United States Department of Labor
Employees' Compensation Appeals Board

E.K., Appellant	)	
and	)	**Docket No. 08-2526**
	)	**Issued: July 1, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Cerro Gordo, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 24, 2008 appellant filed a timely appeal from the July 1, 2008 merit decision of the Office of Workers' Compensation Programs, which awarded schedule compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.[1]

ISSUE

The issue is whether appellant has more than a six percent impairment of her right upper extremity and more than a one percent impairment of her left. On appeal, she argues that the schedule award did not consider three of her five accepted conditions, including adhesive capsulitis shoulder, left brachial plexus lesions and left radial nerve lesion.

[1] Appellant does not appeal the Office's September 12, 2008 nonmerit decision denying a review of her case.

FACTUAL HISTORY

On July 13, 2006 appellant, then a 57-year-old postmaster, filed a claim alleging that she sustained an injury in the performance of duty: "Daily, 6 days a week, for 3 months, I manually distributed approximately 3000 pieces of mail each day for my office by myself. During this time I started having problems with my right elbow and arm and left hand." The Office accepted her claim for bilateral carpal tunnel syndrome and right lateral epicondylitis.

The Office authorized right carpal tunnel surgery, right repair of tennis elbow and right revise arm/leg nerve. On October 31, 2006 appellant underwent: (1) fasciotomy/partial ostectomy, right lateral epicondyle, with excision of 3.5 centimeter (cm) x 1.5 cm area of subcutaneous atrophy/skin depigmentation; (2) release, right posterior interosseous nerve; and (3) release, right carpal tunnel.

The Office also authorized left carpal tunnel surgery, left revision ulnar nerve at elbow and left revise arm nerve. On May 11, 2007 appellant underwent: (1) anterior submuscular transposition, left ulnar nerve; (2) release, left carpal tunnel; and (3) release, left radial tunnel/posterior interosseous nerve. On September 20, 2007 Dr. Mark Greatting, the surgeon, reported that appellant developed some adhesive capsulitis in her shoulder following the May 11, 2007 surgery. He stated that she was at maximum medical improvement. On January 3, 2008 Dr. Greatting released her from care.

On September 24, 2007 and again on January 7, 2008, appellant filed a claim for a schedule award. The Office referred her, together with the medical record and a statement of accepted facts, to Dr. Jack C. Tippett, an orthopedic surgeon.

On June 16, 2008 Dr. Tippett evaluated appellant's impairment. Appellant had complaints in both elbows and wrists and tingling in both forearms. Her left elbow was particularly sore and stiff, "and her main problems seem to be in that area, as far as she is concerned." Dr. Tippett offered no opinion on left elbow impairment because the left elbow was not an accepted condition.

Dr. Tippett found that the most appropriate method of determining impairment was by measurement of joint motion. In the right elbow, he found 132 degrees flexion and 74 degrees pronation, representing a two percent impairment of the right upper extremity. In the right wrist, Dr. Tippett found 45 degrees extension and 16 degrees radial deviation, representing a four percent impairment of the right upper extremity. In the left wrist, he found 55 degrees extension, representing a one percent impairment of the left upper extremity.[2]

In a decision dated July 1, 2008, the Office issued a schedule award for a six percent impairment of the right upper extremity and a one percent impairment of the left.

[2] All other ranges of motion showed no impairment.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[3] 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 American Medical Associations, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

Only individuals with an objectively verifiable diagnosis of entrapment or compression neuropathy should qualify for a permanent impairment rating. The diagnosis is made not only on believable symptoms, but, more important, on the presence of positive clinical findings and loss of function. The diagnosis should be documented by electromyography as well as sensory and motor nerve conduction studies.[5]

If, after optimal recovery time following surgical decompression for carpal tunnel syndrome, an individual continues to complain of pain, paresthesias 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 motor deficits as described in Chapter 16.5b.
>
> "2. Normal sensibility and opposition strength with abnormal sensory or motor latencies or abnormal [EMG] electromyogram testing of the 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."[6]

Any disability resulting from surgery authorized by the Office is compensable.[7] Disability resulting from authorized treatment is compensable even though the treatment is not for an employment-related condition.[8]

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[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] A.M.A., *Guides* 493 (5th ed. 2001).

[6] *Id*. at 495.

[7] *Rose M. Thompson*, 33 ECAB 1947 (1982).

[8] *Kathryn Haggerty*, 45 ECAB 383 (1994); *Carmen Dickerson*, 36 ECAB 409 (1984).

ANALYSIS

On appeal, appellant does not dispute the impairment rating she received for her wrists or right elbow. But Dr. Tippett, the orthopedic surgeon and Office referral physician, based his ratings on range of motion. There is no provision for rating carpal tunnel syndrome, which is a peripheral nerve disorder, by range of motion. The A.M.A., *Guides* has a special section for evaluating impairment due to residual carpal tunnel syndrome, one that sets out three possible scenarios. In the first scenario, if there are positive clinical findings of median nerve dysfunction and electrical conduction delay(s), the impairment is rated according to the sensory or motor deficits described in Chapter 16.5b, not according to loss of motion. In the second scenario, there is normal sensibility and opposition strength but abnormal sensory or motor latencies or an abnormal EMG testing of the thenar muscle. A rating not to exceed five percent may be justified, but not based on range of motion. In the third scenario, there is normal sensibility, normal opposition strength and normal nerve conduction studies rendering no objective basis for any impairment rating. The Board notes that all three scenarios require results from electrodiagnostic testing.

Dr. Tippett also evaluated appellant's right elbow based on range of motion. But any entrapment or compression neuropathy should be evaluated according to the impairment determination method described in section 16.5b, again relating to sensory and motor deficits. Indeed, the A.M.A., *Guides* states: "In the absence of [Complex Regional Pain Syndrome], additional impairment values are not given for decreased motion."[9]

The Board finds, therefore, that this case is not in posture for decision. The Office did not base appellant's July 1, 2008 schedule award on a proper evaluation under the A.M.A., *Guides*.

Appellant's argument is that the award was not based on all her accepted conditions. Technically, this is not the case, because the Office has accepted only carpal tunnel syndrome in the wrists and lateral epicondylitis in the right elbow. The record does not show that it accepted adhesive capsulitis in the left shoulder or left brachial plexus lesions or a left radial nerve lesion, as appellant suggests. But the Office did authorize left revision ulnar nerve at elbow and left revision arm nerve. On May 11, 2007 appellant did undergo an anterior submuscular transposition of the left ulnar nerve and a release of the left radial tunnel/posterior interosseous nerve. Under Board precedent, then, any disability or impairment resulting from the authorized surgery is compensable, even if it was not for an accepted employment-related condition.[10]

The Board will remand the case to the Office for further development on whether the May 11, 2007 authorized surgery caused any impairment of the left upper extremity. If so, the Office shall obtain a proper evaluation of that impairment, together with a proper evaluation of impairment in appellant's wrists and right elbow and shall issue an appropriate final decision on her entitlement to any additional schedule award.

[9] A.M.A., *Guides* 494.

[10] *See* notes 7 and 8 above.

CONCLUSION

The Board finds that this case is not in posture for decision. Further development is warranted.

ORDER

IT IS HEREBY ORDERED THAT the July 1, 2008 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this opinion.

Issued: July 1, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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