis on February 8, 2000. He was able to return to full-time sedentary duty on August 12, 2000.

By report dated February 12, 2001, Dr. Nicholas P. Diamond, Board-certified in pain management, reviewed appellant's factual and medical history, noted his current complaints and the results of his physical examination and discussed his objective and subjective disability factors.[2] Dr. Diamond indicated that, in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, fifth edition,[3] appellant had an impairment in the form of sensory deficit in the right median nerve as follows: 6 percent impairment for the thumb radial palmar aspect; 9 percent for the thumb radial ulnar aspect; 4 percent the middle radial palmar aspect; and a 3 percent for the middle ulnar palmar aspect; plus a 10 percent impairment for right pinch strength deficit, for a combined right upper extremity impairment of 28 percent. He indicated that appellant had a three percent impairment for a left motor strength deficit of the flexor digitorum muscles enervated by the median nerve and a three percent impairment due to left-sided pain, for a total left upper extremity impairment of six percent.

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[1] Concurrent disability not due to injury was noted as right third digit A1 pulley release.

[2] Dr. Diamond noted scar tenderness related to appellant's A1 pullet release.

[3] A.M.A., *Guides* (2001).

On March 8, 2001 appellant was evaluated by Dr. Scott M. Fried, an osteopathic physician Board-certified in orthopedic and hand surgery, who noted that an October 17, 2000 electromyogram (EMG) showed "some low level ulnar neuropathy at 48 on the left as compared to 52 on the right. The median nerves are looking good at the wrists."

Appellant underwent a functional capacity evaluation on March 29, 2001 which was evaluated by Dr. Fried.

Dr. Diamond's report was referred to an Office medical adviser for review. By report dated October 2, 2001, the Office medical adviser noted that paragraph four of the attachment to Federal Employees' Compensation Act[4] Bulletin 01-05 precluded using either grip or pinch strength in determining impairment for compression neuropathy, including carpal tunnel syndrome. The Office medical adviser applied the impairments that Dr. Diamond provided for sensory deficit of the right median nerve to the Combined Values Chart and determined that appellant had a 19 percent permanent impairment of the right upper extremity.[5] The Office medical adviser concurred with Dr. Diamond's impairment rating of six percent for the left upper extremity.

On October 16, 2001 the Office granted appellant schedule awards for a 19 percent permanent impairment of the right upper extremity and a 6 percent permanent impairment of the left upper extremity.[6]

Appellant, through his representative, disagreed with the October 16, 2001 decision and requested an oral hearing before an Office hearing representative.

A hearing was held on May 15, 2002 at which appellant testified and was represented by his designated representative. Appellant claimed that Dr. Diamond provided a more appropriate rating for his right upper extremity impairment than did the Office medical adviser, and he claimed that the Office medical adviser did not consider the EMG findings of October 17, 2000. Appellant also argued that Dr. Diamond's ratings should prevail because he based his ratings on the A.M.A., *Guides*, whereas the Office medical adviser based his finding on a FECA Bulletin.

Appellant submitted a February 14, 2002 report from Dr. Fried. This report did not address appellant's impairment percentages and identified his areas of greatest discomfort as being bilateral wrist and over the bilateral brachial plexus. The report noted as one of appellant's diagnoses, "Status post trigger release right third digit and exploration flexor tendon sheath right third digit, Dr. Kirkpatrick, 1996," but it did not identify any current symptomatology or disability connected therewith.

By decision dated August 5, 2002, the hearing representative affirmed the October 16, 2001 schedule awards finding that the Office medical adviser properly applied the A.M.A., *Guides*, whereas Dr. Diamond improperly combined the impairments for sensory deficit with the

[4] 5 U.S.C. §§ 8101-8193.

[5] A.M.A., *Guides*, pages 604-06.

[6] The award for the left upper extremity is not being contested by appellant on appeal.

impairment for loss of grip and pinch strength in calculating appellant's total right upper extremity permanent impairment. He noted that the FECA Bulletin simply discussed significant changes in the A.M.A., *Guides*, fifth edition and the effect of such changes in determining permanent impairments.

The Board finds that appellant had no greater than a 19 percent impairment of his right upper extremity, for which he received a schedule award.

The schedule award provisions of the Act[7] and its implementing regulation[8] 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 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 uniform standards applicable to all claimants. The A.M.A., *Guides* (fifth edition 2001) has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[9]

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*.[10] 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 2 of the A.M.A., *Guides* (fifth edition) provides a grading scheme and procedure for determining impairment of an effected body part due to pain, discomfort or loss of sensation.[11] The element of pain may serve as the sole basis for determining the degree of impairment for schedule compensation purposes.[12]

The Federal (FECA) Procedure Manual, Chapter 2.808.6.d[13] states that after obtaining all necessary medical evidence, the case record should be referred to the Office medical adviser for an opinion concerning the nature and degree of permanent impairment. The impairment percentage should be computed in accordance with the A.M.A., *Guides* and the Office medical

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] 20 C.F.R. § 10.404 (1999). FECA Transmittal No. 02-12 (issued August 30, 2002) explains that all permanent impairment awards determined on or after February 1, 2001, the effective dated of the A.M.A., *Guides* application, regardless of the date of the medical examination, should be based on the fifth edition of the A.M.A., *Guides*.

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

[11] A.M.A., *Guides* (5th ed. 2001).

[12] *Paul A. Toms*, 38 ECAB 403 (1987); *Robin L. McClain*, 38 ECAB 398 (1987).

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

adviser should provide rationale for the percentage of impairment specified. The Board has held that where an Office medical adviser believes that the evaluating specialist improperly determined a specific impairment, the Office should take into consideration the opinion of the Office medical adviser in determining the percentage of impairment.[14] The Board has also held that where the Office medical adviser provides the only evaluation that fully conforms with the A.M.A., *Guides*, such an evaluation constitutes the weight of the medical evidence.[15]

Dr. Diamond opined that appellant had right upper extremity impairment due to sensory deficits of the median nerve and due to pinch strength deficit. However, this rating was not in accordance with the A.M.A., *Guides*. The Office medical adviser referred to paragraph 4 of the attachment to FECA Bulletin No. 01-05, which implemented the use of the A.M.A., *Guides*, fifth edition, for adjudicating schedule awards as of February 1, 2001 and noted that it precluded using either grip or pinch strength in determining impairment for compression neuropathy, including carpal tunnel syndrome. Paragraph four of the attachment states:[16]

> "The criteria for diagnosing and rating weakness not due to other ratable conditions and for using grip and pinch strength measurements, have been clarified in [s]ection 16.8 (pp. 507-11). The A.M.A., *Guides* now state that the loss of strength should be rated separately only if it is based on an unrelated cause or mechanism. 'Otherwise, the impairment ratings based on objective anatomic findings take precedence. Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated.' Moreover, it continues to say that 'motor weakness associated with disorders of the peripheral nervous system and various degenerative neuromuscular conditions are evaluated according to [s]ection 16.5 and Chapter 13.' Clearly, grip and/or pinch strength should not be used to calculate upper extremity impairment caused by a compression neuropathy such as carpal tunnel syndrome."

The Office medical adviser provided impairment ratings for appellant's upper extremities that are consistent with paragraph four of the FECA Bulletin attachment. Therefore, the Office medical adviser's findings constitute the weight of the medical evidence on the upper extremity impairment issue.[17]

The Board has upheld Office procedures as stated in prior Bulletins and the procedure manual, addressing calculation of impairments using tables with overlapping applications, leading to impairment percentages which are considered to overstate the actual degree of impairment. In the case of *Manuela R. Cortes,*[18] a physician determining impairment in a carpal

[14] *Clyde Franklin Kelly*, 26 ECAB 296 (1975).

[15] *John L. McClenic*, 48 ECAB 552 (1997); *Michael C. Norman*, 42 ECAB 768 (1991); *Bobby L. Jackson*, 40 ECAB 593 (1989).

[16] FECA Bulletin No. 01-05, issued January 29, 2001.

[17] *John L. McClenic*, *supra* note 15; *Michael C. Norman*, *supra* note 15.

[18] Docket No. 00-859 (issued October 23, 2001).

tunnel syndrome patient combined impairment due to loss of grip strength with impairment due to sensory deficit. The Board indicated that the FECA Procedure Manual, Chapter 3.700, Exhibit 4, makes clear that impairment ratings from tables for impairment due to sensory or motor deficits cannot be combined with ratings for grip and pinch strength.[19] In *Cortes* the Board noted that the combined impairment values for maximum percentage of upper extremity impairment with impairment values for grip and pinch strength to estimate a 32 percent impairment, which was not in accordance with the Office's procedure manual." The Board found that this erroneous calculation rendered the examining physicians impairment estimate of diminished probative value.

The Office medical adviser properly evaluated the impairment due to sensory deficit and noted that it cannot be combined with impairment due to pinch strength in determining impairment of the right upper extremity resulting from compression neuropathy such as carpal tunnel syndrome. As Dr. Diamond improperly combined values for sensory deficit and pinch strength, his estimate of impairment is of diminished probative value.

On appeal appellant contends that there is a conflict between the Office medical adviser and Dr. Diamond. The Board finds, however, that there is no conflict between Dr. Diamond and the Office medical adviser. The Office medical adviser did not disagree with Dr. Diamond's findings of individual percentages of impairment, only with his application of the A.M.A., *Guides* to those percentages to determine total impairment. Dr. Diamond did not properly apply the A.M.A., *Guides* and, therefore, the Board finds the report of the Office medical adviser constitutes the weight of the medical evidence on the issue of appellant's impairment ratings.[20]

Further, the Board finds that the medical record does not support any right upper extremity impairment due to a right third digit A1 pulley release, such that an impairment rating for that 1996 preexisting surgically corrected problem is not appropriate.

[19] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.0700, Exhibit 4, Impairment Tables Which are Incompatible (June 2003).

[20] *John L. McClenic*, *supra* note 15; *Michael C. Norman*, *supra* note 15.

The decision of the Office of Workers' Compensation Programs dated August 5, 2002 is hereby affirmed.

Dated, Washington, DC
January 12, 2004

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member