United States Department of Labor
Employees' Compensation Appeals Board

M.B., Appellant	)	
and	)	**Docket No. 09-1164**
	)	**Issued: February 3, 2010**
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:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 25, 2009 appellant filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated December 24, 2008. 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 of the left upper extremity, for which she has received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board on appeal. On June 2, 1996 appellant, then a 49-year-old human resources specialist, filed an occupational disease 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 her 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. It 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 on May 13, 1999. The Office authorized medical treatment for bilateral carpal tunnel syndrome on May 10, 2000.

Appellant requested a schedule award and submitted a report dated June 13, 2007 from Dr. Steven Simon, a physiatrist, who noted appellant's history of injury and medical history. Dr. Simon found a loss of grip strength on the right and wasting of the first dorsal interosseous on the right. He concluded that appellant had a Grade 4 impairment of the left upper extremity or a 20 percent sensory deficit of the left upper extremity[1] and 40 percent sensory deficit on the right due to a Grade 3 impairment.[2] Dr. Simon also found 20 percent loss of strength on the right and 10 percent loss of strength on the left based on grip strength.[3] 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 she had residual carpal tunnel based on electromyogram 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 comply with the A.M.A., *Guides* and was inappropriate for determining her 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 her impairment. Appellant appealed this decision to the Board. In a decision dated September 18, 2008,[4] the Board found that this case is not in posture for decision as Dr. Simon did not provide her full impairment rating in accordance with the A.M.A., *Guides* and as the Office medical adviser failed to consider or to apply the A.M.A., *Guides* to the rating for sensory deficit provided by Dr. Simon. On remand, the Board directed the Office to refer appellant to an appropriate physician to determine whether she has any additional entitlement to a schedule award. The facts and the circumstances of the case as set out in the Board's prior decision are adopted herein by reference.

The Office referred appellant for a second opinion evaluation with Dr. William O. Hopkins, a Board-certified orthopedic surgeon, to determine her permanent impairment. Dr. Hopkins examined her on November 11, 2008 and noted her 1997 carpal tunnel releases. He noted that appellant's repeat EMG dated December 20, 2005 supported carpal tunnel syndrome on the right. Dr. Hopkins provided her wrist range of motion and performed sensory testing. He noted that appellant had moderate hypoesthesia in the left thumb and mild hypoesthesia in her index, middle, ring and little finger on her left hand. Dr. Hopkins noted marked thenar atrophy

[1] The American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) 482, Table 16-10.

[2] *Id.*

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

[4] Docket No. 08-1044 (issued September 18, 2008).

on the right and moderate thenar atrophy on the left. He also found that thumb abduction was 4/5 on the right and 3/5 on the left as well as normal finger flexion strength on manual muscle testing and also provided grip and pinch strength measurements. Dr. Hopkins noted that appellant's grip strength testing demonstrated inconsistency. He stated that in accordance with Table 16-16 of the A.M.A., *Guides* she had a bilateral motor deficit of 10 percent bilaterally. Dr. Hopkins found that appellant had degenerative changes in her right wrist in the radial carpal joint and radial carpal degenerative arthritis in the left wrist due to a triangular ligament tear. He found that she had one percent impairment due to loss of left wrist flexion of 55 degrees and one percent impairment due to loss of left wrist radial deviation of 19 degrees and no loss of range of motion on the right. Dr. Hopkins found no sensory deficit in either hand. He found that any loss of grip and pinch strength was not ratable. Dr. Hopkins found that appellant's motor deficit due to her carpal tunnel syndrome entitled her to 10 percent impairment. He concluded that she had 10 percent impairment of her right upper extremity and 10 percent impairment of the left upper extremity.

The district medical adviser reviewed this report on November 28, 2008 and found that Dr. Hopkins failed to correctly apply the A.M.A., *Guides*. He found that Dr. Hopkins did not apply the appropriate table in determining appellant's loss of motor strength. The district medical adviser further noted that Dr. Hopkins stated that her grip and pinch strength testing was inconsistent. He concluded that there was no established motor deficit in the record and that Dr. Hopkins did not provide any physical findings supportive of sensory deficit. The district medical adviser noted that Dr. Hopkins found loss of range of motion of one percent of the left upper extremity.

By decision dated December 24, 2008, the Office denied appellant's claim for an additional schedule award.

On appeal, appellant disagreed with the evaluation performed by Dr. Hopkins.

LEGAL PRECEDENT

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

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999).

[7] *Id.*

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 sensory and motor functions are involved the impairment values derived for each are combined.[10]

ANALYSIS

Appellant filed a claim for a schedule award and the Board remanded the claim for the Office to undertake additional development of the medical evidence. The Office referred her to Dr. Hopkins, a Board-certified orthopedic surgeon, to determine her impairment for schedule award purposes. Dr. Hopkins provided his finding on physical examination and found that appellant had no more than 10 percent impairment of her upper extremities.

As noted above, the A.M.A., *Guides* provide specific procedures for determining permanent impairment due to entrapment neuropathies such as carpal tunnel syndrome. Dr. Hopkins did not follow these procedures in reaching his impairment rating. The A.M.A., *Guides* specifically exclude grip strength testing in determining permanent impairment in compression neuropathies such as carpal tunnel syndrome.[11] Furthermore, although Dr. Hopkins found that appellant had loss of motor strength, he did not clearly identify the nerve involved and determine the value of that nerve as listed on Table 16-15 of the A.M.A., *Guides*[12] and then multiply this value by the degree of impairment explained in Table 16-11.[13]

The district medical adviser reviewed Dr. Hopkins' report and found that he did not apply the appropriate table in determining appellant's loss of motor strength. He further noted that her grip and pinch strength testing was inconsistent and found that therefore there was no established motor deficit in the record. The Board notes that Dr. Hopkins physically examined appellant and

[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.

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

[11] *Id.* at 494.

[12] *Id.* at 492, Table 16-15.

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

clearly believed that she had a ratable impairment due to loss of strength. This was evidenced not only by the admittedly inconsistent and inappropriate grip and pinch strength, but also by the thenar atrophy and the loss of strength of her thumbs on manual muscle testing. The district medical adviser has some obligation to help interpret the findings provided in accordance with the A.M.A., *Guides*. Proceedings under the Act are not adversarial in nature nor is the Office a disinterested arbiter. While appellant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[14] Once the Office has begun an investigation of a claim, it must pursue the evidence as far as reasonably possible.[15] It has an obligation to see that justice is done.[16] In this case, the Office failed to pursue the medical evidence after the second opinion physician did not properly apply the A.M.A., *Guides*. The district medical adviser did not attempt to ascertain the appropriate calculations based on Dr. Hopkins' report and the case must be remanded for further development consistent with this and the previous decision of the Board. On remand, the Office should provide Dr. Hopkins with the appropriate citations to the A.M.A., *Guides* and ask him to apply his findings to these provisions. After this and such other development of the medical evidence as it deems necessary, the Office should issue an appropriate decision.

CONCLUSION

The Board finds that the case is not in posture for decision and must be remanded for additional development of the medical evidence.

[14] *John J. Carlone*, 41 ECAB 354, 359-60 (1989).

[15] *Edward Schoening*, 41 ECAB 277, 282 (1989).

[16] *Lourdes Davila*, 45 ECAB 139, 143 (1993).

ORDER

IT IS HEREBY ORDERED THAT December 24, 2008 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for additional development consistent with this opinion of the Board.

Issued: February 3, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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