United States Department of Labor
Employees' Compensation Appeals Board

HAROLD DAWSON, Appellant	)	
	)	**Docket No. 05-1341**
and	)	**Issued: November 14, 2005**
U.S. POSTAL SERVICE, POST OFFICE, Oklahoma City, OK, Employer	)	

Appearances:
Harold Dawson, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 8, 2005 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated May 16, 2005. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award issue

ISSUE

The issue on appeal is whether appellant has more than a 17 percent permanent impairment of the right upper extremity and more than a 18 percent permanent impairment of the left upper extremity for which he received a schedule award.

FACTUAL HISTORY

On January 17, 2002 appellant, then a 54-year-old clerk filed an occupational disease claim alleging that he developed bilateral carpal tunnel syndrome as a result of the repetitive use of his hands while in the performance of duty. The Office accepted bilateral carpal tunnel syndrome and lesion of the ulnar nerve and authorized bilateral carpal tunnel releases. Appellant did not stop work.

Appellant sought treatment from Dr. Kenneth A. Hieke, a Board-certified general surgeon. On October 9, 2001 Dr. Hieke noted performing a left median nerve release,[1] medial epicondylectomy and carpal tunnel release. He diagnosed cubital tunnel syndrome, pronator's tendon and carpal tunnel syndrome of the left upper extremity. On August 13, 2002 the physician performed a right medial epicondylectomy, carpal tunnel release with flexor tenosynovectomy. Dr. Hieke diagnosed cubital tunnel syndrome, carpal tunnel syndrome and thenar atrophy with inability to appose the thumb. Appellant did not demonstrate much response to the left-sided carpal tunnel surgery and Dr. Hieke recommended further surgery. On November 14, 2002 appellant underwent a reexploration and release of the left carpal canal through an extended incision and reconstruction of the transverse carpal ligament. Dr. Hieke diagnosed recalcitrant carpal tunnel syndrome with thenar atrophy and inability to palmarly abduct the thumb. He noted in reports dated January 20 to March 10, 2003 that appellant demonstrated slow and steady improvement of the left side. Dr. Hieke advised that appellant reached maximum medical improvement as of March 10, 2003 and noted that, under the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[2] (A.M.A., *Guides*) appellant had 28 percent impairment of the right and left upper extremities.

In a report dated March 27, 2003, an Office medical adviser recommended that Dr. Hieke rate appellant's impairment under the fifth edition of the A.M.A., *Guides*.[3]

In a March 19, 2003 report, Dr. Hieke determined that, in accordance with the fifth edition of the A.M.A., *Guides*,[4] appellant sustained a 36 percent permanent impairment of both the right and left upper extremity. Dr. Hieke rated appellant's sensory loss as Grade 3 sensory deficit or pain in the median nerve below the mid forearm under Table 16-10.[5] Impairment due to sensory loss was calculated as 20 percent impairment for both the right and left upper extremity by multiplying the 50 percent grade with the 39 percent maximum impairment allowed for the median nerve below the mid forearm at Table 16-15. He further rated sensory loss of the ulnar nerve as a Grade 4 sensory deficit or pain under Table 16-10.[6] Impairment due to sensory loss of the ulnar nerve was calculated as 2 percent for both the right and left upper extremity by multiplying the 25 percent grade with the 7 percent maximum impairment allowed for the ulnar nerve below the mid forearm. Dr. Hieke also noted grip strength deficits which he calculated to be 20 percent impairment for the right and left upper extremity. Under the Combined Values Chart, he calculated 38 percent impairment of each upper extremity. However, he advised that appellant had a peripheral neuropathy, which was not employment related, to which five percent

[1] The operative report notes that surgery was performed on the right upper extremity; however, upon review of the case record, this appears to be typographical error and that surgery was actually performed on the left upper extremity.

[2] A.M.A., *Guides* (4th ed. 1993).

[3] A.M.A., *Guides* (5th ed. 2001).

[4] *Id.*

[5] A.M.A., *Guides* 482, 492, Table 16-10 and 16-15.

[6] *Id.*

of appellant's bilateral impairment was attributable. Using the Combined Values Chart "in reverse," he opined that appellant had 36 percent of each upper extremity.

Appellant submitted a report from Dr. John W. Ellis, a Board-certified family practitioner, dated July 7, 2003, who advised that appellant was temporarily totally disabled.

In a July 10, 2003 decision, the Office issued a wage-earning capacity decision finding that appellant's full-time work as a clerk, effective April 7, 2003, fairly and reasonably represented his wage-earning capacity.

In a report dated July 25, 2003, an Office medical adviser concurred with Dr. Hieke that appellant had a 36 percent permanent impairment of the right upper extremity and a 36 percent permanent impairment of the left upper extremity.

Appellant submitted a report from Dr. Ellis dated August 10, 2004, who, in accordance with the A.M.A., *Guides*, advised that appellant sustained a 30 percent permanent impairment for the left upper extremity and a 29 percent impairment for the right upper extremity. He noted that maximum medical improvement was August 10, 2004. Dr. Ellis calculated that appellant sustained a 5 percent impairment of the left thumb due to a decreased range of motion,[7] 4 percent impairment for decreased range of motion for the wrist,[8] 2 percent impairment for decreased range of motion for the elbow,[9] 5 percent impairment due to sensory deficit or pain of the median nerve below the mid forearm,[10] 3 percent impairment due to motor deficit of the median nerve below the mid forearm,[11] 3 percent impairment due to sensory deficit or pain of the ulnar nerve,[12] 5 percent impairment due to motor deficit of the ulnar nerve,[13] 3 percent impairment due to motor deficit of the median nerve,[14] 3 percent impairment due to sensory deficit or pain of the median nerve above mid forearm,[15] 3 percent impairment due to motor deficit of the median nerve above mid forearm[16] for an impairment of 30 percent for the left upper extremity using the Combined Values Chart, page 604 of the A.M.A., *Guides*. With respect to the right upper extremity, Dr. Ellis calculated that appellant sustained a 6 percent impairment of the right thumb due to a decrease range of motion,[17] 5 percent impairment for decreased range of motion for the

[7] *Id*. at 456-60, Table 16-8a-b, 16-9, Figure 16-12, 16-19.

[8] *Id.* at 466-69, Figure 16-26 to 16-31.

[9] *Id*. at 471-74, Figure 16-32 to 16-37.

[10] *Id*. at 482-84, Table 16-15, 16-10a.

[11] *Id*. at 482-84, Table 16-15, 16-11.

[12] *Id*. at 482-84, Table 16-15, 16-10a.

[13] *Id*. at 482-84, Table 16-15, 16-11.

[14] *Id.*

[15] *Id*. at 482-84, Table 16-15, 16-10a.

[16] *Id*. at 482-84, Table 16-15, 16-11.

[17] *Id*. at 456-60, Table 16-8a-b, 16-9, Figure 16-12, 16-19.

wrist,[18] 3 percent impairment for decreased range of motion for the elbow,[19] 5 percent impairment due to sensory deficit or pain of the median nerve below the mid forearm,[20] 5 percent impairment due to motor deficit of the median nerve below the mid forearm,[21] 3 percent impairment due to sensory deficit or pain of the ulnar nerve,[22] 5 percent impairment due to motor deficit of the ulnar nerve,[23] for an impairment of 29 percent for the right upper extremity using the Combined Values Chart, page 604 of the A.M.A., *Guides*.

On October 6, 2004 appellant filed a claim for a schedule award.

In a report dated November 2, 2004, an Office medical adviser determined that appellant had 18 percent permanent impairment of the left upper extremity and 17 percent permanent impairment of the right upper extremity.

In a decision dated April 29, 2005, the Office granted appellant a schedule award for 17 percent impairment of the right upper extremity and 18 percent impairment of the left upper extremity. The period of the schedule awards was August 10, 2004 to September 12, 2006. In a letter decision dated May 16, 2005, the Office reissued the decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[24] and its implementing regulation[25] sets 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 regulation as the appropriate standard for evaluating schedule losses.[26]

[18] *Id*. at 466-69, Figure 16-26 to 16-31.

[19] *Id*. at 471-74, Figure 16-32 to 16-37.

[20] *Id*. at 482-84, Table 16-15, 16-10a.

[21] *Id*. at 482-84, Table 16-15, 16-11.

[22] *Id*. at 482-84, Table 16-15, 16-10a

[23] *Id*. at 482-84, Table 16-15, 16-11.

[24] 5 U.S.C. § 8107.

[25] 20 C.F.R. § 10.404 (1999).

[26] *Id.*

ANALYSIS

The Office based its schedule award decision on the August 10, 2004 report of Dr. Ellis and the November 2, 2004 report of its Office medical adviser. The Board has reviewed Dr. Ellis's report and notes that, while the doctor determined that appellant sustained a 30 percent permanent impairment of the left upper extremity and 29 percent permanent impairment of the right upper extremity, he did not adequately explain how he reached his determination in accordance with the standards of the A.M.A., *Guides*.[27]

Dr. Ellis calculated a five percent impairment due to sensory deficit or pain of the median nerve below the mid forearm on both the left and right side,[28] a three percent impairment due to sensory deficit or pain of the ulnar nerve on both the left and right side,[29] and a three percent impairment due to sensory deficit or pain of the median nerve above mid forearm.[30] The A.M.A., *Guides*, Table 16-10, 16-11 and 16-15, page 482, 484 and 492, set forth impairment rating for sensory and motor deficit for the peripheral nerve disorders. Although Dr. Ellis found sensory deficit impairments of the median nerve below the mid forearm, the ulnar nerve and the median nerve above the mid forearm, he did not identify a grade of sensory deficit between one and five as set forth in the A.M.A., *Guides* at Table 16-10.[31] Moreover, he did not explain how he calculated specific impairment values using Table 16-15 on pages 492 of the A.M.A., *Guides*.[32] Dr. Ellis calculated a three percent impairment due to motor deficit of the median nerve below the mid forearm on the left side and five percent impairment on the right side,[33] five percent impairment due to motor deficit of the ulnar nerve on both the left and right side,[34] and a three percent impairment due to motor deficit of the median nerve above mid forearm.[35] As noted, he did not provide a grade of motor and loss of power deficit between 1 and 5 as set forth at Table 16-10.[36] He did not properly explain how he calculated the specific impairment values using Table 16-15, page 492 of the A.M.A., *Guides*.[37] Dr. Ellis noted that appellant had five percent impairment of the left thumb and six percent impairment of the right thumb due to a

[27] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

[28] A.M.A., *Guides* at 482-84, Table 16-15, 16-10a.

[29] *Id.*

[30] *Id*. at 482-84, Table 16-15, 16-10a.

[31] A.M.A., *Guides* 482, Table 16-10a.

[32] *Id.* at 492, Table 16-15.

[33] *Id.* at 484, Table 16-11.

[34] *Id.*

[35] *Id.* at 484, Table 16-11.

[36] *Id.*

[37] *Id*. at 492, Table 16-15.

decreased range of motion[38] and two percent impairment of the left elbow and three percent impairment for the right elbow due to decreased range of motion.[39]

Dr. Ellis further noted that appellant had four percent impairment for decreased range of motion of the left wrist and five percent impairment for the right wrist;[40] however, the Board notes that, in a carpal tunnel schedule award case, there generally will be no ratings based on loss of motion or grip strength.[41] Office procedures[42] 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.[43] Under the fifth edition of the A.M.A., *Guides*, schedule awards for carpal tunnel syndrome are predicated on motor and sensory impairments only.[44] Section 16.5d of the A.M.A., *Guides* further provides:

> "In compression neuropathies, additional impairment values are not given for decreases grip strength. In the absence of CRPS, additional impairment values are not given for decreased motion."[45]

As noted above, the A.M.A., *Guides* specifically provide in the absence of complex regional pain syndrome, additional impairment values derived from section 16.4 are not given for decreased motion to avoid duplication or unwarranted increase in the impairment estimation.[46] In this case there is no evidence of complex regional pain syndrome, consequently, no impairment is attributable for decreased motion of the wrist.[47]

The report of the Office medical adviser dated November 2, 2004 is also deficient. The Office medical adviser determined that, in accordance with the A.M.A., *Guides*, appellant had 18 percent impairment of the left upper extremity and 17 percent impairment of the right upper extremity. However, he did not adequately explain his determination in accordance with the

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[38] *Id*. at 456-60, Table 16-8a-b, 16-9, Figure 16-12, 16-19.

[39] *Id*. at 471-74, Figure 16-32 to 16-37.

[40] A.M.A., *Guides* 466-69, Figure 16-26 to 16-31.

[41] *See id.* at 494-95.

[42] *See* Federal (FECA) Procedure Manual, Part 2 -- Schedule Awards and Permanent Disability Claims, *Evaluation of Schedule Awards*, Chapter 2.808 (August 2002).

[43] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr*., 53 ECAB 331 (2002).

[44] *Robert V. Disalvatore*, 54 ECAB ___ (Docket No. 02-2256, issued January 17, 2003) (where the Board found that the fifth edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory impairments only); *John E. Hesser*, Docket No. 03-1359 (issued December 31, 2003) (where the Board found that in a carpal tunnel schedule award case, there generally will be no ratings based on loss of motion or grip strength as schedule awards for carpal tunnel syndrome are predicated on motor and sensory impairments only).

[45] *See* A.M.A., *Guides*, 5th ed., pp. 494-95 where it is noted "CRPS" refers to complex regional pain syndrome.

[46] *Id*. at 508, section 16.8a.

[47] *See id.* at 480, section 16.5a, Impairment Evaluation Principles.

relevant standards of the A.M.A., *Guides*. He calculated five percent impairment due to sensory deficit or pain of the median nerve below the mid forearm on both the left and right side,[48] and three percent impairment due to sensory deficit or pain of the ulnar nerve on the left and right side.[49] Regarding the sensory deficit impairments, he did not identify a grade of sensory deficit between 1 and 5 as set forth in the Table 16-10 and failed to properly explain how he applied Table 16-15.[50] Regarding motor deficit, the medical adviser calculated impairment due to motor deficit was 3 percent impairment value of the median nerve below the mid forearm on the left and 5 percent on the right,[51] 5 percent for the ulnar nerve on both the right and left side,[52] and 3 percent for the median nerve above the forearm.[53] Again, he did not identify a grade of motor and loss of power deficit as set forth at Table 16-10 and failed to properly explain how he applied Table 16-15. The medical adviser properly found that limited range of motion for the wrist was not to be considered in addition to the median nerve pursuant to the A.M.A., *Guides*, page 494. Additionally, the medical adviser noted that no consideration was given for the elbow and thumb range of motion deficits because there was no accepted elbow or thumb conditions.

The medical adviser's November 2, 2004 report did not refer to Dr. Hieke's findings of March 19, 2003 or the report of the Office medical adviser dated July 25, 2003 which concurred with Dr. Hieke's impairment rating. Dr. Hieke calculated that appellant had a maximum sensory loss of 50 percent of the left and right side, a Grade 3 sensory deficit or pain in the median nerve below the mid forearm under Table 16-10 and 16-15[54] for 20 percent impairment for both the right and left upper extremity for the median nerve below the mid forearm. He further noted that appellant had a maximum sensory loss of 20 percent of both upper extremities, a Grade 4 sensory deficit or pain in the ulnar nerve under Table 16-10 and 16-15[55] for 2 percent impairment for both upper extremities for the ulnar nerve below the mid forearm. While Dr. Hieke provided grip strength deficits, as noted above, additional impairment is not given for decreased grip strength in compression neuropathies.[56] Although not all of Dr. Hieke's findings were properly calculated, his findings with regard to sensory deficit would allow for impairment greater than the 17 percent impairment of the right arm and 18 percent impairment of the left arm granted by the Office.

Proceedings under the Act are not adversary in nature nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office

[48] *Id*. at 482, 492, Table 16-10, 16-15.

[49] *Id.*

[50] *Id*. at 492, Table 16-15.

[51] *Id*. at 484, Table 16-11.

[52] *Id.*

[53] *See id.* at 484.

[54] *Id*. at 482, 292, Table 16-10 and 16-15.

[55] *Id.*

[56] *Supra* note 46.

shares responsibility in the development of the evidence. It has the obligation to see that justice is done. Accordingly, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[57] The Board finds that the Office should further develop the medical evidence. On remand, the Office should refer appellant to an appropriate Board-certified physician to determine the extent of permanent impairment of his upper extremities pursuant to the A.M.A., *Guides*. Following this and any other further development as deemed necessary, the Office shall issue an appropriate merit decision on appellant's schedule award claim.

CONCLUSION

The Board finds that this case is not in posture for decision regarding appellant's entitlement to a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the May 16, 2005 decision of the Office of Workers' Compensation Programs be set aside and the case remanded for further development in accordance with this decision of the Board.

Issued: November 14, 2005
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

[57] *John W. Butler*, 39 ECAB 852 (1988).