United States Department of Labor
Employees' Compensation Appeals Board

S.O., Appellant	)	
and	)	**Docket No. 10-601**
	)	**Issued: November 4, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Urbandale, IA, 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 January 5, 2010 appellant filed a timely appeal from a September 29, 2009 merit decision of the Office of Workers' Compensation Programs denying his claim for an increased schedule award. 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 19 percent permanent impairment of the right arm or 20 percent impairment of the left arm, for which he received schedule awards.

FACTUAL HISTORY

On October 30, 2004 appellant, then a 50-year-old letter carrier, filed an occupational disease claim alleging that he sustained carpal tunnel syndrome due to factors of his federal employment. The Office accepted his claim for bilateral carpal tunnel syndrome. Appellant underwent a right carpal tunnel release on March 7, 2003 and a left carpal tunnel release on January 17, 2005. By decision dated December 13, 2005, the Office granted him schedule

awards for a 19 percent permanent impairment of the right upper extremity and a 20 percent permanent impairment of the left upper extremity. The period of the awards ran for 121.68 weeks from October 4, 2005 to February 2, 2008.

On March 24, 2008 appellant filed a claim for an increased schedule award. By letter dated April 7, 2008, the Office requested that he submit medical evidence from his physician supporting that he sustained increased permanent impairment.

By decision dated June 19, 2008, the Office denied appellant's claim for an increased schedule award. It noted that he had not submitted any supporting medical evidence.

On September 2, 2008 Dr. Teri S. Formanek, a Board-certified orthopedic surgeon, performed a repeat left carpal tunnel release and, on October 15, 2008, she performed a repeat right carpal tunnel release. In an April 16, 2009 report, she noted that appellant had active motor function, but altered sensation in the median nerve bilaterally. Dr. Formanek released him to return to work with restrictions and asserted that she did not believe that his condition would substantially improve.

On April 17, 2009 appellant filed a claim for an increased schedule award. The Office requested that he submit a detailed medical report from his attending physician supporting the extent of permanent impairment in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2008) (A.M.A., *Guides*).

On August 26, 2009 the Office referred appellant to Dr. Charles F. Denhart, a Board-certified physiatrist, for a second opinion examination on the extent of any permanent impairment of the upper extremities. Dr. Denhart evaluated appellant on September 18, 2009. He diagnosed status post bilateral carpal tunnel syndrome with a history of two bilateral carpal tunnel releases. On physical examination, Dr. Denhart provided grip and pinch strength measurements and noted that appellant complained of dyesthesia in the hand in a glove distribution from the wrist and a lack of feeling in the thumb side of his hand on two-point discrimination. He found no Tinel's sign with gentle tapping. Dr. Denhart provided range of motion findings for the bilateral wrists and stated:

> "With respect to percent partial impairment, I have elected to use the wrist range of motion measurements as the basis for his impairment rather than Table 15-23 which concerns entrapment compression neuropathies. I think that this best reflects his functional impairment. In addition, this provides a somewhat higher impairment rating and I am giving [appellant] the benefit of the doubt."

Applying Table 15-32 of the sixth edition of the A.M.A., *Guides*, Dr. Denhart found that appellant had a 14 percent permanent impairment of the right upper extremity and an 18 percent permanent impairment of the left upper extremity. He used grade modifiers for functional impairment to increase the degree of impairment to 15 percent for the right upper extremity and 19 percent for the left upper extremity. Dr. Denhart concluded that appellant reached maximum medical improvement on September 18, 2009 on the right and August 29, 2009 on the left.

On September 25, 2009 the Office medical adviser reviewed Dr. Denhart's impairment rating for bilateral carpal tunnel using range-of-motion measurements of the wrist. He noted that

the sixth edition of the A.M.A., *Guides* provided that range of motion was used "primarily as a physical examination adjustment factor and only to determine impairment … in the rare case when it is not possible to otherwise define impairment." The Office medical adviser found that impairment due to residuals of carpal tunnel syndrome did not constitute a rare case. Dr. Denhart concluded that as appellant previously received a 19 percent impairment for the right upper extremity due to carpal tunnel syndrome and a 20 percent impairment of the left upper extremity due to carpal tunnel syndrome, he had no additional impairment based on Dr. Denhart's opinion.

By decision dated September 29, 2009, the Office determined that appellant was not entitled to a schedule award. The medical evidence did not establish any additional impairment of either the right or left upper extremity.

On appeal, appellant contends that he has pain and limitations due to his bilateral carpal tunnel.

LEGAL PRECEDENT

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[1] Under the sixth edition of the A.M.A., *Guides*, for upper extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS).[2] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[3]

For evaluating impairment related to dysfunction of the median nerves, the sixth edition of the A.M.A., *Guides* 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 of 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.[4]

If carpal 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.[5] In Table 15-23, grade modifiers are described for

[1] A.M.A., *Guides* 385, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[2] *Id*. at 385-419.

[3] *Id*. at 411.

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

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

test findings, history and physical findings. A survey completed by a given claimant, known by the name *Quick*DASH, is used to further modify the grade and to choose the appropriate numerical impairment rating.[6] 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).[7] Under Table 15-21, observed conditions are placed into classes (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.[8]

Proceedings under the Act are not adversarial in nature, nor are the Office a disinterested arbiter.[9] While the claimant has the responsibility to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[10] Accordingly, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[11]

ANALYSIS

The Office accepted that appellant sustained bilateral carpal tunnel syndrome. On December 13, 2005 it granted him a schedule award for a 19 percent permanent impairment of the right upper extremity and a 20 percent permanent impairment of the left upper extremity. Appellant underwent a repeat left carpal tunnel release in September 2008 and a repeat right carpal tunnel release in October 2008. On April 16, 2009 Dr. Formanek, his attending physician, opined that he had reached maximum medical improvement. Appellant subsequently filed a claim for an increased schedule award. On April 30, 2009 the Office referred him to Dr. Denhart for a second opinion examination on the extent of his permanent impairment.

In a September 18, 2009 impairment evaluation, Dr. Denhart diagnosed bilateral carpal tunnel syndrome. He measured range of motion and found dysthesia of the wrists and loss of feeling in the thumbs with no Tinel's sign. Dr. Denhart determined that appellant's impairment rating due to carpal tunnel syndrome should be based on loss of range of motion. He applied Table 15-32 on page 473 of the A.M.A., *Guides* relevant to determining impairment due to loss of range of motion of the wrists and found that appellant had a 14 percent impairment of the right upper extremity and an 18 percent permanent impairment of the left upper extremity. Dr. Denhart adjusted the impairment upward using the grade modifier for functional history to find a 19 percent left upper extremity impairment and a 15 percent right upper extremity impairment. The sixth edition of the A.M.A., *Guides*, however, provides that range of motion is

[6] *Id*. at 448.

[7] *Id*. at 437-40, Table 15-21.

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

[9] *Paul C. Belkind*, 56 ECAB 580 (2005); *Vanessa Young*, 55 ECAB 575 (2004).

[10] *B.S.*, 61 ECAB ___ (Docket No. 09-195, issued October 9, 2009); *Richard E. Simpson*, 55 ECAB 490 (2004).

[11] *Melvin James*, 55 ECAB 406 (2004).

used primarily as a physical diagnosis adjustment factor and only to determine actual impairment values when a grid permits its use as an option or when no other diagnosis-based section is applicable.[12] As discussed, Appendix 15-B on page 487 of the A.M.A., *Guides* contains criteria for evaluating whether carpal tunnel syndrome is present using electrodiagnostic studies. If carpal tunnel syndrome is found under Appendix 15-B, the impairment is evaluated under Table 15-23 on page 449, applicable to determining impairments due to compression neuropathies. If carpal tunnel syndrome is not found under Appendix 15-B, the impairment is evaluated pursuant to Table 15-21 on pages 436-444, applicable to determining peripheral nerve impairments of the upper extremity. Neither Table 15-21 nor Table 15-23 indicate that range of motion may be used as a stand alone rating and the A.M.A., *Guides* provides a diagnosis-based section for determining impairments due to compression neuropathies and peripheral nerve impairments. Thus, appellant's impairment rating for carpal tunnel syndrome should not have been based on range of motion. An Office medical adviser reviewed Dr. Denhart's finding and noted that he had incorrectly utilized the A.M.A., *Guides*. He concluded, however, that as Dr. Denhart found no additional impairment, appellant was not entitled to a schedule award.

Proceedings under the Act are not adversarial in nature and the Office is not a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility to see that justice is done.[13] Once the Office undertakes to develop the medical evidence further, it has the responsibility to do in a manner that will resolve the relevant issues in the case.[14] Neither the second opinion examiner Dr. Denhart nor the Office medical adviser appropriately utilized the A.M.A., *Guides* to determine the extent of appellant's permanent impairment of the upper extremities. As the Office undertook development of the medical evidence by referring appellant for a second opinion examination, it should secure a report adequately addressing the relevant issue of the extent of his permanent impairment under the sixth edition of the A.M.A., *Guides*. After such further development as it deems necessary, the Office shall issue an appropriate decision regarding whether appellant is entitled to an increased schedule award.

CONCLUSION

The Board finds that the case is not in posture for decision.

[12] *Id.* at 387; *see also* A.M.A., *Guides* at 461 (range of motion section is to be used as a stand alone rating when other grids refer to range of motion section or when no other diagnosis based estimate sections are applicable).

[13] *L.D.*, 61 ECAB ___ (Docket No. 09-1503, issued April 15, 2010); *Jimmy A. Hammons*, 51 ECAB 219 (1999).

[14] *See Paul C. Belkind*, *supra* note 9; *Melvin James*, *supra* note 11.

ORDER

IT IS HEREBY ORDERED THAT the September 29, 2009 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded for further proceedings consistent with this opinion of the Board.

Issued: November 4, 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