United States Department of Labor
Employees' Compensation Appeals Board

E.D., Appellant	)	
	)	
and	)	**Docket No. 07-2111**
	)	**Issued: July 1, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, 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
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 14, 2007 appellant filed a timely appeal from the April 3, 2007 decision of an Office of Workers' Compensation Programs' hearing representative who affirmed her schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than 15 percent permanent impairment of the right arm and 5 percent permanent impairment of the left arm, for which she received schedule awards.

FACTUAL HISTORY

On June 3, 2002 appellant, then a 41-year-old clerk, sustained injury to her right shoulder when a customer grabbed a package out of her hand at work.[1] The Office accepted her claim for right shoulder sprain and strain and torn supraspinatous tendon. It authorized arthroscopic

[1] A magnetic resonance imaging (MRI) scan of the right shoulder dated June 29, 2002 revealed rotator cuff tendinitis with a small partial thickness tear of the supraspinatus tendon.

surgery which was performed on December 26, 2002. The record also contains a separate claim for compensation, No. 03-193654, accepted by the Office for bilateral carpal tunnel syndrome and hand strain. Appellant did not undergo surgery for her carpal tunnel syndrome.

On November 12, 2003 appellant filed a schedule award claim. In an August 14, 2003 report, Dr. Nicholas Diamond, an osteopath, noted that appellant reached maximum medical improvement on that date. He stated that right shoulder examination revealed forward elevation of 180 degrees, abduction of 100 degrees, adduction of 60 degrees, external rotation of 90 degrees and abnormal internal rotation. Wrist examination revealed positive Phalen's and Tinel's sign bilaterally; range of motion for dorsiflexion was 65 degrees bilaterally, palmar flexion was 60 degrees on the right and 65 degrees on the left, radial deviation was 15 degrees on the right and 20 degrees on the left, and ulnar deviation of 25 degrees on the right and 30 degrees on the left. Grip strength testing revealed 18 kilograms (kg) of force strength for the left and the right. Sensory examination revealed decreased sensation to light touch and pinprick over the median nerve distribution of the right and left arms. Dr. Diamond diagnosed post-traumatic right shoulder partial thickness tear of the supraspinatous tendon, status post arthroscopy of the right shoulder and bilateral carpal tunnel syndrome. Based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,*[2] he advised that appellant had 44 percent impairment of the right arm and 41 percent impairment of the left arm. Loss of range of motion to the right shoulder in abduction of 100 degrees represented 4 percent impairment;[3] while right wrist radial deviation of 15 degrees was 1 percent impairment[4] and ulnar deviation of 25 degrees was 1 percent impairment.[5] Dr. Diamond allowed 10 percent impairment on the right for grip strength deficit,[6] 31 percent impairment for sensory deficit of the right median nerve;[7] and 3 percent for pain.[8] With regard to the left arm, appellant had 10 percent impairment for grip strength deficit,[9] 31 percent impairment for sensory deficit of the left median nerve;[10] and 3 percent for pain-related impairment.[11]

On November 20, 2003 an Office medical adviser reviewed the medical reports related to both appellant's accepted bilateral carpal tunnel syndrome and right shoulder condition. He found that she sustained two percent permanent impairment of the right arm. The Office medical

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

[3] *Id.* at 477, Figure 16-43.

[4] *Id.* at 469, Figure 16-31.

[5] *Id.*

[6] *Id.* at 509, Table 16-32, 16-34.

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

[8] *Id.* at 574, Figure 18-1.

[9] *Id.* at 509, Table 16-34.

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

[11] *Id.* at 574, Figure 18-1.

adviser recommended referring appellant to a neurologist for a second opinion to determine impairment due to median nerve entrapment.

On December 24, 2003 the Office granted appellant a schedule award for two percent impairment of the right arm. On December 30, 2003 she requested a hearing.

The Office referred appellant to Dr. William R. Wasserstrom, a Board-certified neurologist, for a second opinion on the extent of impairment related to her carpal tunnel condition. In a February 25, 2004 report, Dr. Wasserstrom advised that appellant reached maximum medical improvement. He noted the motor examination revealed an intact median nerve, no atrophy or fasciculations, normal reflexes, intact sensory examination and negative Tinel's and Phalen's signs. Dr. Wasserstrom stated that she had five percent whole person impairment. In a supplemental report dated March 22, 2004, he noted that appellant had 10 percent impairment of the arms due to her bilateral carpal tunnel syndrome.

In a June 4, 2004 decision, an Office hearing representative vacated the December 24, 2003 decision. The case was remanded for the Office to combine appellant's carpal tunnel and shoulder claims and to further develop the evidence regarding permanent impairment.

In a July 1, 2004 report, an Office medical adviser opined that appellant had 10 percent permanent impairment of the right arm. He noted that the reports of Dr. Diamond and Dr. Wasserstrom were not consistent as to physical findings pertaining to carpal tunnel. The medical adviser noted right shoulder abduction of 160 degrees was one percent impairment, right wrist flexion of 100 degrees was one percent impairment, and allowed five percent impairment for right carpal tunnel syndrome pursuant to 16.5d, page 495 of the A.M.A., *Guides* and three percent for pain-related impairment under Chapter 18. He did not rate the left arm.

In a July 6, 2004 decision, the Office granted appellant a schedule award for 10 percent permanent impairment of the right arm, less the prior 2 percent award.

On July 9, 2004 appellant requested an oral hearing.

The Office referred appellant for a second opinion to Dr. I. Howard Levin, a Board-certified neurologist. In a November 11, 2004 report, Dr. Levin diagnosed mild bilateral carpal tunnel syndrome. He noted that appellant's history was significant for diabetes mellitus and obesity. Dr. Levin advised that the motor examination revealed normal tone and bulk, and excellent strength in both arms with no atrophy or weakness. Sensory examination revealed diminution of pinprick in the first to fourth digits of both hands but very good two point discrimination. Dr. Levin opined that there was no evidence to suggest the accepted carpal tunnel involvement resulted in any motor impairment and the relative diminution of sensation in appellant's hands was mild with no accompanying loss of two-point discrimination. He concurred with Dr. Wasserstrom that appellant had 10 percent impairment of the right arm due to her right shoulder injury and opined that there was a low probability that appellant's carpal tunnel syndrome was work related as it was likely due to diabetes and obesity.

In a decision dated April 8, 2005, the hearing representative vacated the July 6, 2004 schedule award, finding a conflict in medical opinion between Dr. Diamond and the Office medical adviser as to the extent of permanent impairment to appellant's upper extremities.

The Office referred appellant to Dr. David A. Bundens, a Board-certified orthopedic surgeon, selected as the impartial medical specialist. In a June 28, 2005 report, Dr. Bundens reviewed the record and listed findings on physical examination of appellant. He advised that appellant had reached maximum medical improvement. Dr. Bundens diagnosed persistent right shoulder pain, some element of adhesive capsulitis, impingement and bilateral carpal tunnel syndrome. On physical examination on the right arm, he noted minimal tenderness in the anterior acromial area, good sensation in her hands, good strength and intrinsic function with positive Phalen's and Tinel's signs. Dr. Bundens noted range of motion for the right shoulder of forward flexion of 150 degrees, or two percent impairment;[12] abduction of 110 degrees, or three percent impairment;[13] internal rotation of 10 degrees, or five percent impairment;[14] and external rotation of 60 degrees, or zero percent impairment.[15] As to the diagnosed bilateral carpal tunnel syndrome, he noted that appellant experienced no sensory or motor deficit and opined that she had five percent impairment in each hand pursuant to 16.5d, page 495 of the A.M.A., *Guides*. Dr. Bundens rated total impairment as 10 percent for the right shoulder and 5 percent of each hand for her bilateral carpal tunnel syndrome.

On November 4, 2005 an Office medical adviser agreed with Dr. Bundens that appellant had 10 percent right shoulder impairment. He further noted that appellant had five percent impairment for right carpal tunnel syndrome under section 16.5d, of the A.M.A., *Guides.* Pursuant to the Combined Values Chart, appellant had 15 percent impairment of the right arm. The medical adviser noted that Dr. Bundens incorrectly found five percent impairment for left carpal tunnel syndrome as the statement of accepted facts list only right carpal tunnel syndrome as an accepted condition. He noted maximum medical improvement was June 28, 2005.

In a January 17, 2006 decision, the Office granted appellant schedule awards for an additional 5 percent impairment of her right arm, for a total of 15 percent, and 5 percent impairment for the left arm. The period of the awards was August 18, 2004 to March 24, 2005.

On January 23, 2006 appellant requested an oral hearing.

In a decision dated April 13, 2006, the hearing representative vacated the January 17, 2006 schedule awards and remanded the case for further development. The hearing representative noted that the Office failed to properly combine appellant's claim for bilateral carpal tunnel syndrome with the right shoulder claim and refer both files to the referee physician. The hearing representative instructed the Office to combine the files and prepare an updated statement of accepted facts and refer the case back to Dr. Bundens for a supplemental impairment rating.

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[12] A.M.A., *Guides* 476, Figure 16-40.

[13] *Id.* at 477, Figure 16-43.

[14] *Id.* at 479, Figure 16-46.

[15] *Id.*

On May 17, 2006 the Office combined appellant's claims and referred the case to Dr. Bundens, together with an updated statement of accepted facts, for a rating of appellant's upper extremity impairment.

In a May 22, 2006 report, Dr. Bundens reviewed the medical records related to appellant's bilateral carpal tunnel syndrome and right shoulder conditions. He advised that his impairment rating remained unchanged. Dr. Bundens opined that appellant had 5 percent impairment to each hand for bilateral carpal tunnel syndrome and 10 percent impairment for her right shoulder based loss of range of motion. In a report dated July 21, 2006, an Office medical adviser agreed with the rating provided by Dr. Bundens.

In an August 11, 2006 decision, the Office denied appellant's claim for an additional schedule award.

Appellant requested an oral hearing which was held on December 14, 2006.

By decision dated April 3, 2007, an Office hearing representative affirmed the August 11, 2006 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[16] and its implementing regulations[17] 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.

ANALYSIS

Appellant's claims were accepted for a right shoulder injury, for which she under went surgical repair of the right rotator cuff, and for bilateral carpal tunnel syndrome. On appeal, she contends that she has more than 15 percent impairment of the right arm and 5 percent impairment of the left arm.

The Board initially notes that an Office hearing representative found that a conflict in medical opinion arose in the impairment ratings of appellant's attending physician, Dr. Diamond, and an Office medical adviser. It does not agree, as the impairment ratings provided by both physicians did not conform to the protocols of the A.M.A., *Guides*.

[16] 5 U.S.C. § 8107.

[17] 20 C.F.R. § 10.404.

Dr. Diamond rated appellant's right upper extremity impairment as 44 percent. He identified right shoulder range of motion loss in abduction of 100 degrees, or 4 percent impairment at Figure 16-43. Dr. Diamond found right wrist radial deviation of 15 degrees and 25 degrees ulnar deviation, both constituting one percent impairment under Figure 16-31. Dr. Diamond allowed 10 percent impairment for right grip strength; however, the A.M.A., *Guides* provide at page 493-94 that in making impairment ratings of compression neuropathies, additional impairment values are not given for decreased grip strength. He rated impairment for sensory loss (pain) of the right median nerve as 31 percent. However, Dr. Diamond cited generally to Tables 16-15 and 16-10 without addressing how he applied the tables to rate sensory loss.[18] Moreover, he allowed an additional three percent impairment for pain under Figure 18-1, page 574. The Board notes that the Office has advised that Chapter 18 is "not to be used in combination with other methods to measure impairment due to sensory pain…."[19] Dr. Diamond did not provide any discussion as to why an additional impairment rating for pain was appropriate in this case after having rated sensory loss under the tables of Chapter 16. This provides a duplicative rating for pain. For these reasons, the Board finds that the 44 percent impairment rating of appellant's right upper extremity is of diminished probative value. In turn, the 41 percent impairment rating by Dr. Diamond of appellant's left upper extremity was made in the same manner and incorporates the noted procedural errors. His rating of impairment cannot be considered as probative.

On July 1, 2004 an Office medical adviser rated appellant's impairment as 10 percent of the right arm.[20] He rated loss of range of motion of the right shoulder of 160 degrees of abduction, one percent impairment under Figure 16-43, and 100 degrees of flexion as one percent impairment under Figure 16-40. However, the Board notes that Figure 16-40 provides that flexion of 100 degrees of the shoulder represents five percent impairment. The medical adviser also allowed five percent right arm impairment for carpal tunnel syndrome pursuant to 16.5d of the A.M.A., *Guides*. However, in rating carpal tunnel syndrome, page 495 notes that the three scenarios provided are following "optimal recovery time" after surgery. The Board has held that the three scenarios described at page 495 do not apply to an individual with carpal tunnel syndrome who has not undergone surgical decompression.[21] The medical evidence of record reflects that appellant did not undergo surgery for her accepted bilateral carpal tunnel syndrome. Therefore, any rating of sensory or strength loss should have been made in compliance with Tables 16-15, 16-10 and 16-11 of the A.M.A., *Guides*. The final error of the Office medical adviser was to also allow three percent impairment for pain under Chapter 18. As noted, this does not conform to the Office's protocols pertaining to the fifth edition. For

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[18] The Board notes that Table 16-15 allows a maximum 39 percent impairment for sensory deficit involving the median nerve. It must be assumed that under Table 16-10, page 482, Dr. Diamond allowed an 80 percent Grade 2 deficit.

[19] FECA Bulletin No. 01-05 (issued January 29, 2001). *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 Exhibit 4, Use of Fifth Edition of A.M.A., *Guides* (November 2002).

[20] The Board notes that the medical adviser apparently relied on a June 12, 2003 report of Dr. Jatin D. Gandi, a Board-certified orthopedic surgeon, who provided a second opinion evaluation.

[21] *See E.L.*, 59 ECAB ___ (Docket No. 07-2421, issued March 10, 2008).

these reasons, the impairment rating of the Office medical adviser is also of diminished probative value.

The opinion of Dr. Bundens, therefore, is that of a second opinion medical specialist. However, his impairment rating is also of reduced probative value. Dr. Bundens rated impairment as 15 percent of the right upper extremity and 5 percent of the left upper extremity. He rated right shoulder range of motion impairment of 150 degrees flexion as two percent;[22] 110 degrees abduction as three percent;[23] and 10 degrees internal rotation as five percent.[24] This resulted in a total 10 percent impairment for loss of range of right shoulder motion and conforms to the A.M.A., *Guides*.

Dr. Bundens rated impairment of both the right and left upper extremities as five percent for appellant's accepted bilateral carpal tunnel syndrome. However, he rated appellant's impairment pursuant to 16.5d Entrapment/Compression Neuropathy, Carpal Tunnel Syndrome, page 495, of the A.M.A. *Guides*. As noted, however, the scenarios presented at page 495 pertain to individuals who have undergone surgical decompression. As appellant did not undergo surgery to correct her carpal tunnel symptoms, the method for determining residual impairment due to carpal tunnel syndrome post surgery are not applicable to the facts of this case. Under the fifth edition of the A.M.A., *Guides*, the schedule award for carpal tunnel syndrome in this case should be based on motor and sensory impairments.[25] Therefore, Dr. Bundens did properly address whether appellant's carpal tunnel syndrome resulted in motor or sensory impairment. Because his rating of permanent impairment does not conform to the standards adopted by the Office, it is also of diminished probative value.

The Board will set aside the Office's April 3, 2007 decision and remand the case for proper development of the medical evidence. After such further development as may be required, the Office shall issue an appropriate final decision on appellant's entitlement to schedule award compensation.

[22] A.M.A., *Guides* 476, Figure 16-40.

[23] *Id.* at 477, Figure 16-43.

[24] *Id.* at 479, Figure 16-46.

[25] *Id.* at 494-95; *David D. Cumings*, 55 ECAB 285 (2004).

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 April 3, 2007 and August 11, 2006 decisions of the Office of Workers' Compensation Programs be set aside and the case remanded for further action consistent with this opinion.

Issued: July 1, 2008
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