United States Department of Labor
Employees' Compensation Appeals Board

JEANETTE BARTELS, Appellant	)	
	)	
and	)	**Docket No. 04-1134**
	)	**Issued: September 30, 2004**
DEPARTMENT OF LABOR, EMPLOYMENT STANDARDS ADMINISTRATION, San Francisco, CA, Employer	)	

Appearances:
Jeanette Bartels, 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 March 22, 2004 appellant filed a timely appeal from a merit decision of the Office of Workers' Compensation Programs dated December 17, 2003 granting her a schedule award for the right and left upper extremities. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award decision.

ISSUE

The issue is whether appellant has more than a four percent permanent impairment of the right upper extremity and a four percent permanent impairment of the left upper extremity for which she received a schedule award. On appeal, appellant contends that she is entitled to a greater award.

FACTUAL HISTORY

This case is before the Board for the second time. In the first appeal, the Board affirmed the Office's October 8 and September 3, 2002 decisions terminating appellant's entitlement to

compensation on the grounds that she had no further disability due to her accepted condition of an aggravation of bilateral carpal tunnel syndrome. The Board further affirmed the Office's finding that she had not established that she had any continuing disability after September 2, 2002.[1] The findings of fact and conclusions of law from the prior decision are hereby incorporated by reference.

In a report dated November 25, 2002, Dr. Roman P. Kownacki, who is Board-certified in preventive medicine, found that appellant had reached maximum medical improvement. He indicated that she could not perform repetitive activities with her hands due to residuals of her bilateral carpal tunnel syndrome.

On January 7, 2003 appellant requested a schedule award. The Office, by letter dated March 20, 2003, referred appellant to Dr. Stanley Baer, a Board-certified orthopedic surgeon, for a second opinion examination on the issue of whether she had a permanent impairment of the upper extremities.

In a report dated April 15, 2003, Dr. Baer discussed appellant's history of bilateral carpal tunnel syndrome with a right carpal tunnel release on April 30, 2002 and a left carpal tunnel release on July 12, 2002. He opined that she had not yet reached maximum medical improvement on the left side and recommended that she be evaluated on both sides in approximately four months in order for her to have a full year of recovery following her left carpal tunnel release surgery. An Office medical adviser reviewed Dr. Baer's opinion that appellant had not yet reached maximum medical improvement on the left side and found it supported by the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001) (A.M.A., *Guides*).[2] The Office informed appellant on May 15, 2003 that it would take no further action on her schedule award claim until after July 12, 2003.[3]

On September 2, 2003 the Office referred appellant to Dr. Alan Kimelman, a Board-certified physiatrist, for a determination of whether she had a permanent impairment of her upper extremities in accordance with the fifth edition of the A.M.A., *Guides*. The Office included instructions from an Office medical adviser for evaluating carpal tunnel syndrome under the fifth edition of the A.M.A., *Guides*.

In a report dated October 3, 2003, based on examinations of September 26 and October 3, 2003, Dr. Kimelman diagnosed residuals of bilateral carpal tunnel releases. He noted that appellant's "[t]wo-point discrimination was reduced to 10 millimeters in the median nerve distributions bilaterally." Dr. Kimelman listed findings of a tender Tinel's sign and 10-second Phalen's test bilaterally. He found that neurological testing "performed for this evaluation revealed moderate median mononeuropathy at the wrists, consistent with moderate bilateral carpal tunnel syndrome and radial sensory mononeuropathy at the right wrist." Dr. Kimelman determined that, for the right wrist, appellant had no impairment in range of motion, a 20 percent

[1] *Jeanette Bartels*, Docket No. 03-240 (issued April 11, 2003).

[2] A.M.A., *Guides* at 507.

[3] The Office informed appellant that it would take no further action on her claim until after July 12, 2002 rather than July 12, 2003; however, it is apparent that this is a typographical error.

impairment due to loss of grip strength and a 3.9 percent impairment due to a sensory deficit of the median nerve below the mid forearm.[4] He combined his impairment findings and concluded that appellant had a 14 percent permanent impairment of the right upper extremity. For the left wrist, Dr. Kimelman opined that appellant had no impairment due to loss of range of motion, no impairment due to loss of grip strength, and a 3.9 percent impairment due to pain in the median nerve below the mid forearm, for a total impairment of the left upper extremity of 2 percent.[5] He further concluded that appellant had reached maximum medical improvement.

Accompanying Dr. Kimelman's report are the results of electromyogram (EMG) and nerve conduction studies (NCS) which listed Dr. Kimelman as the physician who performed the tests. The date indicated on the test results is March 10, 2003.

In a letter dated October 24, 2003, an Office medical adviser informed Dr. Kimelman that he was precluded by the A.M.A., *Guides*, from using grip strength measurements in rating appellant's impairment due to carpal tunnel syndrome. He requested that Dr. Kimelman submit a supplemental report.

In a revised report dated December 11, 2003, Dr. Kimelman omitted his grip strength findings. He concluded that appellant had a 3.9 percent impairment of the right and left upper extremity due to pain in the median nerve below the mid forearm. Dr. Kimelman stated:

> "I awarded [appellant] a 10 percent grade in the distribution of the median nerve below the mid-forearm level based on the pain behavior seen during examination. Maximum impairment of the median nerve below the mid forearm level is 39 percent. No motor deficit was noted."

Dr. Kimelman multiplied the 10 percent graded pain by the 39 percent maximum nerve impairment according to Tables 16-11 and 16-15 on pages 484 and 492 of the A.M.A., *Guides* in finding that appellant had a 3.9 percent bilateral impairment of the upper extremities.

An Office medical adviser reviewed Dr. Kimelman's supplemental report on December 1, 2003. He opined that Dr. Kimelman's finding that appellant had a four percent impairment of both the right and left upper extremity was consistent with the A.M.A., *Guides*. The Office medical adviser noted that appellant had reached maximum medical improvement on October 3, 2003.

By decision dated December 17, 2003, the Office granted appellant a schedule award for a four percent permanent impairment of both the right and left upper extremities. The period of the award ran for 24.06 weeks from October 3 to March 25, 2004.[6]

[4] A.M.A., *Guides* 482, 492, Tables 16-10, 16-15.

[5] *Id*.

[6] It appears that the Office intended the award to run from October 3, 2003 until March 25, 2004 rather than March 25, 2003 as noted on the letter of award.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[7] and its implementing federal 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 for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[9] 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.[10]

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.
> >
> > (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."[11]

The A.M.A., *Guides* further provides that, "In compression neuropathies, additional impairment values are not given for decreased grip strength."[12] Carpal tunnel syndrome is an entrapment/compression neuropathy of the median nerve.[13]

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[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] 20 C.F.R. § 10.404(a).

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

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

[12] *Id*. at 494; *see* also FECA Bulletin No. 01-05, issued January 29, 2001.

[13] *Id*. at 492.

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.[14] 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 improve further.[15] 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.[16]

Proceedings under the Act are not adversarial in nature, nor is the Office a disinterested arbiter.[17] Although the claimant has the burden of establishing entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[18] Once the Office starts to develop the medical opinion evidence, it must do so in a fair and impartial manner. The Office has the responsibility to obtain from a referral physician an evaluation that will resolve the issue involved in the case.[19]

ANALYSIS

In this case, the Office accepted appellant's claim for an aggravation of bilateral carpal tunnel syndrome. Appellant underwent a right carpal tunnel release on April 30, 2002 and a left carpal tunnel release on July 12, 2002. She requested a schedule award on January 7, 2003. The Office initially referred appellant to Dr. Baer for an impairment evaluation; however, in a report dated April 15, 2003, Dr. Baer opined that appellant had not yet reached maximum medical improvement on the left side and recommended that she be evaluated on both sides in approximately four months.

The Office subsequently referred appellant to Dr. Kimelman on September 2, 2003. In a report dated October 3, 2003, Dr. Kimelman opined that appellant had reached maximum medical improvement. He listed bilateral findings of a tender Tinel's sign and a 10-second Phalen's test. Dr. Kimelman further indicated that appellant had reduced two-point discrimination bilaterally. He found that neurological testing yielded results consistent with moderate carpal tunnel syndrome on both sides. Dr. Kimelman concluded that, on the right side, appellant had a 20 percent impairment due to loss of grip strength and a 3.9 percent impairment due to a sensory deficit of the median nerve below the mid forearm, which he combined to find a 14 percent permanent impairment of the right upper extremity.[20] On the left side, he found that

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

[15] *Id*.

[16] 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).

[17] *Jimmy A. Hammons*, 51 ECAB 219 (1999).

[18] *Id.*; *see also William J. Cantrell*, 34 ECAB 1233 (1983).

[19] *Mae Z. Hackett*, 34 ECAB 1421 (1983).

[20] A.M.A., *Guides* 482, 492, Tables 16-10, 16-15.

appellant had no impairment due to loss of grip strength and a 3.9 percent impairment due to pain in the median nerve below the midforearm, which he combined to find a total impairment of the left upper extremity of 2 percent.[21] However, as properly found by the Office medical adviser, the A.M.A., *Guides* specifically precludes the use of grip strength measurements in evaluating compression neuropathies such as carpal tunnel syndrome.[22]

In a supplemental report dated December 11, 2003, Dr. Kimelman found that appellant had a 3.9 percent impairment of the right and left upper extremity due to pain in the median nerve below the mid forearm according to Tables 16-11 and 16-15 on pages 484 and 492.[23] An Office medical adviser reviewed Dr. Kimelman's supplemental report and concurred with his findings.

As noted above, the A.M.A., *Guides* provides a specific method for determining the permanent impairment due to carpal tunnel syndrome. The A.M.A., *Guides* specifically notes 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* provides methods of rating an appellant depending on whether he or she has positive clinical findings of median nerve dysfunction and electrical conduction delay.[24] The A.M.A., *Guides* thus 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.[25]

In this case, it is not clear whether the electrodiagnostic testing relied upon by Dr. Kimelman in determining appellant's degree of permanent impairment were performed comtemporaneous to his September 26 and October 3, 2003 examinations. While Dr. Kimelman indicated in the October 3, 2003 report that he had performed electrodiagnostic studies, the date indicated on the test form accompanying Dr. Kimelman's report is March 10, 2003, seven months prior to October 3, 2003, the date appellant reached maximum medical improvement and six months prior to the date the Office referred her to Dr. Kimelman for an impairment evaluation.

As noted above, proceedings before the Office are not adversarial in nature and the Office is not a disinterested arbiter; in a case where the Office "proceeds to develop the evidence and to procure medical evidence, it must do so in a fair and impartial manner."[26] In this case, the

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[21] *Id*.

[22] *Id.* at 494.

[23] In the October 3, 2003 report, Dr. Kimelman used Table 16-10 rather than Table 16-11 in determining the grade of appellant's impairment.

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

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

[26] *Walter A. Fundinger, Jr.*, 37 ECAB 200, 204 (1985).

Office referred appellant for a second opinion evaluation to determine the extent of her permanent impairment due to her aggravation of bilateral carpal tunnel syndrome; however, it is not clear whether the electrodiagnostic studies relied upon by the second opinion physician in reaching his impairment determination were performed after appellant reached maximum medical improvement.

On remand, the Office should clarify whether the studies relied upon by Dr. Kimelman were performed contemporaneously with his examinations and impairment determination. If the studies were performed prior to the date appellant reached maximum medical improvement, the Office should refer appellant to an appropriate physician and authorize the necessary electrodiagnostic testing to determine the extent of her permanent impairment due to carpal tunnel syndrome. After such further development as the Office deems necessary, it should issue an appropriate decision.[27]

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 due to her accepted condition of an aggravation of bilateral carpal tunnel syndrome.

[27] On appeal, appellant contends that she should be placed on "permanent disability" due to her carpal tunnel syndrome. However, a schedule award is not intended to be compensation for wage loss or potential wage loss. Section 8107 provides a compensation schedule for payment of awards for permanent impairment of listed body members. The schedule establishes how many weeks of compensation an employee will receive in the event of total functional loss or dismemberment. Partial loss of function of the bodily member is awarded for a proportionate number of weeks. A schedule award is made without regard to whether or not there is a loss of wage-earning capacity resulting from the injury and regardless of its effects upon employment or social opportunities. *Renee M. Straubinger* 51 ECAB 667 (2000).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 17, 2003 is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: September 30, 2004
Washington, DC

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member