United States Department of Labor
Employees' Compensation Appeals Board

J.M., Appellant	)	
and	)	**Docket No. 09-974**
	)	**Issued: November 18, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Bellmawr, NJ, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 3, 2009 appellant filed a timely appeal from the May 30 and December 17, 2008 merit decisions of the Office of Workers' Compensation Programs concerning schedule award compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met her burden of proof to establish that she has more than a four percent permanent impairment of her right arm, for which she received a schedule award.

FACTUAL HISTORY

The Office accepted that on December 15, 2004 appellant, then a 42-year-old mail handler, sustained right carpal tunnel syndrome, right hand tenosynovitis and right shoulder and

upper arm sprains due to lifting heavy mail trays at work.[1] She received compensation for periods of disability. The findings of April 4, 2005 electromyogram (EMG) testing showed signs of right carpal tunnel syndrome.

In a December 14, 2006 report, Dr. Nicholas Diamond, an attending osteopath, stated that appellant reported that her right arm symptoms interfered with her activities of daily living. On examination, appellant's right wrist revealed tenderness in the palmar aspect. The Tinel's sign and the carpal compression tests were negative but the one-minute Phalen's sign was positive. Dr. Diamond reported findings for various range of motion, sensory loss and strength tests. He used Tables 16-10 and 16-15 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) to determine that appellant had a Grade 2 sensory deficit of the right median nerve which equaled a 31 percent impairment of the right arm. Dr. Diamond indicated that applying Tables 16-33 and 16-34 showed that appellant had a right lateral pinch deficit that equaled a 20 percent impairment of the right arm. He used the Combined Values Chart on page 604 of the A.M.A., *Guides* to combine these impairments to find a total 45 percent impairment to her right arm.[2]

In a July 30, 2007 report, Dr. Andrew Merola, a Board-certified orthopedic surgeon serving as an Office medical adviser, stated that Dr. Diamond's rating based on pinch strength was invalid in that he had not shown that the deficit was due to the accepted carpal tunnel syndrome. He found that the examination findings for right arm sensory loss at most justified a 10 percent impairment rating.

The Office determined that a conflict in medical opinion arose between Dr. Diamond and Dr. Merola regarding the extent of the permanent impairment to appellant's right arm. In order to resolve the conflict, the Office referred appellant to Dr. Thomas J. O'Dowd, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on the matter.[3]

In a December 4, 2007 report, Dr. O'Dowd stated that appellant complained of pain and numbness in her hands, right greater than left. She described pain that radiated from her shoulders (mostly from the trapezius) all the way down into her hands. Appellant indicated that her symptoms had waxed and waned since the initial onset without there being complete resolution. Dr. O'Dowd stated that examination of appellant's upper extremities revealed she had subjective decreased sensation in the right hand compared to the left in all dermatomes in the hand and to some degree in the upper arm which was not clearly dermatomal in pattern. Appellant had a negative Tinel's sign over the radial, ulnar and median nerves bilaterally at the wrists and elbows, but she had a positive Tinel's sign over her right basilar joint of the thumb. She had a negative Phalen's sign bilaterally. Dr. O'Dowd stated that there was no opponens muscle weakness and she had intact function, good muscle strength and normal reflexes in both upper extremities. Appellant had normal sensation, motor and reflex examinations. Examination

[1] On December 22, 2004 appellant filed an occupational disease claim alleging that she developed right arm problems due to her repetitive arm duties over time. In connection with this claim, the Office accepted that she sustained right carpal tunnel syndrome.

[2] Dr. Diamond also provided left arm calculations but the Office has not accepted a left arm condition.

[3] *See* 5 U.S.C. § 8123(a).

of her neck revealed that she has some nonphysiologic tenderness in the right trapezius. Light touch reproduced her pain and there was no anterolateral cervical body pain.

Dr. O'Dowd found that appellant did not have any of the provocative tests to show thoracic outlet syndrome. There was no particular tenderness over the brachial plexus of either shoulder and examination of both shoulders revealed no signs of impingement. Appellant had full range of motion of both shoulders with only discomfort noted in the right trapezius. Dr. O'Dowd stated that appellant did not have any clear-cut evidence of carpal tunnel syndrome of her left upper extremity and had minimal signs of carpal tunnel syndrome on the right upper extremity. Appellant did not have any clear-cut defects except for sensory deficit. She also had evidence of some basilar joint symptoms of arthritis in the right thumb which was her most current residual symptom complex. Dr. O'Dowd found no evidence of a cervical radiculopathy, but there was some evidence of an enhancement of symptoms with superficial tenderness in the right trapezius muscle. He concluded:

> "Again, falling short of having a carpal tunnel release surgery done on the right hand, the patient's current disability based on the review of the [fifth edition of the A.M.A., *Guides*] using Table 16-10 on page 482 and using Table 16-15 on page 492, this patient evidences a Grade 4 deficit on her right upper extremity which we would classify as 10 percent based on today's exam[ination] which results in a 4 percent disability impairment of her right upper extremity."

In a March 6, 2008 report, Dr. Merola agreed with Dr. O'Dowd's assessment of the permanent impairment to appellant's right arm.

In a May 30, 2008 decision, the Office granted appellant a schedule award for a four percent permanent impairment of her right arm. The award ran for 12.48 weeks from December 4, 2007 to February 29, 2008. The Office based the schedule award on the opinion of Dr. O'Dowd.

Appellant requested a hearing before an Office hearing representative. At the hearing held on October 27, 2008, she testified about the history of her right arm condition and contended that the weight of the medical opinion with respect to arm impairment rested with the opinion of Dr. Diamond.

In a December 17, 2008 decision, the Office hearing representative affirmed the May 30, 2008 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing regulations[5] 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

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

the body. However, the Act does not specify the manner in which the percentage of loss 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 A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[6] It is well established that, in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[7]

The A.M.A., *Guides* evaluates the permanent impairment caused by carpal tunnel syndrome by determining whether such a condition falls within one of three categories discussed in section 16.5d.[8] Under the first category, if there are positive clinical findings of median nerve dysfunction and an electrical conduction delay, the condition is rated under the standards found earlier in Chapter 16 for evaluating sensory or motor deficits due to peripheral nerve disorders. Under the second category, if there is normal sensibility (evaluated by two-point discrimination and Semmes-Weinstein monofilament testing) and normal opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles, an impairment rating not to exceed five percent of the upper extremity may be justified. Under the third category, if there is normal sensibility, opposition strength and nerve conduction studies, there is no objective basis for an impairment rating.[9]

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."[10] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.[11] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[12] In a situation where the Office secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, the Office has

---

[6] *Id*.

[7] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b. (June 1993). This portion of Office procedure provides that the impairment rating of a given scheduled member should include "any preexisting permanent impairment of the same member or function."

[8] *See* A.M.A., *Guides* 495.

[9] *Id.*

[10] 5 U.S.C. § 8123(a).

[11] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

[12] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[13]

ANALYSIS

The Office accepted that appellant sustained work-related right carpal tunnel syndrome, right hand tenosynovitis and right shoulder and upper arm sprains. Appellant received a schedule award for a four percent permanent impairment of her right arm but claimed that she was entitled to additional schedule award compensation. The Office based its award on the opinion of Dr. O'Dowd, a Board-certified orthopedic surgeon who served as an impartial medical specialist.

The Office properly determined that there was a conflict in the medical opinion between Dr. Diamond, an attending osteopath, and Dr. Merola, a Board-certified orthopedic surgeon acting as an Office medical adviser, regarding the extent of appellant's right arm impairment.[14] In order to resolve the conflict, the Office referred appellant, pursuant to section 8123(a) of the Act, to Dr. O'Dowd for an impartial medical examination and an opinion on the matter.[15]

In his December 4, 2007 report, Dr. O'Dowd concluded that appellant had a four percent permanent impairment of her right arm based on sensory loss associated with the right median nerve below the midforearm. He found that, using Tables 16-10 and 16-15 of the A.M.A., *Guides*, appellant had a Grade 4 sensory loss of 10 percent and multiplied this value times the 39 percent value for sensory loss associated with the median nerve below the midforearm to yield a 4 percent impairment rating.[16]

The Board finds, however, that Dr. O'Dowd's report is in need of further clarification. Dr. O'Dowd made various conclusions regarding appellant's condition without adequately describing the tests that were used to obtain these findings. For example, he noted that appellant had good muscle strength, and normal reflexes in both upper extremities and had normal sensation, motor, and reflex examinations. The A.M.A., *Guides* provides specific testing techniques for obtaining such findings, but it is unclear from the record whether Dr. O'Dowd performed these test. For example, Dr. O'Dowd did not indicate whether he performed manual muscle testing under the standards of the A.M.A., *Guides* to test strength.[17] He indicated that

[13] *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232, 238 (1988).

[14] In a December 14, 2006 report, Dr. Diamond determined that appellant had a Grade 2 sensory deficit of his right median nerve which equaled a 31 percent impairment of the right arm. He indicated that she also had right lateral pinch deficit that equaled a 20 percent impairment of the right arm. In contrast, Dr. Merola indicated on July 30, 2007 that Dr. Diamond's rating based on pinch strength was invalid in that he had not shown that this deficit was related to the work-related carpal tunnel syndrome. He also found that the examination findings for right arm sensory loss at most justified a 10 percent impairment rating.

[15] *See supra* notes 9 and 10.

[16] *See* A.M.A., *Guides* 482, 492, Tables 16-10, 16-15. Dr. O'Dowd rounded the result of the multiplication (3.9 percent) up to 4 percent.

[17] *See* A.M.A., *Guides* 509-11.

appellant had full range of shoulder motion, but he did not report any particular range of motion measurements to support this finding.

In addition, Dr. O'Dowd did not explain which particular examination or diagnostic testing results led him to select a Grade 4 sensory loss of 10 percent under Table 16-10.[18] Perhaps most importantly, he did not explain how his assessment comported with the specific standards for evaluating impairment associated with carpal tunnel syndrome under the A.M.A., *Guides.* Permanent impairment caused by carpal tunnel syndrome is evaluated by determining whether such a condition falls within one of three categories discussed in section 16.5d of Chapter 16.[19] However, Dr. O'Dowd did not evaluate appellant's right arm impairment under this section.

For the above-described reasons, the opinion of Dr. O'Dowd is in need of clarification and elaboration. Therefore, in order to resolve the continuing conflict in the medical opinion, the case will be remanded to the Office for referral of the case record, a statement of accepted facts, and, if necessary, appellant, to Dr. O'Dowd for a supplemental report regarding the extent of her right arm impairment.[20] If Dr. O'Dowd is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his or her rationalized medical opinion on the issue.[21] After such further development as the Office deems necessary, an appropriate decision should be issued regarding appellant's entitlement to schedule award compensation.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant has more than a four percent permanent impairment of her right arm. The case is remanded to the Office for further development.

[18] Dr. O'Dowd noted that appellant had evidence of some basilar joint symptoms of arthritis in the right thumb which was her most current residual symptom complex. He did not evaluate whether this was a preexisting condition which should be included in the impairment rating. *See supra* note 6.

[19] *See supra* notes 7 and 8.

[20] *See supra* note 12. The Board notes that the Office has not accepted a left arm condition and there is no evidence of record that she has a work-related left arm condition.

[21] *Harold Travis*, 30 ECAB 1071, 1078 (1979).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' December 17 and May 30, 2008 decisions are set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: November 18, 2009
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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