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WONDA J. WATSON, Appellant	)	
	)	
and	)	Docket No. 05-1753
	)	Issued: January 3, 2006
DEPARTMENT OF THE AIR FORCE,	)	
TINKER AIR FORCE BASE, OK, Employer	)	
	)	

Case Submitted on the Record

Before:
DAVID S. GERSON, Judge
WILLIE T.C. THOMAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

On August 23, 2005 appellant filed a timely appeal from an Office of Workers' Compensation Programs' decision dated February 11, 2005, denying her claim for a schedule award and April 7 and August 4, 2005 decisions, denying modification of the February 11, 2005 decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award case.

The issue is whether appellant has any permanent impairment of her upper extremities, entitling her to a schedule award.

On August 15, 2002 appellant, then a 47-year-old education technician, filed an occupational disease claim alleging that she developed bilateral carpal tunnel syndrome due to her job duties, which included typing and data entry, lifting heavy files and pulling heavy file drawers. The Office accepted her claim for bilateral carpal tunnel syndrome and bilateral

enthesopathy of the wrist and carpus.¹ On January 23 and July 24, 2003 she underwent carpal tunnel release surgery on her right and left upper extremities. Effective January 23, 2003 appellant was placed on the periodic rolls to receive compensation for temporary total disability. On February 27, 2004 appellant filed a claim for a schedule award.

In a January 5, 2004 report, Dr. Paramjit S. Bajaj, an attending plastic surgeon, opined that appellant had an 11 percent permanent impairment of the left upper extremity and a 20 percent impairment of the right upper extremity due to her carpal tunnel syndrome based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). However, the physician did not explain how he calculated this impairment rating with reference to the applicable sections of the A.M.A., *Guides*.

In an April 1, 2004 memorandum, Dr. Ronald H. Blum, an Office medical adviser, stated that Dr. Bajaj's report could not be used to determine an impairment rating. He advised the Office to obtain an impairment evaluation from an appropriate medical specialist to include the date of maximum medical improvement, a detailed description of objective findings and pertinent subjective findings with references to appropriate tables in the fifth edition of the A.M.A., *Guides*.

The Office referred appellant to Dr. Archana Barve, a Board-certified physiatrist for an impairment rating. In a July 1, 2004 report, Dr. Barve opined that appellant had not reached maximum medical improvement.

On August 18, 2004 the Office referred appellant to Dr. Houshang Seradge, a Board-certified orthopedic surgeon, for an impairment rating. In a September 22, 2004 report, Dr. Seradge stated that appellant's grip strength measured 0, 0, 5, 0 and 0 pounds on the left and 0, 5, 0, 0 and 5 pounds on the right. He stated that the measurements indicated abnormal grip strength and evidence of significant symptom magnification and he would conduct further testing. In a November 9, 2004 report, Dr. Seradge stated that appellant reported pain in both hands. He stated that computerized grip strength testing performed on September 27, 2004 was again invalid for both hands. The September 27, 2004 test results were signed by the physical therapist, who performed the testing but not by Dr. Seradge.²

In a December 23, 2004 memorandum, Dr. R. Meador, an Office medical adviser, stated that appellant had no permanent impairment based on the reports of Dr. Seradge, which indicated that valid grip strength measurements were impossible to obtain due to submaximal effort for both hands. Dr. Meador stated: "[i]mpairment cannot be determined at this time due to lack of probative medical evidence."

¹ Enthesopathy is a disorder of the muscular or tendinous attachment to bone. *Dorland's Illustrated Medical Dictionary*, 562 (27th ed. 1988).

² The September 27, 2004 test report bears the signature of an "S. Schmidt" at the top of each page but there is no indication that this individual is a physician.

By decision dated February 11, 2005, the Office denied appellant's claim for a schedule award on the grounds that the medical evidence did not establish that she had any permanent impairment of her upper extremities.

On February 17, 2005 appellant requested reconsideration and submitted additional evidence.

In reports dated March 8, April 19, May 17 and June 14, 2005, Dr. Mehdi N. Adham, a Board-certified plastic surgeon, diagnosed recurrent bilateral carpal tunnel syndrome, mild reflex sympathetic dystrophy on the right and bilateral cubital canal syndrome. He provided findings on physical examination and the results of grip strength testing performed on March 8, 2005.³

By decisions dated April 7 and August 4, 2005, the Office denied modification of its February 11, 2005 decision.⁴

LEGAL PRECEDENT

The Office is not a disinterested arbiter but rather performs the role of adjudicator on the one hand and gatherer of the relevant facts and protector of the compensation fund on the other, a role that imposes an obligation on the Office to see that its administrative processes are impartially and fairly conducted.⁵ Although the claimant has the burden of establishing entitlement to compensation, the Office shares responsibility in the development of the evidence.⁶ Once the Office starts to procure medical opinion, it must do a complete job.⁷ The Office has the responsibility to obtain from its referral physician an evaluation that will resolve the issue involved in the case.⁸

ANALYSIS

The Office referred appellant to Dr. Seradge for the purpose of evaluating appellant's permanent impairment causally related to her accepted upper extremity conditions and subsequent surgery. However, his reports are not sufficient to determine appellant's entitlement to a schedule award.

³ Appellant also provided reports from an occupational therapist. However, as a physical therapist is not a physician under the Act, these reports do not constitute probative medical evidence. See *Jennifer L. Sharp*, 48 ECAB 209.

⁴ Appellant submitted additional evidence subsequent to the Office decision of August 4, 2005. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. See 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

⁵ *Richard F. Williams*, 55 ECAB ____ (Docket No. 03-1176, issued February 23, 2004); *Thomas M. Lee*, 10 ECAB 175 (1958).

⁶ *William J. Cantrell*, 34 ECAB 1233 (1983).

⁷ See *William N. Saathoff*, 8 ECAB 769 (1956).

⁸ *Richard F. Williams*, *supra* note 5; see also *Mae Z. Hackett*, 34 ECAB 1421 (1983); *Richard W. Kinder*, 32 ECAB 863 (1981) (in these cases the report of the Office referral physician did not resolve the issue in the case).

In his September 22, 2004 report, Dr. Seradge provided appellant's grip strength measurements and stated that the measurements indicated abnormal grip strength and evidence of significant symptom magnification. In a November 9, 2004 report, Dr. Seradge stated that appellant had pain in both hands. He indicated that grip strength testing performed on September 27, 2004 was again invalid for both hands. The September 27, 2004 test results were signed by the physical therapist, who performed the testing but not by Dr. Seradge.⁹

The A.M.A., *Guides* provides:

"Because strength measurements are functional tests influenced by subjective factors that are difficult to control and the [A.M.A.,] *Guides* for the most part is based on anatomic impairment, the [A.M.A.,] *Guides* does not assign a large role to such measurements."

* * *

"In a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by the methods in the [A.M.A.,] *Guides*, the loss of strength may be rated separately ... If the examiner judges that loss of strength should be rated separately in an extremity that presents other impairments, the impairment due to loss of strength *could be combined* with the other impairments, *only* if based on unrelated etiologic or pathomechanical causes. *Otherwise, the impairment ratings based on objective anatomic findings take precedence.* Decreased strength *cannot* be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts (e.g., thumb amputation) that prevent effective application of maximal force in the region being evaluated."¹⁰ (Emphasis in the original.)

As noted, Dr. Seradge's impairment rating was based solely on grip strength. However, the A.M.A., *Guides* provides a specific method for determining permanent impairment due to carpal tunnel syndrome. An impairment for carpal tunnel syndrome is rated on motor and sensory deficits.¹¹ FECA Bulletin No. 01-05, issued January 29, 2001, provides:

"[U]pper extremity impairment secondary to carpal tunnel syndrome and other entrapment neuropathies should be calculated using section 16.5d, 'Entrapment/Compression Neuropathy,' and Tables 16-10, 16-11 and 16-15. The fifth edition clearly states that 'in compression neuropathies, additional impairment values are not given for decreased grip strength' (page 494)."

⁹ A medical report cannot be considered as probative medical evidence if there is no indication that the person completing the report qualifies as a "physician" as defined in 5 U.S.C. § 8101(2). See *Merton J. Sills*, 39 ECAB 572 (1988) (unsigned notes of medical treatments). The Board has consistently held that unsigned medical reports are of no probative value. See *Vicky C. Randall*, 51 ECAB 357 (2000).

¹⁰ A.M.A., *Guides*, 507-08, Chapter 16, 16.8 "Strength Evaluation."

¹¹ *Kimberly M. Held*, 56 ECAB ____ (Docket No. 05-1050, issued August 16, 2005); A.M.A., *Guides*, 495.

The Board finds that the report of Dr. Seradge is not based upon correct application of the relevant sections of the fifth edition of the A.M.A., *Guides* pertaining to impairment due to carpal tunnel syndrome. Therefore, his opinion is not sufficient to resolve the issue of appellant's entitlement to a schedule award for her accepted upper extremity conditions, bilateral carpal tunnel syndrome and bilateral enthesopathy of the wrist and carpus. Having undertaken further development of the medical opinion evidence by sending appellant to an Office referral physician for an impairment rating, the Office should not have issued a final decision on the matter without obtaining a medical rating based on correct application of Office procedures and the A.M.A., *Guides*. On remand, the Office should refer appellant to Dr. Seradge or another appropriate medical specialist and request a thorough impairment evaluation based on correct application of the relevant sections of the A.M.A., *Guides* and Office procedures.

CONCLUSION

The Board finds that this case is not in posture for a decision on whether appellant has any permanent impairment of her upper extremities causally related to her accepted employment injury. Additional development of the medical evidence is warranted. After such development as may be necessary, the Office shall issue an appropriate final decision on appellant's claim for a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated August 4, April 7 and February 11, 2005 are set aside and the case remanded for further action consistent with this decision.

Issued: January 3, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Willie T.C. Thomas, Alternate Judge
Employees' Compensation Appeals Board

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