United States Department of Labor
Employees' Compensation Appeals Board

P.L., Appellant	)	
and	)	**Docket No. 09-1302**
	)	**Issued: January 19, 2010**
DEPARTMENT OF THE NAVY, NORFOLK NAVAL SHIPYARD, Portsmouth, VA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 17, 2009 appellant filed a timely appeal of a March 30, 2009 decision of the Office of Workers' Compensation Programs adjudicating her schedule award claim. 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 five percent impairment of her left upper extremity or any impairment of her right upper extremity causally related to her accepted bilateral carpal tunnel syndrome.

On appeal, she contends that she has right upper extremity impairment and that she has more than five percent left upper extremity impairment.

FACTUAL HISTORY

This case was previously before the Board.[1] By decision dated December 4, 2008, the Board set aside a March 19, 2008 Office decision and remanded the case for further development of the medical evidence. The facts and the law of the case in the Board's prior decision are incorporated herein by reference.

Dr. Indravadan S. Gatilwala, a Board-certified neurologist, interpreted a March 14, 1996 electromyogram (EMG) study as abnormal, with bilateral distal motor sensory median neuropathy, compatible with a compression of the nerve in the carpal tunnel area. October 16, 1997 magnetic resonance imaging (MRI) scan examinations of appellant's wrists were interpreted as normal studies by a Dr. Ronald C. Washington. Appellant's claim was accepted for bilateral carpal tunnel syndrome. She underwent a right wrist carpal tunnel release on February 25, 1998 and a left carpal tunnel release on March 31, 1998. On March 29, 2005 appellant filed a claim for a schedule award.

On January 30, 2009 the Office found a conflict in medical opinion between Dr. Lawrence R. Morales, an attending Board-certified orthopedic surgeon, and Dr. Willie E. Thompson, a Board-certified orthopedic surgeon and an Office medical adviser, as to appellant's right and left upper extremity impairment. It referred her to Dr. Daniel E. Carr, a Board-certified orthopedic surgeon, for a referee examination to resolve the conflict.

In a February 26, 2009 report, Dr. Carr reviewed appellant's medical history and provided findings on physical examination. He noted that she underwent bilateral carpal tunnel release with no complications. When appellant returned to work she occasionally experienced numbness, tingling and aching in her hands. However, repeat bilateral nerve conduction studies and EMGs were normal. Appellant subsequently retired from her job but maintained that she had persistent pain in her hands. Dr. Carr noted that she had well-healed carpal tunnel incisions on both wrists. Appellant had equal and full range of motion of both wrists. There was no tenderness over the surgical incisions. Phalen's and Tinel's signs were negative. Appellant had normal two-point discrimination in both the ulnar and median nerve distributions. She advised that she experienced occasional pain in her distal interphalangeal (DIP) joints and the base of her thumb but she attributed this pain to arthritis, not carpal tunnel syndrome. Appellant no longer awoke at night having to shake her hands. She advised that she occasionally had a sensation of numbness and tingling but none was demonstrated objectively at the time of her examination. Appellant had full range of motion of her intrinsic muscle groups. There was no hypothenar or thenar atrophy with good muscle strength noted. Appellant had excellent grip strength and her pinch strength was appropriate for her age. Dr. Carr found, based on objective testing and her physical examination, that appellant had three percent impairment of the left upper extremity based on pain at the wrist carpometacarpal (CMC) joint along the volar aspect and slight weakness in that area that could be related to her carpal tunnel or to arthritis. He found that she had no right upper extremity impairment based on normal nerve conduction tests and EMGs, full range of motion, negative Tinel's sign and normal two-point discrimination. Dr. Carr indicated that he applied the impairment rating guidelines at page 495 of the fifth edition of the American

[1] *See* Docket No. 08-1630 (issued December 4, 2008).

Medical Association, *Guides to the Evaluation of Permanent Impairment* (the A.M.A., *Guides*). He opined that appellant had fully recovered from her work-related bilateral carpal tunnel syndrome with the exception of some residual pain and mild weakness in the thenar region of her left hand which represented three percent left upper extremity impairment. Appellant's other hand symptoms were unrelated to her accepted employment injury and were caused by degenerative arthritis at the DIP and CMC joints of both hands.

By decision dated March 30, 2009, the Office denied appellant's claim for an additional schedule award.[2]

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 A.M.A., *Guides*.[4]

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.[5] Office procedures[6] 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.[7]

Additionally, the fifth edition of the A.M.A., *Guides*, regarding impairment due to carpal tunnel syndrome, provides:

> "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 [in Tables 16-10a and 16-11a].

[2] Subsequent to the March 30, 2009 Office decision, additional evidence was associated with the file. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

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

[6] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[7] A.M.A., *Guides* 482, 484, 492, 494, respectively.

2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal [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."[8]

The Board has noted that the fifth edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory deficits only.[9]

Section 8123(a) of the Act provides that "if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary [of Labor] shall appoint a third physician who shall make an examination."[10] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[11]

ANALYSIS

Dr. Carr reviewed appellant's medical history and provided findings on physical examination. He noted that she underwent bilateral carpal tunnel release with no complications. Appellant indicated that she had persistent pain in her hands following her retirement from her job. However, repeat bilateral nerve conduction studies and EMGs were normal. On physical examination, Dr. Carr noted that appellant had well-healed carpal tunnel incisions on both wrists with no tenderness over the incisions. She had equal and age-specific full range of motion of both wrists. Phalen's and Tinel's signs were negative. Appellant had normal two-point discrimination in both the ulnar and median nerve distributions. She advised that occasional pain in her DIP joints and the base of her thumb were caused by arthritis, not carpal tunnel syndrome. Appellant no longer awoke at night having to shake her hands. She advised that she occasionally had a sensation of numbness and tingling but there was no objective evidence of this on physical examination. Appellant had full range of motion of her intrinsic muscle groups. There was no hypothenar or thenar atrophy with good muscle strength noted. Appellant had excellent grip strength and her pinch strength was appropriate for her age. Dr. Carr found, based on objective testing and physical examination, that appellant had three percent impairment of the left upper extremity based on pain and slight weakness at the wrist CMC joint. He found that she had no right upper extremity impairment based on normal nerve conduction tests and EMGs, full range

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

[9] *Kimberly M. Held*, 56 ECAB 670, 674 (2005).

[10] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

[11] *See Roger Dingess*, 47 ECAB 123 (1995); *Glenn C. Chasteen*, 42 ECAB 493 (1991).

of motion, negative Tinel's sign and normal two-point discrimination. Dr. Carr indicated that he applied the impairment rating guidelines at page 495 of the fifth edition of the A.M.A., *Guides* to the findings on physical examination. He opined that appellant had fully recovered from her work-related bilateral carpal tunnel syndrome with the exception of some residual pain and mild weakness in the thenar region of her left hand which represented three percent left upper extremity impairment. Appellant's other bilateral hand symptoms were unrelated to her accepted employment injury and were caused by degenerative arthritis.

The Board finds that Dr. Carr's impairment rating of appellant's left and right upper extremities is entitled to special weight. His impairment rating is based on a review of the factual and medical history and the results of objective testing, as well as a thorough physical examination. Dr. Carr provided medical rationale in support of his impairment rating. He explained that the only residuals of appellant's bilateral carpal tunnel syndrome were residual pain and mild weakness in the thenar region of her left hand. Appellant's other hand symptoms were caused by degenerative arthritis. It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments are to be included.[12] As the October 16, 1997 MRI scan studies of appellant's wrists were normal, there is no evidence of record that appellant's degenerative arthritis of the wrists is a preexisting condition, which would entitle her to an additional award.

Dr. Carr applied the applicable section of the A.M.A., *Guides* regarding impairment due to carpal tunnel syndrome to his findings on physical examination. His report establishes that appellant has no more than five percent left upper extremity impairment and no right upper extremity impairment.

CONCLUSION

The Board finds that appellant has no more than five percent left upper extremity impairment and no right upper extremity impairment.

[12] *Lela M. Shaw*, 51 ECAB 372 (2000).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 30, 2009 is affirmed.

Issued: January 19, 2010
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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