United States Department of Labor
Employees' Compensation Appeals Board

R.D., Appellant	)	
and	)	**Docket No. 08-1080**
	)	**Issued: September 23, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Minneapolis, MN, Employer	)	

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 March 4, 2008 appellant filed a timely appeal from the December 10, 2007 merit decision of the Office of Workers' Compensation Programs, which denied an increased schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant has more than a 7 percent permanent impairment of his right upper extremity or more than a 16 percent permanent impairment of his left upper extremity causally related to the accepted employment injury.

FACTUAL HISTORY

On December 28, 1995 appellant, then a 51-year-old letter sorting machine clerk, filed a claim alleging that his carpal tunnel syndrome was a result of his federal employment: "I have been keying mail in a letter sorting machine for 11 years. I believe that repetitive movement of hands and fingers caused it. Also I have been sorting and reviewing mail manually up to the

present date." The Office accepted his claim for bilateral carpal tunnel syndrome. It determined that this injury caused a five percent permanent impairment of each upper extremity due to very mild median nerve compression at the wrist.

Appellant underwent a right carpal tunnel release on January 31, 2005. He later requested an increased schedule award and submitted an evaluation of his impairment. On November 22, 2005 Dr. Roeber-Rice, a resident specialist in occupational medicine, evaluated appellant with Dr. Beth A. Baker, an occupational medicine staff physician. Dr. Roeber-Rice related appellant's history and complaints. She noted that he had no electromyography (EMG) after his surgery. Dr. Roeber-Rice noted that appellant had a history of diabetes and had some paresthesias in his feet. On physical examination, testing range of motion elicited a marked response. Dr. Roeber-Rice reported 2/5 motor strength on the right and 3/5 on the left. She stated that sensory testing was quite inconsistent but "[appellant] is intact to light touch to the upper extremities bilaterally." Two-point discrimination was 15 millimeters (mm) in the forearms bilaterally, 18 mm in the right hand[1] and 11 mm in the left hand. There was no muscle atrophy or wasting. Specifically, the thenar eminence was symmetric bilaterally. Tinel's and Phalen's signs were both positive bilaterally.

Dr. Roeber-Rice stated that a rating was complicated "due to some discrepant exam[ination] findings between examiners Dr. Baker and myself." In addition, appellant's two-point discrimination -- worse in the forearms than distally in the wrist -- was not consistent with median nerve compression.

> "However, pursuant to the A.M.A., *Guides*, 5th edition, based on evaluation of carpal tunnel syndrome symptoms following surgical compression on page 495, indicate that residual symptoms may justify a rating not to exceed five percent of the upper extremity. This would equate to three percent of the whole person for the right hand and three percent for the left hand of whole person impairment."

Dr. Roeber-Rice also evaluated impairment due to range of motion and sensory and motor loss. She found a 17 percent impairment due to loss of wrist motion on the right, as well as a 6 percent impairment due to 2/5 motor strength and 20 percent due to 3/5 sensory loss. On the left, Dr. Roeber-Rice found a 13 percent impairment due to loss of wrist motion, a 3 percent impairment due to motor strength and a 20 percent loss due to sensory loss.

Dr. Baker examined appellant and reviewed Dr. Roeber-Rice's findings. She noted that strength was 2/5 on the right and 3/5 on the left but "it is difficult to tell if he is making significant effort." Sensory testing was "also insignificant."[2] Dr. Baker reported somewhat inconsistent grip strength and stated it was difficult to know how to rate appellant. She found that appellant was at maximum medical improvement on the right and stated that he might improve if he had carpal tunnel surgery on the left.

[1] Two-point discrimination greater than 15 mm is considered a total sensory loss, with no response to touch, pinprick, pressure or vibratory stimuli. American Medical Association, *Guides to the Evaluation of Permanent Impairment* 446-447 (5th ed. 2001).

[2] It appears she meant "inconsistent."

Dr. Baker rated appellant under Scenario 2, page 495 of the A.M.A., *Guides* (5th ed. 2001):

> "Page 495 of the A.M.A., *Guide*s, they talked about evaluation of carpal tunnel syndrome and talked about residual symptom should not justify rating to exceed more than five percent of the upper extremity. Reviewing his symptoms in his right and left hand, it appears that he has approximately three percent whole person impairment in the right hand and three percent of the left hand regarding his carpal tunnel syndrome."

Dr. Baker then stated that appellant could be rated using sensory and motor deficits and loss of motion. "Unfortunately," she stated, "the range of motion measurements are variable from exam[ination] to exam[ination], and the sensory findings were also variable from exam[ination] to exam[ination]." Dr. Baker added that his two-point discrimination was actually worse in his forearms than his hands, which was not consistent with just carpal tunnel syndrome. She thought it was possible he had diabetic neuropathy. Dr. Baker ended her report by stating the following:

> "[Appellant] does have decreased active range of motion of both wrists and is unclear if that is just due to carpal tunnel or it is due to decreased further inconsistencies on his part. Quite frankly, the most appropriate rating for the patient appears to be a three percent whole body impairment for each wrist due to the carpal tunnel or three percent per each wrist seems the most appropriate rating."

An Office medical adviser reviewed the evaluations by Drs. Roeber-Rice and Baker and reported an upper extremity impairment of two percent for Grade 4 residual pain or sensory deficit in the right hand and four percent for the same in the left.

On January 25, 2006 the Office issued a schedule award for a 2 percent additional impairment of the right upper extremity (total 7 percent) and a 4 percent additional impairment of the left (total 16 percent).

On November 27, 2006 Dr. Shafqat Ullah, appellant's orthopedic surgeon, reported that appellant's right wrist "has been going quite well for him." Appellant still had occasional positional tingling, but his strength and pain symptoms were improved. On the left, he was having more symptoms. Clinical findings included a positive Tinel's sign on the left "but otherwise the strength is good." Dr. Ullah gave his impression: "Bilateral work[ers'] comp[ensation] carpal tunnels with right release doing well and left awaiting scheduling for release which we will work around the patient's other issues. Of note is he does have shoulder decompression planned in the upcoming month."

On January 30, 2007 an Office hearing representative affirmed the Office's January 25, 2006 schedule award.

On February 28, 2007 the Office authorized a carpal tunnel release on the left.

Appellant requested reconsideration of the hearing representative's January 30, 2007 decision and submitted an EMG and nerve conduction study obtained on May 2, 2007. The EMG was consistent with a moderate severe lesion of the right median nerve at the level of the wrist, as is seen in carpal tunnel syndrome. Compared to an EMG obtained in 2004, there was a slight improvement in the sensory and motor nerve conduction studies. Appellant's current findings "might represent incomplete recovery following surgery or new injury to the median nerve." The 2007 EMG was consistent with a moderate lesion of the left median nerve at the level of the wrist, as is seen in carpal tunnel syndrome. These findings were slightly worse than those obtained in 2004.

Dr. Ullah reported on May 15, 2007 that appellant had progressive bilateral hand pain and numbness related to his accepted employment injury. He noted that appellant declined referral to surgery.

In a decision dated December 10, 2007, the Office reviewed the merits of appellant's case and denied modification of its prior decision. On appeal, appellant argues that his schedule award should be based on the findings of Dr. Roeber-Rice.

LEGAL PRECEDENT

The Federal Employees' Compensation Act provides compensation for the disability or death of an employee resulting from personal injury sustained while in the performance of duty.[3] Section 8107 provides that if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[4] 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 A.M.A., *Guides*.[5]

A claimant seeking compensation under the Act has the burden to establish the essential elements of his claim by the weight of the reliable, probative and substantial evidence.[6] A claimant seeking a schedule award under section 8107, therefore, has the burden to establish that his permanent impairment is causally related to an injury sustained in the performance of duty.[7]

ANALYSIS

Appellant's claim for an increased schedule award rests on the November 22, 2005 impairment evaluations performed by Drs. Roeber-Rice and Baker, specialists in occupational

[3] 5 U.S.C. § 8102(a).

[4] *Id.* at § 8107(a).

[5] 20 C.F.R. § 10.404 (1999).

[6] *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

[7] *See, e.g., Ernest P. Govednik*, 27 ECAB 77 (1975) (no medical evidence that the employment injury caused the claimant to have a permanent loss of use of a leg or any other member of the body specified in the schedule).

medicine. But these evaluations do not establish that he has more than a seven percent permanent impairment of his right upper extremity or more than a 16 percent permanent impairment of his left upper extremity, for which he has already received schedule awards.

A claimant is not entitled to an increased schedule award simply because his impairment is now greater than it used to be. The impairment must be causally related to the accepted employment injury. Dr. Roeber-Rice, the resident, reported that appellant had a history of diabetes and had some paresthesias in his feet. She noted sensory findings in the upper extremities that were not consistent with median nerve compression. Dr. Baker, the staff physician, also noted sensory findings in the upper extremities that were not consistent with just carpal tunnel syndrome. She thought it was possible appellant had diabetic neuropathy. This raises a substantial question of whether any worsening of appellant's upper extremity impairment was a result of his accepted employment injury or was instead a result of his diabetes.

Dr. Ullah, appellants' orthopedic surgeon, reported on May 15, 2007 that appellant had progressive bilateral hand pain and numbness related to his accepted employment injury, but he provided no medical rational to support this opinion. He did not account for the possibility that appellant had diabetic neuropathy. Medical conclusions unsupported by rationale are of little probative value.[8]

There is the issue of maximum medical improvement. The Office issues schedule awards for permanent impairment. The A.M.A., *Guides* explains that impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized:

> "It is understood that an individual's condition is dynamic. Maximal medical improvement refers to a date from which further recovery or deterioration is not anticipated, although over time there may be some expected change. Once an impairment has reached MMI [maximum medical improvement], a permanent impairment rating may be performed."[9]

A finding of MMI is thus a prerequisite for any evaluation of permanent impairment. Dr. Roeber-Rice did not address this issue. Dr. Baker reported that appellant reached MMI on the right. She indicated, however, that appellant was not at MMI on the left because he had not had surgery and might improve. Because Dr. Baker did not consider the current condition of appellant's left wrist to be permanent, any rating given for the left upper extremity is of little value in establishing appellant's entitlement to an increased schedule award.[10]

[8] *Ceferino L. Gonzales*, 32 ECAB 1591 (1981); *George Randolph Taylor*, 6 ECAB 968 (1954).

[9] A.M.A., *Guides* 19.

[10] On the issue of whether further recovery could be anticipated, Dr. Ullah reported one year later that appellant's right wrist "has been going quite well for him." His strength and pain symptoms were improved. Appellant had a positive Tinel's sign on the left "but otherwise the strength is good." These descriptions are vague, but they appear to reflect a general improvement in appellant's sensory and motor functions following the evaluations by Drs. Roeber-Rice and Baker.

There is also the issue of reliable clinical findings. Dr. Roeber-Rice reported a marked response to range of motion testing. She reported sensory testing that was "quite inconsistent." Dr. Roeber-Rice explained that rating appellant's impairment was complicated "due to some discrepant exam[ination] findings between examiners Dr. Baker and myself." Dr. Baker agreed. She questioned appellant's sensory testing. Dr. Baker noted range of motion testing that was somewhat inconsistent from one trial to the other and reported that it was unclear if this was due just to carpal tunnel syndrome "or if it is due to decreased further inconsistencies on his part." Grip strength settings were also somewhat inconsistent. Dr. Baker admitted that it was difficult to know how to rate appellant.

Given the questions raised concerning appellant's effort and the reliability of his clinical findings, the Board finds that the ratings given by Drs. Roeber-Rice and Baker are of diminished probative value in establishing the extent of permanent impairment. Indeed, Dr. Baker suggested that appellant's clinical findings were so variable that he should not be rated for sensory or motor deficits or range of motion. "Quite frankly," she admitted, the most appropriate rating appeared to be under Scenario 2, in which an impairment rating not to exceed five percent of the upper extremity may be justified for residual carpal tunnel syndrome. This does not support appellant's claim that he has more than a 7 percent permanent impairment of his right upper extremity or more than a 16 percent permanent impairment of his left.

Finally, there is the issue of whether Drs. Roeber-Rice and Baker properly applied the A.M.A., *Guides*. Both rated impairment for decreased motion, which is not permitted.[11] Both rated motor strength "2/5" on the right and "3/5" on the left but without explanation. Additional impairment values may not be given for decreased grip strength,[12] and neither doctor provided a sufficient description of muscle function under the classifications given in Table 16-11, page 484, to justify the severity of the motor deficit. Dr. Roeber-Rice graded the motor strength of appellant's right hand as Grade 2 but did not report the necessary finding that he had complete active range of motion only with gravity eliminated. She graded motor strength on the left as Grade 3 but did not mention that he had complete active range of motion only against gravity and without resistance.

The Board finds that appellant has not met his burden of proof. Dr. Roeber-Rice's rating of a 6 percent motor impairment on the right, a 3 percent motor impairment on the left and a 20 percent sensory impairment bilaterally is of diminished probative value. Dr. Baker's opinion that the most appropriate rating would not exceed five percent bilaterally does not establish appellant's entitlement to an increased schedule award. The Board will affirm the Office's December 10, 2007 decision denying an increased award.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he has more than a 7 percent permanent impairment of his right upper extremity or more than a 16

[11] In compression neuropathies, additional impairment values are not given for decreased motion in the absence of complex regional pain syndrome. A.M.A., *Guides* 494.

[12] *Id*.

percent permanent impairment of his left upper extremity causally related to his accepted employment injury.

ORDER

IT IS HEREBY ORDERED THAT the December 10, 2007 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 23, 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