United States Department of Labor
Employees' Compensation Appeals Board

GOONAWANTE WILLIAMS, Appellant	)	
and	)	**Docket No. 03-2287**
	)	**Issued: June 24, 2004**
U. S. POSTAL SERVICE, POST OFFICE, Bellmawr, NJ, Employer	)	

Appearances:
Thomas R. Uliase, for the appellant,
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
WILLIE T.C. THOMAS, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On September 16, 2003 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated June 30, 2003. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue is whether appellant met her burden of proof to establish that she sustained more than a five percent permanent impairment of her right upper extremity and a seven percent permanent impairment of her left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On September 18, 1989 appellant, then a 44-year-old clerk, filed an occupational disease claim alleging that she sustained carpal tunnel syndrome in the performance of duty. Appellant indicated that she first became aware of the disease on August 9, 1989 and realized that it was caused or aggravated by her employment on September 15, 1999. She did not stop work. In a

separate statement dated September 29, 1989, appellant indicated that her position involved many repetitive activities including keying and labeling.[1] The Office accepted appellant's claim for bilateral carpal tunnel syndrome and left trigger finger.[2] Appellant received compensation benefits.

In a January 27, 1998 report, Dr. Todd M. Lipschultz, a Board-certified orthopedic surgeon, indicated that appellant came in with bilateral hand pain and numbness. He noted that he had treated appellant seven or eight years previously and, at that time, she was diagnosed with moderate right carpal tunnel and early left carpal tunnel syndrome (CTS). Dr. Lipschultz reported that appellant had a progression of her symptoms and a positive Tinel's bilaterally, and multiple trigger digits particularly in the right hand, index, long and ring fingers. He injected both carpal tunnels and provided appellant splints for both hands. In a report dated February 23, 1998, Dr. Lipschultz noted that appellant was also complaining of intermittent triggering from other digits, particularly her right hand. He opined that there was a good chance that this could be related to her chronic repetitive activity.

Appellant filed a notice of recurrence on March 24, 1998. The Office subsequently doubled appellant's claim on July 27, 1998, merging the old claim with her recurrence claim.

In a September 14, 1998 report, Dr. Lipschultz reported that appellant was actively triggering and that catching was occurring on her long and ring fingers on the left. In a follow-up report dated October 12, 1998, Dr. Lipschultz indicated an electromyelogram (EMG) study revealed a mild to moderate right CTS and early left CTS,[3] advising that appellant's major complaint was the locking and triggering of her left hand, long and ring fingers and that she was a candidate for a trigger digit release.[4] In a May 25, 1999 report, Dr. Lipschultz indicated that appellant would benefit from an endoscopic carpal tunnel release with a left trigger finger release.[5] In a July 6, 1999 report, the physician stated appellant's trigger finger condition stemmed from overuse resulting in tendon swelling and related the condition to the repetitive aspects of her employment and requested additional authorization for a trigger finger release. The Office authorized trigger finger release on August 13, 1999 and Dr. Lipschultz performed the surgery on September 15, 1999.[6] On January 31, 2000 he stated that appellant had reached maximum medical improvement and provided permanent restrictions on February 14, 2000.

[1] Appellant filed a subsequent occupational disease claim for carpal tunnel syndrome of the left hand on January 25, 1991.

[2] An earlier decision dated February 1, 1990 denying appellant's claim was vacated.

[3] The EMG was dated September 29, 1998 and was conducted by Dr. Daniel J. Ragone, Jr., Board-certified in physical medicine and rehabilitation.

[4] On November 4, 1998 the Office authorized left carpal tunnel surgery.

[5] Although the Office provided an earlier authorization, it appears that nothing occurred at that time.

[6] The record reflects that appellant filed notices of recurrence on June 10 and September 10, 1999 and returned to limited-duty, casing mail, on November 30, 1999.

On February 14, 2000 appellant filed a notice of recurrence for February 8, 2000, and on August 30, 2000, the Office accepted appellant's recurrence claim. On September 19, 2000 appellant completed a Form CA-7 for compensation for a schedule award.

In an August 3, 2000 report, Dr. David Weiss, an osteopath,[7] referred to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed. 1993) (A.M.A., *Guides*) and found that appellant had an 11 percent impairment of the left upper extremity and a 36 percent impairment to the right upper extremity.[8] He indicated that appellant reached maximum medical improvement on July 25, 2000.

In a report dated December 1, 2000, Dr. Donald F. Leatherwood, a Board-certified orthopedic surgeon and employing establishment physician, opined that appellant required permanent restrictions and placed her on permanent light duty. In a January 4, 2001 report, Dr. Leatherwood utilized the fifth edition of the A.M.A., *Guides* and found that appellant had a left upper extremity impairment of 18 percent and a right upper extremity impairment of 32 percent.[9]

[7] The Board-certification directories contain several listings for David Weiss; however, none appear to be this physician.

[8] He noted appellant's history of injury and treatment and found that appellant had tenderness on palpation over the flexor tendon involving the long finger, a negative Tinel sign, and a positive Phalen's and carpal tunnel compression test. He noted range of motion revealed dorsiflexion of 0-75/75 degrees, palmar-flexion of 0-75/75 degrees, radial deviation of 0-20/20 degrees and ulnar deviation of 0-35/35 degrees. The thenar abduction of the left hand was graded at 4/5. Dr. Weiss examined the right hand and wrist finding the fist presentation was abnormal with appellant lacking 1 centimeter (cm) to the distal palmar crease and a triggering phenomenon of the third, fourth and fifth digits with tenderness over the flexor tendons. Dr. Weiss noted that appellant had a positive Tinel's sign and positive Phalen's sign and provided range of motion limitations for the index, middle, ring and little fingers and reported essentially the same findings for dorsiflexion, palmar flexion, radial deviation and ulnar deviation as identified for the left hand. Dr. Weiss found claimant had circumference measurements of 28 cm for both arms and measured grip strength of 8 kilograms (kg) of force for both hands. He noted that sensory examination revealed a perceived sensory deficit over the median nerve distribution of the left hand and diagnosed bilateral carpal tunnel syndrome, left carpal tunnel release, left trigger finger phenomenon and left A-1 pulley release of the left long finger and trigger finger phenomenon of the third, fourth and fifth digits. Dr. Weiss reported subjective and objective factors of disability and referred to Tables 1 and 2 of Figure 21, of the A.M.A., *Guides* which entitled appellant to a 1 percent permanent impairment for range of motion of the left long finger and Table 16 entitled appellant to a 10 percent impairment for left median nerve entrapment or 11 percent impairment of the left upper extremity. With respect to the right hand, Dr. Weiss provided ratings of 11, 5 and 5 percent for the right third, fourth and fifth fingers respectively based on Table 29, page 63, Table 18, page 58 and opined that appellant had a 20 percent permanent impairment for right median nerve entrapment at the wrist for a combined total rating of 36 percent for the right upper extremity.

[9] In his report, he noted that appellant had two issues which needed to be considered with regard to her impairment rating of the upper extremities. The physician indicated that the first was her proximal interphalangeal flexion contractures of the long fingers, which according to the A.M.A., *Guides* 463, 16-23, represented a three percent impairment for each one of the long fingers. Dr. Leatherwood indicated that the second issue was appellant's carpal tunnel syndrome, which he opined was difficult to measure due to appellant's questionable strength and sensibility. However, he determined that appellant suffered from a mild left carpal tunnel syndrome and a moderate right carpal tunnel syndrome. The physician advised that, pursuant to the A.M.A., *Guides* 492, 16-5, this represented a 45 percent total impairment, assessing 15 percent to the left side and 30 percent to the right side.

In a June 27, 2001 report, an Office medical adviser determined that appellant was entitled to a 6 percent impairment of her left upper extremity and a 26 percent impairment of her right upper extremity.[10]

By letter dated September 15, 2001, the Office advised appellant that a conflict existed between the reports of Dr. Weiss and the Office medical adviser regarding the degree of impairment and referred her for an impartial medical examination with Dr. Howard Zeidman, a Board-certified orthopedic surgeon. The Office disqualified Dr. Zeidman's opinion and report when he informed the Office that he had previously treated appellant in 1989 and 1990.[11] By letter dated November 15, 2001, the Office advised appellant of his disqualification and by letter dated February 7, 2002, the Office scheduled appellant for a new impartial medical examination with Dr. Stanley Askin, a Board-certified orthopedic surgeon.

In a March 2, 2002 report, Dr. Askin utilized the fifth edition of the A.M.A., *Guides*, and found that appellant suffered from degenerative processes affecting both hands, to include her diabetes, history of left CTS, and triggering diathesis of bilateral index through small digits and objective findings of trigger digit phenomena. He noted that appellant had full motion of the neck, shoulders, elbows, forearms and wrists, with full extension and flexion of the index, long, ring and small digits. The physician found that thumb motion was full for abduction and opposition, but adduction to the fifth metacarpal head was not full by 3 cm. on the right, and 5 cm on the left, noting that this was under appellant's control. Dr. Askin indicated muscle function was intact and forearm measurements were 28.5 and 28 cm. He conducted grip strength measurements and found that the Adson's and Wright's were negative, with Allen's testing revealing the radial and ulnar arteries to be patent. Watson's and Shuck's tests for carpal instability were negative. The physician noted the distal and radiolunar joints and pistriquetral joints were benign, and sensation to touch was intact in all 10 digits. Subjective abnormalities were noted as a positive Phalen's on the right and a negative on the left, with Tinel's negative bilaterally. Percussion at the Guyon's canals on the right caused radiation to the palm, and on the left radiation to the hypothenar eminence, with a tender right abductor pollicis longus muscle belly. He advised that appellant appeared to be posturing regarding her left long finger and noted objective findings of flexor tendon nodules without triggering of the right index, long, ring and small digits and for the left hand he noted nodules and triggering. Dr. Askin reported that appellant had objective findings of trigger digit phenomena, and referred to Table 16-29, page 507 of the A.M.A., *Guides*. For the right hand, he noted a mild category of a 20 percent digit impairment for the 4 fingers and a moderate category for the left of a 40 percent digit impairment, stating there was no objective evidence of any other impairment. He subsequently utilized the digit impairment factors and referred to Table 16-18 on page 499 of the A.M.A.,

[10] In his report, the Office medical adviser indicated that, regarding the left upper extremity, the maximum for CTS was 5 percent not 10 percent pursuant to the A.M.A., *Guides* at 495, plus a 1 percent impairment for range of motion of the finger, which equated to 6 percent instead of 11 percent. Regarding the right upper extremity, the Office medical adviser indicated that, pursuant to the A.M.A., *Guides* at 464, 16-25, for the third digit, appellant had an 11 percent impairment, and for the fourth and fifth digits, appellant had a 5 percent impairment for each one. He again noted that the maximum was 5 percent for carpal tunnel. He totaled the impairments to equate to a 26 percent impairment for the right upper extremity.

[11] In an October 1, 2001 report, Dr. Zeidman indicated that appellant had a 26 percent impairment of the right upper extremity and a 6 percent impairment of the left upper extremity.

Guides and determined that each index and long digit equated to 11 percent of the whole person and for the right hand, 20 percent of 11 percent times 2 equated to 4.4 percent of the whole person and for the ring and small fingers, it equated to 20 percent of 5 times 2 or 2 percent. Dr. Askin also reported that appellant had a 6.4 percent whole person impairment for the triggering of the right hand. For the left hand, he stated the multiplier was 40 percent, and the calculation was 40 percent of 11 percent times 2, or 8.8 percent of the whole person for the index and long, and 40 percent of 5 percent times two for the ring and small fingers, for a total whole person impairment of the left ring and small digits of 4 percent, concluding that appellant had a left hand whole person impairment of 12.8 percent, and a total whole person impairment of 19 percent. Dr. Askin noted that, according to page 493 of the A.M.A., *Guides*, "only individuals with an objectively verifiable diagnosis should qualify for permanent impairment rating" with respect to compression neuropathy such as carpal tunnel syndrome and there were presently no objective features. He noted that, on page 495, for residua of CTS, an "impairment rating not to exceed 5 percent of the upper extremity may be justified" and indicated that per Table 16-3 on page 439, 5 percent of the upper extremity would equal 3 percent of the whole person. Consequently, Dr. Askin indicated that, if residua of appellant's carpal tunnel syndrome for one extremity would be accepted as a work-related impairment, then her total impairment would be 3 plus 19, or 22 percent whole person impairment.

In a June 20, 2002 report, the Office medical adviser referred to page 495 of the A.M.A., *Guides,* and noted that for the left hand, residuals of CTS were 5 percent, with no objective findings to justify anything higher. He reported that a left trigger finger with a "moderate triggering effect" but nothing really objective on examination equated to 6 percent of the hand at page 499 and multiplied by 40 percent per Table 16-29, page 507, which equated to 2 percent of the hand for a total of 7 percent of the left hand. For the right hand, he referred to page 495 and indicated it was the same as the left hand, since no trigger finger on the right side had been accepted as employment related and opined that appellant had a 5 percent impairment to the right hand. The Office medical adviser concluded that appellant had a 7 percent impairment of the left hand and a 5 percent impairment of the right hand.

Accordingly, on July 23, 2002 the Office granted appellant a schedule award for seven percent permanent impairment of the left upper extremity and five percent permanent impairment of the right upper extremity. The award covered a period of 37.44 weeks from July 25, 2000 to April 13, 2001.

By letter dated July 26, 2002, appellant, through her attorney, requested a hearing, which was held on March 11, 2003.[12] In a June 30, 2003 decision, the Office hearing representative affirmed the July 23, 2002 decision.

[12] Appellant testified that the postal service hired her as a mark-up clerk and she developed pain in her hands in 1989. She stated her fingers would lock. Appellant indicated she returned to work three months after her surgery and current restrictions included no lifting over 10 pounds, with limited pushing, pulling and fine manipulation and her receptionist position met her restrictions. She indicated her left middle finger stayed in a lock down position and she had to physically move it and the trigger finger release did not completely resolve her problems with her left middle finger. Further, she indicated that she had a dull aching pain in the palm of her left hand and a sharper pain and numbness in the right arm. She further stated that she did not have the recommended surgery on her right hand because she was afraid, given the outcome of her left hand surgery.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[13] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[14] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[15] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[16]

The fifth edition of the A.M.A., *Guides*, regarding carpal tunnel syndrome, provides that 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 is rated according to the sensory and/or motor deficits; (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; and (3) normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies, in which case there is no objective basis for an impairment rating.[17]

The impairment percent due to constrictive tenosynovitis is multiplied by the relative hand value of the digit to derive its hand impairment. This impairment may be combined with other impairments of the digit (Combined Values Chart, p. 604) but not with decreased motion.[18]

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides.*[19] However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.

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[13] 5 U.S.C. §§ 8101-8193.

[14] 5 U.S.C. § 8107.

[15] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

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

[17] *Silvester DeLuca*, 53 ECAB ___ (Docket No. 01-1904, issued April 12, 2002).

[18] A.M.A., *Guides* 506.

[19] *See William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

Section 8123(a) of the Act provides, in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[20] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[21]

ANALYSIS

In this case, Dr Weiss, an attending osteopath, determined that appellant had an 11 percent permanent impairment of the left upper extremity and a 36 percent permanent impairment of the right upper extremity. An Office medical adviser reviewed Dr. Weiss' report and determined that appellant had a 6 percent impairment of the left upper extremity and a 26 percent impairment of the right upper extremity. As a conflict existed in the medical opinion evidence between Dr. Weiss[22] and the Office medical adviser, the Office properly referred appellant to Dr. Askin for an impartial medical examination.

The Board finds that the thorough and well-documented report of Dr. Askin, the impartial medical specialist selected to resolve the conflict in the medical opinion evidence, is based upon correct application of the A.M.A., *Guides* and is entitled to special weight. Dr. Askin took measurements, referred to pages and tables in the A.M.A., *Guides* and explained his calculations. In his report, Dr. Askin noted objective findings of trigger digit phenomena and found that appellant had 2 percent for the right hand and 4 percent for the left hand and a total whole person impairment of 19 percent. Further, he indicated that appellant had residua of her carpal tunnel syndrome and opined that, if this were accepted as work related, then her impairment would be 5 percent of the upper extremity which equated to 3 percent of the whole percent plus the 19 percent for a 22 percent whole person impairment. The Board notes that, although Dr. Askin provided ratings for the right finger triggering, which was not an accepted condition, this does not invalidate the report, as it merely indicates the physician conducted a thorough examination. The Board further notes that Dr. Askin provided the maximum rating for appellant's carpal tunnel syndrome, which as previously indicated, may not exceed five percent of the upper extremity.[23]

Upon receipt of Dr. Askin's report, a subsequent Office medical adviser, in a June 20, 2002 memorandum, utilized Dr. Askin's findings and advised that, although the impartial medical specialist provided ratings related to right finger triggering, the Office had not accepted this condition, therefore, those calculations were not related to the accepted employment injury. Therefore, the Office medical adviser correctly determined that appellant was not entitled to a

[20] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB ___ (Docket No. 01-1599, issued June 26, 2002); *Rita Lusignan* (*Henry Lusignan*), 45 ECAB 207, 210 (1993).

[21] *See Roger Dingess*, 47 ECAB 123, 126 (1995); *Juanita H. Christoph*, 40 ECAB 354, 360 (1988); *Nathaniel Milton*, 37 ECAB 712, 723-24 (1986).

[22] Dr. Weiss based his impairment calculations on the fourth edition of the A.M.A., *Guides.*

[23] *See* footnote 17.

rating for the right finger triggering condition. The Office medical adviser also noted that the deficits related to triggering of the left long finger, would entitle appellant to an additional two percent impairment to the left hand. When combining the five percent rating for the presence of carpal tunnel syndrome, the Office medical adviser properly concluded appellant had a five percent and seven percent impairment for the right and left upper extremities respectively.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she sustained more than a five percent permanent impairment of her right upper extremity and a seven percent permanent impairment of her left upper extremity, for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 30, 2003 is hereby affirmed.

Issued: June 24, 2004
Washington, DC

Colleen Duffy Kiko
Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member