United States Department of Labor
Employees' Compensation Appeals Board

NANCY A. SPERA, Appellant	)	
and	)	**Docket No. 04-1674**
	)	**Issued: November 23, 2004**
DEPARMENT OF VETERANS AFFAIRS, CLEVELAND VETERANS MEDICAL CENTER, Brecksville, OH, Employer	)	

Appearances:
Nancy A. Spera, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On June 21, 2004 appellant filed a timely appeal from a March 16, 2004 decision of the Office of Workers' Compensation Programs granting her a schedule award for an additional impairment of the right upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award issue in this case.

ISSUE

The issue is whether appellant has more than a 58 percent permanent impairment of the right upper extremity for which she received schedule awards.

FACTUAL HISTORY

This case is before the Board for the second time on the issue of the extent of appellant's permanent impairment of the right upper extremity. In the first appeal, the Board set aside the Office's July 11 and February 25, 1997 decisions finding that appellant had no more than a 30

percent permanent impairment of the right upper extremity.[1] The Board found that the Office should have determined appellant's total right upper extremity impairment prior to subtracting the amount previously awarded and remanded the case to the Office for recalculation of the extent of permanent impairment.[2]

In a decision dated February 29, 2000, the Office found that appellant was entitled to an additional 12 percent permanent impairment of the right arm for a total right arm impairment of 51 percent.[3]

The Office accepted that on October 5, 2000 appellant sustained bilateral rotator cuff tears and an aggravation of preexisting right carpal tunnel syndrome. The Office assigned the claim file No. 09-2003026. Appellant returned to light-duty employment following the injury on December 10, 2000. She retired from the employing establishment on March 31, 2001.

On July 3, 2001 appellant requested a schedule award for impairments to her right and left arms resulting from her October 5, 2000 employment injury.

By letter dated October 3, 2001, the Office requested that appellant submit a report from her attending physician addressing the degree of her impairment of the upper extremities in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001).

On November 26, 2001 appellant informed the Office that she wanted to pursue an increased schedule award on the left side only. She submitted reports dated December 11 and 26, 2001 from her attending physician, Dr. John H. Paul, an orthopedic surgeon, addressing the extent of impairment of her left upper extremity.

In a decision dated March 8, 2002, the Office granted appellant a schedule award for an additional 16 percent impairment of the left upper extremity.

The Office received a letter from appellant on March 10, 2003 requesting reconsideration of the left arm award and adjudication of an increased schedule award for the right upper extremity.

In support of her request for reconsideration, appellant submitted electromyogram (EMG) and nerve conduction velocity (NCV) studies dated May 2, 2002 showing moderate right median neuropathy. She further submitted an impairment evaluation dated March 4, 2003 from Dr. Paul, who noted that appellant had EMG testing performed on May 2, 2002 which revealed moderate

[1] *Nancy A. Spera*, Docket No. 98-513 (issued November 26, 1999).

[2] In a decision dated November 7, 1997, the Board affirmed a July 19, 1995 Office decision finding that appellant had a 10 percent permanent impairment of the left upper extremity. *Nancy A. Spera*, Docket No. 96-126 (issued November 7, 1997). By decision dated December 24, 2997, the Office found appellant entitled to an additional one percent impairment of the left arm.

[3] The Office noted that it had previously granted appellant schedule awards for a 20 percent impairment of the right arm due to for carpal tunnel syndrome and a 19 percent impairment of the right arm due to shoulder problems.

carpal tunnel syndrome. He opined that she reached maximum medical improvement on March 4, 2003. Dr. Paul diagnosed an aggravation of preexisting right carpal tunnel syndrome, a right rotator cuff tear and right adhesive capsulitis "due to not being able to use her shoulder normally as shoulder movements continue to be difficult and painful from the rotator cuff tear." He found that, for the right shoulder, appellant had 10 degrees of forward flexion which constituted a 16 percent impairment,[4] 30 degrees of abduction which constituted a 7 percent impairment,[5] 20 degrees of adduction which constituted a 1 percent impairment,[6] 20 degrees of extension which constituted a 2 percent impairment,[7] 10 degrees of internal rotation which constituted a 5 percent impairment[8] and 2 degrees of external rotation which constituted a 2 percent impairment.[9] Dr. Paul added the impairment findings and determined that appellant had a total right shoulder impairment of 33 percent. For the right elbow, he found that appellant had no impairment due to loss of flexion,[10] a 4 percent impairment due to 110 degrees of extension,[11] a 2 percent impairment due to 50 degrees of pronation,[12] and a 3 percent impairment due to 10 degrees of supination,[13] for a total right elbow impairment of 9 percent. Dr. Paul listed range of motion findings for appellant's right wrist as follows: 10 degrees of flexion which constituted an 8 percent impairment,[14] 10 degrees of extension which constituted an 8 percent impairment,[15] 5 degrees radial deviation which constituted a 3 percent impairment[16] and 5 degrees ulnar deviation which constituted a 4 percent impairment.[17] He further found that appellant's maximum impairment due to a sensory deficit of the right median nerve below the midforearm was 39 percent which he multiplied by 25 percent, the applicable percentage for a Grade 4 sensory loss, to find a total impairment due to right carpal tunnel syndrome of 23 percent.[18] Dr. Paul combined his impairment findings of 33 percent for the shoulder, 23 percent for the

[4] A.M.A., *Guides* 476, Figure 16-40.

[5] *Id*. at 477, Figure 16-43.

[6] *Id*.

[7] *Id*. at 476, Figure 16-40.

[8] *Id*. at 479, Figure 16-46.

[9] *Id*.

[10] *Id*. at 472, Figure 16-34.

[11] *Id*.

[12] *Id*. at 474, Figure 16-37.

[13] *Id*.

[14] *Id* at 467, Figure 16-28.

[15] *Id*.

[16] *Id*. at 469, Figure 16-31.

[17] *Id*.

[18] *Id*. at 492, 482, Tables 16-15, 16-10.

right wrist and 9 percent for her right elbow and concluded that she had a 53 percent impairment of the right upper extremity.

By decision dated June 19, 2003, the Office denied reconsideration of its March 8, 2002 decision. The Office noted that, since it had not addressed the issue of the extent of appellant's right upper extremity impairment in its March 8, 2002 decision, it did not do so in the June 19, 2003 decision.

On June 24, 2003 appellant filed a schedule award claim for the right upper extremity. In a letter dated October 7, 2003, appellant requested a final decision on the extent of her permanent impairment of the upper extremities. She further requested that her claim be referred to an Office medical adviser for evaluation of her right upper extremity impairment. She noted that she had previously requested reconsideration because she believed all her injuries had been combined in one claim.[19]

An Office medical adviser reviewed Dr. Paul's March 4, 2003 report and concurred with his findings. He noted, however, that Dr. Paul neglected to add in appellant's sensory deficit of 10 percent due to carpal tunnel syndrome. The Office medical adviser combined the range of motion losses of 33 percent for the right shoulder, 8 percent for the right elbow, 23 percent for the right wrist with the 10 percent impairment due to a right-sided sensory deficit. He concluded that appellant had a 58 percent impairment of the right upper extremity. The Office medical adviser further opined that appellant reached maximum medical improvement on March 4, 2003.

By decision dated March 16, 2004, the Office granted appellant a schedule award for an additional seven percent impairment of the right upper extremity. The period of the award ran for 21.84 weeks from March 4 to August 3, 2003. The Office further vacated its June 19, 2003 decision[20] and found that the evidence was sufficient to establish that appellant was entitled to an additional seven percent permanent impairment of the right upper extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[21] and its implementing regulation,[22] 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 for all claimants, the

[19] Appellant has multiple injury claims. Under master file No. 09-0372325, the Office included claims accepted for right and left carpal tunnel syndrome, right shoulder and elbow strains, right shoulder impingement syndrome, a right rotator cuff tear, left shoulder strain, bilateral rotator cuff tears and an aggravation of preexisting right carpal tunnel syndrome. She underwent a subacromial decompression of the right shoulder due to her impingement syndrome on February 23, 1994.

[20] The Office indicated that it was vacating a December 19, 2003 decision; however, it appears that this is a typographical error.

[21] 5 U.S.C. § 8107.

[22] 20 C.F.R. § 10.404.

Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[23] The Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[24]

The fifth edition of the A.M.A., *Guides*, regarding carpal tunnel syndrome, provides:

> "If, after optimal recovery time following surgical decompression, an individual continues to complain of pain, parethesias and/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/or motor deficits as described earlier.[25]
> >
> > 2. Normal sensibility and opposition strength with abnormal sensory and/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."[26]

The A.M.A., *Guides* further provides that, "In compression neuropathies, additional impairment values are not given for decreased grip strength."[27] Carpal tunnel syndrome is an entrapment/compression neuropathy of the median nerve.[28] Additionally, the Board has found that the fifth edition of the A.M.A., *Guides* provides that an impairment for carpal tunnel syndrome be rated on motor and sensory deficits only.[29]

It is well established that the period covered by the schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury.[30] The Board has explained that maximum medical improvement means that the physical condition of the injured member of the body has stabilized and will not

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[23] 20 C.F.R. § 10.404(a).

[24] *See* FECA Bulletin No. 01-05 (issued January 29, 2001).

[26] A.M.A., *Guides* 495; *see also Silvester DeLuca*, 53 ECAB ___ (Docket No. 01-1904, issued April 12, 2002).

[27] A.M.A., *Guides* 494; *see* also FECA Bulletin No. 01-05 (issued January 29, 2001).

[28] A.M.A., *Guides* 492.

[29] A.M.A., *Guides* 494, *Robert V. Disalvatore*, 54 ECAB ___ (Docket No. 02-2256, issued January 17, 2003).

[30] *See James E. Earle*, 51 ECAB 567 (2000).

improve further.[31] The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record, and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[32]

A claimant may seek an increased schedule award if the evidence establishes that he or she sustained an increased impairment at a later date causally related to an employment injury. Office procedures state that claims for increased schedule awards may be based on an incorrect calculation of the original award or new exposure.[33] To the extent that a claimant is asserting that the original award was erroneous based on his or her medical condition at that time, this would be a request for reconsideration. A claim for an increased schedule award may be based on new exposure or medical evidence indicating the progression of an employment-related condition, without new exposure to employment factors, has resulted in a greater impairment than previously calculated.[34]

FECA Bulletin No. 01-05 provides, "A claimant who has received a schedule award calculated under a previous edition may later make a claim for an increased award, which should be calculated according to the fifth edition."[35]

Before the A.M.A., *Guides* can be utilized, a description of appellant's impairment must be obtained from her physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[36]

ANALYSIS

In this case, the Office accepted that, on the right side, appellant sustained carpal tunnel syndrome, shoulder strain, elbow strain, impingement syndrome of the shoulder, two rotator cuff tears and an aggravation of preexisting carpal tunnel syndrome. The Office granted appellant schedule awards for a total of a 51 percent impairment of the right upper extremity. On March 10, 2003 appellant requested an increased schedule award on the right side. She submitted a report dated March 4, 2003 from her attending physician, Dr. Paul, who listed detailed range of motion findings for appellant's right shoulder and elbow. For the right

[31] *Id*.

[32] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3(a) (June 2003); *see also Richard Larry Enders*, 48 ECAB 184 (1996).

[33] *Linda T. Brown*, 51 ECAB 115 (1999).

[34] *Id*.

[35] FECA Bulletin No. 01-05 (issued January 29, 2001).

[36] *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

shoulder he found that 10 degrees of forward flexion equaled a 16 percent impairment,[37] 30 degrees of abduction equaled a 7 percent impairment,[38] 20 degrees of adduction equaled a 1 percent impairment,[39] 20 degrees of extension equaled a 2 percent impairment,[40] 10 degrees of internal rotation equaled a 5 percent impairment[41] and 2 degrees of external rotation equaled a 2 percent impairment.[42] Dr. Paul added the impairment findings[43] and determined that appellant had a total right shoulder impairment of 33 percent. An Office medical adviser concurred with Dr. Paul's findings and application of the A.M.A., *Guides* regarding his impairment findings for the right shoulder. The Board finds that Dr. Paul properly provided range of motion measurements for appellant's right shoulder and properly correlated these findings with the appropriate sections of the A.M.A., *Guides* to conclude that appellant had a 33 percent right shoulder impairment.

Regarding appellant's right elbow, Dr. Paul determined that appellant had 0 degrees of flexion which equaled no impairment,[44] 110 degrees of extension which equaled a 4 percent impairment,[45] 50 degrees of pronation which equaled a 2 percent impairment,[46] and 10 degrees of supination which equaled a 3 percent impairment.[47] Dr. Paul added the impairment percentages due to loss of range of motion of the elbow for a total of a 9 percent impairment.[48] The Office medical adviser concurred with Dr. Paul's findings. The Board notes, however, that according to Figure 16-34 on page 472 of the A.M.A., *Guides*, 110 degrees of extension constitutes a 27 percent impairment instead of a 4 percent impairment. Additionally, it is unclear whether Dr. Paul found that appellant had 0 degrees of flexion, which would constitute a 42 percent impairment or had no impairment due to loss of flexion. Consequently, as a person reviewing the file is unable to visualize the extent of the impairment with resulting restrictions and limitations, the Board finds that the medical evidence is insufficient to establish the extent of appellant's permanent impairment of the right elbow due to her employment injury.[49]

[37] A.M.A., *Guides* 476, Figure 16-40.

[38] *Id*. at 477, Figure 16-43.

[39] *Id*.

[40] *Id*. at 476, Figure 16-40.

[41] *Id*. at 479, Figure 16-46.

[42] *Id*.

[43] *Id.* at 474.

[44] *Id*. at 472, Figure 16-34.

[45] *Id*.

[46] *Id*. at 474, Figure 16-37.

[47] *Id*.

[48] *Id.* at 470.

[49] *See Robert B. Rozelle, supra* note 36.

Dr. Paul next listed range of motion findings for appellant's right wrist due to carpal tunnel syndrome and determined that she had a 23 percent impairment due to loss of range of motion. The Office medical adviser concurred with Dr. Paul's determination. Dr. Paul further found that appellant had a 39 percent impairment of the right median nerve below the midforearm according to Table 16-15 on page 492 of the A.M.A., *Guides* and a 25 percent, or Grade 4, sensory loss. The Office medical adviser multiplied the 39 percent maximum impairment of the median nerve by the 25 percent graded sensory loss to find a 9.75 percent sensory deficit, which he rounded up to 10 percent. The Board finds, however, that Dr. Paul and the Office medical adviser incorrectly applied the A.M.A., *Guides* in calculating appellant's impairment of the right wrist due to carpal tunnel syndrome.

As noted above, the A.M.A., *Guides* provide a specific method for determining the permanent impairment due to carpal tunnel syndrome. An impairment for carpal tunnel syndrome is rated on motor and sensory deficits.[50] Appellant, therefore, should not have received an impairment rating for loss of range of motion of the wrist in addition to a sensory loss for carpal tunnel syndrome. Additionally, the A.M.A., *Guides* specifically note that prior to determining a permanent impairment due to carpal tunnel syndrome an optimal recovery time following surgical decompression must be allowed. If the individual continues to experience pain, parethesias or difficulty with certain activities, the A.M.A., *Guides* provide methods of rating an appellant depending on whether he or she has positive clinical findings of median nerve dysfunction and electrical conduction delay.[51] The A.M.A., *Guides* then require positive clinical findings of median nerve dysfunction and electrical conduction delay. The A.M.A., *Guides* require that, after a claimant has reached maximum medical improvement, additional electrodiagnostic studies and physical findings are necessary to determine the extent of the permanent impairment. Evidence of electrical conduction delay predating maximum medical improvement cannot be utilized to determine the extent of permanent impairment.[52]

In this case, both Dr. Paul and the Office medical adviser opined that appellant reached maximum medical improvement on March 4, 2003. The Board finds, however, that the electrodiagnostic studies relied upon by the physicians in determining her sensory loss due to carpal tunnel syndrome were performed on May 2, 2002, around 10 months prior to the date of maximum medical improvement.

On remand, the Office should authorize the necessary electrodiagnostic testing to determine the extent of appellant's permanent impairment due to carpal tunnel syndrome and refer appellant to an appropriate physician to determine the extent of her permanent impairment of the right upper extremity. After such further development as the Office deems necessary, it should issue an appropriate decision.

[50] A.M.A., *Guides* 494; *Robert V. Disalvatore*, *supra* note 29.

[51] A.M.A., *Guides* 495.

[52] *Ebony T. Burtis*, Docket No. 04-1207 (issued August 20, 2004).

CONCLUSION

The Board finds that the case is not in posture for decision. The case requires additional development of the medical evidence to determine the extent of appellant's permanent impairment of her right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 16, 2004 is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: November 23, 2004
Washington, DC

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member