United States Department of Labor
Employees' Compensation Appeals Board

S.S., Appellant	)	
and	)	**Docket No. 10-597**
	)	**Issued: November 22, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Carol Stream, IL, 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
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 30, 2009 appellant filed a timely appeal of a November 17, 2009 Office of Workers' Compensation Programs' merit decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

ISSUE

The issue is whether appellant has more than four percent impairment of the right upper extremity and one percent impairment of the left upper extremity for which she received schedule awards.

FACTUAL HISTORY

On December 11, 2007 appellant, then a 38-year-old mail handler, filed an occupational disease claim alleging that she developed carpal tunnel syndrome due to her employment duties. She underwent electrodiagnostic studies, including nerve conduction studies on December 10, 2007. On January 7, 2008 the Office accepted appellant's claim for right carpal tunnel syndrome. In a letter dated February 11, 2008, it accepted the additional conditions of

ulnar/cubital tunnel syndrome on the right. The Office accepted the condition of left carpal tunnel syndrome on February 26, 2008.

Dr. Richard D. Shin, a Board-certified surgeon, performed right endoscopic carpal tunnel decompression on March 11, 2008. On April 11, 2008 he performed left endoscopic carpal tunnel decompression. Appellant returned to light-duty work on June 18, 2008.

In a report dated July 18, 2008, Dr. Shin advised that appellant had reached maximum medical improvement with respect to her bilateral carpal tunnel syndrome. He found a positive Tinel's sign over the right cubital tunnel and positive elbow flexion/compression test. Dr. Shin stated that appellant's current symptoms were due to right cubital tunnel syndrome. The Office authorized anterior transposition of the ulnar nerve in the right elbow on December 10, 2008. Dr. Shin performed this surgery on December 12, 2008.

Appellant returned to light-duty work on March 13, 2009. In a report dated June 12, 2009, Dr. Shin stated that she had reached maximum medical improvement with regard to her right elbow. He stated that appellant had normal active range of motion and adequate grip and pinch strength. Dr. Shin opined that her level of permanent disability was mild. On June 16, 2009 appellant requested a schedule award.

Dr. Shin evaluated appellant's permanent impairment on July 2, 2009 found normal range of motion in the wrists. He also noted mild intermittent alteration of sensation in the right ulnar nerve distribution. Dr. Shin indicated that appellant and an impairment rating between 0 to 10 percent. In evaluating appellant's right elbow, he found minimal alteration of sensation around the incision, normal range of motion and minimal intermittent numbness and tingling involving right ring and small fingers. Dr. Shin opined that appellant had 10 percent impairment.

The Office medical adviser, Dr. Neil Ghodadra, reviewed the medical evidence on August 23, 2009. He rated appellant's permanent impairment in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment.*[1] The Office medical adviser found that appellant's history of carpal tunnel syndrome with mild symptoms and normal functional scale was a grade modifier 1 impairment and one percent impairment for each upper extremity based on Table 5-23 of the A.M.A., *Guides*.[2] He found that residual compression symptoms of the right ulnar nerve with mild intermittent symptoms and decreased sensation lead to a high grade modifier 1 impairment and an impairment rating of three percent. The Office medical adviser concluded that appellant had four percent impairment of the right upper extremity and one percent impairment of the left upper extremity.

By decision dated November 17, 2009, the Office granted appellant schedule awards for four percent impairment of the right upper extremity and one percent impairment of the left upper extremity.

[1] A.M.A., *Guides* (6th ed. 2009).

[2] *Id*. at 449, Table 15-23.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] provides for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption. Effective May 1, 2009, the Office began using the sixth edition of the A.M.A., *Guides* to calculate schedule awards.[4]

For evaluating impairment related to dysfunction of the median and ulnar nerves, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) contains Appendix 15-B (Electrodiagnostic Evaluation of Entrapment Syndromes). It provides that the criteria for carpal tunnel syndrome include distal motor latency longer than 4.5 milliseconds for an 8-centimeter study; distal peak sensory latency longer than 4.0 centimeters for a 14-centimeter distance; and distal peak compound nerve latency of longer than 2.4 milliseconds for a transcarpal or midpalmar study of 8 centimeters. If different distances were used in testing, correction to the above-stated distances could be accomplished by assuming each one centimeter of distance required 0.2 milliseconds.[5] For ulnar nerve entrapment there must be motor conduction velocity less than 50 milliseconds for an 8 to 10-centimeter segment of the nerve posterior to the elbow, or an above elbow to below elbow 8 to 10-centimeter segment conduction velocity that is at least 10 milliseconds slower than the conduction velocity in the below elbow to wrist segment.

If carpal tunnel syndrome or cubital tunnel syndrome is found under the standards of Appendix 15-B, impairment is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[6] In Table 15-23, grade modifiers are described for test findings, history and physical findings. A survey completed by a given claimant, known by the name QuickDASH, is used to further modify the grade and to choose the appropriate numerical impairment rating.[7] If carpal tunnel syndrome is not found under the standards of Appendix 15-B, impairment due to median nerve dysfunction is evaluated under the scheme found in Table 15-21 (Peripheral Nerve Impairment: Upper Extremity Impairments).[8] Under Table 15-21, observed conditions are placed into classes

[3] 5 U.S.C. §§ 8101-8193.

[4] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[5] *Id*. at 487, Appendix 15-B.

[6] *See id.* at 449, Table 15-23.

[7] *Id*. at 448.

[8] *Id*. at 437-40, Table 15-21 (portion relating to median nerves).

(ranging from Class 0 to Class 4) based on diagnosis and the severity of the condition. After the class is identified, the precise degree of the impairment can be modified by various factors, including functional history, physical examination and clinical studies.[9]

Proceedings before the Office are not adversarial in nature and the Office is not a disinterested arbiter; in a case where the Office "proceeds to develop the evidence and to procure medical evidence, it must do so in a fair and impartial manner."[10]

ANALYSIS

The Office accepted that appellant developed bilateral carpal tunnel syndrome and ulnar/cubital tunnel syndrome on the right. Appellant requested a schedule award and submitted a July 2, 2009 report from Dr. Shin reporting mild intermittent alteration of sensation in the right ulnar nerve distribution, minimal alteration of sensation around the incision in appellant's right elbow as well as minimal intermittent numbness and tingling involving right ring and small fingers. Dr. Shin rated appellant's impairment at 10 percent without further explanation of how he reached this rating. He did not attempt to correlate his findings with the A.M.A., *Guides*. Dr. Shin did not clearly indicate whether appellant's carpal tunnel findings were bilateral or whether one extremity was worse than the other. It is also unclear from his report whether he believed that appellant had up to 10 percent impairment due to her carpal tunnel syndrome and an additional 10 percent impairment due to ulnar/cubital tunnel syndrome. Without detailed findings or any medical reasoning supporting Dr. Shin's 10 percent impairment ratings, this report is not sufficient to meet appellant's burden of proof.

On August 23, 2009 Dr. Ghodadra, reviewed the sixth edition of the A.M.A., *Guides*. He found that carpal tunnel syndrome with mild symptoms and normal functional scale leads to a grade modifier 1 impairment and one percent impairment for each upper extremity based on Table 15-23 of the A.M.A., *Guides*.[11] Dr. Ghodadra noted that residual compression symptoms of the right ulnar nerve with mild intermittent symptoms and decreased sensation led to a high grade modifier 1 impairment and an impairment rating of three percent. He concluded that appellant had four percent impairment of the right upper extremity and one percent impairment of the left upper extremity.[12]

With respect to evaluating impairment related to dysfunction of the median nerves, Appendix 15-B (Electrodiagnostic Evaluation of Entrapment Syndromes) contains criteria for evaluating whether carpal tunnel or cubital tunnel syndrome is present. If carpal tunnel or cubital syndrome is found under the standards of Appendix 15-B, impairment is evaluated under the scheme found in Table 15-23. If carpal tunnel or cubital tunnel syndrome is not found under the standards of Appendix 15-B, impairment due to median or ulnar nerve dysfunction is evaluated under the scheme found in Table 15-21. There is no evidence that either Dr. Shin or

[9] *Id*. at 406-09.

[10] *Walter A. Fundinger, Jr.*, 37 ECAB 200, 204 (1985).

[11] A.M.A., *Guides* 449, Table 15-23.

[12] *Id.*

Dr. Ghodadra addressed the content of Appendix 15-B. It is not clear whether the electrodiagnostic nerve testing of December 10, 2007 was sufficiently complete to allow evaluation of the existence of carpal tunnel syndrome or cubital tunnel syndrome under Appendix 15-B. The testing results did not indicate over what distance nerve conduction was tested or provide findings for distal peak compound nerve latency.[13]

For these reasons, the case will be remanded for development regarding the extent of appellant's impairment.[14] After such development as it deems necessary, the Office will issue an appropriate decision regarding appellant's entitlement to schedule award compensation.

CONCLUSION

The Board finds that the case is not in posture for decision regarding the extent of appellant's permanent impairment to her upper extremities.

ORDER

IT IS HEREBY ORDERED THAT the November 17, 2009 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: November 22, 2010
Washington, DC

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

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

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

[13] *Id*. at 487, Appendix 15-B.

[14] *W.W.*, Docket No. 09-2243 (issued June 24, 2010).