United States Department of Labor
Employees' Compensation Appeals Board

L.P., Appellant	)	
and	)	**Docket No. 06-856**
	)	**Issued: February 26, 2007**
DEPARTMENT OF THE NAVY, NAVAL AIR SYSTEMS COMMAND, San Diego, CA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 6, 2006 appellant filed a timely appeal from the Office of Workers' Compensation Programs' August 2, 2005 merit decision concerning his entitlement to schedule award compensation. 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 met his burden of proof to establish that he has more than a 36 percent permanent impairment of his right arm, a 22 percent permanent impairment of his left arm, and a 9 percent permanent impairment of his left leg due to his accepted cervical, thoracic and lumbar conditions and more than a 10 percent permanent impairment of his right arm due to his accepted carpal tunnel condition.

FACTUAL HISTORY

On May 13, 1998 appellant, then a 49-year-old aircraft sheet metal mechanic, filed a traumatic injury claim (file number 13-1162978) alleging that he sustained injury to his neck and

back while helping a coworker lift an elevator part.[1] He later indicated that his condition was due to the performance of his work duties over a period of time. The Office accepted an employment-related permanent aggravation of appellant's preexisting cervical, thoracic and lumbar degenerative disc disease and paid appropriate compensation for periods of disability.

The findings of nerve conduction testing obtained in February 2000 by Dr. Timothy Armstrong, an attending Board-certified neurologist, showed evidence of bilateral radial, ulnar and median compression at the wrist. The median compression at the wrist was moderate and the remaining compressions were mild. The findings of electromyogram (EMG) testing obtained at the same time showed no evidence of cervical root injury in either arm. On September 8, 2000 appellant underwent discectomy and fusion surgery at C4-5, C5-6 and C6-7 which was authorized by the Office.[2]

In July 2000, appellant filed an occupational disease claim (file number 13-2007596) alleging that he sustained injury to his arms due to the repetitive duties of his job. The Office accepted that he sustained bilateral carpal tunnel syndrome and de Quervain's tendinitis of the left wrist.[3]

Appellant received treatment for his various medical conditions and in early 2001 his attending physicians indicated that he was capable of performing limited-duty work. In December 2000, Dr. William Devor, an attending Board-certified neurologist, performed nerve conduction studies on appellant's upper extremities. The test results were normal and Dr. Devor indicated that the continuing sensory symptoms in appellant's hands were "most likely secondary to a persisting cervical myelopathy." The results of magnetic resonance imaging (MRI) scan testing obtained in early 2001 showed degenerative disc disease at various levels of the cervical, thoracic and lumbar spines with the most significant results at C6-7, T6-7 and L3-4.

In July 2001, the Office referred appellant for further evaluation to Dr. Thomas R. Dorsey, a Board-certified orthopedic surgeon, and Dr. Bruce Lasker, a Board-certified neurologist. On August 13, 2001 Dr. Dorsey concluded that appellant continued to have residuals of his employment injuries but could work four hours per day with limitations. He recommended that appellant undergo carpal tunnel surgery in both wrists. On August 14, 2001 Dr. Lasker suggested that appellant undergo EMG and nerve conduction testing to further evaluate his neurological condition. He also recommended limited-duty work for four hours per day.

In May 2002, Dr. Armstrong performed EMG and nerve conduction testing of the upper extremities and determined that the results were normal. He indicated that, despite these results,

[1] Appellant's job involved assembling, modifying and repairing aircraft parts and required lifting up to 45 pounds and working in awkward positions. He sustained right elbow and shoulder strains due to an October 7, 1992 employment injury and in 1993 and 1996 he underwent right shoulder surgery which included decompression and resection procedures.

[2] Appellant was terminated for cause from the employing establishment effective September 8, 2000.

[3] The Office doubled the two case records together.

appellant had a chronic cervical myelopathy secondary to cord compression from degenerative disease which caused involuntary leg jerking.

On September 16, 2002 Dr. Peter Low, an attending Board-certified orthopedic surgeon, performed an evaluation of appellant's medical condition. He provided an extensive description of appellant's findings on examination and diagnostic testing. Dr. Low included findings for range of motion testing for both shoulders and wrists, manual muscle testing for both arms and grip strength testing for both hands. He stated that strength testing showed that appellant had 5/5 strength in his left arm, 3/4 strength in his right biceps and triceps, 4/5 strength in the other muscles of his right arm, 4/5 strength in his left leg and 5/5 strength in his right leg.[4] Dr. Low indicated that appellant had reached maximum medical improvement and had permanent impairment but he did not provide any calculation of permanent impairment.

On December 24, 2002 Dr. Leonard A. Simpson, a Board-certified orthopedic surgeon and district medical director, evaluated the findings of Dr. Low. He concluded that, under the relevant standards of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, appellant had a 42 percent permanent impairment of his right arm, a 22 percent permanent impairment of his left arm and a 9 percent permanent impairment of his left leg. Dr. Simpson discussed all of appellant's accepted conditions and summarized the findings of examination and diagnostic testing. He noted that the records indicated bilateral wrist pain greater on the left which apparently was maximized in the left thumb. Dr. Simpson reported that there was no limitation of wrist range of motion and no left upper extremity weakness and stated:

> "This reviewer would recommend grading the left thumb complaints a maximal Grade 3 as per the [g]rading [s]cheme (Table 16-10, [p]age 482, fifth edition of the [A.M.A.,] *Guides*). This would be pain and/or altered sensation that may interfere with activities, or a 60 percent grade of a maximal 5 percent (branches of the radial nerve), equivalent to a 3 percent impairment of the upper left extremity. Pain involving the right upper extremity was not as intense, and would be graded a maximal Grade 4 or a 25 percent grade of a maximal 5 percent (branches of the radial nerve), equivalent to a 1.25 or rounded off the 1 percent impairment for right wrist pain. In addition, there was evidence of mild right carpal tunnel syndrome, and this would be assessed a maximal Grade 4 or a 25 percent grade of a maximal 39 percent for the median nerve, equivalent to a rounded-off 10 percent impairment involving the right upper extremity…. The records do indicate decreased range of motion of the right shoulder compared to the left with abduction of 95/170, equivalent to a four percent impairment. Forward flexion of 170/170 would be equivalent to a zero percent impairment. Internal rotation of 65/60 would be equivalent to a two percent impairment. External rotation of 75/80 would be equivalent to a zero percent impairment. Extension of 20/30 would be equivalent to an additional one percent impairment for a total of seven percent impairment for loss of shoulder range of motion. Right shoulder loss of strength of 3-4/5 would be assessed a 6 percent impairment for a loss of flexion power, a 2 percent impairment for loss of extension power, a 3 percent

[4] Dr. Low also and indicated that appellant had a positive Phalen's test on the right.

impairment for loss of abduction power, a 2 percent impairment for loss of adduction power, a 2 percent impairment for loss of internal rotations power, a 2 percent impairment for loss of external rotations power for a total of 17 percent impairment for loss of shoulder strength. In addition, the records do indicate a loss of grip strength on the left of approximately 43 percent, which would be equivalent to a 20 percent impairment according to Table 16-34. The loss of grip strength in the right major hand of greater than 61 percent would be assessed a 30 percent upper extremity impairment. One would utilize this larger value of 30 percent versus a 17 percent for loss of shoulder girdle strength in assessing the right upper extremity due to weakness.

"The records do not indicate any right lower extremity weakness, but do indicate 4/5 weakness on the left compared to the right. One would utilize branches of L5 which is assessed a maximal 37 percent impairment as Table 15/18. A 4/5 weakness would be graded a maximal Grade 4 or a 25 percent motor deficit of this 37 percent to arrive at a 9.25 or rounded off to 9 percent impairment for left lower extremity weakness."[5]

On January 6, 2004 appellant filed a schedule award claim for permanent impairment related to his accepted employment injuries.

In February 2004, the Office requested that Dr. Simpson make two permanent impairment evaluations, one for the impairment related to accepted cervical, thoracic and lumbar injuries and one for the impairment related to appellant's accepted bilateral carpal tunnel syndrome.

On May 16, 2004 Dr. Simpson summarized the findings of his December 2002 impairment evaluation and stated, "In relationship to the bilateral carpal tunnel syndrome, these records would indicate evidence of continued right carpal tunnel syndrome described as mild, but no evidence of continued left carpal tunnel syndrome." Dr. Simpson determined that, due to his carpal tunnel condition, appellant had a 10 percent permanent impairment of his right arm and a 0 percent permanent impairment of his left arm. He indicated that on December 24, 2002 he had found that appellant had a 42 percent impairment of his right arm and that the 42 percent impairment included the 10 percent impairment attributable to his carpal tunnel condition. Dr. Simpson stated that, if he separated the impairment of the right arm caused by the injuries accepted in connection with appellant's two claims, he would have a 10 percent impairment due to his carpal tunnel condition and a 36 percent impairment due to his cervical, thoracic and lumbar condition.[6]

In a May 28, 2004 decision, the Office granted appellant a schedule award (under case number 13-200759, accepted for bilateral carpal tunnel syndrome) for a 10 percent impairment

[5] Dr. Simpson then used the Combined Values Chart to combine the above-described impairments for each extremity. A.M.A., *Guides* 604, Combined Values Chart.

[6] Dr. Simpson noted that, under the Combined Values Chart, a 36 percent impairment combined with a 10 percent impairment to equal a 42 percent impairment. A.M.A., *Guides* 604, Combined Values Chart.

of his right arm. In another May 28, 2004 decision, the Office granted appellant a schedule award (under case number 13-1162978, accepted for aggravation of cervical, thoracic and lumbar disc disease) for a 36 percent impairment of his right arm, a 22 percent impairment of his left arm and a 9 percent impairment of his left leg.

By decision dated and finalized August 2, 2005, the Office hearing representative affirmed the May 28, 2004 schedule awards.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] and its implementing regulation[8] 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 regulation as the appropriate standard for evaluating schedule losses.[9]

The A.M.A., *Guides* evaluates the permanent impairment caused by carpal tunnel syndrome by determining whether such a condition falls within one of three categories discussed in section 16.5d of Chapter 16.[10] Under the first category, if there are positive clinical findings of median nerve dysfunction and an electrical conduction delay, the condition is rated under the standards found earlier in Chapter 16 for evaluating sensory or motor deficits due to peripheral nerve disorders. Under the second category, if there is normal sensibility (evaluated by two-point discrimination and Semmes-Weinstein monofilament testing) and normal opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles, an impairment rating not to exceed five percent of the upper extremity may be justified. Under the third category, if there is normal sensibility, opposition strength and nerve conduction studies, there is no objective basis for an impairment rating.[11]

The A.M.A., *Guides* provides that the evaluation of grip strength under Tables 16-31 through 16-34 should only be included in the calculation of an upper extremity impairment if such a deficit has not been considered adequately by other impairment rating methods for the upper extremity. An example of an impairment that would not be adequately considered by

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999).

[9] *Id*.

[10] *See* A.M.A., *Guides* 495.

[11] *Id.*

other rating methods would be loss of strength caused by a severe muscle tear that healed leaving "a palpable muscle defect."[12]

It is well established that proceedings under the Act are not adversarial in nature, and while the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[13]

ANALYSIS

In connection with a May 1998 claim, the Office accepted that appellant sustained an employment-related permanent aggravation of his preexisting cervical, thoracic and lumbar degenerative disc disease. In connection with a July 2000 claim, the Office accepted that appellant sustained employment-related bilateral carpal tunnel syndrome. In two May 28, 2004 decisions, the Office granted appellant schedule awards for a 10 percent impairment of his right arm due to his accepted carpal tunnel condition and for a 36 percent impairment of his right arm, a 22 percent impairment of his left arm, and a 9 percent impairment of his left leg due to his accepted cervical, thoracic and lumbar conditions.

The Office based its determination regarding schedule award entitlement on the December 24, 2002 and May 14, 2004 reports of Dr. Simpson, a Board-certified orthopedic surgeon who served as an Office district medical adviser. The Board finds, however, that additional development of the medical evidence is necessary to properly evaluate the permanent impairment of appellant's extremities.

Dr. Simpson did not adequately explain how he derived his impairment rating due to appellant's carpal tunnel syndrome. It appears that he determined that appellant's right carpal tunnel condition fell within the first category discussed in section 16.5d of Chapter 16 of the A.M.A., *Guides*, *i.e.*, the category which provides that if there are positive clinical findings of median nerve dysfunction and an electrical conduction delay, the condition is rated under the standards found earlier in Chapter 16 for evaluating sensory or motor deficits due to peripheral nerve disorders.[14] He then applied the portion of Chapter 16 which deals with sensory and motor deficits due to peripheral nerve injury and concluded that appellant had a 10 percent impairment of the right arm due to peripheral sensory deficit.[15] Although the findings of nerve conduction testing obtained in February 2000 showed that the median nerve compression at the right wrist was moderate and the median nerve compression at the left wrist was mild, the findings of nerve conduction testing obtained in December 2000 and May 2002 showed normal results. It is not

[12] A.M.A., *Guides* 508. If the rating physician determines that loss of strength should be rated separately in an extremity that presents other impairments, "the impairment due to loss of strength *could be combined* with the other impairments, *only* if based on unrelated etiologic or pathomechanical causes. *Otherwise, the impairment ratings based on objective anatomic findings take precedence.*" (Emphasis in the original.) The A.M.A., *Guides* further provides that decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts that prevent effective application of maximum force. *Id.*

[13] *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[14] *See supra* notes 10 and 11 and accompanying text.

[15] A.M.A., *Guides* 482, 492, Tables 16-10, 16-15.

clear why Dr. Simpson apparently concluded that appellant had an electrical conduction delay in the right median nerve and he did not discuss whether appellant still had clinical signs of carpal tunnel on the right.[16] Therefore, additional evaluation is necessary to determine which of the three categories in Chapter 16 appellant falls under for determination of his impairment due to carpal tunnel syndrome.

Additional clarification is also required for evaluation of any impairment rating which might be due to appellant for muscle weakness in the upper extremities. Dr. Simpson concluded that the impairment of appellant's upper extremity weakness should be determined by his grip strength deficits and granted him a 30 percent impairment rating on the right and a 20 percent impairment on the left. However, grip strength ratings should only be included in the calculation of an upper extremity impairment if such a deficit has not been considered adequately by other impairment rating methods for the upper extremity.[17] The record also contains the results of manual muscle testing for the upper extremities and it has not been explained why it would be more appropriate to use grip strength testing to evaluate appellant's upper extremity weakness in the present case.[18]

The Board further notes that the evaluation of appellant's upper and lower extremity impairments is complicated by the fact that Dr. Simpson made his first evaluation of these impairments in December 2002 and then made a determination in May 2004 about which aspect of the December 2002 impairment calculation related to the accepted cervical, thoracic, and lumbar conditions and which aspect of the December 2002 impairment calculations related to the accepted bilateral carpal tunnel condition. As noted above, the Office shares in the responsibility for development of the medical evidence and the circumstances of the present case require additional evaluation of the permanent impairment of appellant's extremities. Therefore, the case should be remanded to the Office for further development of this matter to be followed by an appropriate decision.

CONCLUSION

The Board finds that the case is not in posture for decision regarding the permanent impairment of appellant's extremities and the case must be remanded to the Office for further development.

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[16] Moreover, if it were found that appellant had a nerve conduction delay on the right, it is not clear why it would not be found that he also had such a delay on the left as the February 2000 nerve conduction testing showed median compression on both the right and the left.

[17] *See supra* note 12 and accompanying text.

[18] A.M.A., *Guides* 510, Tables 16-35. The Board further notes that, if it were found that appellant's carpal tunnel syndrome should be evaluated under the standards for evaluating peripheral nerve deficits, such an impairment would not ordinarily be added to any impairment for loss of muscle strength. *See id.* at 526, Table 17-2. In order to include both classes of impairments, a physician would have to explain why the nature of appellant's particular condition warranted including both peripheral nerve and loss of muscle strength impairment ratings. The Board notes that Dr. Simpson appears to have properly evaluated the impairment of appellant's right arm due to limited shoulder motion and the impairment of his left leg due to peripheral injury associated with the L5 nerve. *See id.* at 424-25, 476-77, 479, Tables 15-15, 15-16 and 15-18, Figures 16-40, 16-43 and 16-46.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' August 2, 2005 decision is set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: February 26, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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