United States Department of Labor
Employees' Compensation Appeals Board

E.A., Appellant	)	
and	)	**Docket No. 08-72**
	)	**Issued: May 7, 2008**
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 October 9, 2007 appellant filed a timely appeal from a schedule award decision of the Office of Workers' Compensation Programs dated August 23, 2007. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award.

ISSUE

The issue is whether appellant has met his burden of proof to establish that he has more than five percent impairment of the right upper extremity for which he received a schedule award.

FACTUAL HISTORY

On August 2, 2005 appellant, a 54-year-old sandblaster, filed a Form CA-2, occupational disease claim, for a hand condition. He did not stop work. On September 7, 2005 the Office accepted that appellant sustained employment-related right carpal tunnel syndrome, and on May 23, 2006 Dr. Ronald K. Freund, a hand surgeon Board-certified in orthopedics, performed

surgical release. Appellant returned to limited duty on June 12, 2006. On August 29, 2006 he returned to full duty and filed a schedule award claim.

In an August 28, 2006 report, Dr. Freund advised that, in accordance with page 509 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[1] appellant had a 10 percent upper extremity impairment based on grip strength deficit. He also answered Office questions regarding appellant's degree of impairment, advising that maximum medical improvement was reached on August 28, 2006, that appellant had a 10 percent impairment based on loss of strength and a 0 impairment due to sensory deficit, pain or discomfort. By report dated February 1, 2006, an Office medical adviser, Dr. Willie E. Thompson, Board-certified in orthopedic surgery, noted that he had reviewed appellant's medical record and advised that, since appellant had surgery on May 23, 2006, he would not reach maximum medical improvement until May 23, 2007 and should have an updated electromyographic (EMG) study prior to revisiting whether he was entitled to a schedule award.

Appellant retired effective January 4, 2007 and, in a March 26, 2007 treatment note, Dr. Freund noted appellant's complaint of pain with gripping activities. Examination findings included static two-point discrimination (S2PD) testing of five millimeter (mm) with some variability from time to time in all digits. He recommended an EMG. Dr. Armistead Williams, a Board-certified neurologist, performed an EMG examination on April 3, 2007. He noted appellant's medical history and his report that, while the surgery initially helped, he had begun to have numbness and pain again. Dr. Williams interpreted the right arm EMG as demonstrating mild right carpal tunnel syndrome, minimally worse than in a prior study of October 2004 with no evidence of superimposed cervical nerve root compression, ulnar neuropathy or polyneuropathy. In a July 5, 2007 report, the Office medical adviser, Dr. Thompson, noted that he had reviewed the medical evidence of record including the April 3, 2007 EMG study. He found that the date of maximum medical improvement was May 23, 2007 and advised that, under the fifth edition of the A.M.A., *Guides*, normal sensibility and opposition strength and abnormal sensory and/or motor latencies or abnormal EMG testing with a residual carpal tunnel syndrome resulted in an impairment rating not to exceed five percent of the upper extremity.

By decision dated August 23, 2007, appellant was granted a schedule award for a five percent permanent impairment of the right arm, for a total of 10 weeks, to run from May 23 to August 4, 2007.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulations,[3] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in

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

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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*[4] has been adopted by the Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5] Chapter 16 provides the framework for assessing upper extremity impairments.[6]

Regarding carpal tunnel syndrome, the A.M.A., *Guides* provide:

> "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 [carpal tunnel syndrome] is rated according to the sensory and/or motor deficits as described earlier.[7]
>
> 2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS is still present, and an impairment rating not to exceed 5 percent of the upper extremity may be justified.
>
> 3. 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."[8]

Section 16.5d of the A.M.A., *Guides* provide that, in compression neuropathies, additional impairment values are not given for decreased grip strength. Carpal tunnel syndrome is an entrapment/compression neuropathy of the median nerve, and the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory deficits only.[9] Office procedures further provide that, after obtaining all necessary medical evidence, the file should be

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[4] A.M.A., *Guides, supra* note 1.

[5] *See Joseph Lawrence, Jr., supra* note 1; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[6] A.M.A., *Guides, supra* note 1 at 433-521.

[7] Section 16.5b of the A.M.A., *Guides* describes the methods for evaluating upper extremity impairments due to peripheral nerve disorders and provides that the severity of the sensory or pain deficit and motor deficit should be classified according to Tables 16-10a and 16-11a respectively. The impairment is evaluated by multiplying the grade of severity of the sensory or motor deficit by the respective maximum upper extremity 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. *Id*. at 481; *Kimberly M. Held*, 56 ECAB 670 (2005).

[8] *Id.* at 495.

[9] *Id*. at 494; *Kimberly M. Held, supra* note 7.

routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment.[10]

ANALYSIS

The Board notes that the August 23, 2007 decision contains a factual error. Section 8107 of the Act provides that the compensation schedule for a 100 percent loss of use of the arm is 312 weeks.[11] Thus, five percent upper extremity impairment would equal 15.6 weeks, not the 10 weeks granted in the August 23, 2007 schedule award. The Board also finds this case is not in posture for decision for other reasons. As noted above, the A.M.A., *Guides* provides three scenarios for assessing impairment due to carpal tunnel syndrome following a surgical decompression.[12] Dr. Freund's initial impairment rating dated August 28, 2005 is of no probative value because he based his rating on grip strength testing found on page 509 of the A.M.A., *Guides* rather than providing proper analysis as provided on page 495, and the guidelines found for assessing compression neuropathies found in section 16.5d of the A.M.A., *Guides* provide that additional impairment values are not given for decreased strength.[13] Dr. Freund also provided a March 26, 2007 treatment note in which he advised that appellant continued to have pain with gripping activities and provided examination findings of S2PD testing of five mm. He, however, did not explain the significance of the S2PD finding. On April 3, 2007 Dr. Williams noted appellant's account that numbness and pain had returned following surgery and advised that his EMG study demonstrated mild carpal tunnel syndrome that was minimally worse than in October 2004. In his July 5, 2007 report, the Office medical adviser, Dr. Thompson, rated appellant's impairment under scenario two enunciated above. He, however, did not explain what medical evidence he relied on in reaching his conclusion.

If, on examination, a physician finds positive clinical findings of median nerve dysfunction and electrical conduction delay, the impairment due to residual carpal tunnel syndrome is to be rated according to the sensory and/or motor deficits described in section 16.5b of the A.M.A., *Guides*.[14] If examination demonstrates normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles, a residual carpal tunnel syndrome is still present, and an impairment rating not to exceed five percent of the upper extremity may be justified.[15]

Notwithstanding the factual error in the August 23, 2007 schedule award regarding the number of weeks of compensation, the Board also concludes that it is unclear from the medical evidence of record whether appellant's right carpal tunnel syndrome should be rated under the

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[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(d) (August 2002).

[11] 5 U.S.C. § 8107(c)(1).

[12] A.M.A., *Guides, supra* note 1 at 495.

[13] *Supra* note 8.

[14] *Supra* note 7.

[15] *Supra* note 8.

first or second scenario for assessing carpal tunnel syndrome as found on page 495 of the A.M.A., *Guides.* The case must therefore be remanded to the Office. On remand the Office should further develop the medical record to determine appellant's degree of right upper extremity impairment, to be followed by an appropriate decision.

CONCLUSION

The Board finds this case is not in posture for decision as the August 23, 2007 schedule award contains a factual error and the medical evidence of record is insufficient to determine whether appellant's right upper extremity carpal tunnel syndrome impairment falls under the first or second rating scheme found on page 495 of the A.M.A., *Guides.*

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 23, 2007 be vacated and the case remanded to the Office for proceedings consistent with this opinion of the Board.

Issued: May 7, 2008
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