United States Department of Labor
Employees' Compensation Appeals Board

J.C., Appellant	)	
and	)	**Docket No. 06-1877**
	)	**Issued: January 29, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 11, 2006 appellant filed a timely appeal from a schedule award decision of the Office of Workers' Compensation Programs dated August 2, 2006. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish that she has greater than a 12 percent impairment of the right upper extremity and a 5 percent impairment of the left upper extremity for which she has received schedule awards.

FACTUAL HISTORY

On July 22, 1992 appellant, then a 56-year-old mail handler, filed a Form CA-2, occupational disease claim, alleging that her employment duties caused pain in her fingers, hands and upper arms. On October 21, 1992 the Office accepted that she sustained employment-related bilateral carpal tunnel syndrome and bilateral shoulder tendinitis. Appellant underwent carpal tunnel repair on the left on March 3, 1993 and on the right on October 8, 1993. She returned to

limited duty for four hours a day on November 29, 1993. She received wage-loss compensation for four hours a day and retired effective December 5, 1994, electing to receive retirement benefits from the Office of Personnel Management.

On January 4, 2001 appellant filed a schedule award claim. The Office referred her to Dr. Robert D. Aiken, Board-certified in neurology, for an impairment evaluation. In an April 4, 2002 report, Dr. Aiken advised that February 21, 1995 was the date of maximum medical improvement. He noted examination findings of bilateral thenar muscle atrophy, full wrist range of motion, mild pain and no upper extremity weakness. In a report dated April 29, 2002, an Office medical adviser reviewed the medical record, including Dr. Aiken's evaluation. He agreed that maximum medical improvement had been reached on February 21, 1995. Based on appellant's complaints of mild pain and Dr. Aiken's findings of thenar atrophy bilaterally, under page 495 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*)[1] appellant had five percent impairment to both upper extremities.

By decision dated April 30, 2002, appellant was granted a schedule award for five percent impairment to each upper extremity. On May 26, 2002 she requested a hearing that was held on December 11, 2002. In a January 4, 2003 decision, an Office hearing representative affirmed the April 30, 2002 schedule award decision.

On August 20, 2003 appellant requested an additional schedule award. She submitted a December 24, 2002 report from Dr. Maxell Stepanuk, a Board-certified osteopath specializing in orthopedic surgery. He noted her complaints of cervical and hand pain. Examination findings included decreased shoulder motion on the left. Dr. Stepanuk's diagnosed cervical strain and sprain, degenerative arthritis of the cervical spine, disc bulges at C3-4, bilateral hand pain post carpal tunnel surgery and bilateral shoulder tendinitis and recommended treatment at a pain clinic. In a September 29, 2003 report, an Office medical adviser opined that Dr. Stepanuk's report was insufficient to establish entitlement to an increased schedule award because he did not provide an impairment rating establishing greater impairment due to the accepted carpal tunnel syndrome. He noted that the accepted shoulder tendinitis would not be a permanent condition. By decision dated October 1, 2003, the Office denied modification of the previous decision.

On November 14, 2004 appellant, through her attorney, submitted a November 1, 2004 report from Dr. Aaron J. Kolb, Board-certified in family and occupational medicine, who noted review of various medical records and appellant's complaints of upper extremity and shoulder pain. Examination findings included decreased shoulder range of motion and normal range of motion of the elbows, wrists and fingers with muscle atrophy at the thenar eminence and decreased sensation over the hands and fingers. Dr. Kolb utilized Tables 16-10, 16-11 and 16-15 to determine that appellant's right median nerve deficit below midforearm yielded a 16 percent sensory impairment and a 2 percent motor impairment for a total 18 percent right upper extremity impairment. He found no motor deficit on the left and determined that under Tables 16-15 and 16-10 she had a 16 percent left upper extremity sensory impairment. Dr. Kolb diagnosed bilateral carpal tunnel syndrome, bilateral shoulder tendinitis, bilateral hand and wrist

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

pain. He opined that appellant had reached maximum medical improvement and that pain alone provided a moderately severe impairment based on Tables 18-6 and 18-7 of the A.M.A., *Guides*.

In a January 2, 2005 report, an Office medical adviser opined that page 495 of the A.M.A., *Guides*, established a five percent left upper extremity impairment. Regarding the right upper extremity, he noted that Table 16-15 provided a maximum 39 percent sensory deficit and a 10 percent motor deficit. When combined with the 25 percent grade under Table 16-10, appellant had a 9.75 percent sensory impairment and 2.5 percent motor deficit equal a 12 percent right upper extremity impairment.

By decision dated January 25, 2005, appellant was granted a schedule award for an additional seven percent right upper extremity impairment, for a total of 152.88 days, to run from January 2 to June 2, 2004.[2]

On January 27, 2005 through her attorney, appellant requested a hearing and, on February 14, 2005, changed the request to a review of the written record. In a November 14, 2005 decision, an Office hearing representative found no evidence that she had a preexisting condition that would warrant an increased schedule award. However, a conflict in medical evidence was found between the opinions of Dr. Kolb and the Office medical adviser. The hearing representative remanded the case to the Office for referral to a Board-certified specialist for an impartial medical evaluation regarding appellant's entitlement to an increased schedule award.

On June 21, 2006 the Office referred appellant to Dr. Russell N. Worobec, Board-certified in orthopedic surgery, for an impartial evaluation. In a report dated July 11, 2006, Dr. Worobec noted his review of the statement of accepted facts and medical record. He advised that at the time of his examination appellant had recently been hospitalized for congestive heart failure. Dr. Worobec recorded her complaints of continued upper extremity pain and numbness. Physical examination demonstrated full active motion in the hands and wrists and manual thumb testing demonstrated excellent strength and flexion. Grip strength testing showed a lack of cooperation and pinprick testing demonstrated symptom magnification. Bilateral shoulder range of motion demonstrated a lack of 10 degrees of forward flexion and external rotation was minimally restricted. Dr. Worobec advised that maximum medical improvement was reached on November 1, 2004. He determined that under Table 16-15 appellant had below midforearm median nerve sensory and motor impairments. Pursuant to Table 16-10, she had a Grade 4 sensory impairment of 20 percent which, when multiplied by the maximum sensory impairment of 39 found at Table 16-15, yielded a bilateral sensory impairment rating of 7.8 percent. Dr. Worobec advised that, under Table 16-11 appellant's motor impairment was also a 20 percent, Grade 4 deficit. When multiplied by the maximum motor impairment of 10 percent found at Table 16-15, she had bilateral motor impairment of 2 percent. By decision dated August 2, 2006, the Office determined that appellant was not entitled to a schedule award greater than was previously awarded.

[2] The Board notes that the January 25, 2005 schedule award decision contains a typographical error stating that the award was for 152.88 weeks.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[3] and section 10.404 of the implementing federal regulation,[4] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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*[5] has been adopted by the Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[6]

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the figures and tables found in the A.M.A., *Guides*. However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.[7]

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.[8] 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 [carpal tunnel syndrome] (CTSS) 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 CTSS is still present, and an impairment rating not to exceed five percent of the upper extremity may be justified.

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] A.M.A., *Guides*, *supra* note 1.

[6] *See Joseph Lawrence, Jr., supra* note 1; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[7] *Robert V. Disalvatore*, 54 ECAB 351 (2003).

[8] A.M.A., *Guides*, *supra* note 1 at 433-521.

(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."[9]

Section 16.5b of the A.M.A., *Guides* describes the methods for evaluating upper extremity impairments due to peripheral nerve disorders and provides that the severity of the sensory or pain deficit and motor deficit should be classified according to Tables 16-10a and 16-11 respectively. The values for maximum impairment are then to be discerned, utilizing the appropriate table for the nerve structure involved. The grade of severity for each deficit is then to be multiplied by the maximum upper extremity impairment value for the nerve involved to reach the proper upper extremity impairment for each function. Mixed motor and sensory or pain deficits for each nerve structure are then to be combined.[10] The A.M.A., *Guides* provides that in evaluating the hand, the total range of motion percentages should be combined with the percentages for sensory loss.[11]

Section 8123(a) of the Act provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[12] When the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[13] Office procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from a physician is obtained.[14]

ANALYSIS

The Board finds that appellant has bilateral upper extremity impairment of 11 percent. The Office found that a conflict was created regarding appellant's degree of impairment between the opinions of Dr. Kolb and the Office medical adviser. Appellant was referred to Dr. Worobec for an impartial evaluation. In a July 11, 2006 report, Dr. Worobec opined that maximum medical improvement had been reached on November 1, 2004. He utilized Tables 16-15, 16-10 and 16-11 to determine that appellant had bilateral upper extremity sensory and motor impairments of 7.8 and 2 percent respectively.

Table 16-15 of the A.M.A., *Guides* provides maximum upper extremity impairment values caused by peripheral nerve injury.[15] Dr. Worobec found that appellant had a below

[9] *Id.* at 495.

[10] *Id.* at 481.

[11] *Janae J. Triplette*, 54 ECAB 792 (2003).

[12] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[13] *Manuel Gill*, 52 ECAB 282 (2001).

[14] *See Thomas J. Fragale*, 55 ECAB 619 (2004). Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(d) (August 2002).

[15] A.M.A., *Guides*, *supra* note 1 at 492.

midforearm median nerve impairment. Under Table 16-15, the maximum percent of upper extremity impairment for sensory deficit impairment is 39 percent and motor deficit is 10 percent.[16] Dr. Worobec utilized Tables 16-10 and 16-11 to determine that appellant had a Grade 4 impairment, which he rated as 20 percent. He properly multiplied each grade with the maximum 39 percent sensory impairment and 10 percent motor impairment to find that appellant had a bilateral upper extremity sensory impairment of 7.8, rounded to 8 percent and a bilateral motor impairment of 2 percent.[17]

The Board notes, however, that Dr. Worobec also found on physical examination that appellant lacked 10 degrees of forward shoulder flexion bilaterally. Figure 16-40 of the A.M.A., *Guides* provides that a lack of 10 degrees of forward shoulder flexion yields a 1 percent impairment.[18] Section 16.9 provides that motion impairments and peripheral nerve disorders are to be combined.[19] Thus, under the Combined Values Chart,[20] appellant would be entitled to an 11 percent right upper extremity impairment and an 11 percent left upper extremity impairment. As she has previously received a schedule award for 12 percent right upper extremity impairment, appellant is not entitled to an increased schedule award on the right. She, however, only received a schedule award for a five percent left upper extremity impairment. Therefore, she is entitled to a schedule award for an additional six percent for her left upper extremity.

CONCLUSION

The Board finds that appellant has not established greater than the 12 percent impairment of her right upper extremity impairment. She is entitled to an additional 6 percent impairment for her left upper extremity.

[16] *Id.*

[17] *Id.* at 482, 484. The policy of the Office is to round the calculated percentage of impairment to the nearest whole point. *Marco A. Padilla*, 51 ECAB 202 (1999).

[18] *Id.* at 476.

[19] *Id*. at 511-12.

[20] *Id.* at 604.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 2, 2006 be affirmed, as modified.

Issued: January 29, 2007
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board