U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PATRICIA L. PENKWITZ and U.S. POSTAL SERVICE, POST OFFICE, Milwaukee, WI

Docket No. 01-2187; Submitted on the Record;
Issued April 12, 2002

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON, A. PETER KANJORSKI

The issue is whether appellant has more than a 10 percent impairment of her right upper extremity and a 10 percent impairment of her left upper extremity, for which she received a schedule award.

The Board has duly reviewed the case record and finds that appellant is not entitled to an additional schedule award.

The Office of Workers' Compensation Programs accepted that appellant sustained a right medial epicondylitis, a left lateral epicondylitis and bilateral carpal tunnel syndrome with subsequent surgical procedures while in the performance of her duties. By decision dated September 21, 1995, the Office granted appellant a schedule award for a 10 percent permanent loss of use of her right upper extremity and a 10 percent permanent loss of use of her left upper extremity. The period of the award ran from November 12, 1994 through January 22, 1996.

Appellant filed a claim for additional impairment. By decision dated November 6, 2000, the Office found that the weight of the medical evidence established that appellant was not entitled to an additional schedule award. She requested reconsideration and submitted additional evidence. By decision dated August 13, 2001, the Office denied modification of its previous decision finding that, although appellant established a 2 percent permanent loss of use of both her right and left upper extremities, no additional award was due as appellant had previously been awarded a 10 percent permanent loss of each extremity, which was higher than the current impairment determination.

Under section 8107 of the Act[1] and section 10.404 of the implementing regulations,[2] schedule awards are payable for permanent impairment of specified body members, functions or organs. However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the American Medical Association (A.M.A.), *Guides to the Evaluation of Permanent Impairment*[3] as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[4]

In an April 18, 2000 report, Dr. Greg P. Watchmaker, a Board-certified plastic surgeon, specializing in hand surgery, recommended a five percent permanent partial impairment of appellant's bilateral upper extremities. In his examination notes of April 6, 2000, he advised that appellant had no discomfort in her forearms bilaterally. She had been able to return to her regular work. Dr. Watchmaker noted that appellant's greatest difficulty was with supination activities, but advised the weakness was common following radial tunnel release and lateral epicondylar release. He opined that it was likely that appellant would have some permanent deficit in strength and noted that she measured 50 pounds of grip in the left and 65 pounds on the right. Dr. Watchmaker rated her final impairment as five percent compared with amputation at the elbow for persistent weakness in her arms bilaterally.

In a report dated August 2, 2000, an Office medical consultant, Dr. Mark Stewart, an orthopedic surgeon, advised that he reviewed Dr. Watchmaker's records submitted with the medical narrative. He noted that appellant's original injury was accepted as occurring on March 22, 1999 and that she underwent bilateral fasciotomies. Appellant was noted to be 41 years old, currently working her regular job and did not report discomfort on her last examination. Dr. Stewart further noted that as Dr. Watchmaker's records indicated appellant's condition continued to improve until April 6, 2000, that should be the date of maximum medical improvement. Appellant had a grip strength measurement of 65 pounds on the right (dominant hand) and 50 pounds on the left. Dr. Stewart noted there was a reported slight decrease in supination, but stated this was not part of her fasciotomies. He further noted that Dr. Watchmaker, in his report of April 18, 2000, had recommended an award of five percent permanent partial impairment for the bilateral upper extremities without specific references to

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

[3] A.M.A., *Guides* (5th ed., 2000).

[4] *James R. Bradford*, 48 ECAB 320, 324 (1997); *Henry G. Flores, Jr.*, 43 ECAB 901 (1992). The Board notes that, in this case, the Office based its November 6, 2001 decision on the fourth edition of the A.M.A., *Guides*. The fifth edition of the A.M.A., *Guides*.became effective February 1, 2001. FECA Bullentin 01-5 (issued January 29, 2001), advises that awards calculated according to any previous edition should be evaluated according to ehe edition originally used. Any recalculations of previous awards which result friom hearings reconsideration or appeals should, however, be based on the fifth edition of the A.M.A., *Guides* effevtive February 1, 2001. Since the August 13, 2001 decision was a reconsideration involving a recalculationof a previous schedule award, the Office properly used the fifth edition of the A.M.A., *Guides*. A comparison of the fourth and fifth edition of the A.M.A., *Guides* shows that the specific section used for calculating the schedule award in this case remains virtually unchanged. A.M.A., Guides, page 3/64-65,"Strength Evaluation" (4th ed., 1993); page 507-510, "Strength Evaluation" (5th ed., 2000).

the A.M.A., *Guides*, fourth edition. Utilizing the A.M.A., *Guides*, Dr. Stewart calculated grip strength loss.[5] Her calculated grip strength on the right was 29.5 kg,[6] which was noted to be the grip strength average for a 23.4 year old. The calculated grip strength on the right was 22.7 kg, which was noted to be the grip strength average for a 21.5 year old. Dr. Stewart advised that appellant received zero points for the right and left sides as she exceeded the average grip strength. He found that the grip strength, range of motion and lack of pain provided a zero percent permanent partial impairment rating for the affected limbs.

As the report of the Office medical adviser is based on an appropriate use of the A.M.A., *Guides*, it properly represented the weight of the evidence in the Office's decision of November 6, 2000, which found that appellant was not entitled to an additional schedule award. Thus, appellant had not established that she is entitled to a schedule award for more than the 10 percent impairment to her bilateral upper extremities, which had already been awarded.

In her request for reconsideration, appellant submitted completed tables from the A.M.A., *Guides* indicating that she had a permanent impairment to both extremities. As a result of this new information, the Office referred appellant to Dr. Vijay Kulkarni, a Board-certified orthopedist, for a second opinion evaluation.

In a July 26, 2001 report, Dr. Kulkarni provided a history of the occupational injury, reviewed appellant's medical records and objective studies, provided his findings on examination and diagnosed bilateral carpal tunnel syndrome, bilateral lateral and medial epicondylitis and bilateral radial nerve entrapment at the elbow as being causally related to appellant's work injury. He advised that maximum medical improvement was reached as of April 6, 2000 and appellant's prognosis was good. In accordance with the A.M.A., *Guides* (5th ed.), Dr. Kulkarni advised that he referenced page 495 and opined that appellant had suffered a 5 percent impairment in her left hand and a 5 percent impairment in her right hand as related to the upper extremity and 0 percent

[5] A.M.A., *Guides*, Table 32, p. 3/65 (4th ed. 1993); Table 16-32, p. 509 (5th ed. 2000).

[6] A pound is equivalent to 0.45359237 kilograms.

in each elbow.[7] The clinical findings and impairment criteria used were: Surgery both hands and elbows, electromygram reports, weakness of grip strength, normal range of motion and strength in both elbows and the ability to work without restrictions in the present job.

In a report dated August 6, 2001, an Office medical consultant, Dr. David H. Garelick, an orthopedic surgeon, advised that the A.M.A., *Guides* (5th ed.) and Dr. Kulkarni's July 26, 2001 report was used to estimate appellant's impairment. Dr. Garelick noted that appellant complained of loss of strength in both hands. Physical examination (of Dr. Kulkarni) demonstrated full range of motion of both wrists, forearms and elbows. There was no sensory or motor deficit in either hand. In the elbows, there was tenderness in both later epicondyle. There was no muscle wasting. Grip strength measurements from a prior examination[8] revealed that the right grip was 29.5 kg and the left was 22.7 kg.[9] Dr. Garelick found that both of these measurements were above the threshold at which permanent partial impairment was awarded according to Table 16-31, p. 509 of the A.M.A., *Guides*.[10] Dr. Garelick further found that the only permanent partial impairment which could be awarded was the residual pain in both lateral epicondyle which he found equated to a 2 percent bilateral upper extremity impairment for a Grade 3 pain in the distribution of the lateral antebrachial cutaneous nerve (musculocutaneous) in accordance with

[7] For carpal tunnel syndrome, the Board notes that the A.M.A., *Guides*, p. 495 states:

> If, after an optimal recovery time following surgical decompression, and individual continues to complain of pain parasthesia 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 computerized tomography scan (CTS) is rated according to the sensory and/or motor deficits as described earlier.
> >
> > (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 five 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] This refers to the office notes from Dr. Watchmaker.

[9] *See supra* note 6.

[10] The Board notes that this is a typographical error as the correct Table is 16-32, p. 509.

Table 16-15, p. 492 and Table 16-10, p. 482 of the A.M.A., *Guides*.[11] The date of maximum medical improvement remained April 6, 2000.

The Board notes that both Drs. Kulkarni and Garelick utilized different methodologies for arriving at appellant's new impairment rating for her right and left upper extremities resulting from her accepted work conditions and provided rationale for their conclusion based on an appropriate use of the A.M.A., *Guides*. However, neither Dr. Kulkarni nor Dr. Garelick opined that appellant had any impairment to either her right upper extremity or her left upper extremity greater than the 10 percent permanent impairment already awarded for both her right and left upper extremities. Accordingly, the Board finds that the Office properly found that the medical evidence failed to support an increase in the amount of permanent impairment necessitating an increased award in its August 13, 2001 decision.

The August 13, 2001 and November 6, 2000 decisions of the Office of Workers' Compensation Programs are hereby affirmed.

Dated, Washington, DC
April 12, 2002

Alec J. Koromilas
Member

David S. Gerson
Alternate Member

A. Peter Kanjorski
Alternate Member

[11] The Board notes that although Dr. Garelick found that appellant had a two percent bilateral upper extremity impairment due to pain this was miscalculated and should be a three percent bilateral upper extremity impairment. The Board notes, however, that this miscalculation equates to a harmless error as it does not effect the ultimate result in this case. In performing the calculation for determining the impairment of appellant's upper extremity due to sensory deficit or pain, Table 16-10, p. 482 provides that a Grade 3 classification of pain equates to a 26 to 60 percent sensory deficit. The maximum upper extremity impairment value due to sensory deficit or pain for the major peripheral nerve, Table 16-15, p. 492, of the lateral antebrachial cutaneous nerve (musculocutaneous) is 5 percent. Multiplying the two values of the severity of the sensory deficit by the maximum upper extremity impairment value (60 percent times 5 percent) equals a 3 percent upper extremity impairment value for the right and the left upper extremity.