United States Department of Labor
Employees' Compensation Appeals Board

W.K., Appellant	)	
and	)	**Docket No. 07-2168**
	)	**Issued: February 11, 2008**
DEPARTMENT OF THE NAVY, PUGET SOUND NAVAL SHIPYARD, Bremerton, WA, Employer	)	

Appearances:
Appellant, pro se
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 August 22, 2007 appellant filed a timely appeal of the Office of Workers' Compensation Programs' hearing representative's merit decision dated May 31, 2007, finding that he was not entitled to additional schedule awards. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than five percent impairment of his right upper extremity and five percent impairment of his left upper extremity, for which he has received schedule awards.

FACTUAL HISTORY

On February 20, 2003 appellant, then a 65-year-old shipfitter, filed a traumatic injury disease claim alleging that he developed carpal tunnel syndrome (CTS) due to his employment duties. The Office accepted his claim for bilateral CTS on May 9, 2003. Dr. John D. Stewart, a

Board-certified orthopedic surgeon, performed a right carpal tunnel surgical release on June 25, 2003 and a left carpal tunnel surgical release on July 14, 2003. Appellant returned to light-duty work on August 11, 2003 and retired on August 29, 2003. He requested a schedule award on November 25, 2003. By decision dated May 7, 2004, the Office granted appellant a schedule award for five percent impairment of each of his upper extremities. He requested lump sum payment of this schedule award on May 26, 2004.

Dr. Stewart performed additional surgery on appellant's right wrist due to recurrent right CTS on March 28, 2005. The procedure was a neurolysis of the medial nerve in the right carpal tunnel with mobilization of the hypothenar fat pad flap. Dr. Stewart performed similar surgery on appellant's left wrist on April 18, 2005. Appellant requested an additional schedule award on November 2, 2005.

Appellant submitted additional electrodiagnostic studies dated November 2, 2005, which demonstrated a mild bilateral distal median neuropathy as a residual accepted bilateral CTS. He submitted a report of electrodiagnostic testing dated January 6, 2006 from Dr. Yu Zhu, a Board-certified neurologist, who stated that the nerve conduction studies revealed normal motor response in both median and both ulnar nerves. Dr. Zhu noted that sensory nerve conduction studies demonstrated prolonged latencies in both median nerves. He found that appellant had abnormal studies with mild median mononeuropathy with compression at the wrists bilaterally. In a report dated February 15, 2006, Dr. Zhu again noted that appellant's January 6, 2006 nerve conduction study and electromyelogram (EMG) showed abnormalities. He indicated that appellant could either live with his symptoms or seek an opinion of a different hand surgeon.

Dr. Neville A. Lewis, a Board-certified neurologist, examined appellant on March 31, 2006 and diagnosed bilateral flexor tenosynovitis and bilateral wrist arthrosis at the radial column as well as persistent mild neuropathy. On physical examination he found good range of motion of the wrists, well-healed surgical scars and mild loss of range of motion of the right wrist. Dr. Lewis noted full flexibility of appellant's digits and normal thenar strength. He found mild Tinel's sign and mildly positive Phalen's sign bilaterally. In an addendum dated April 28, 2006, Dr. Lewis found that appellant's examination was unchanged, that his right ring digit was still numb and that he demonstrated 40 pounds of grip strength on the right and 50 pounds on the left. He opined that appellant had five percent impairment of each upper extremity based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) due to persistent mild neuropathy.

The Office referred Dr. Lewis' report to the Office medical adviser on August 2, 2006. On August 8, 2006 the Office medical adviser concluded that appellant reached maximum medical improvement on March 31, 2006. He opined that the A.M.A., *Guides*, provided for no more than five percent impairment of each upper extremity due to normal sensibility and opposition strength with abnormal sensory or motor latencies or abnormal EMG testing of the thenar muscles.

By decision dated September 1, 2006, the Office denied appellant's claim for an additional schedule award on grounds that the medical evidence did not support an increase in the percentage of impairment as calculated by the A.M.A., *Guides*.

Appellant requested an oral hearing on September 26, 2006. He submitted a report dated October 6, 2006, noting his continuing complaints of hand pain with weakness and dropping of objects. Appellant testified at his oral hearing on February 27, 2007 and asserted that his symptoms had worsened following his repeat surgeries.

By decision dated May 31, 2007, the hearing representative found that the medical evidence did not support an impairment rating of more than five percent impairment of each of appellant's upper extremities due to his accepted bilateral CTS.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulations[2] 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 regulations as the appropriate standard for evaluating schedule losses.[3] Effective February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[4]

The A.M.A., *Guides* note that CTS involves compression of the median nerve at the volar aspect of the wrist.[5] The A.M.A., *Guides* list the symptoms, signs and findings of CTS as pain and paresthesias in the median nerve distribution, including sensory autonomic disturbances in the radial 3.5 digits, weakness or atrophy of the thenar muscles, a positive percussion sign at the wrist, presence of Phalen's sign and motor and sensory electroneuromyographic abnormalities.[6]

In evaluating CTS, the A.M.A., *Guides* provide that, 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. The first situation is: "Positive clinical finding of median nerve dysfunction and electrical conduction delay(s): The impairment due to residual CTS is rated according to the sensory and/or motor deficits as described earlier."[7] In this situation, the impairment due to residual CTS is evaluated

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999).

[3] *Id.*

[4] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims,* Chapter 2.808.6(a) (August 2002).

[5] A.M.A., *Guides* 495.

[6] *Id.*

[7] *Id.*

by multiplying the grade of severity of the sensory or motor deficit by the respective maximum upper extremity impairment 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]

In the second scenario: "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." Finally, the A.M.A., *Guides* provide: "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]

ANALYSIS

Appellant received a schedule award for five percent impairment of each of his upper extremities due to evidence of continued CTS following surgery on May 7, 2004. He underwent additional surgeries on each hand in 2005. Appellant then requested an additional schedule award. Dr. Zhu, a Board-certified neurologist, completed nerve conduction studies on January 6, 2006 and found that sensory nerve conduction studies demonstrated prolonged latencies in both median nerves. Dr. Lewis, a Board-certified neurologist, reviewed Dr. Zhu's findings and examined appellant on March 31 and April 28, 2006. He reported clinical findings of mild Tinel's sign and mildly positive Phalen's sign bilaterally as well as numbness of appellant's right ring finger and loss of grip strength on the right. Dr. Lewis opined that appellant had five percent impairment of each upper extremity based on the A.M.A., *Guides* due to persistent mild neuropathy.

While Dr. Lewis provided findings on clinical examination including a mildly positive Phalen's sign, numbness of the right ring finger and loss of grip strength on the right, he did not opine that these findings were sufficient to constitute the "positive clinical findings of median nerve dysfunction" required by the A.M.A., *Guides,* which in addition to appellant's electrical conduction delays reported by Dr. Zhu would qualify appellant for evaluation under the first method of impairment rating listed above.[10] Instead, he and the Office medical adviser apparently agreed that appellant demonstrated normal sensibility and opposition strength with an abnormal sensory latency indicating that a residual CTS was still present. Both physicians agreed that appellant was entitled to an impairment rating of not more than five percent of the upper extremity in accordance with the second scenario presented in the A.M.A., *Guides* and listed above.[11] As there is no medical evidence in the record supporting that appellant has positive clinical findings of median nerve dysfunction, then there is no evidence that he is entitled to more than five percent impairment of each of his upper extremities. Appellant

[8] *Id*. at 494, 481.

[9] *Supra* note 5.

[10] *Supra* note 5. The Board notes that it is possible to receive a schedule award due to CTS of more than five percent unilaterally due to impairment of the median nerve under this evaluation method.

[11] *Supra* note 5.

received a schedule award for this degree of impairment on May 7, 2004 and the record currently before the Board does not support an additional schedule award.

CONCLUSION

The Board finds that the medical evidence does not support that appellant has more than five percent impairment of each upper extremity for which he has received schedule awards. Therefore, appellant is not entitled to any additional schedule award under the Act.

ORDER

IT IS HEREBY ORDERED THAT the May 31, 2007 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 11, 2008
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