

**United States Department of Labor
Employees' Compensation Appeals Board**

D.D., Appellant

and

**U.S. POSTAL SERVICE, POST OFFICE,
Duluth, GA, Employer**

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**Docket No. 07-1132
Issued: September 25, 2007**

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

Case Submitted on the Record

DECISION AND ORDER

Before:

DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 20, 2007 appellant filed a timely appeal from the March 6, 2007 merit decision of the Office of Workers' Compensation Programs, which awarded schedule award compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the schedule award.

ISSUE

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

FACTUAL HISTORY

On April 26, 2004 appellant, then a 34-year-old mail processor, filed a claim alleging that the pain in her wrists and right shoulder was a result of performing the duties of her federal employment on the workroom floor, which involved many repetitive tasks. The Office accepted right shoulder impingement syndrome and bilateral carpal tunnel syndrome (mild). Appellant underwent an authorized right shoulder arthroscopy on June 10, 1996 involving debridement of a

frayed rotator cuff, subacromial bursectomy and anterior near arthroplasty.¹ She underwent an authorized right carpal tunnel release on October 1, 2004.

Appellant submitted a June 6, 2006 impairment evaluation by Dr. Eric D. Solomon, a physiatrist, who reported that appellant complained of pain in her right shoulder girdle and right wrist, greater than left. On physical examination, Dr. Solomon described this pain as mild. He reported normal range of motion in all joints and 5/5 muscle strength throughout the upper extremities “except for external rotation 4/5.” Neurologically Dr. Solomon reported that appellant was intact “CN2-12.” He also reported mild sensation deficits in the right median nerve distribution and positive Tinel’s sign on the right. Dr. Solomon noted right shoulder pain at 145 degrees abduction. No diagnostic testing was available. Dr. Solomon determined that appellant had a two percent impairment of the right upper extremity due to lack of shoulder abduction. He appeared to find a two percent impairment due to strength deficit based on manual muscle testing of the right shoulder. Dr. Solomon reported a 10 percent impairment of the right upper extremity due to median nerve deficits.

On August 15, 2006 appellant filed a claim for a schedule award.

On November 30, 2006 Dr. Solomon offered a supplemental report clarifying his impairment rating:

“This letter is in response to the question of this patient’s impairment from shoulder girdle deficits. The impairment given was based specifically on weakness of the shoulder. I had indicated that she had rotator cuff weakness with 4/5 strength. In the report when I referred to movement I was speaking specifically of strength and the tables referred to in the report discuss the deficit specifically on the basis of strength impairment. This report does give shoulder strength deficits although joint range of motion is normal. There is no restriction in range of motion and there is no impairment for any range of motion restrictions.

“This patient has reached maximum medical improvement and I do not have information available regarding the time frame of surgery or follow-up physical therapy program. The patient certainly has reached maximum medical improvement at this point and most likely was at maximum medical improvement within one or two years following surgery.”

On January 18, 2007 an Office medical adviser reviewed Dr. Solomon’s findings and determined that appellant had a five percent impairment of her right upper extremity due to a mild median nerve deficit following carpal tunnel release. He found no impairment of the right upper extremity due to loss of shoulder motion or shoulder weakness with external rotation, noting that appellant was neurologically intact.

¹ The surgeon shaved the anterior and inferior surface of the acromion.

In a decision dated March 6, 2007, the Office awarded schedule compensation for a five percent permanent impairment of appellant's right upper extremity. On appeal, appellant asks for the percentage reported by Dr. Solomon.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act² 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment*.³

ANALYSIS

If, after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias 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.

“2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG [electromyogram] 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.”⁴

Dr. Solomon, appellant's evaluating physiatrist, found a 10 percent impairment of the right upper extremity under Scenario 1. He noted mild deficits in the right median nerve distribution and a positive Tinel's sign, so he applied the grading scheme and procedure for determining impairment due to sensory deficits or pain resulting from peripheral nerve disorders.⁵ But this method of evaluation is appropriate only in the presence of positive electrical conduction delays, and Dr. Solomon had no nerve conduction studies available for review.

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.

⁵ *Id.* at 482, Table 16-10; *see id.* at 492, Table 16-15.

The Office medical adviser found a five percent impairment of the right upper extremity under Scenario 2. But he did not justify this scenario in the absence of electrodiagnostics and explicit sensibility testing.

The Board finds that Dr. Solomon's evaluation does not permit a proper application of the A.M.A., *Guides* for evaluating impairment due to residual carpal tunnel syndrome. Where the impairment has not been correctly described, Office procedures state that a new or supplemental evaluation should be obtained.⁶ The Board will therefore set aside the March 6, 2007 schedule award and remand the case for further development of the medical evidence.

The only other impairment Dr. Solomon reported was a two percent impairment due to strength deficit from musculoskeletal disorders based on manual muscle testing of the shoulder.⁷ Although he reported that appellant was neurologically intact "CN2-12," appellant did undergo a right shoulder arthroscopy on June 10, 1996, with debridement of a frayed rotator cuff, subacromial bursectomy and anterior neer arthroplasty. So there may be an anatomic basis for the reported weakness. The A.M.A., *Guides* cautions, however, that decreased strength cannot be rated in the presence of painful conditions that prevent effective application of maximal force in the region being evaluated."⁸ As appellant's chief complaint included pain in her right shoulder girdle, and as Dr. Solomon reported right shoulder pain at 145 degrees abduction, it is unclear whether loss of strength may be rated separately.

The A.M.A., *Guides* states that because strength measurements are functional tests influenced by subjective factors that are difficult to control, and the A.M.A., *Guides* is for the most part based on anatomic impairment, the A.M.A., *Guides* does not assign a large role to such measurements.⁹ Nonetheless, in a rare case, if the examining physician believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the A.M.A., *Guides*, the loss of strength may be rated separately if based on unrelated etiologic or pathomechanical causes.¹⁰ On further development of this case, the examining physician should address whether there is any impairment of the shoulder and provide a rating that conforms with the A.M.A., *Guides*.

CONCLUSION

The Board finds that this case is not in posture for decision. The evaluation appellant submitted to support her claim for a schedule award does not sufficiently describe her

⁶ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.d(2) (August 2002); *see id.*, Chapter 2.808.6.a (the Office should advise any physician evaluating permanent impairment to use the applicable edition of the A.M.A., *Guides* and to report findings in accordance with those guidelines).

⁷ A.M.A., *Guides* 510, Table 16-35.

⁸ *Id.* at 508.

⁹ *Id.* at 507.

¹⁰ *Id.* at 508.

impairment in accordance with the A.M.A., *Guides*. Further development of the medical evidence is warranted.

ORDER

IT IS HEREBY ORDERED THAT the March 6, 2007 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: September 25, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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