United States Department of Labor
Employees' Compensation Appeals Board

MICHELLE L. COLLINS, Appellant	)	
and	)	**Docket No. 05-443**
	)	**Issued: May 18, 2005**
U.S. POSTAL SERVICE, POST OFFICE, Kansas City, MO, Employer	)	

Appearances:
Michelle L. Collins, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On December 14, 2004 appellant filed a timely appeal from the September 17, 2004 merit decision of the Office of Workers' Compensation Programs, which denied modification of an earlier schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the schedule award issue.

ISSUE

The issue is whether appellant has more than a 10 percent impairment of her left upper extremity.

FACTUAL HISTORY

On September 10, 2001 appellant, then a 44-year-old manual clerk, filed an occupational disease claim alleging that she injured her wrists in the performance of duty while manually casing letters. The Office accepted her claim for bilateral carpal tunnel syndrome and authorized surgery. She underwent a left carpal tunnel release on April 30, 2002 and a right carpal tunnel release on August 6, 2002.

The record indicates that appellant requested a schedule award and on April 1, 2003 the Office medical adviser noted that she was eligible for an impairment rating. The Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. George Varghese, a specialist in physical medicine and rehabilitation, for an evaluation of permanent impairment.

On May 6, 2003 Dr. Varghese noted as follows:

> "Today[1] [appellant] reports that her right upper extremity symptoms have improved the most. The tingling sensation is gone and she no longer has the constant achy pain in her hand and forearm. [Appellant] does still occasionally have pain with certain activities, however, such as lifting heavy objects or pushing forcefully with the palmar aspect of her hand. She also feels much weaker in both hands. In addition to the weakness on the left, [appellant] notes persistent tingling at all times over the scar region at her wrist. She also complains of a sensation of numbness, primarily in the thumb, 4^{th} and 5^{th} digits and across the proximal aspect of the palm on the left side. [Appellant] is not currently taking any pain medications. She denies significant swelling in her hands."
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> "At work, the main activity which [appellant] is still unable to perform is lifting a full tray of mail, which causes pain over the proximal palms and thenar eminences. Instead, she carries only one half tray at a time. At home, she is unable to lift heavy objects, such as a gallon of milk, heavy pots and pans, groceries, buckets of water for cleaning or laundry baskets. [Appellant] also occasionally drops even light-weight items. [She] is able to complete her ADL's [activities of daily living] independently, though admits to some difficulty fastening her undergarments and curling her hair now. [Appellant] is independent with mobility without an assistive device and denies any problems with driving."

On physical examination Dr. Varghese noted mild weakness of the right abductor pollicis brevis (APB). Sensory testing revealed two-point discrimination of seven millimeters on the left and six millimeters on the right. Dr. Varghese concluded that appellant had residual symptoms of pain and weakness that interfered with some activities:

> "[Appellant] was treated for bilateral carpal tunnel syndrome with bilateral carpal tunnel releases. She does not have any significant residual impairment in range of motion. She does, however, complain of weakness in both hands now. Clinical exam[ination] reveals mild right thenar atrophy and weakness on the right APB. Additionally, [appellant] does have mild residual pain in the right hand which interferes with some activities. She is slightly more symptomatic in the left hand, with constant tingling in the wrist and worsening numbness, primarily along the ulnar nerve distribution. The residual symptoms of pain and weakness prevent [appellant] from lifting heavy objects both at work and at home and also interferes with several of her ADL's."

[1] Dr. Varghese examined appellant on May 5, 2003.

Finding that appellant had reached maximum medical improvement, Dr. Varghese used the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) to determine that she had an 11 percent impairment of the right upper extremity and a 16 percent impairment on the left. Using Table 16-10, page 482, he classified her sensory deficit or pain as Grade 3 bilaterally: "Distorted superficial tactile sensibility (diminished two-point discrimination), with some abnormal sensations or slight pain that interferes with some activities." From a range of 26 to 60 percent, Dr. Varghese rated the severity of appellant's deficit at 26 percent on the right and 40 percent on the left.

On May 14, 2003 Dr. Daniel D. Zimmerman, the Office medical adviser, informed Dr. Varghese that the grade he chose to classify appellant's sensory deficit or pain was excessive because, based to his two-point discrimination findings, it was obligatory to classify her as Grade 4 with a deficit range of 1 to 25 percent. "I will leave it to you to choose the grade," he stated. "I would, however, anticipate that the grades would be in the lower end of the spectrum since you found two-point discrimination on the right to be six millimeters and on the left seven millimeters in the distribution of the median nerve which is in the lower end of the spectrum for Grade 4 from Table 16-10."

On June 2, 2003 Dr. Varghese explained his rating:

> "I received the inquiry from Dr. Zimmerman regarding my impairment rating of [appellant]. I agree with [his] statement that two-point discrimination is only mildly abnormal, so could possibly use lower end of Grade 4. However, the reason I chose lower end of Grade 3 is because of the detailed history obtained which talked about how it interferes with the activity. According to Table 16-10, Grade 4 is when that is forgotten during activity. Based on the history, I felt that it does interfere with some of the activities so I decided to choose lower end for right upper extremity and middle grade for left upper extremity.
>
> "I hope Dr. Zimmerman will accept this explanation why I used Grade 3 instead of lower Grade 4."

On June 22, 2003 Dr. Zimmerman reported that, in his opinion, Dr. Varghese excessively emphasized the pain complaint using Table 16-10, page 482 and ignored column one of page 483, which indicates that grades of sensory deficit or pain are predicated in part on two-point discrimination. He stated that grading sensory deficit on the left at 40 percent was not credible: "Using reasonable medical judgment, a grade from Table 16-10 of 25 percent is the maximum that can be given and still conform to the fact that two[-]point discrimination was reported to be seven [millimeters]." Dr. Zimmerman addressed how a grade of 25 percent represented a 10 percent impairment of the left upper extremity under the A.M.A., *Guides*.

On June 26, 2003 the Office issued a schedule award for an 11 percent impairment of the right upper extremity and a 10 percent impairment of the left upper extremity.

Appellant requested reconsideration, but in decisions dated January 16 and September 17, 2004, the Office denied modification of the June 26, 2003 schedule award. On appeal she contests only the schedule award she received for her left upper extremity.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[2] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[3]

ANALYSIS

If, after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias or difficulties performing certain activities and there are positive clinical findings of median nerve dysfunction and electrical conduction delays, the impairment due to residual carpal tunnel syndrome is rated according to sensory or motor deficits.[4]

Table 16-10, page 482, of the A.M.A., *Guides* sets forth a grading scheme and procedure for determining impairment of the upper extremity due to sensory deficits or pain resulting from peripheral nerve disorders. Dr. Zimmerman, an Office medical adviser, correctly noted that the accompanying text on page 483 offers additional information to aid in the interpretation of the various grades of severity:

> "In interpretation of Table 16-10a, individuals in [G]rade 4 have diminished light touch, with fair (6-10 millimeters) to good two-point discrimination, localization of sensory stimuli and good protective sensibility. Abnormal sensations or pain, if present, is minimal and forgotten during activity. Individuals in [G]rade 3 have diminished light touch and two-point discrimination. There is mislocalization of sensory stimuli with some abnormal or increased irritability sensations or pain that interferes with activities. Protective sensibility is normal. Individuals in [G]rade 2 have decreased protective sensibility, which is defined as a conscious appreciation of pain, temperature or pressure before tissue damage results from the stimulus. They have diminished hand function. The mislocalization and overresponse (hyperesthesia or paresthesias, hyperpathia or allodynia) to sensory stimuli result in decreased manipulative skills and gripping function and complaints of hand weakness. It is possible to have gross appreciation of two-point discrimination (11-15 millimeters) at this level."

Dr. Zimmerman explained that appellant's 2-point discrimination of 7 millimeters fell within the range of 6 to 10 millimeters associated with Grade 4 and, therefore, Dr. Varghese's Grade 3 classification did not conform to the A.M.A., *Guides*. The Board notes, however, that

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001 the Office began using the A.M.A., *Guides* (5th ed. 2001).

[4] A.M.A., *Guides* 495; *see id.* at 482 (Table 16-10, page 482, is to be used for pain that is due to nerve injury or disease that has been documented with objective physical findings or electrodiagnostic abnormalities).

while the text does associate a 2-point discrimination of 6 to 10 millimeters with Grade 4, it then associates a discrimination of 11 to 15 millimeters with Grade 2, leaving Grade 3 no apparent range of its own.

Using these ranges of discrimination to draw a bright line between grades is not a workable application of the A.M.A., *Guides* because it effectively precludes a Grade 3 classification. Moreover, two-point discrimination is only one factor to consider when grading sensory deficit or pain under Table 16-10. The grade descriptions and the text on page 483 offer characterizations of tactile and protective sensibilities and pain that are intended to be helpful, not necessarily determinative. One cannot assume that all claimants will present with histories and complaints and symptoms that neatly fit into only one category. Proper classification may, therefore, require the examining physician's clinical judgment.

The A.M.A., *Guides* states that Table 16-10a classifies levels of "functional" sensibility.[5] It is the extent to which sensory deficit or pain affects activity that primarily distinguishes the grades. In Grade 4, sensory deficit or pain is forgotten during activity. In Grade 3, it interferes with some activities. In Grade 2, it may prevent some activities. In Grade 1, it prevents most activities. In Grade 0, it prevents all activity.

Dr. Varghese agreed that appellant's two-point discrimination was only mildly abnormal and that he could possibly classify her at the end of Grade 4, but he explained that he chose Grade 3 because her detailed history established that sensory deficit or pain interfered with some of appellant's activities. He noted that residual symptoms of pain and weakness prevented her from lifting heavy objects both at work and at home[6] and also interfered with several of appellant's activities of daily living. Dr. Varghese observed that under Grade 4 sensory deficit or pain is forgotten during activity, which did not reflect appellant's history.

Having based the grade of severity on the extent to which sensory deficit or pain affected appellant's activity, Dr. Varghese then estimated the appropriate percentage of sensory deficit or pain within the range of values shown for Grade 3. Here, the A.M.A., *Guides* makes clear that the examiner must use his or her clinical judgment.[7] Noting that appellant was slightly more symptomatic in the left hand, with constant tingling in the wrist and worsening numbness and taking into account only mildly abnormal two-point discrimination, Dr. Varghese chose the lowest deficit possible in Grade 3 for the right upper extremity and something short of the midpoint of the range for the left.

The Board has held that the opinion of an examining physician in the appropriate field of medicine takes precedence over the opinion of an Office medical adviser when considering subjective factors.[8] Because Dr. Varghese considered subjective factors and supported his

[5] *Id*. at 483.

[6] Sensory deficit or pain "that may prevent some activities," such as lifting a gallon of milk, is characteristic of Grade 2.

[7] A.M.A., *Guides* at 482.

[8] *Richard Giordano*, 36 ECAB 134 (1984).

opinion with sound rationale consistent with a proper application of the A.M.A., *Guides*, the Board finds that appellant is entitled to a greater schedule award for her left upper extremity. According to Table 16-15, page 492, the maximum upper extremity impairment due to unilateral sensory deficit of the median nerve below the midforearm is 39 percent. Following the procedure set forth in Table 16-10b, page 482, a 40 percent sensory deficit in Grade 3 multiplied by the 39 percent maximum value of the affected nerve is a 15.6 percent impairment of the left upper extremity, which rounds up to the 16 percent impairment determined by Dr. Varghese.

The Board will set aside the Office's September 17, 2004 decision, insofar as it awarded a schedule award of 10 percent impairment for the left upper extremity. The Board will remand the case to the Office to compensate appellant for 16 percent impairment of the left upper extremity.

CONCLUSION

The Board finds that appellant has a 16 percent impairment of her left upper extremity. Although the Office medical adviser opined that Dr. Varghese placed too much emphasis on her complaint of pain and that two-point discrimination required the selection of a lesser grade, the well-reasoned opinion of the examining physician takes precedence.

ORDER

IT IS HEREBY ORDERED THAT the September 17, 2004 decision of the Office of Workers' Compensation Programs is set aside on the issue of the left upper extremity and is otherwise affirmed. The case is remanded for further action consistent with this opinion.

Issued: May 18, 2005
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member