United States Department of Labor
Employees' Compensation Appeals Board

C.M., Appellant	)	
and	)	**Docket No. 09-909**
	)	**Issued: November 16, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Richmond, VA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
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, 2009 appellant filed a timely appeal from the September 16, 2008 and January 15, 2009 merit decisions of the Office of Workers' Compensation Programs concerning her entitlement to schedule award compensation. 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 met her burden of proof to establish that she has more than a five percent permanent impairment of her left arm, for which she received a schedule award.

FACTUAL HISTORY

The Office accepted in mid 2006 that appellant, then a 50-year-old mail handler, sustained bilateral carpal tunnel syndrome due to her job duties, including lifting, carrying, pulling and pushing mail trays. It also accepted that she sustained left trigger thumb due to these job duties. Appellant underwent a left carpal tunnel release on May 9, 2006, a right carpal tunnel release on September 8, 2006 and a left trigger thumb release on August 2, 2007. These surgical

procedures were authorized by the Office and were performed by Dr. Timothy J. Marqueen, an attending Board-certified orthopedic surgeon. Appellant worked as a modified mail handler for the employing establishment and she received appropriate compensation for periods of disability. In a February 23, 2007 decision, the Office adjusted appellant's compensation based on its determination that her actual wages as a modified mail handler fairly and reasonably represented her wage-earning capacity.

On February 1, 2007 appellant filed a claim for a schedule award.

In a February 28, 2007 report, Dr. Marqueen stated that appellant had made a reasonable recovery. Appellant's wrist range of motion was satisfactory following a course of hand therapy and her light touch sensation had improved. Dr. Marqueen stated that she still had residual thenar atrophy and some loss of thenar strength and her grip strength was satisfactory for short duration of activity. Her functional capacity examination revealed decreased grip in the right hand and no restrictions in the left hand. Dr. Marqueen stated that appellant's estimated percent disability was two percent in the left hand and three percent in the right hand. However, he posited that appellant might not achieve maximal improvement until a year following her surgery and indicated that she may need repeat electromyogram (EMG) testing to assess for residual nerve injury which might increase the percent of disability.

In a January 8, 2008 report, Dr. Marqueen stated, "[Appellant] has a history of bilateral carpal tunnel syndrome. Appellant underwent left carpal tunnel release on May 9, 2006 and right carpal tunnel release on September 8, 2006. Overall, she has recovered from the surgery. Appellant still has some residual muscle atrophy and weakness in the hands. The upper extremity impairment rating is five percent."

In a May 9, 2008 report, Dr. Lawrence A. Manning, a Board-certified orthopedic surgeon serving as an Office medical adviser, stated that Dr. Marqueen did not provide sufficient information to allow him to quantify appellant's impairment. He noted that medical records as a whole were not helpful as far as giving objective evidence and indicated it was not clear to which arm Dr. Marqueen applied the five percent impairment rating.

In connection with a May 14, 2008 examination, Dr. Marqueen stated that appellant complained of pain in her left arm (primarily the forearm) and had some subjective numbness and tingling in her left hand. He indicated that visual inspection of the left elbow revealed no soft tissue swelling or bony abnormality and that palpation demonstrated no tenderness over the lateral epicondyle, medial epicondyle or wrist extensor complex. There was some tenderness to palpation over the mobile wad of the left elbow, but the elbow was stable and there was no pain with range of motion. Dr. Marqueen indicated that left arm strength was normal and sensation was intact to light touch. There was an equivocal Tinel's sign over the left mobile wad and negative impingement signs in the shoulders. Examination of the left hand revealed no bony abnormality, ecchymosis, or edema. The left carpal tunnel incision was healing well and appellant had full range of motion of the left wrist and hand, including the digits. Dr. Marqueen stated that there is no tenderness to palpation at the A1 pulley of the thumb. Appellant was otherwise nontender to palpation in the wrist region as well as the hand and fingers and there was no instability of the wrist or hand. There was no triggering of the fingers, Finkelstein test was negative and there was no snuffbox tenderness. Dr. Marqueen stated that appellant had a full

composite fist and there was no angulation or rotation of the digits. He diagnosed left arm pain and questionable recurrent carpal tunnel syndrome.

The findings of June 5, 2008 EMG and nerve conduction velocity (NCV) testing of the left arm showed no electrodiagnostic evidence of recurrent carpal tunnel syndrome. The studies showed significant interval improvement in the left median motor and sensory nerve conduction latencies as well as amplitude consistent with carpal tunnel release. Left median motor amplitude was normalized as compared to the nearly absent amplitude prior to the surgery. Left median sensory nerve conduction studies were prolonged but obtainable as compared to the absent responses in the previous study.

On June 26, 2008 Dr. Manning noted that additional information had been obtained from Dr. Marqueen along with updated EMG and NCV studies. While the diagnostic testing showed no evidence of recurrent left carpal tunnel syndrome, it did reveal prolonged sensory nerve conduction on the left. Dr. Marqueen found normal motor strength and sensory examination in the left upper extremity and appellant did complain of forearm pain and subjective numbness and paresthesias in the hand. Given this information, Dr. Manning found that appellant had a five percent permanent impairment of her left arm based on page 495 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). The second scenario for rating postoperative carpal tunnel syndrome stated, "Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles; a residual [carpal tunnel syndrome] CTS is still present, and an impairment rating not to exceed five percent of the upper extremity may be justified."

In a September 16, 2008 decision, the Office granted appellant a schedule award for a five percent permanent impairment of her left arm. The award ran from September 7 to December 2, 2007.[1] The Office relied on the opinion of Dr. Manning.

Appellant requested a review of the written record by an Office hearing representative. She asserted that she was entitled to greater schedule award compensation because her work-related condition prevented her from working overtime and from bidding on a permanent position and taking advantage of other career opportunities.

In a January 15, 2009 decision, the Office hearing representative affirmed the September 16, 2008 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] 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

[1] In an August 1, 2008 decision, the Office had denied appellant's claim that she sustained a recurrence of total disability on or after May 13, 2008 due to her accepted employment injuries.

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

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 regulations as the appropriate standard for evaluating schedule losses.[4]

In some instances, the Office medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides*. In this instance, a detailed opinion by the Office medical adviser which gives a percentage based on reported findings and the A.M.A., *Guides* may constitute the weight of the medical evidence.[5]

The A.M.A., *Guides* evaluates the permanent impairment caused by carpal tunnel syndrome by determining whether such a condition falls within one of three categories discussed in section 16.5d.[6] Under the first category, if there are positive clinical findings of median nerve dysfunction and an electrical conduction delay, the condition is rated under the standards found earlier in Chapter 16 for evaluating sensory or motor deficits due to peripheral nerve disorders. Under the second category, if there is normal sensibility (evaluated by two-point discrimination and Semmes-Weinstein monofilament testing) and normal opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles, an impairment rating not to exceed five percent of the upper extremity may be justified. Under the third category, if there is normal sensibility, opposition strength, and nerve conduction studies, there is no objective basis for an impairment rating.[7]

ANALYSIS

The Office accepted that appellant sustained employment-related bilateral carpal tunnel syndrome and left trigger thumb. Appellant underwent a left carpal tunnel release on May 9, 2006, a right carpal tunnel release on September 8, 2006 and a left trigger thumb release on August 2, 2007. These surgical procedures were authorized by the Office and were performed by Dr. Marqueen, an attending Board-certified orthopedic surgeon.

The Board finds that the Office properly relied on the opinion of Dr. Manning, a Board-certified orthopedic surgeon serving as an Office medical adviser, in determining that appellant has a five percent permanent impairment of her left arm.

In a January 8, 2008 report, Dr. Marqueen stated, "[Appellant] has a history of bilateral carpal tunnel syndrome…. Overall, she has recovered from the surgery. [Appellant] still has

[4] *Id*.

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(h) (April 1993).

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

[7] *Id.*

some residual muscle atrophy and weakness in the hands. The upper extremity impairment rating is five percent." Dr. Marqueen did not indicate how he applied the A.M.A., *Guides* or identify which arm was impaired. Therefore, the Office properly found that this assessment of appellant's arm impairment was inadequate and referred the case to Dr. Manning for further evaluation in his role as Office medical adviser.[8]

At the time of his evaluation, Dr. Manning had sufficient clinical findings from Dr. Marqueen and recent electrodiagnostic testing to review.[9] In a June 26, 2008 report, he stated that additional information had been obtained from Dr. Marqueen along with updated EMG and NCV studies. Dr. Manning noted that, while the diagnostic testing showed no evidence of recurrent left carpal tunnel syndrome, it did reveal prolonged sensory nerve conduction on the left. He noted that Dr. Marqueen found normal motor strength and sensory examination in the left upper extremity and appellant did complain of forearm pain and subjective numbness and paresthesias in the hand. Dr. Manning concluded that appellant had a five percent permanent impairment of her left arm. The Board finds that he properly determined that this degree of impairment was supported by the A.M.A., *Guides* on page 495 where the second scenario for rating postoperative carpal tunnel syndrome stated, "Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG 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."[10]

Appellant contends that she is entitled to a greater schedule award because her work-related condition prevents her from working overtime and from bidding on a permanent position and taking advantage of other career opportunities. However, a schedule award is based solely on impairment as determined according to the A.M.A., *Guides.* The inability to work overtime and to obtain a particular position are not factors considered in this determination.[11] For the above-detailed reasons, appellant did not show that she was entitled to additional schedule award compensation.

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish that she has more than a five percent permanent impairment of her left arm, for which she received a schedule award.

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[8] *See supra* note 5.

[9] In connection with a May 14, 2008 examination, Dr. Marqueen provided extensive findings regarding appellant's upper extremities. He noted that appellant complained of pain in her left arm (primarily the forearm) and had some subjective numbness and tingling in her left hand. Dr. Marqueen indicated that appellant had normal sensation and strength in her arms. The findings of June 5, 2008 EMG and NCV testing of the left arm showed no electrodiagnostic evidence of recurrent carpal tunnel syndrome. However, the testing did show prolonged left median motor amplitude.

[10] *See* A.M.A., *Guides* 495. The Board further notes that there is no medical evidence of record that appellant had permanent impairment due to right carpal tunnel syndrome or left trigger thumb.

[11] Section 8107 does not take into consideration the effect the impairment may have on employment opportunities, sports, hobbies or other lifestyle activities. *See Denise L. Croach*, 57 ECAB 161 (2005).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' January 15, 2009 and September 16, 2008 decisions are affirmed.

Issued: November 16, 2009
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