United States Department of Labor
Employees' Compensation Appeals Board

LINDA L. HERSHEY, Appellant	)	
and	)	**Docket No. 05-1118**
	)	**Issued: September 12, 2005**
U.S. POSTAL SERVICE, POST OFFICE, Bellmawr, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On April 22, 2005 appellant filed a timely appeal from the Office of Workers' Compensation Programs' December 6, 2004 merit decision regarding her entitlement to a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2), the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant did not meet her burden of proof to establish that she has more than a five percent permanent impairment of her right arm and a five percent permanent impairment of her left arm, for which she received schedule awards.

FACTUAL HISTORY

On March 29, 1999 appellant, then a 52-year-old flat sorter operator, filed an occupational disease claim alleging that she sustained bilateral carpal tunnel syndrome due to repetitive upper extremity motion required by her job. The Office accepted that appellant sustained employment-related bilateral carpal tunnel syndrome and authorized the performance

of left carpal tunnel release surgery on August 16, 1999 and right carpal tunnel release surgery on December 6, 1999.

Appellant received treatment for her upper extremity problems from Dr. Bruce A. Monaghan, an attending Board-certified orthopedic surgeon. In a report dated April 14, 1999, Dr. Monaghan noted that appellant sustained a left distal radius fracture in the past and indicated that she had good wrist motion and reported "minimal difficulties with regard to this deformity."[1] In a report dated February 9, 2000, Dr. Monaghan stated that appellant "appears to have new-onset cervical disc disease with radiculitis of her left upper extremity which is unrelated to her carpal tunnel syndrome." The results of April 25, 2000 electromyogram (EMG) and nerve conduction testing showed delayed median nerve sensory and motor conduction and were consistent with bilateral carpal tunnel syndrome and a left C6-7 radiculopathy.[2]

In May 2001 appellant claimed a schedule award compensation due to her bilateral carpal tunnel syndrome.

Appellant submitted a June 15, 2001 report in which Dr. Monaghan indicated that she had a 10 percent permanent impairment of each arm based on the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.

Appellant also submitted a February 12, 2001 report in which Dr. David Weiss, an attending osteopath and Board-certified orthopedic surgeon, discussed her upper extremity and neck complaints. Dr. Weiss concluded that appellant had a 19 percent permanent impairment of her left arm which was calculated by combining a 9 percent impairment "for the left C6 nerve root motor strength deficit" with another 9 percent impairment "for the left C6 nerve root motor strength deficit" and a 3 percent impairment "for pain-related impairment."[3] He also determined that appellant had a 13 percent impairment of her right arm which was calculated by combining a 4 percent impairment "for the right 4/5 motor strength deficit, thumb abduction" with another 6 percent impairment "for the right 4/5 motor strength deficit, biceps" and a 3 percent impairment "for pain-related impairment."[4]

In a July 22, 2002 report, an Office medical adviser determined that appellant had a 4 percent impairment due to a 4/5 motor loss deficits per the standards of Tables 16-11 and 16-15 of the A.M.A., *Guides*.

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[1] Other evidence of record indicates that the fracture occurred in 1997 or 1998 and that the injury was not employment related.

[2] Appellant also filed a claim (file number 02-2002411) for employment-related C6-7 radiculopathy and aggravation of her carpal tunnel syndrome.

[3] He indicated that these ratings were based on Tables 16-11 and 16-13 of the A.M.A., *Guides*. It appears that Dr. Weiss used the Combined Values Chart to combine his calculation figures. *See* A.M.A., *Guides* at 604-05 (5th ed. 2001).

[4] He indicated that these ratings were based on Tables 16-11 and 16-15 of the A.M.A., *Guides*. In a report dated October 16, 2002, Dr. Weiss indicated that appellant's cervical condition was not related to her carpal tunnel syndrome.

By award of compensation dated March 20, 2003, the Office granted appellant a schedule award for a four percent permanent impairment of her right arm. The award ran for 12.48 weeks.

Appellant requested a hearing before an Office hearing representative. Prior to the hearing being held, the Office hearing representative determined that the Office's March 20, 2003 decision should be set aside. She found that the impairment rating calculations contained in the medical reports of Dr. Monaghan and Dr. Weiss compelled the Office to refer appellant to another physician for a second opinion. The Office hearing representative remanded the case to the Office for this purpose and directed the Office, after any development deemed necessary, to issue a *de novo* decision on this matter.

The Office referred appellant to Dr. Irving Strouse, a Board-certified orthopedic surgeon, for a second opinion evaluation of her upper extremity impairment.

In a report dated December 24, 2003, Dr. Strouse concluded that appellant had a five percent permanent impairment of her right arm and a five percent permanent impairment of her left arm. Dr. Strouse noted appellant's complaints of pain, numbness and tingling in her arms and hands and her difficulty in grasping objects with her hands. He indicated that appellant also had cervical problems which were not accepted as work related and that she reported sustaining a fracture of her left distal radius in 1998. Dr. Strouse indicated that appellant had no muscle weakness in her upper extremities and adequate to excellent strength in the fingers and thumbs, respectively, in both hands. He indicated that EMG testing from April 25, 2000 showed delayed median nerve motor and sensory conduction indicative of mild residual bilateral carpal tunnel syndrome. Dr. Strouse concluded that appellant had a five percent permanent impairment of her right arm and a five percent permanent impairment of her left arm under the standards of the discussion of carpal tunnel syndrome found on page 495 of the fifth edition of the A.M.A., *Guides*.[5]

On January 20, 2004 an Office medical adviser indicated that he agreed with Dr. Strouse's assessment of appellant's upper extremity impairment.

By award of compensation dated January 20, 2004, the Office granted appellant a schedule award for an additional one percent permanent impairment of her right arm and for a five percent permanent impairment of her left arm.[6] The award ran for 18.72 weeks.

Appellant requested a hearing before an Office hearing representative which was held on September 28, 1994. Appellant argued that the Office wrongly discounted the opinion of Dr. Weiss and that his opinion created a conflict with that of Dr. Strouse. She further asserted that Dr. Strouse's rating calculations did not adequately consider her cervical problems or her left wrist fracture in the late 1990s and claimed that Dr. Strouse should have included rating figures for loss of upper extremity motion.

[5] Dr. Strouse indicated that there was no significant atrophy of the upper extremities, noting that there was some very mild atrophy of the thenar muscles. He indicated that appellant's left wrist lacked the last 10 degrees of flexion and the last 15 degrees of ulnar deviation.

[6] In total, appellant received schedule awards for a five percent permanent impairment of her right arm and a five percent permanent impairment of her left arm.

By decision dated and finalized December 6, 2004, an Office hearing representative affirmed the Office's January 20, 2004 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] and its implementing regulation[8] sets 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* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[9]

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

> "If, after an *optimal recovery time* following surgical decompression, an individual continues to complain of pain, paresthesias [abnormal sensation] 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 CTS [carpal tunnel syndrome] is rated according to the sensory and/or motor deficits as described earlier.[10]
>
> "2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS 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." (Emphasis in the original.)[11]

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999).

[9] *Id.*

[10] Table 16-10 at page 482 of the A.M.A., *Guides* is used, in conjunction with other tables identifying affected nerve distributions, for pain due to nerve injury or disease that has been documented with objective physical findings or electrodiagnostic abnormalities.

[11] *See* A.M.A., *Guides* at 495.

ANALYSIS

The Office accepted that appellant sustained employment-related bilateral carpal tunnel syndrome and authorized the performance of left carpal tunnel release surgery on August 16, 1999 and right carpal tunnel release surgery on December 6, 1999. In total, appellant received schedule awards for a five percent permanent impairment of her right arm and a five percent permanent impairment of her left arm. She claimed that she sustained a greater degree of upper extremity impairment.

The Office based its findings regarding appellant's upper extremity impairment on a December 24, 2003 report of Dr. Strouse, a Board-certified orthopedic surgeon to whom it referred her for a second opinion. Dr. Strouse concluded that appellant had a five percent permanent impairment of her right arm and a five percent permanent impairment of her left arm under the standards of the discussion of carpal tunnel syndrome found on page 495 of the fifth edition of the A.M.A., *Guides*. He therefore determined that appellant had a five percent impairment of the left upper extremity according to scenario 2 described in the A.M.A., *Guides* at page 495, regarding normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles.[12] However, it appears from Dr. Strouse's description of appellant's impairment that scenario 1 at page 495 of the A.M.A., *Guides* pertaining to median nerve dysfunction may provide for a higher percentage of impairment. The criteria for scenario 1 at page 495 includes positive clinical findings of nerve dysfunction and electrical conduction delays. Dr. Strouse stated that appellant had pain, numbness and tingling in her arms and hands, which suggests median nerve dysfunction. He also noted that EMG and nerve conduction testing revealed delayed median nerve motor and sensory conduction. In light of Dr. Strouse's findings regarding appellant's median nerve dysfunction, clarification is necessary to determine whether appellant's upper extremity impairment should be rated under scenario 1 of the A.M.A., *Guides*, rather than under scenario 2.[13] The Board finds that this case requires further medical development.

CONCLUSION

The Board finds that this case is not in posture for a decision regarding whether appellant has more than a five percent permanent impairment of her right arm and a five percent

[12] An Office medical adviser later indicated that he agreed with Dr. Strouse's assessment of appellant's upper extremity impairment, but he did not provide any further explanation of his reasoning.

[13] Appellant argued that the February 12, 2001opinion of Dr. Weiss, an attending osteopath and Board-certified orthopedic surgeon, supported a finding that she had a 19 percent permanent impairment of her left arm and a 13 percent impairment of her right arm. However, Dr. Weiss' calculations are inaccurate as he included appellant's cervical problems despite the fact that it has not been shown that these problems were employment related or preceded her carpal tunnel syndrome. *See Dale B. Larson*, 41 ECAB 481, 490 (1990) (finding that preexisting impairments of the body are to be included in impairment ratings). Moreover, Dr. Weiss failed to provide a full explanation of how his assessment of permanent impairment was derived in accordance with the standards of the A.M.A., *Guides*. For example, he made reference to tables concerning motor loss but did not identify specific grades for motor loss or the specific affected nerves. *See supra* note 9 and accompanying text. A June 15, 2001 report of Dr. Monaghan, which indicated that appellant had a 10 percent permanent impairment of each arm, is deficient for similar reasons.

permanent impairment of her left arm as it requires further medical development. On remand, the Office should request a supplemental report from Dr. Strouse to clarify his rating of appellant's upper extremity impairment with further explanation in support of his rating determination. After such further development as it deems necessary, the Office should issue an appropriate decision.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' December 6, 2004 decision is set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: September 12, 2005
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board