United States Department of Labor
Employees' Compensation Appeals Board

M.B., Appellant	)	
and	)	**Docket No. 08-1044**
	)	**Issued: September 18, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Kansas City, MO, Employer	)	

Appearances:
Appellant, pro se
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 February 25, 2008 appellant filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated February 7, 2008 finding that she was not entitled to an additional schedule award. 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 15 percent impairment of her right upper extremity and 4 percent impairment of her left upper extremity for which she has received schedule awards.

FACTUAL HISTORY

On June 2, 1996 appellant, then a 49-year-old human resources specialist, filed an occupational disease claim alleging that she developed carpal tunnel syndrome due to factors of her federal employment. The Office accepted her claim for right carpal tunnel syndrome on July 30, 1996. Appellant underwent a right carpal tunnel release on May 22, 1997 and left carpal

tunnel release on July 7, 1997. The Office granted appellant a schedule award for 15 percent impairment of the right upper extremity and 4 percent impairment of the left upper extremity on November 25, 1998.[1] The Office terminated appellant's wage-loss compensation on January 14, 1999. The Branch of Hearings and Review affirmed this decision on June 24, 1999.

Appellant filed a recurrence of disability claim on May 13, 1999. The Office authorized medical treatment for bilateral carpal tunnel syndrome on May 10, 2000. Appellant underwent a nerve conduction study on June 1, 2000 which was normal with no evidence of carpal tunnel syndrome. She filed an additional recurrence of disability claim on May 7, 2001.

Appellant's attending physician, Dr. Bernard M. Abrams, a Board-certified neurologist, completed a report on February 3, 2003. He stated that appellant did not have carpal tunnel syndrome but had a chronic pain syndrome of both upper extremities. On February 24, 2003 Dr. Abrams noted that appellant did not require additional carpal tunnel surgery and diagnosed bilateral carpal tunnel syndrome and chronic pain syndrome. On July 16, 2003 he found that appellant's forearms were swollen and painful and that Tinel's sign was positive. Appellant underwent electrodiagnostic testing on July 28, 2003 which revealed a thenar muscle atrophy, but no acute median entrapment neuropathy or ulnar entrapment neuropathies.

Following Dr. Abrams' retirement, the Office authorized Dr. Samuel R. Lehman, a Board-certified neurologist, as appellant's attending physician. In a report dated December 20, 2005, Dr. Lehman found appellant had electrodiagnostic findings from a December 20, 2005 electromyelogram (EMG) consistent with carpal tunnel syndrome on the right and recommended a repeat surgical decompression. He stated that the distal latency of the right medial nerve was 3.8 with an amplitude of 3.0 mV while normal was less than 4.2. Dr. Lehman repeated his findings and conclusions on July 7, 2006. In a report dated December 5, 2006, he stated that appellant's symptoms had increased, but that she had reached maximum medical improvement unless further surgery was performed.

In a letter dated May 24, 2007, the Office informed appellant that medical evidence was required to establish her entitlement to an additional schedule award. On June 11, 2007 Dr. Lehman stated that appellant had increasing weakness of her right hand consistent with carpal tunnel syndrome and that she had reached maximum medical improvement. He referred appellant to Dr. Steven Simon, a physiatrist, for an impairment rating. In a report dated June 13, 2007, Dr. Simon noted appellant's history of injury and medical history. He found a loss of grip strength on the right and wasting of the first dorsal interosseous on the right. Dr. Simon stated, "Sensory examination using monofilament appears to be physiologic in sensation; however, there is a misinterpretation of sensation as a burning one when this is touched to the hand." He found that the vibratory test shows minus nine in both median and ulnar tests on the right and minus four on the left. Dr. Simon concluded that appellant had a Grade 4 impairment of the left upper extremity or a 20 percent sensory deficit of the left upper extremity[2] and 40 percent sensory deficit on the right due to a Grade 3 impairment.[3] He also found 20 percent loss of

[1] The record reflects that the Office accepted left carpal tunnel syndrome under a different claim number.

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

[3] *Id.*

strength on the right and 10 percent loss of strength on the left based grip strength.[4] He concluded that appellant had 30 percent impairment of the right upper extremity and 17 percent impairment of the left upper extremity. Dr. Simon stated that appellant had residual carpal tunnel based on EMG on the right.

The Office medical adviser reviewed Dr. Simon's report on August 11, 2007 and stated that it was inappropriate to use the grip strength table to measure appellant's impairment due to carpal tunnel syndrome. He concluded that Dr. Simon did not follow the A.M.A., *Guides* and his estimate was inappropriate for determining appellant's impairment for schedule award purposes.

By decision dated February 7, 2008, the Office denied appellant's request for an additional schedule award on the grounds that Dr. Simon did not use the appropriate sections of the A.M.A., *Guides* to evaluation appellant's impairment.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulation[6] 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 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 regulation as the appropriate standard for evaluating schedule losses.[7] 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.[8]

In evaluating carpal tunnel syndrome, 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 [carpal tunnel syndrome] is rated according to the sensory and/or motor deficits as described earlier."[9] In this situation, the impairment due to residual carpal tunnel syndrome is evaluated 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

[4] *Id.* at 509, Table 16-34.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999).

[7] *Id.*

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

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

sensory and motor functions are involved the impairment values derived for each are combined.[10] 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 [carpal tunnel syndrome] is still present, and an impairment rating not to exceed five percent of the upper extremity may be justified." In the final situation: "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."[11]

To accurately evaluate sensory impairment clinically and reduce the subjective nature of these findings,[12] the A.M.A., *Guides* recommend either the two-point test for fine discrimination, the monofilament touch-pressure threshold test or the pinprick test.[13]

Grip strength is used to evaluate power weaknesses related to the structures in the hand wrist or forearm.[14] The A.M.A., *Guides* do not encourage the use of grip strength as an impairment rating because strength measurements are functional tests influenced by subjective factors that are difficult to control and the A.M.A., *Guides* for the most part is based on anatomic impairment. Thus the A.M.A., *Guides* does not assign a large role to such measurements. Only in rare cases should grip strength be used, and only when it represents an impairing factor that has not been otherwise considered adequately.[15] The A.M.A., *Guides* state, "*Otherwise, the impairment ratings based on objective anatomic findings take precedence*." (Emphasis in the original.)[16] It is the responsibility of the evaluating physician to explain in writing why a particular method to assign the impairment rating was chosen.[17]

ANALYSIS

Appellant received schedule awards for 15 percent impairment of her right upper extremity and 4 percent impairment of her left upper extremity. She requested an additional schedule award and submitted a report from Dr. Lehman, a Board-certified neurologist, noting that her symptoms had worsened and recommending additional surgery. Dr. Lehman stated that appellant had reached maximum medical improvement absent additional surgery. Appellant submitted a report dated June 13, 2007 from Dr. Simon, a physiatrist, detailing her current permanent impairment. Dr. Simon provided impairment ratings for sensory deficits and loss of

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

[11] *Id.* at 495.

[12] *Id.* at 446.

[13] *Id.* at 445.

[14] *Id.* at 508, 16.8b.

[15] *Id.* at 507, 16.8 Strength Evaluation; *Cerita J. Slusher*, 56 ECAB 532 (2005); *Mary L. Henninger*, 52 ECAB 408, 409 (2001).

[16] A.M.A., *Guides* 508.

[17] *Tara L. Hein*, 56 ECAB 431 (2005).

grip strength of both upper extremities. He did not mention the appropriate section of the A.M.A., *Guides* for evaluating permanent impairment due to carpal tunnel syndrome. As noted, this section allows for three possible scenarios. The record before the Board suggests that appellant's right upper extremity could be evaluated in accordance with the first scenario as appellant demonstrated electrical conduction delay as well as clinical findings of medial nerve dysfunction. This section would allow for evaluation of sensory deficits of the right upper extremity in accordance with Dr. Simon's report. He found that appellant had a Grade 3, 26 to 60 percent, sensory impairment of the median nerve with a value of 39 percent[18] or 40 percent impairment. However, as there is no evidence in the record of positive clinical findings of median nerve dysfunction and electrical conduction delays in the left upper extremity, a separate scenario would be applicable for evaluating this scheduled member not to exceed five percent. Dr. Simon did not address which scenario provided by the A.M.A., *Guides* was appropriate for appellant's left upper extremity.

Dr. Simon evaluated appellant's loss of strength in both upper extremities based on a loss of grip strength. However, this method of evaluation is not favored under the A.M.A., *Guides.* Dr. Simon did not offer any medical reasoning for using this rating method rather than evaluating the loss of strength in the right upper extremity in appropriate muscle in accordance with Table 16-11[19] as directed by the A.M.A., *Guides*.

The Office medical adviser reviewed Dr. Simon's report and disagreed with his impairment ratings based on grip strength. However, he did not provide analysis or any impairment regarding appellant's sensory deficits. The Board finds that the case is not in posture for decision as there is no medical evidence comporting to the A.M.A., *Guides* for evaluating appellant's permanent impairment due to bilateral carpal tunnel syndrome. On remand, the Office should develop the evidence to address the extent of permanent impairment in accordance with the A.M.A., *Guides*.

CONCLUSION

The Board finds that this case is not in posture for decision as further medical development is necessary. On remand the Office should refer appellant to an appropriate physician to determine the extent of any additional impairment.

[18] A.M.A., *Guides* 492, Table 16-15.

[19] *Id.* at 484, Table 16-11.

ORDER

IT IS HEREBY ORDERED THAT the February 7, 2008 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded for further development consistent with this decision of the Board.

Issued: September 18, 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