United States Department of Labor
Employees' Compensation Appeals Board

THOMAS N. ROSA, Appellant	)	
	)	**Docket No. 05-1184**
and	)	**Issued: September 16, 2005**
U.S. POSTAL SERVICE, POST OFFICE, Deerfield, FL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
WILLIE T.C. THOMAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On May 4, 2005 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit schedule award decision dated December 6, 2004. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case

ISSUE

The issue is whether appellant has more than a five percent impairment of the right upper extremity.

FACTUAL HISTORY

On December 7, 1998 appellant, then a 50-year-old distribution clerk, filed an occupational disease claim alleging that he developed bilateral carpal tunnel syndrome as a result of performing his clerk duties. He became aware of his condition on November 12, 1998 and did

not stop work. The Office accepted appellant's claim for bilateral carpal tunnel syndrome and authorized surgical releases which were performed on June 21 and October 5, 1999.[1]

Appellant submitted reports from Dr. Alan M. Lazar, a Board-certified orthopedic surgeon, from December 9, 1998 to October 5, 1999. He diagnosed bilateral carpal tunnel syndrome and recommended surgical intervention. Dr. Lazar noted that an electromyogram (EMG) dated January 2, 1999 revealed moderate to severe bilateral median neuropathies of the wrist. He performed a left carpal tunnel release on June 21, 1999 and a right carpal tunnel release on October 5, 1999. In reports dated October 19, 1999 to January 20, 2000, Dr. Lazar noted that appellant was progressing post surgery; however, he was still experiencing pain performing his light duties and recommended that he continue in physical therapy. On March 24, 2000 he determined that appellant reached maximum medical improvement and recommended permanent restrictions. Upon physical examination, Dr. Lazar noted tenderness around the surgical scars, tingling, subjective weakness, no neurovascular compromise, no atrophy and advised that neurologically appellant was grossly intact. He determined that, in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[2] appellant sustained a six percent whole body impairment.

By letter dated September 14, 2000, the Office requested that Dr. Lazar provide a determination of impairment of each upper extremity rather than the whole person impairment rating. In a report dated May 14, 2001, he noted the motor examination of the upper extremities was intact and symmetric, the sensory examination demonstrated intact sensation to light touch throughout, the reflexes were intact and symmetric at biceps, triceps and brachioradialis, the pulses were intact and there was no evidence of myelopathy.

On January 4, 2002 appellant filed a claim for a schedule award.

In a report dated January 18, 2002, an Office medical adviser determined that appellant was entitled to a five percent impairment of the right upper extremity based on page 495 of the A.M.A., *Guides* (5th ed. 2001). He indicated that Dr. Lazar's reports of March 24, 2000 and May 14, 2001 noted no neurological compromise, subjective weakness, no atrophy and advised that appellant was grossly intact.

By a decision dated February 22, 2002, the Office granted appellant a schedule award for five percent impairment of the right upper extremity. The period of the award was from March 24 to July 11, 2000. The Office reissued this decision on January 21, 2004 as it was originally mailed to the incorrect address.

By letter dated January 26, 2004, appellant requested an oral hearing before an Office hearing representative. The hearing was held on September 28, 2004. Appellant submitted a report from Dr. Nicholas Diamond, an osteopath, dated July 12, 2001, who stated that he reached

[1] Appellant filed a separate claim for a traumatic injury which occurred on February 28, 1996 which was accepted for sprain of the cervical, thoracic and lumbar spine, file number 06-0646924. This case was consolidated with the current case on appeal before the Board.

[2] A.M.A., *Guides* (4th ed. 1993).

maximum medical improvement on June 14, 2001. He noted that physical examination of the right wrist revealed a scar, dorsal and palmar tenderness, positive Tinel and Phalen's sign, dorsiflexion of 60/75 degrees, palmar flexion of 75/75 degrees, radial deviation of 20/20 and ulnar deviation of 35/35 degrees. Examination of the left wrist revealed dorsal and palmar tenderness, positive Tinel and Phalen's sign, dorsiflexion of 60/75 degrees, palmar flexion of 75/75 degrees, radial deviation of 20/20 and ulnar deviation of 35/35 degrees. Dr. Diamond further noted grip strength testing on the right via Jamar Hand Dynamometer at Level 3 revealed 25 kilogram of force strength versus 25 kilogram of force strength on the left. He noted that sensory examination revealed decreased pinprick and light touch over the C5-6 dermatomes bilaterally. Dr. Diamond diagnosed post traumatic L3-4 herniated nucleus pulposus, cumulative trauma to the bilateral wrists and hands, status post bilateral carpal tunnel syndrome release, chronic pain syndrome, chronic cervical and lumbosacral spine strain and sprain, right C5 and left C6 radiculopathy and bilateral lumbar radiculitis. He noted that, based on the A.M.A., *Guides* (5th ed.),[3] appellant would receive a 20 percent impairment on the right for grip strength deficit,[4] 4 percent impairment for right C5 sensory nerve root deficit,[5] 6 percent impairment for right C6 nerve root deficit,[6] 3 percent for pain-related impairment[7] for a total impairment rating of 31 percent of the right upper extremity. Dr. Diamond further noted a 20 percent impairment on the left for grip strength impairment,[8] 4 percent impairment for left C5 sensory nerve root deficit,[9] 6 percent impairment for left C6 nerve root deficit,[10] and 3 percent for pain-related impairment,[11] for a total of 31 percent permanent impairment for the left upper extremity.

In a decision dated December 6, 2004, the hearing representative affirmed the January 21, 2004 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[12] and its implementing regulation[13] 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

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

[4] Table 16-32, 16-34, page 509 (A.M.A., *Guides*).

[5] Table 16-13, 16-10, pages 489, 482 (A.M.A., *Guides*).

[6] *Id.*

[7] Figure 18-1, page 574.

[8] Table 16-32, 16-34, page 509 (A.M.A., *Guides*).

[9] Table 16-13, 16-10, pages 489, 482 (A.M.A., *Guides*).

[10] *Id.*

[11] Figure 18-1, page 574.

[12] 5 U.S.C. § 8107.

[13] 20 C.F.R. § 10.404 (1999).

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 regulations as the appropriate standard for evaluating schedule losses.

ANALYSIS

On appeal, appellant contends that he is entitled to an impairment rating of 31 percent for the right and left upper extremity as set forth by Dr. Diamond. The Board has carefully reviewed his report dated July 12, 2001, which determined appellant's upper extremity impairment and notes that, while Dr. Diamond determined that appellant sustained a 31 percent impairment of both the right and left upper extremities, he did not base his impairment estimates in accordance with the relevant standards of the A.M.A., *Guides*.[14] Office procedures[15] specifically provide that upper extremity impairment secondary to carpal tunnel syndrome and other entrapment neuropathies should be calculated using section 16.5d and Tables 16-10, 16-11 and 16-15.[16]

Regarding carpal tunnel syndrome, the A.M.A., *Guides* provide:

> "If, after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias 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 [computerized tomography scan] CTS 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] 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."[17]

[14] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

[15] *See* Federal (FECA) Procedure Manual, Part 2 -- Schedule Awards and Permanent Disability Claims, *Evaluation of Schedule Awards*, Chapter 2.808 (August 2002).

[16] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[17] A.M.A., *Guides*, *supra* note 8 at 495.

Section 16.5d of the A.M.A., *Guides* further provides that in rating compression neuropathies additional impairment values are not given for decreased grip strength.[18]

Dr. Diamond determined that appellant sustained a 20 percent impairment for grip strength deficit for both the right and left upper extremity.[19] However, as noted above, the A.M.A., *Guides* provides that, "in compression neuropathies, additional impairment values are not given for decreased grip strength."[20] Additionally, the Board has found that the fifth edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory impairments only. Dr. Diamond determined that appellant sustained a four percent impairment for both the right and left C5 sensory nerve root deficit[21] and a six percent impairment for both the right and left C6 nerve root deficit[22] and cited to Table 16-13, 16-10, pages 489, 482 (A.M.A., *Guides*). However, he failed to identify a percentage of sensory deficit between 1 and 25 percent as set forth in the A.M.A., *Guides*[23] or properly explain how he calculated a 4 percent impairment for the C5 sensory nerve and 6 percent impairment for the C6 sensory nerve for each of the left and right upper extremity using Table 16-13, page 489 of the A.M.A., *Guides.*[24] Dr. Diamond also found a three percent impairment for pain for each of the left and right upper extremities; however, he did not explain how this rating was made in conformance with the relevant standards of the A.M.A., *Guides*.[25]

The Office medical adviser who reviewed the medical evidence and correlated the findings of Dr. Lazar to the specific provisions in the A.M.A., *Guides.* On January 18, 2002 he determined that appellant sustained a five percent impairment of the right upper extremity in accordance with the A.M.A., *Guides*.[26] Dr. Lazar noted that appellant reached maximum medical improvement on March 24, 2000. The Office medical adviser indicated that Dr. Lazar noted subjective weakness, no neurological compromise, no sensory or motor deficits, no atrophy and advised that appellant was grossly intact. He cited to page 495 of the A.M.A., *Guides* and advised that, after optimal recovery time following surgical decompression, appellant experienced a residual carpal tunnel syndrome and would be entitled to an impairment rating of five percent of the upper extremity. This is consistent with the second criterion noted on that

[18] *Id.* at 494.

[19] Table 16-32, 16-34, page 509 (A.M.A., *Guides*).

[20] *See* page 494, the (5th ed.) of the A.M.A., *Guides; see also Robert V. Disalvatore*, 54 ECAB ___ (Docket No. 02-2256, issued January 17, 2003) (where the Board found that the (5th ed.) of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory impairments only).

[21] Table 16-13, 16-10, pages 489, 482 (A.M.A., *Guides*).

[22] *Id.*

[23] Table 16-10, page 482 (A.M.A., *Guides*).

[24] Table 16-13, page 489 (A.M.A., *Guides*).

[25] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992); *see also* FECA Bulletin No. 01-05, which precludes a rating for pain impairment if other methods to measure impairment due to sensory pain are used.

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

page of the A.M.A., *Guides*. As noted above, no consideration was given for grip strength deficit as the A.M.A., *Guides* provides that, "in compression neuropathies, additional impairment values are not given for decreased grip strength."[27] Additionally, an impairment rating for pain is precluded when other methods to measure impairment due to sensory pain are used as noted in Dr. Diamond's report of July 12, 2001.

The Office medical adviser properly applied the A.M.A., *Guides* to the information provided in the record and determined that appellant had a five percent impairment of the right upper extremity. This evaluation conforms to the A.M.A., *Guides* and establishes that he has no more than a five percent impairment of the right upper extremity.

CONCLUSION

The Board, therefore, finds that appellant has no more than a five percent impairment of the right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the December 6, 2004 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 16, 2005
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Willie T.C. Thomas, Alternate Judge
Employees' Compensation Appeals Board

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

[27] *See* page 494, the (5th ed.) of the A.M.A., *Guides; see also Robert V. Disalvatore*, 54 ECAB ___ (Docket No. 02-2256, issued January 17, 2003) (where the Board found that the (5th ed.) of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory impairments only).