United States Department of Labor
Employees' Compensation Appeals Board

K.M., Appellant	)	
and	)	**Docket No. 08-564**
	)	**Issued: February 4, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Charlestown, WV, Employer	)	

Appearances:
Martin Kaplan, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 18, 2007 appellant filed a timely appeal of a November 21, 2007 Office of Workers' Compensation Programs' hearing representative's schedule award decision.[1] Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the schedule award claim.

ISSUE

The issue is whether appellant has established more than 22 percent right upper extremity impairment and more than 20 percent left upper extremity impairment, for which he received a schedule award.

[1] The record contains an Office decision dated November 29, 2007 concerning appellant's wage-earning capacity. Appellant has not contested this decision on appeal; therefore, the Board will not review this decision. 20 C.F.R. § 501.2(c).

FACTUAL HISTORY

On December 23, 1995 appellant, then a 34-year-old modified mail handler, filed an occupational disease claim for a bilateral upper extremity condition he attributed to his employment. The Office accepted the claim for bilateral carpal tunnel syndrome and bilateral epicondylitis and paid appropriate benefits. Appellant underwent bilateral ulnar nerve transposition and bilateral carpal tunnel surgeries, which the Office authorized. He eventually returned to work in a limited-duty capacity.

On July 30, 2001 the Office paid a schedule award for 14 percent permanent impairment of the right upper extremity and 14 percent permanent impairment of the left upper extremity.[2] The award covered the period July 9, 2001 through March 12, 2003, which appellant elected to receive in a lump sum.

On April 5, 2005 appellant filed a claim for an increased schedule award. In a March 14, 2005 report, Dr. Christopher Brigham, Board-certified in occupational medicine, opined that appellant had 18 percent permanent impairment of the right arm and 16 percent permanent impairment of the left arm under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). His findings were based on range of motion impairments of the elbow and sensory and motor deficits of the ulnar nerve. For range of motion impairments of the elbow, Dr. Brigham found 129 degrees flexion resulted in one percent upper extremity impairment and 19 degrees extension resulted in two percent impairment. He also found flexion of 130 degrees equaled one percent upper extremity impairment and 5 degrees' extension equaled one percent upper extremity impairment. Under Table 16-15 of the A.M.A., *Guides*, Dr. Brigham noted the maximum loss for the ulnar nerve above midforearm was 7 percent upper extremity impairment for sensory deficits and 46 percent upper extremity impairment for motor deficits. Under Tables 16-10 and 16-11, he opined that appellant had a Grade 3 or 60 percent sensory deficit of the ulnar nerve and a Grade 4 or 25 percent motor deficit of the ulnar nerve. Dr. Brigham found appellant had 4 percent ulnar nerve sensory deficit (60 percent times 7 percent) and 11 percent ulnar nerve motor deficit (25 percent times 46 percent) for 15 percent upper extremity impairment on both sides. He combined the range of motion and neurological impairments to arrive at 18 percent right arm impairment and 16 percent left arm impairment. On March 31, 2005 Dr. Brigham noted that this impairment included previously awarded and current impairments for the elbow.

On May 17, 2005 an Office medical adviser reviewed Dr. Brigham's report and advised range of motion calculations could not be used in contribution with neurologic award. Thus, he opined that appellant had less impairment than that awarded.[3]

[2] This was based on an Office medical adviser's report of July 23, 2001. The medical adviser utilized the examination findings of a prior physician and found that appellant had 7 percent median nerve motor and sensory impairment and ulnar nerve motor and sensory impairment of 8 percent, for a combined impairment of 14 percent for each upper extremity.

[3] The Office medical adviser opined that appellant had 12 percent impairment to his right upper extremity and 12 percent impairment to his left upper extremity.

By decision dated August 1, 2005, the Office denied appellant's claim for an additional schedule award as it was less than what had previously been awarded.

In a November 29, 2005 medical report, the Office medical adviser rereviewed Dr. Brigham's March 14 and 31, 2005 reports along with the medical evidence of record and opined that appellant had 14 percent permanent impairment of the right upper extremity and 15 percent permanent impairment of the left upper extremity. The Office medical adviser indicated that he concurred with the findings and impairment rating calculated by Dr. Brigham, but he "did not believe there [wa]s any clinical evidence on examination of the patient to justify any motor deficit [of the ulnar nerve] and therefore there [wa]s no justification for a schedule award for any motor deficit [of the ulnar nerve]."

By decision dated March 13, 2006, the Office awarded an additional one percent permanent impairment of the right upper extremity. This equated to a total schedule award of 15 percent right upper extremity and 14 percent left upper extremity. The award covered the period July 11 through August 1, 2004.

Appellant disagreed with this decision and requested a review of the written record. By decision dated June 12, 2006, an Office hearing representative affirmed the Office's March 13, 2006 decision.

Appellant requested reconsideration. In an August 25, 2006 report, Dr. Brigham reiterated his opinion that appellant had 18 percent right arm impairment and a 16 percent left arm impairment. He disagreed with the Office medical adviser's assessment that there was no impairment for an ulnar nerve motor deficit as there was ample evidence to support strength loss as it related to the ulnar nerve injury and subsequent surgery performed. Dr. Brigham stated the recorded physical examination findings documented intrinsic hand weakness and thumb opposition weakness.[4] He noted intrinsic hand weakness was associated with ulnar nerve lesion pursuant to the A.M.A., *Guides*. Dr. Brigham also noted that, under Table 15-11, strength loss for the ulnar nerve was conservatively recorded as a Grade 4 or 25 percent motor deficit. He reiterated his impairment rating of 18 percent right arm and 16 percent left arm rating were based on the combined value of the sensory and motor loss of the ulnar nerve and range of motion losses.

The Office referred appellant's medical records to a different Office medical adviser, Dr. Morley Slutsky, for review. In a November 9, 2006 report, Dr. Slutsky found Dr. Brigham's supplemental report and medical information in appellant's chart sufficient to support Dr. Brigham's opinion that appellant had 16 percent impairment to the left arm and 18 percent impairment to the right arm. He advised that both the former Office medical adviser and Dr. Brigham had the same right and left upper extremity ratings for ulnar nerve sensory deficits and loss of elbow range of motion. Dr. Slutsky further found that the record contained clinical evidence dating back to 2001 for ulnar nerve strength deficits and objective testing which showed ulnar nerve irritation. He opined that Dr. Brigham properly calculated appellant's impairment for range of motion and sensory and motor deficits of the ulnar nerve. Dr. Slutsky

[4] Dr. Brigham advised the thumb opposition weakness is normally related to median nerve involvement and was not considered in the impairment assessment of the ulnar nerve injury.

further opined that the final upper extremity impairment was equal to the combination of impairments due to bilateral/lateral epicondylitis and carpal tunnel syndrome. Using the Combined Values Chart on page 604 of the A.M.A., *Guides*, he found that right arm impairment was 22 percent and left arm impairment was 20 percent. The right upper extremity impairment consisted of 5 percent impairment for right carpal tunnel and 18 percent impairment for right lateral epicondylitis. The left upper extremity impairment consisted of 5 percent impairment for left carpal tunnel syndrome and 16 percent impairment for left lateral epicondylitis.

By decision dated November 20, 2006, the Office vacated the March 13, 2006 decision. Appellant's case was accepted for 18 percent permanent impairment to the right arm and 16 percent permanent impairment to the left arm.

By decision dated November 21, 2006, the Office awarded an additional 3 percent impairment for the right upper extremity, for a total of 18 percent, and an additional 2 percent impairment for the left upper extremity, for a total of 16 percent. The award covered the period August 2 to November 19, 2004.

Appellant requested a review of the written record. He argued that Dr. Brigham's rating excluded consideration of impairment for the accepted bilateral carpal tunnel conditions. On March 27, 2007 an Office hearing representative reversed the Office's November 21, 2006 decision. The Office hearing representative found the Office failed to explain the reasons why the Office did not award compensation as determined by Dr. Slutsky, the Office medical adviser. Additionally, the hearing representative found the Office's award of November 21, 2006 excluded five percent impairment for carpal tunnel impairment of each arm. The hearing representative noted that appellant already received compensation for a total of 18 percent impairment of the right arm and 16 percent impairment of the left arm and was entitled to an additional 4 percent impairment of each upper extremity for a 22 percent total impairment of the right upper extremity and 20 percent total impairment of the left upper extremity.

By decision dated July 19, 2007, the Office issued an additional schedule award of 4 percent for each arm, as determined by Dr. Slutsky's opinion that appellant had a 22 percent impairment of the right upper extremity and a 20 percent impairment of the left upper extremity based on the accepted bilateral epicondylitis and bilateral carpal tunnel conditions. The period of the award ran from November 20, 2004 to May 13, 2005 for a total of 24.96 weeks.

Appellant requested a review of the written record. He stated that records indicated he previously received a seven percent rating for bilateral carpal tunnel syndrome, not five percent. Appellant argued that the bilateral epicondylitis rating should have been combined with a seven percent rating for bilateral carpal tunnel, not the five percent bilateral rating received.

By decision dated November 21, 2007, an Office hearing representative affirmed the previous decision.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[5] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. 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.*[6]

Office procedures[7] provide that upper extremity impairment secondary to carpal tunnel syndrome and other entrapment neuropathies should be calculated using section 16.5d and Tables 16-10, 16-11 and 16-15.8

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.[9] Regarding 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 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] is rated according to the sensory and/or motor deficits as described earlier.[10]
> >
> > (2) Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG [electromyogram] testing of the

[5] 5 U.S.C. § 8107.

[6] *See* 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001). *See also Linda Beale*, 57 ECAB 429 (2006).

[7] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003). *See also Cristeen Falls*, 55 ECAB 420 (2004).

[8] A.M.A., *Guides* 491, 482, 484, 492, respectively; *see Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[9] A.M.A., *Guides* 433-521.

[10] 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 Tables 16-10a and 16-11a 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. *Id.* at 481; *Kimberly M. Held,* 56 ECAB 670 (2005).

> thenar muscles: a residual [carpal tunnel syndrome] is still present and an impairment rating not to exceed five percent of the upper extremity may be justified.
>
> (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."[11]

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides,* with the Office medical adviser providing rationale for the percentage of impairment specified.[12]

ANALYSIS

In a July 19, 2007 decision, the Office granted appellant an award for a 22 percent right upper extremity impairment and a 20 percent left upper extremity impairment for his accepted bilateral lateral epicondylitis and bilateral carpal tunnel conditions. It based its award on the November 9, 2006 report of Dr. Slutsky, the Office medical adviser, who reached his medical impairment ratings by incorporating the clinical findings of Dr. Brigham in his reports of March 14, 2005 and August 25, 2006.

Dr. Brigham opined that appellant had 18 percent right arm impairment and a 16 percent left arm impairment due to the accepted bilateral lateral epicondylitis conditions. This was based on range of motion impairments of the elbows and sensory and motor deficits of the ulnar nerve. In his November 9, 2006 report, the Office medical adviser, Dr. Slutsky, concurred with Dr. Brigham's findings and impairment calculations. Dr. Brigham found appellant had an above midforearm ulnar nerve sensory and motor impairment. He properly found that, under Table 16-15, the maximum upper extremity impairment for a sensory deficit was 7 percent and for a motor deficit was 46 percent.[13] Dr. Brigham then utilized Table 16-10 and determined that appellant had a Grade 3 sensory impairment, which he rated at 60 percent and properly multiplied this value with the maximum 7 percent sensory impairment to find that appellant had an above midforearm ulnar nerve sensory impairment of 4 percent bilaterally. He also utilized Table 16-11 and determined that appellant had a Grade 4 impairment, which he rated at 25 percent and properly multiplied this value with the maximum 46 percent sensory impairment to find appellant had an above midforearm ulnar nerve motor impairment of 11 percent bilaterally. Dr. Brigham combined the sensory and motor impairment values of the ulnar nerve above midforearm to find a total ulnar nerve impairment of 15 percent bilaterally. He also properly determined that, on appellant's right side, 129 degrees flexion resulted in one percent upper extremity impairment and 19 degrees extension resulted in two percent impairment, for a total

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

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

[13] A.M.A., *Guides* 492.

three percent right upper extremity impairment of the elbow joint.[14] On the left side, 130 degrees flexion equaled one percent upper extremity impairment and 5 degrees extension equaled a half or one percent upper extremity impairment, for a total of two percent left upper extremity impairment of the elbow joint.[15] Dr. Brigham then properly utilized the Combined Values Chart of the A.M.A., *Guides* to combine the various values for appellant's arms.[16] The Board notes that this equates to 18 percent right upper extremity impairment and 17 percent left upper extremity impairment.[17]

The Office medical adviser also noted that appellant was entitled to a five percent upper extremity impairment for carpal tunnel syndrome for each upper extremity under page 495 item 2 of the A.M.A., *Guides*. This section of the A.M.A., *Guides* allows for an impairment rating not to exceed five percent in situations where a person has normal sensibility and abnormal sensory with optimal recovery time after surgical decompression. While appellant contends he previously received a seven percent rating for carpal tunnel syndrome, there is no current medical evidence of record to support any greater impairment for his carpal tunnel syndrome. The record supports that bilateral carpal tunnel was evaluated based on page 495 item 2 of the A.M.A., *Guides,* which allows for five percent impairment following optimal recovery from carpal tunnel release. There is no current medical evidence to support a greater impairment for carpal tunnel syndrome under the A.M.A., *Guides*.

The Board notes that the 18 percent right and 17 percent left epicondylitis rating combined with 5 percent impairment for carpal tunnel syndrome for each upper extremity, results in 22 percent right upper extremity impairment and 21 percent left upper extremity impairment. Thus, appellant has an additional one percent impairment of the left arm beyond that which was previously awarded.

CONCLUSION

The Board finds appellant has no more than 22 percent right upper extremity impairment, for which he received a schedule award. The Board further finds that appellant has no more than a 21 percent left upper extremity impairment and is entitled to an additional 1 percent impairment for the left upper extremity.

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[14] *See id.* at 471-72, Figures 16-33 and 16-34.

[15] *Id.*

[16] *See id.* at 604-05, Combined Values Chart.

[17] Dr. Brigham and the Office medical adviser found that appellant had 16 percent left upper extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the November 21 and July 19, 2007 decisions of the Office of Workers' Compensation Programs are affirmed as modified.

Issued: February 4, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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