United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 08-13**
	)	**Issued: May 22, 2008**
DEPARTMENT OF THE NAVY, NAVAL AIR FACILITY, El Centro, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 1, 2007 appellant filed a timely appeal from the September 6, 2007 merit decision of an Office of Workers' Compensation Programs' hearing representative who denied her claim for an increased schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award decision.

ISSUE

The issue is whether appellant has established more than 14 percent impairment to both her right and left upper extremities, for which she received a schedule award.

FACTUAL HISTORY

On July 17, 2000 appellant, then a 38-year-old quality assurance evaluator, filed a claim for employment-related carpal tunnel syndrome (CTS). The Office accepted bilateral CTR, bilateral lesion of the ulnar nerve, right wrist ganglion cyst and right radial styloid tendinitis. Appellant underwent a left carpal tunnel release and injection of the bilateral cubital tunnels on April 16, 2001 a right carpal tunnel release on May 3, 2001 a left ulnar nerve transposition with

injection of the bilateral first dorsal compartments on August 12, 2002 a right ulnar nerve anterior transposition on December 17, 2003 a right first dorsal compartment release with injection of the left first dorsal compartment on April 5, 2004 and a left first dorsal compartment release on December 9, 2005. The Office paid appropriate benefits. Appellant returned to full-time modified-duty work after each surgery.

In a January 23, 2002 report, appellant's attending physician Dr. James R. Moitoza, a Board-certified orthopedic surgeon, indicated that she reached a permanent and stationary status. He diagnosed bilateral flexor tenosynovitis, resolved bilateral CTS, left cubital tunnel syndrome and resolved right de Quervain's tenosynovitis and resolved lateral epicondylitis of the bilateral elbows. Dr. Moitoza noted that appellant continued to experience pain, numbness and tingling in both upper extremities. Examination revealed limited range of motion of the right elbow from 5 to 130 degrees and the left elbow from 8 to180 degrees. Range of motion of the right wrist was noted as: 71 degrees flexion, 60 degrees extension, 80 degrees pronation, 90 degrees supination, 21 degrees radial deviation and 19 degrees ulnar deviation. Range of motion of the left wrist was noted as: 72 degrees flexion, 55 degrees extension, 80 degrees pronation, 90 degrees supination, 20 degrees radial deviation and 19 degrees ulnar deviation. Appellant had decreased sensation in the median and ulnar nerve distribution with inability to discriminate the texture and size of unseen objects. She was also noted to have pain which became moderate to severe with an increase in activities.

On April 14, 2002 the Office referred the claim to an Office medical adviser, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, for an opinion on appellant's permanent impairment. In a March 28, 2002 report, Dr. Harris opined that appellant had 14 percent right arm impairment and 14 percent left arm impairment based on Dr. Moitoza's January 23, 2002 report based on loss of strength and pain. The medical adviser found that appellant had a "Grade 4 pain/decreased sensation that is forgotten with activity [25 percent] (Table 16-10/[p]age 482) of the median nerve/sensory function [39] (Table 16-15/[p]age 492), resulting in 10 percent impairment of each upper extremity." Dr. Harris also found that appellant had a "Grade 3 pain/decreased sensation that interferes with some activity [60 percent] (Table 16-10/[p]age 482) of the ulnar/sensory function [7] (Table 16-15/[p]age 492), resulting in 4 percent impairment of each upper extremity." Combining the totals of the 10 percent residual CTS with the 4 percent residual cubital tunnel syndrome symptoms, Dr. Harris found that appellant had 14 percent impairment to both arms. Dr. Harris noted that the date of maximum medical improvement was January 23, 2002, when Dr. Moitoza described appellant as a permanent and stationary status.

On June 5, 2002 the Office granted appellant a schedule award for 14 percent permanent impairment of the right and left upper extremities. The period of the awards was 87.36 weeks, from January 23, 2002 through September 26, 2003.

Dr. Moitoza continued to report on appellant's condition. In a July 1, 2002 report, he advised that appellant's left elbow symptoms had not improved and there was additional evidence of constriction of the canal on magnetic resonance imaging (MRI) scan. Dr. Moitoza recommended a left anterior transposition of the ulnar nerve, which appellant underwent on August 12, 2002. On December 18, 2002 he opined that appellant reached permanent and stationary status from her upper extremity overuse syndromes. Dr. Moitoza noted that she had

residuals of her de Quervain's tenosynovitis of both wrists and residual flexor tenosynovitis, mostly on the left. Examination of the right elbow and left elbow demonstrated range of motion of 0 to 140 degrees with 90 degrees of pronation and supination, without instability. Examination of the right wrist demonstrated limited range of motion with palmar flexion 70 degrees, dorsiflexion 70 degrees, radiation deviation 20 degrees and ulnar deviation 23 degrees. Examination of the left wrist demonstrated limited range of motion with palmar flexion 75 degrees, dorsiflexion 58 degrees, radial deviation 15 degrees and ulnar deviation 19 degrees. Appellant was noted to have 25 percent loss of grip strength with diminished sensation in the median and ulnar nerve distribution.

The record reflects that appellant underwent additional surgery. On December 17, 2003 she underwent an anterior transposition of the right ulnar nerve. On April 5, 2004 she underwent a right first dorsal compartment release and injection of left first dorsal compartment. In an August 25, 2004 report, Dr. Moitoza opined that appellant was permanent and stationary from her April 5, 2004 right wrist surgery and left first dorsal compartment injections of April 5 and June 2, 2004. In an October 25, 2004 report, he opined that appellant was permanent and stationary from the ulnar nerve transposition. Examination findings of the right elbow revealed 10 degree extension and 135 degree flexion with 90 degrees pronation and supination. Full range of motion in flexion, extension, pronation and supination of both wrists were noted. Appellant was noted to have a 10 to 15 percent loss in grip strength of the left arm.

On November 2, 2004 appellant requested an increased schedule award. She submitted reports of Dr. Moitoza dated December 18, 2002 to October 25, 2004.

On November 30, 2004 the Office referred the file to Dr. Harris for an opinion on the degree of appellant's permanent impairment. The Office noted the accepted conditions as: bilateral CTS, bilateral ulnar nerve lesions, right wrist ganglion cyst and right radial styloid tendinitis. In a December 2, 2004 report, Dr. Harris noted the prior impairment rating of March 2002. Since then, appellant had three additional operations performed by Dr. Moitoza. Based on Dr. Moitoza's December 18, 2002 report, Dr. Harris concluded that appellant had 15 percent permanent impairment of the right upper extremity and 17 percent permanent impairment of the left upper extremity. The impairment to the right upper extremity was comprised of: 1 percent impairment for loss of wrist motion; 10 percent impairment for residual CTS; and 4 percent impairment for residual cubital tunnel syndrome. The impairment to the left upper extremity was comprised of: 3 percent impairment for loss of wrist motion; 10 percent impairment for residual CTS; and 4 percent impairment for residual cubital tunnel syndrome. Dr. Harris found that the date of maximum medical improvement was December 18, 2002, when Dr. Moitoza found appellant's condition to be permanent and stationary.

On September 21, 2005 Dr. Harris noted the October 25, 2004 report of Dr. Moitoza that appellant reached permanent and stationary status on August 26, 2004. Appellant had limited range of motion of 10 to 135 degrees with 90 degrees of pronation and supination. Dr. Harris also had full wrist range of motion. He advised that appellant had no current neurologic deficit in either arm. Dr. Harris found that, for schedule award purposes, appellant's condition had not changed since his December 2, 2004 report. He opined that appellant had 15 percent permanent impairment of the right arm and 17 percent permanent impairment of the left arm. Dr. Harris

noted, however, that the date of maximum medical improvement was August 26, 2004, the date of Dr. Moitoza's examination.

In an October 10, 2005 report, Dr. Moitoza diagnosed recurrent left de Quervain's tenosynovitis and, on December 9, 2005, appellant underwent a left first dorsal compartment release. In a December 20, 2006 report, Dr. Moitoza opined that appellant was permanent and stationary.

On December 22, 2006 appellant requested an increased schedule award. In a March 22, 2007 report, Dr. Moitoza opined that appellant was permanent and stationary with maximum medical improvement reached December 20, 2006. Range of motion for the right wrist revealed: dorsiflexion 60 degrees; palmar flexion 78 degrees;[1] radial deviation 22 degrees; ulnar deviation 25 degrees; supination 90 degrees; and pronation 80 degrees. Range of motion for the left wrist revealed: dorsiflexion 60 degrees; palmar flexion 80 degrees; radial deviation 27 degrees; ulnar deviation 17 degrees; supination 90 degrees; and pronation 80 degrees. With respect to pain, Dr. Moitoza advised that there were no ulnar nerve symptoms, but appellant had numbness and tingling and dysesthesias and loss of sensation in the median nerve distribution on both the right and left, with the left side being more severe. He advised that most of the time the pain was mild but became moderate to severe after 5 to 10 minutes when appellant engaged in activities affecting her upper extremities. Dr. Moitoza stated that appellant had no significant atrophy of the upper extremities but there was a 25 percent loss in grip strength with repetitive use caused by pain and discomfort.

In a May 7, 2007 report, Dr. Harris reviewed the medical record and noted appellant's last surgery of December 9, 2005. Based on Dr. Moitoza's March 22, 2007 report, the medical adviser concluded that appellant had 9 percent impairment of the right arm and 12 percent impairment of the left arm. With respect to the right arm, Dr. Harris found that appellant had "Grade 3 pain/decreased sensation that interferes with some activity (Table 16-10/[p]age 482) of the ulnar nerve/sensory function [7] (Table 16-15 at page 492), resulting in [four] percent impairment." Under Chapter 16 page 495, he found that appellant had five percent impairment as a result of having a satisfactory result following carpal tunnel release. With respect to the left arm, Dr. Harris found that, under Figure 16-31 at page 469, appellant had three percent impairment for loss of wrist ulnar deviation. He found that appellant had a "Grade 3 pain/decreased sensation that interferes with some activity (Table 16-10/[p]age 482) of the ulnar nerve/sensory function [7] (Table 16-15/[p]age 492), resulting in a four percent impairment." Under Chapter 16 at page 495, appellant had five percent impairment as a result of a satisfactory left carpal tunnel release. Dr. Harris additionally found that the date of maximum medical improvement was December 20, 2006 as indicated by Dr. Moitoza.

By decision dated May 23, 2007, the Office denied an additional schedule award. The Office noted that Dr. Harris reviewed the medical file and found that the evidence did not establish additional permanent impairment beyond that previously awarded.

On May 30, 2007 appellant requested a review of the written record. She disagreed with Dr. Harris' rating noting that she continued to experience pain due to her work injury and noted

[1] In his May 7, 2007 report, Dr. Harris noted that appellant's right palmar flexion was 70 degrees.

how her symptoms affected her daily life. Copies of material previously of record were submitted. In a June 20, 2007 report, Dr. Moitoza diagnosed neuropathic pain syndrome, left greater than right side and overuse flexor tenosynovitis, bilateral wrists and forearms.

In a September 6, 2007 decision, an Office hearing representative affirmed the May 23, 2007 decision. The hearing representative found that the Office increased appellant's original schedule award from 14 percent permanent impairment of both arms to 15 percent permanent impairment of the right arm and 17 percent permanent impairment of the left arm. The hearing representative further found that there was no medical evidence which would warrant an increased impairment rating over the amended schedule award.

LEGAL PRECEDENT

A claim for an increased schedule award may be based on new exposure.[2] Absent any new exposure to employment factors, a claim for an increased schedule award may also be based on medical evidence indicating that the progression of an employment-related condition has resulted in a greater permanent impairment than previously calculated.[3]

In determining entitlement to a schedule award, preexisting impairment to the scheduled member should be included.[4] Any previous impairment to the member under consideration is included in calculating the percentage of loss except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.[5]

The schedule award provision of the Federal Employees' Compensation Act[6] and its implementing regulations[7] 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. The Act, however, does not specify the manner in which the percentage loss of a member 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001) has been adopted by the Office for evaluating schedule losses.[8]

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[2] *Linda T. Brown*, 51 ECAB 115 (1999).

[3] *Id.*

[4] *Carol A. Smart*, 57 ECAB 340 (2006); *Michael C. Milner*, 53 ECAB 446, 450 (2002).

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.7(a)(2) (November 1998).

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *See* 20 C.F.R. § 10.404; *see also David W. Ferrall*, 56 ECAB 362 (2005).

The A.M.A., *Guides* note that CTS involves compression of the median nerve at the volar aspect of the wrist.[9] The A.M.A., *Guides* list the symptoms, signs and findings of CTS as pain and paresthesias in the median nerve distribution, including sensory autonomic disturbances in the radial 3.5 digits, weakness or atrophy of the thenar muscles, a positive percussion sign at the wrist, presence of Phalen's sign and motor and sensory electroneuromyographic abnormalities.[10]

In evaluating CTS, 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 is rated according to the sensory and/or motor deficits as described earlier.[11] In this situation, the impairment due to residual CTS 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.[12]

In the second scenario: Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal electromyogram 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. Finally, the A.M.A., *Guides* provide: Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies: there is no objective basis for an impairment rating.[13]

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides,* with the Office medical adviser providing rationale for the percentage of impairment specified.[14]

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

[10] *Id.*

[11] *Id.*

[12] *Id*. at 494, 481.

[13] *Id.* at 495.

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

ANALYSIS

On June 5, 2002 the Office granted appellant a schedule award for 14 percent permanent impairment of the right arm and 14 percent permanent impairment of the left arm. Although the Office developed the medical evidence in response to appellant's November 2, 2004 request for an increased schedule award, a new schedule award decision was not issued. Her condition worsened and she underwent additional surgeries, the most recent being December 9, 2005.[15] In its May 23, 2007 decision, the Office denied appellant's December 22, 2006 request for an increased award on the basis that the medical evidence did not establish any additional permanent impairment beyond the 14 percent impairment found for both upper extremities, for which she received a schedule award. While an Office hearing representative affirmed the denial of an increased schedule award in his September 6, 2007 decision, the hearing representative incorrectly stated that the schedule award was comprised of 15 percent right arm impairment and 17 percent left arm impairment. The record on appeal indicates, however, that appellant only received a schedule award for 14 percent permanent impairment to both upper extremities.

In a March 22, 2007 report, Dr. Moitoza provided a thorough description of findings on examination but did not provide an impairment rating under the A.M.A., *Guides*. In accordance with Office procedures, Dr. Harris, a medical adviser, reviewed the evidence and determined that appellant had 9 percent impairment of the right upper extremity and a 12 percent impairment of the left upper extremity. The nine percent right upper extremity impairment was based on four percent pain impairment and five percent impairment as a result of a satisfactory carpal tunnel release. The 12 percent left upper extremity impairment was based on 3 percent loss of motion, 4 percent pain impairment and 5 percent impairment as a result of a satisfactory carpal tunnel release. Loss of grip strength was not included in Dr. Harris' impairment calculation.

The Board finds that the case is not in posture for decision regarding whether appellant is entitled to an increased schedule award, Dr. Harris did not adequately explain how his impairment ratings were reached.

Dr. Harris properly applied option two on page 495 of the A.M.A., *Guides* to both the left and right upper extremity to allow for an impairment rating not to exceed five percent in situations where a person has normal sensibility and abnormal sensory with optimal recovery time after surgical decompression.[16] The A.M.A., *Guides* provide, except in rare circumstances, ratings based on loss of motion or grip strength are not allowed in carpal tunnel award cases, unless the medical evidence clearly establishes why such additional award is necessary.[17] Dr. Harris properly excluded an impairment rating based on loss of grip strength. However, he did not explain his basis for including impairment based on loss of range of motion (three percent) for the left upper extremity.

[15] *See generally Mark A. Holloway*, 55 ECAB 321, 325 (2004).

[16] A.M.A., *Guides* at 495.

[17] *Cristeen Falls*, 55 ECAB 420 (2004).

Additionally, Dr. Harris erroneously based the four percent pain impairment to both the left and right upper extremity on a decreased sensation to the ulnar nerve. In his March 22, 2007 report, Dr. Moitoza advised that appellant's numbness and tingling and dysesthesias and loss of sensation arose from the median nerve distribution on both the right and left side and that no ulnar nerve symptoms were present. The Board notes that, under Table 16-15 at page 492 of the A.M.A., *Guides*, the maximum upper extremity impairment due to unilateral sensory deficit of the median nerve below the midforearm is 39 percent while the maximum upper extremity impairment of the ulnar nerve below the midforearm is 7 percent. Moreover, Dr. Harris classified appellant's impairment of the upper extremity due to sensory deficit or pain as that of a Grade 3 deficit but applied the percentage deficit, which is noted as 25 percent, as that of a Grade 4 deficit.[18] In calculating sensory loss to both the left and right upper extremity, Dr. Harris did not use the correct maximum impairment value for the proper peripheral nerve (39 percent for the median nerve below the midforearm) or correlate the proper sensory deficit percentage range for the classification of appellant's sensory deficit or pain. Dr. Harris should clarify how he rated impairment under the A.M.A., *Guides* the Board will remand the case to the Office so that it may request clarification from Dr. Harris.[19]

[18] A.M.A., *Guides*, Table 16-10 at page 482. A Grade 3 sensory deficit represents a distorted superficial tactile sensibility (diminished light touch and two point discrimination), with some abnormal sensations or slight pain, that interferes with some activities and is assigned a sensory deficit range of 26 to 60 percent. A Grade 4 sensory deficit represents a distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity and is assigned a sensory deficit range of 1 to 25 percent.

[19] The Board notes that appellant disputes some of the conditions which the Office accepted, such as a right wrist ganglion cyst. A review of the record does not establish that appellant had such a diagnosis.

CONCLUSION

The Board finds that the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the September 6, 2007 decision of the Office of Workers' Compensation Programs is set aside and remanded for additional development consistent with this decision of the Board.

Issued: May 22, 2008
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board