United States Department of Labor
Employees' Compensation Appeals Board

G.V., Appellant	)	
and	)	**Docket No. 08-1551**
	)	**Issued: December 8, 2008**
DEPARTMENT OF TRANSPORTATION, FEDERAL AVIATION ADMINISTRATION, Oklahoma City, OK, Employer	)	

Appearances:
James R. Linehan, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 5, 2008 appellant, through her attorney, filed a timely appeal from a February 29, 2008 merit decision of the Office of Workers' Compensation Programs granting her a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

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

FACTUAL HISTORY

On March 14, 2005 appellant, then a 53-year-old packer, filed an occupational disease claim alleging that she experienced pain and numbness from her fingers, hands and wrists through her elbows due to factors of her federal employment. The Office accepted her claim for bilateral carpal tunnel syndrome.

Dr. Thomas Lehman, a Board-certified orthopedic surgeon, performed a right carpal tunnel release on August 10, 2005 and a left carpal tunnel release on November 23, 2005. In a report dated September 12, 2006, he discussed appellant's complaints of discomfort in her upper extremities and radiating pain throughout both arms. Dr. Lehman found two-point discrimination of 5 millimeters in all fingertips and measured grip strength of 18, 22, 22, 22 and 22 on the right and 14, 16, 18, 18 and 18 on the left. He opined that appellant had a one percent permanent impairment of the upper extremities bilaterally due to scarring and discomfort after her carpal tunnel releases. Dr. Lehman determined that appellant had reached maximum medical improvement.

On June 11, 2007 appellant filed a claim for a schedule award and submitted an impairment evaluation dated March 27, 2007 from Dr. John W. Ellis, Board-certified in family practice. He found that appellant had a minimally positive Finkelstein's test on the right and a positive Tinel's test bilaterally. Dr. Ellis provided grip strength measurements of 2, 4, 2, 3 and 3 kilograms on the right and 2 kilograms on the left and found two-point discrimination of the fingers ranging from 5 to 11 millimeters. He found tenderness to palpation of the right dorsal compartment bilaterally and some thenar atrophy. Dr. Ellis applied Table 16-10 and Table 16-15 on pages 482 and 492 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*) in finding a 15 percent permanent impairment of each upper extremity. He opined that appellant reached maximum medical improvement on January 9, 2006.

On July 11, 2007 an Office medical adviser compared the measurements for grip strength and two-point discrimination obtained by Dr. Ellis and Dr. Lehman. He was unable to determine a schedule award from either of the two reports due to discrepancies between the physical findings of the examining physicians. The Office medical adviser recommended referring appellant for a second opinion examination.

On July 23, 2007 the Office referred appellant to Dr. Michael Shawn Smith, a physiatrist, for a second opinion examination. In a report dated August 14, 2007, Dr. Smith discussed appellant's complaints of continued numbness and weakness bilaterally without significant wrist pain following bilaterally carpal tunnel releases. He measured range of motion of the wrists and grip strength. Dr. Smith found a positive Tinel's sign bilaterally and measured two-point discrimination from one to one and a half centimeters in the first one to one and a half digits bilaterally. He noted that appellant had a marked decrease in grip strength. Using Table 16-15 on page 492 of the A.M.A., *Guides*, Dr. Smith found that the maximum impairment of first one and a half digits was 23 percent. He further determined that appellant had a Grade 4, or 10 percent, sensory impairment of the median nerve for the first one to one-half digit bilaterally.[1] Dr. Smith multiplied the 10 percent sensory impairment by the maximum impairment allowed for an impairment of the first one and a half digits of 23 percent to find a 2.3 percent sensory impairment bilaterally.[2] He further found that appellant had a Grade 4, or 25 percent, impairment due to motor weakness bilaterally. Dr. Smith multiplied the 25 percent impairment due to motor weakness by 10 percent, the maximum impairment of the median nerve below the

[1] A.M.A., *Guides* 482, Table 16-10.

[2] *Id*. at 492, Table 16-15.

midforearm, to find a 2.5 percent bilateral impairment due to motor weakness. He combined his impairment findings due to sensory and motor loss and concluded that appellant had a five percent permanent impairment of the right and left upper extremity. Dr. Smith opined that she reached maximum medical improvement on September 12, 2006.

On January 23, 2008 an Office medical adviser reviewed Dr. Smith's report and concurred with his findings. He noted that the maximum impairment of the median nerve below the midforearm affecting the first two digits was 23 percent.

By decision dated February 29, 2008, the Office granted appellant schedule awards for a five percent impairment of each upper extremity. The award ran for 31.2 weeks from September 13, 2006 to April 19, 2007.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing federal regulations[4] set 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 for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[5] Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[6]

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 [CTS] is rated according to the sensory and/or m 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 5 percent of the upper extremity may be justified.

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] 20 C.F.R. § 10.404(a).

[6] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

(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."[7] (Emphasis in the original.)

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 Table 16-10 and 16-11 respectively. The impairment is evaluated by multiplying the grade of severity of the sensory or motor deficit by the respective maximum upper extremity value resulting from sensory or motor deficits of each nerve structure involved. When both sensory and motor functions are involved, the impairment values derived for each are combined.[8]

ANALYSIS

The Office accepted that appellant sustained bilateral carpal tunnel syndrome causally related to factors of her federal employment. Appellant underwent a right carpal tunnel release on August 10, 2005 and a left carpal tunnel release on November 23, 2005. On September 12, 2006 Dr. Lehman listed findings on examination of two-point discrimination of five millimeters in all fingertips and measured grip strength of 18, 22, 22, 22 and 22 on the right and 14, 16, 18, 18 and 18 on the left. He concluded that she had a one percent permanent impairment of the upper extremities bilaterally due to scarring and discomfort after her carpal tunnel releases. On March 27, 2007 Dr. Ellis measured grip strength as 2, 4, 2, 3 and 3 kilograms on the right and 2 kilograms on the left and found two-point discrimination of the fingers ranging from 5 to 11 millimeters. He determined that appellant had a 15 percent permanent impairment of the right and left upper extremity. An Office medical adviser reviewed the reports of Dr. Lehman and Dr. Ellis and asserted that he was unable to determine the extent of her upper extremity impairment due to the disparate findings on examination between Dr. Ellis and Dr. Lehman. He recommended referring appellant for a second opinion examination.

On August 14, 2007 Dr. Smith, an Office referral physician, discussed appellant's complaints of continued numbness and weakness bilaterally without "significant pain in [appellant's] wrist" following bilaterally carpal tunnel releases. He found a positive Tinel's sign and a loss of grip strength bilaterally. Dr. Smith measured two-point discrimination from one to one and a half centimeters in the first one to one and a half digits bilaterally. The A.M.A., *Guides* provides three scenarios for assessing impairment due to carpal tunnel syndrome following a surgical decompression.[9] When a physician finds positive clinical findings of median nerve dysfunction, the impairment due to residual carpal tunnel syndrome is to be rated according to the sensory and/or motor deficits described in section 16.5b of the A.M.A., *Guides*.[10] Dr. Smith found that the maximum impairment for sensory loss of the first one and a half digits was 23 percent, which he multiplied by a Grade 4, or 10 percent, sensory impairment

[7] A.M.A., *Guides* at 495.

[8] A.M.A., *Guides* at 481; *Kimberly M. Held*, 56 ECAB 670 (2005).

[9] *Id*.

[10] *See T.A.*, 59 ECAB ___ (Docket No. 07-1836, issued November 20, 2007).

of the median nerve, to find a 2.3 percent sensory impairment bilaterally.[11] He further found that appellant had a Grade 4 or 25 percent, impairment due to motor weakness which he multiplied by 10 percent, the maximum impairment of the median nerve, to find a 2.5 percent bilateral impairment due to motor weakness. Dr. Smith combined his impairment findings due to sensory and motor loss and concluded that she had a five percent permanent impairment of the right and left upper extremity. The Office medical adviser reviewed Dr. Smith's August 14, 2007 report and concurred with his findings. There is no probative medical evidence showing that appellant has a greater impairment.

On appeal appellant's attorney argues that the Office's decision was not supported by any medical findings. He contended that Dr. Ellis' opinion constituted the weight of the medical evidence. As noted, however, Dr. Smith's opinion constitutes the weight of the evidence and establishes that appellant has no more than a five percent impairment of each upper extremity.

CONCLUSION

The Board finds that appellant has no more than a five percent permanent impairment of each upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 29, 2008 is affirmed.

Issued: December 8, 2008
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[11] A.M.A., *Guides*, at 428, Table 16-10.