United States Department of Labor
Employees' Compensation Appeals Board

B.F., Appellant	)	
and	)	**Docket No. 10-356**
	)	**Issued: October 19, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Pittsburgh, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
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 November 20, 2009 appellant, through her attorney, filed a timely appeal of an August 14, 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 23 percent permanent impairment of her left upper extremity and 5 percent of the right upper extremity for which she received schedule awards.

FACTUAL HISTORY

This case has previously been on appeal before the Board. On November 12, 2004 appellant, then a 50-year-old clerk, filed an occupational disease claim alleging that she developed a bilateral wrist condition as a result of her federal employment. She underwent an electromyogram (EMG) and nerve conduction studies on December 7, 2004 which demonstrated bilateral carpal tunnel syndrome and mild Guyon's canal syndrome bilaterally. On April 11,

2005 the Office accepted the claim for bilateral carpal tunnel syndrome. Dr. A. Lee Osterman, a Board-certified orthopedic surgeon, performed left median nerve decompression and neurolysis, as well as flexor tenosynovectomy and bursectomy on July 26, 2006. An electromyogram dated June 20, 2005 demonstrated carpal tunnel syndrome on the right and very borderline carpal tunnel syndrome on the left. Dr. Osterman performed a right median nerve decompression and neurolysis and flexor tenosynovectomy and bursectomy of the right wrist on October 4, 2005. Appellant underwent an additional EMG on March 27, 2006 which demonstrated mild median nerve neuropathy at the right wrist.

By decision dated April 25, 2006, the Office denied appellant's claim for a recurrence of disability beginning February 4, 2006. Appellant requested a review of the written record on May 18, 2006. By decision dated August 28, 2006, the hearing representative affirmed the April 25, 2006 decision. Appellant through her attorney requested reconsideration on December 11, 2006. The Office denied modification by decision dated February 2, 2007. In the January 15, 2008 decision and order, the Board found that appellant had not established a recurrence of disability on or after February 4, 2006 and affirmed the Office's decisions.[1] The facts and the circumstances of the case as set out in the Board's prior decision are adopted herein by reference.

Appellant requested a schedule award and submitted a report from Dr. David Weiss, an osteopath, dated September 9, 2008. He stated that appellant's March 27, 2006 EMG demonstrated mild medial nerve neuropathy. Dr. Weiss reported no thenar or hypothenar atrophy. He found normal range of motion in both hands with positive Tinel's and Phalen's signs. The right hand had normal opposition strength and resisted thumb abduction. Dr. Weiss found loss of grip strength on the right with 14 kilograms on the right and 30 kilograms on the left. He also found three kilograms of pinch testing on the right and seven kilograms on the left. The left hand demonstrated 4/5 resisted thumb abduction and normal opposition strength. Dr. Weiss found two-point discrimination was 10 millimeters on the left and 6 millimeters on the right. He concluded that appellant had loss of motor strength in the left thumb of 9 percent, Grade 2 sensory deficit of the left median nerve resulting in 10 percent impairment for 18 percent impairment of the left upper extremity. Dr. Weiss reported 20 percent impairment due to right lateral pinch deficit and 3 percent impairment due to pain under Chapter 18 for a total right upper extremity impairment of 23 percent. He provided citations to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.

The district medical adviser, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon, reviewed appellant's claim on December 21, 2008. He noted that Dr. Weiss' examination of the right hand demonstrated no thenar or hypothenar atrophy and that sensory examination demonstrated diminished light touch over the left median nerve and two-point discrimination of 10 millimeters (mm) on the left median nerve. Dr. Berman found that Dr. Weiss' calculations did not indicate any sensory deficit in the right upper extremity. He concluded that as there was no evidence of atrophy it would not be appropriate to consider an award for weakness. Dr. Berman further noted that under the A.M.A., *Guides* decreased strength cannot be rated in the presence of painful conditions. He reviewed Dr. Weiss' recommendation

[1] Docket No. 07-1670 (issued January 15, 2008).

of a pain-related impairment of three percent and disagreed that either this or a decreased strength rating were appropriate. Dr. Berman opined that appellant's clinical picture correlated with normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG of the thenar muscles and a permanent impairment rating of five percent of the right upper extremity based on findings of no atrophy and normal strength testing.

In regard to the left upper extremity, Dr. Berman noted that Dr. Weiss' examination demonstrated no thenar or hypothenar atrophy with loss of thumb strength of 4/5. He opined that two-point discrimination of 10 mm is very abnormal and noted there was diminished light touch over the left median nerve. Dr. Berman found that appellant had abnormal two-point discrimination which was a Grade 3 deficit of 60 percent, multiplied by the sensory value of the median nerve of 39 percent to reach 23 percent permanent impairment of the left upper extremity. He found that motor strength award may not be granted according to the A.M.A., *Guides*.

By decision dated January 13, 2009, the Office granted appellant schedule awards for 23 percent impairment of her left upper extremity and 5 percent impairment of her right upper extremity. Appellant, through her attorney, requested an oral hearing. She testified at the oral hearing on May 27, 2009. In a decision dated August 14, 2009, the hearing representative affirmed the January 13, 2009 decision, finding that the district medical adviser's report represented the weight of the medical evidence.

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 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. Effective 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.[4]

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

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a) (August 2002).

rated according to the sensory and/or motor deficits as described earlier.[5] 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. In the second scenario there is normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles, a residual CTS is still present and an impairment rating not to exceed five percent of the upper extremity may be justified. The final scenario is normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies, in which case there is no objective basis for an impairment rating.[6]

The A.M.A., *Guides* state, "In compression neuropathies, additional impairment values are not given for decreased grip strength."[7] The A.M.A., *Guides* note that carpal tunnel syndrome is the most common of nerve compression lesions.[8]

The fifth edition of the A.M.A., *Guides* allows for an impairment percentage to be increased by up to three percent for pain by using Chapter 18, which provides a qualitative method for evaluating impairment due to chronic pain. If an individual appears to have a pain-related impairment that has increased the burden on his or her condition slightly, the examiner may increase the percentage up to three percent. However, examiners should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides.*[9]

It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides* his opinion is of diminished probative value in establishing the degree of permanent impairment and the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[10]

ANALYSIS

Appellant's accepted condition was bilateral carpal tunnel syndrome. She underwent surgical carpal tunnel releases on both hands. Appellant also underwent postsurgical electrodiagnostic studies on March 27, 2006 which demonstrated positive findings on the right. Dr. Weiss, an osteopath, provided his findings on physical examination. He opined that appellant had 23 percent impairment of the right upper extremity and 18 percent impairment of

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

[6] *Silvester DeLuca*, 53 ECAB 500 (2002). A.M.A., *Guides* 495.

[7] A.M.A., *Guides* 494.

[8] *Id*. at 495.

[9] Federal Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); A.M.A., *Guides* at 18.3(b); *see also Philip Norulak*, 55 ECAB 690 (2004).

[10] *Linda Beale*, 57 ECAB 429, 434 (2006).

the left upper extremity. The district medical adviser, Dr. Berman, a Board-certified orthopedic surgeon, reviewed Dr. Weiss' findings and concluded that appellant had five percent impairment of the right upper extremity and 23 percent impairment of the left upper extremity.

The Board finds that this case is not in posture for decision as neither physician appropriately applied the A.M.A., *Guides* to appellant's physical findings. As noted above, appellant had normal electrodiagnostic testing of the left upper extremity. While Dr. Weiss stated that appellant's March 27, 2006 EMG demonstrated mild medial nerve neuropathy, the Board notes that this test report stated that appellant had borderline slow median motor conduction across the right wrist and that the remainder of the test results were within normal limits. There was no mention in the March 27, 2006 report of left wrist findings. Therefore in accordance with the A.M.A., *Guides*, appellant could not receive a rating impairment of more than five percent of the left upper extremity as she did not have positive electrodiagnostic findings regarding this extremity. Both Drs. Weiss and Berman awarded appellant more than five percent impairment of the left upper extremity in contradiction of the applicable edition of the A.M.A., *Guides*. Therefore these reports are of diminished probative value and cannot establish appellant's permanent impairment of the left upper extremity.

In regard to appellant's right upper extremity, she had an abnormal EMG finding of borderline slow median motor conduction across the right wrist. The A.M.A., *Guides* provide that in this situation if appellant has clinical findings of median nerve dysfunction her impairment could be rated based on the impairment of the median nerve.[11] Dr. Weiss found loss of grip and pinch strength on the right. However, the A.M.A., *Guides* provide that grip strength should not be accorded an additional impairment value in a compression neuropathy such as the diagnosed condition of carpal tunnel syndrome. Dr. Weiss did not provide findings of any other motor deficit of the right upper extremity. As Dr. Berman noted, Dr. Weiss did not indicate any sensory deficit in the right upper extremity and did not accord an impairment rating for a sensory condition in this extremity. Based on the preceding statements, there is no evidence in the record of clinical findings of median nerve dysfunction on the right. Without clinical findings corresponding to the electrodiagnostic testing, there is no medical evidence supporting a schedule award for the right upper extremity.

Dr. Weiss found that appellant had three percent impairment of the right upper extremity due to pain under Chapter 18 of the A.M.A., *Guides*. As noted above, the A.M.A., *Guides* provide that examiners should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*. Dr. Weiss did not offer any explanation as to why appellant's pain-related impairment could not be rated based on a sensory impairment of the medial nerve. Therefore based on the A.M.A., *Guides*, appellant is not entitled to an additional three percent impairment rating for pain in found in Chapter 18.

On appeal, appellant's attorney argued that there was an unresolved conflict of medical opinion evidence between Dr. Weiss and Dr. Berman, the district medical adviser. As noted above, neither Dr. Weiss nor Dr. Berman appropriately applied the A.M.A., *Guides* to the

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

physical findings in the record. The Board finds that there is no appropriately rationalized medical evidence correlated with the A.M.A., *Guides* in the record to support appellant's schedule award.

CONCLUSION

The Board finds that none of the medical evidence in the record correlates appellant's documented physical findings with the appropriate sections of the A.M.A., *Guides*. On remand, the Office should refer appellant and a statement of accepted facts to a second opinion physician to determine if she has any permanent impairment of her upper extremities entitling her to a schedule award.[12]

ORDER

IT IS HEREBY ORDERED THAT August 14, 2009 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this decision of the Board.

Issued: October 19, 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

[12] The Board notes that appellant's claim should now be developed under the sixth edition of the A.M.A., *Guides*. For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008. FECA Bulletin No. 09-03 (issued March 15, 2009).