United States Department of Labor
Employees' Compensation Appeals Board

G.M., Appellant	)	
and	)	**Docket No. 10-418**
	)	**Issued: September 13, 2010**
DEPARTMENT OF THE NAVY, NAVAL AIR DEPOT, Cherry Point, NC, 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 December 2, 2009 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated November 12, 2009. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue is whether appellant met his burden of proof to establish that he sustained more than a five percent permanent impairment of his right arm or more than a five percent permanent impairment of his left arm, for which he received a schedule award.

FACTUAL HISTORY

On September 18, 2006 appellant, then a 50-year-old aircraft mechanic filed an occupational disease claim alleging that he sustained bilateral carpal tunnel syndrome, bilateral ulnar nerve impairment and tennis elbow as a result of turning, wrenching, torquing bolts and turning ratchets on aircraft carriers for 23 years while in the performance of duty. He did not stop work. The Office accepted appellant's claim for bilateral epicondylitis, carpal tunnel

syndrome, lesion of the ulnar nerve and ulnar nerve entrapment. It authorized a left carpal tunnel release and ulnar nerve entrapment at the wrist, which was performed on July 7, 2007. The Office also authorized a right carpal tunnel release and tennis elbow release, which was performed on January 18, 2008.

In a November 4, 2008 report, Dr. Brian J. Battersby, a Board-certified orthopedic surgeon, noted that appellant had reached maximum medical improvement with regard to his left carpal tunnel release and left tennis elbow release. He referred to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (hereinafter A.M.A., *Guides*). Under Table 16-15 of the A.M.A., *Guides*, Dr. Battersby determined that appellant had five percent impairment of the left upper extremity.[1] He advised that appellant had done well after surgery, but he continued to have discomfort.

In a November 19, 2008 report, Dr. Battersby noted that appellant had reached maximum medical improvement with regard to his right carpal tunnel release and tennis elbow release. He referred to Table 16-15 of the A.M.A., *Guides* and determined that appellant had a five percent impairment of the left upper extremity. Dr. Battersby noted that appellant continued to have clinical symptoms despite doing well postoperatively.

In a report dated December 1, 2008, an Office medical adviser reviewed the medical evidence and the November 4, 2008 report from Dr. Battersby. He noted that appellant had a left carpal tunnel and left cubital tunnel release. The Office medical adviser concurred with Dr. Battersby and opined that appellant had five percent impairment of the left arm.

In a letter dated December 8, 2008, the Office advised appellant that his report from Dr. Battersby entitled him to a schedule award for the left arm. It advised him that he could claim his award by filing a Form CA-7. On December 15, 2008 appellant filed a claim for a schedule award.

In a decision dated December 18, 2008, the Office granted appellant a schedule award for five percent impairment of the left upper extremity. The award covered a period of 15.6 weeks from November 4, 2008 to February 21, 2009.

On January 15, 2009 appellant filed a claim for a schedule award for the right arm.

In a report dated January 20, 2009, the Office medical adviser noted that appellant had right carpal tunnel and tennis elbow release on January 18, 2008. He advised that appellant reached maximum medical improvement on November 19, 2008 and that he concurred with Dr. Battersby that appellant had five percent impairment of the right arm.

In a decision dated March 12, 2009, the Office granted appellant a schedule award for five percent impairment of the right upper extremity. The award covered a period of 15.6 weeks from February 22 to June 11, 2009.

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

On September 21, 2009 the Office received a letter from appellant advising that he did not believe the amount he received was adequate compensation for the pain and suffering that he endured. Appellant alleged that he had constant pain and would endure it for the rest of his life. The Office received treatment notes dated March 4, June 4 and a September 10, 2009 prescription for Motrin from Dr. Battersby, who advised that appellant continued to have bilateral carpal tunnel syndrome and ulnar nerve entrapment at the elbows.

In a letter dated September 22, 2009, the Office advised appellant that he needed to indicate which appeal option he was seeking.

On October 8, 2009 appellant requested reconsideration. He advised the Office that he did not feel that the schedule award was adequate compensation.

By decision dated November 12, 2009, the Office denied modification of its prior decisions.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[2] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[3] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[4] The Act's implementing regulations has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule award losses.[5]

The fifth edition of the A.M.A., *Guides*, regarding carpal tunnel syndrome (CTS), provides that, 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 CTS is rated according to the sensory and/or motor deficits; (2) normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal electromyography (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 and (3) 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]

[2] 5 U.S.C. §§ 8101-8193.

[3] 5 U.S.C. § 8107.

[4] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[5] 20 C.F.R. § 10.404.

[6] *Silvester DeLuca*, 53 ECAB 500 (2002).

ANALYSIS

The Office accepted appellant's claim for bilateral epicondylitis, carpal tunnel syndrome, bilateral lesion of the ulnar nerve and bilateral ulnar nerve entrapment. Appellant underwent left carpal tunnel release and ulnar nerve entrapment surgery on July 7, 2007. He underwent a right carpal tunnel release and tennis elbow release on January 18, 2008.

As noted above, the A.M.A., *Guides* provide three scenarios for determining the permanent impairment due to CTS after an optimal recovery time following surgical decompression.[7] Utilizing these scenarios, the Board finds that the medical evidence does not establish that appellant was entitled to receive more than five percent impairment of the right upper extremity and five percent impairment of the left upper extremity, for which he received schedule awards.

In this case, both Dr. Battersby, the treating physician, in November 4 and 19, 2008 reports and the Office medical adviser were in agreement regarding the extent of appellant's impairment. For the right arm, they noted that appellant continued to have residual symptoms. Using the criteria for rating CTS set forth on page 495 of the A.M.A., *Guides*, the Board notes that appellant would be in the second scenario and be entitled to a five percent impairment. Dr. Battersby noted that appellant continued to have residual symptoms following the surgery. Both he and the Office medical adviser referred to page 495 of the A.M.A., *Guides*, the section on carpal tunnel syndrome. The Board notes that this provision provides for three possible scenarios after optimum recovery time following surgical decompression in carpal tunnel cases. As noted, the second scenario allows for up to five percent impairment of the arm where residual CTS is present and there is normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles. Dr. Battersby concluded that appellant had residuals of carpal tunnel syndrome, such as discomfort and explained the findings that supported the rating under the second scenario and opined that appellant would be entitled to an impairment rating of five percent of the right upper extremity. They found that appellant reached maximum medical improvement on November 19, 2008 more than a year after his carpal tunnel release.

For the left arm, Dr. Battersby essentially made the same findings noted above for the right arm and referred to the criteria for rating carpal tunnel syndrome set forth on page 495 of the A.M.A., *Guides*. As explained above, appellant's continued symptoms are consistent with the second scenario for residuals and discomfort following surgery. The Board notes that appellant would be entitled to a five percent impairment of the left arm. Dr. Battersby, the treating physician, found that appellant reached maximum medical improvement on November 4, 2008, more than a year after his carpal tunnel release. He did not provide any other reports that noted any greater percentage of impairment pursuant to the A.M.A., *Guides*.

The Board finds that the weight of the medical evidence, as represented by the opinions of Dr. Battersby and the Office medical adviser, establishes that appellant has no more than five percent impairment of the left arm or five percent of the right arm. There is no other medical

[7] *See id.*.

evidence of record, based upon a correct application of the A.M.A., *Guides*, to establish that appellant has more than five percent permanent impairment of the right upper extremity or more than a five percent impairment of the left upper extremity, for which he received a schedule award.

On appeal appellant submitted new medical evidence. However, the Board may not consider this evidence for the first time on appeal as its review of a case is limited to the evidence that was in the case record that was before the Office at the time of its final decision.[8]

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he sustained more than a five percent permanent impairment of his right upper extremity or more than a five percent permanent impairment of his left upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 12, 2009 is affirmed.

Issued: September 13, 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

[8] 20 C.F.R. § 501.2(c).