United States Department of Labor
Employees' Compensation Appeals Board

G.S., Appellant **and** **DEPARTMENT OF THE NAVY, TRIDENT REFIT FACILITY, Kings Bay, GA, Employer**	))))))))	**Docket No. 08-559** **Issued: June 16, 2008**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On December 18, 2007 appellant filed a timely appeal from an Office of Workers' Compensation Programs' schedule award decision dated November 15, 2007. 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 five percent permanent impairment of both his right and left upper extremities for which he received a schedule award.

FACTUAL HISTORY

On April 4, 2006 appellant, then a 56-year-old mechanical production controller, filed an occupational disease claim alleging that he sustained bilateral carpal tunnel syndrome (CTS) in the performance of duty. He realized the condition was caused or aggravated by his employment on December 14, 2005. Appellant did not initially stop work.

On May 10, 2006 the Office accepted his claim for bilateral CTS. The Office authorized right and left carpal tunnel releases, which were performed on May 22 and June 12, 2006. He received appropriate compensation benefits.

On July 2, 2007 appellant requested a schedule award.

By letters dated July 16 and September 21, 2007, the Office requested that appellant's physician provide an assessment of permanent impairment based upon the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (5th ed. 2001) (A.M.A., *Guides*).

In an October 9, 2007 report, Dr. Chason Hayes, a Board-certified orthopedic surgeon and treating physician, noted that appellant had complaints of bilateral hand pain with numbness, and a long history of CTS. He advised that, despite surgery over a year prior, appellant had "never really gotten any better." Dr. Hayes examined the right and left wrists and noted tenderness over the scar, no swelling or effusion, full flexion, extension, supination and pronation. He opined that appellant had a 30 percent permanent impairment to both wrists due to decreased motion, grip strength and residual neurological deficits. Dr. Hayes advised that appellant had severe residual symptoms but there were no restrictions in his duties.

In a November 8, 2007 report, the Office medical adviser noted appellant's history of injury and treatment, which included bilateral carpal tunnel releases on May 22 and June 12, 2006. He utilized the A.M.A., *Guides* and found that maximum medical improvement was reached on October 9, 2007, the date of Dr. Hayes' report. The Office medical adviser noted that appellant had bilateral pain and numbness in the median nerve tendons bilaterally with 4/5 grip strength loss but no sensory deficit and full range of motion. He noted that it would be reasonable for appellant to have a five percent permanent impairment on account of residuals for each upper extremity following carpal tunnel surgery release. Furthermore, the Office medical adviser explained that a rating of 30 percent would not be warranted according to page 508 of the A.M.A., *Guides* because loss of strength was not to be used in cases of decreased motion, pain, deformities or amputations.

In a memorandum of telephone call dated November 14, 2007, appellant advised the Office that the schedule award should be paid based on the Office medical adviser's report. Appellant indicated that he did not wish to wait any longer.

On November 15, 2007 the Office granted appellant a schedule award for a five percent permanent impairment to both the right and left arms. The award covered a period of 31.2 weeks from October 9, 2007 to May 14, 2008.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[1] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions

[1] 5 U.S.C. §§ 8101-8193.

and organs of the body.[2] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[3] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[4]

The fifth edition of the A.M.A., *Guides*, regarding CTS, provides that 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 CTS is rated according to the sensory and/or motor deficits; (2) 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; and (3) normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies, in which case there is no objective basis for an impairment rating.[5]

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 tables in the A.M.A., *Guides*.[6] 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.

ANALYSIS

The Office accepted that appellant sustained bilateral CTS in the performance of duty and authorized bilateral carpal tunnel releases.

Dr. Hayes provided some findings, but failed to provide an impairment rating that comports with the A.M.A., *Guides*. For example, he stated that appellant had a 30 percent permanent impairment to both wrists due to decreased motion, grip strength and residual neurological deficits. However, Dr. Hayes did not explain how he derived this estimate with reference to the specific tables in the A.M.A., *Guides*. Furthermore, regarding lost motion, the Board has found that the fifth edition of the A.M.A., *Guides* provides that impairment for CTS

[2] 5 U.S.C. § 8107.

[3] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[4] A.M.A., *Guides* (5th ed. 2001); 20 C.F.R. § 10.404.

[5] *Silvester DeLuca*, 53 ECAB 500 (2002); A.M.A., *Guides* 495.

[6] *See William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

be rated on motor and sensory deficits only.[7] Likewise, in evaluating impairment due to carpal tunnel syndrome, there generally will be no ratings based on loss of grip strength.[8]

It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the protocols of the A.M.A., *Guides*, his opinion is of diminished probative value in establishing the degree of any permanent impairment. In such cases, the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[9]

The Office determined that appellant had five percent impairment to his left and right upper extremities. The Office medical adviser applied the A.M.A., *Guides*. Pursuant to the A.M.A., *Guides,* the second category Chapter 16, section 16.5d states that, when normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal electromyogram testing of the thenar muscles, a residual CTS is still present, an impairment rating not to exceed five percent of the upper extremity may be justified.[10] The Office medical adviser determined that, based on appellant's residuals following surgery, he had five percent impairment to each upper extremity. The Board finds that the Office medical adviser properly applied the A.M.A., *Guides*. There is no evidence of record that appellant sustained greater than five percent impairment to each upper extremity. The Office properly found that appellant had five percent impairment to his left upper extremity and five percent impairment to his right upper extremity.

CONCLUSION

The Board finds that appellant does not have more than five percent impairment of his left upper extremity and five percent impairment of his right upper extremity.

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

[8] *See E.L.*, 59 ECAB ___ (Docket No. 07-2421, issued March 10, 2008).

[9] *See John L. McClanic*, 48 ECAB 552 (1997); *see also Paul R. Evans*, 44 ECAB 646, 651 (1993).

[10] *See* A.M.A., *Guides* 495.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 15, 2007 is affirmed.

Issued: June 16, 2008
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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