United States Department of Labor
Employees' Compensation Appeals Board

S.C., Appellant	)	
and	)	**Docket No. 09-1751**
	)	**Issued: August 12, 2010**
DEPARTMENT OF HEALTH & HUMAN SERVICES, SOCIAL SECURITY ADMINISTRATION, OFFICE OF HEARINGS & APPEALS, Middlesboro, KY, Employer	)	

Appearances:
Alan J. Shapiro, 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 June 29, 2009 appellant, through counsel, filed a timely appeal of an April 30, 2009 merit decision of the Office of Workers' Compensation Programs denying her claim for a schedule award. 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 sustained permanent impairment of her left arm due to her accepted employment injury.

On appeal, counsel contends that the Office's decision is contrary to fact and law.

FACTUAL HISTORY

On July 20, 2005 appellant, then a 47-year-old paralegal specialist, filed an occupational disease claim alleging that on April 7, 2005 she became aware of her left carpal tunnel

syndrome.[1] The Office assigned the case File No. xxxxxx791. On April 17, 2005 appellant realized that her condition was caused by repetitive use of her hands while working at the employing establishment. On August 19, 2005 the Office accepted her clam for left carpal tunnel syndrome and she underwent surgical release on September 14, 2005. On May 3, 2007 appellant filed a claim (Form CA-7) for a schedule award.[2]

By letter dated May 18, 2007, the Office requested that appellant submit a medical report from an attending physician which provided a permanent impairment rating based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001). Appellant was afforded 30 days to submit the requested evidence. She did not respond.

By decision dated July 2, 2007, the Office denied appellant's claim for a schedule award. It found that the medical evidence was insufficient to establish that she sustained any permanent impairment of her left arm.

On March 31, 2008 appellant requested reconsideration. A March 31, 2006 report from Gwen Jones, an occupational therapist, stated that she sustained a 30 percent impairment of the left upper extremity and an 18 percent impairment of the whole person based on the results of a functional capacity evaluation (FCE).

On April 11, 2008 Dr. G.M. Pujadas, an Office medical adviser, reviewed appellant's medical records including the March 31, 2008 FCE report. He recommended a current medical report providing the date appellant reached maximum medical improvement and objective findings related to residuals of her employment injury.

By decision dated May 15, 2008, the Office denied modification of the July 2, 2007 decision. It noted that an occupational therapist was not a "physician" as defined under the Federal Employees' Compensation Act and found that there was no probative medical evidence to establish that appellant sustained any permanent impairment to her left arm.

By letter dated October 21, 2008, appellant requested reconsideration. In a February 3, 2006 form report, Dr. Margaret Napolitano, a Board-certified plastic surgeon, advised that appellant reached maximum medical improvement on April 3, 2006.[3] In a May 16, 2008 letter Laura Schrader, a nurse practitioner, signed on behalf of Dr. Napolitano. She stated that Dr. Napolitano agreed with the FCE finding that appellant sustained an 18 percent whole person impairment.

[1] On June 28, 2006 appellant filed a Form CA-2 assigned File No. xxxxxx696 alleging that on February 13, 2006 she became aware of her right carpal tunnel syndrome and realized that her condition was caused by her repetitive work duties. By letter dated September 27, 2006, the Office accepted her claim for right carpal tunnel syndrome.

[2] On May 11, 2007 appellant retired from the employing establishment on medical disability.

[3] In her October 21, 2008 reconsideration request, appellant stated that Dr. Napolitano's February 3, 2006 report was accompanied by attachments stating that she sustained 18 percent impairment to her thumb, 35 percent impairment to her index finger, 40 percent impairment to her middle finger, 40 percent impairment to her ring finger and 39 percent impairment to her little finger, resulting in an 18 percent impairment to her left upper extremity. The Board notes that this evidence is not contained in the case record.

On November 21, 2008 Dr. H.P. Hogshead, an Office medical adviser, reviewed appellant's medical records and advised that a description of objective findings related to any residuals of median nerve compression was required before an impairment evaluation could be made. He also recommended a second opinion medical examination.

The Office found a conflict in the medical opinion evidence between Dr. Napolitano and Dr. Hogshead. By letter dated December 16, 2008, it referred appellant, together with the case record and a statement of accepted facts, to Dr. Mark D. Turner, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a January 15, 2009 report, Dr. Turner determined that appellant sustained a 30 percent impairment of the left upper extremity which also represented an 18 percent whole person impairment based on the A.M.A., *Guides*. Appellant reached maximum medical improvement on March 31, 2006. Dr. Turner reviewed a history of her employment-related injury and medical treatment. He listed essentially normal findings on physical examination of the left upper extremity, noting mild thenar atrophy, positive Tinel's, Phalen's and compression test results and diminished grip strength and key pinch of the left hand. Dr. Turner listed essentially normal findings on sensory examination, noting appellant's complaint of significant pain primarily in the palmar surface around the scar on her left wrist, especially in the proximal area. X-ray of the left wrist showed no fracture, dislocation or any undue evidence of osteoporosis. Dr. Turner advised that appellant was status post left carpal tunnel release with persistent discomfort. He stated that a postoperative electromyogram and nerve conduction velocity study showed improvement in the preoperative evidence of compressive median neuropathy at the wrist. Dr. Turner noted that the findings of the March 31, 2006 FCE were based on loss of range of motion in each of appellant's digits and were correct based on the A.M.A., *Guides*. He stated that she also sustained impairment secondary to loss of radial deviation of the left wrist, which appeared to be appropriate. Appellant did not have any disability secondary to any dysesthesias. Dr. Turner agreed with the use of complex regional pain syndrome (CRPS) to determine her disability. He recommended further testing to confirm the CRPS diagnosis as the skin on appellant's left upper extremity did not show any evidence of edema, decreased temperature or abnormal coloration, soft tissue atrophy or abnormal nail changes.

On April 30, 2009 Dr. Pujadas reviewed the medical evidence, stating that appellant reached maximum medical improvement on January 15, 2009. He advised, however, that Dr. Turner did not properly apply the A.M.A., *Guides* as he used loss of radial deviation of the wrist and CRPS to rate 30 percent impairment to the left upper extremity. Dr. Pujadas stated that CRPS had not been accepted by the Office.

In an April 30, 2009 decision, the Office denied modification of the May 15, 2008 decision. It found that Dr. Turner's opinion was not entitled to special weight accorded an impartial medical specialist as he failed to properly apply the A.M.A., *Guides* and provide sufficient rationale to establish appellant's entitlement to a schedule award.

LEGAL PRECEDENT

The schedule award provision of the Act[4] and its implementing regulations[5] set forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[6] 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 adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[7]

The fifth edition of the A.M.A., *Guides*, regarding impairment due to carpal tunnel syndrome, provides:

> "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 [carpal tunnel syndrome] is rated according to the sensory and/or motor deficits as described [in Tables 16-10a and 16-11a].
> >
> > 2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal [electromyogram] 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.
> >
> > 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]

The Board has found that the fifth edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory deficits only.[9]

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[4] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[5] 20 C.F.R. § 10.404.

[6] 5 U.S.C. § 8107(c)(19).

[7] *Supra* note 5.

[8] A.M.A., *Guides* at 495 (5th ed. 2001); *see T.A.*, 59 ECAB ___ (Docket No. 07-1836, issued November 20, 2007).

[9] *Kimberly M. Held*, 56 ECAB 670 (2005).

ANALYSIS

The Office accepted appellant's claim for left carpal tunnel syndrome. Appellant contends that she is entitled to a schedule award for permanent impairment to her left upper extremity. The Board finds that the case is not in posture for decision.

The Office determined that there was a conflict in the medical opinion evidence between Dr. Napolitano, an attending physician, and Dr. Hogshead, an Office medical adviser, as to whether appellant sustained any permanent impairment of the left upper extremity due to her accepted carpal tunnel syndrome. It referred appellant to Dr. Turner, selected as the impartial medical specialist. The Board finds, however, that a conflict did not arise between Dr. Napolitano and Dr. Hogshead. Dr. Napolitano did not perform the surgical release of 2005 or provide any impairment rating. On May 16, 2008 Ms. Schrader simply advised that Dr. Napolitano agreed with the whole person impairment rating. In turn Dr. Hogshead simply noted that there was not sufficient evidence on which to base an impairment rating. For this reason, Dr. Turner is a second opinion physician and not an impartial specialist.

Dr. Turner's impairment rating is based on loss of radial nerve deviation. As noted, the A.M.A., *Guides* on page 495 states that, following surgical decompression, if there remains positive clinical findings of median nerve dysfunction, the impairment should be rated according to sensory and motor deficits.[10] Because Dr. Turner relied on radial nerve dysfunction rather than on medial nerve dysfunction in determining appellant's impairment due to her employment-related carpal tunnel syndrome, he failed to properly the A.M.A., *Guides*. Further, his impairment rating is based on a diagnoses of CRPS. This condition has not been accepted by the Office. Moreover, Dr. Turner indicated that further testing was necessary to confirm the diagnosis of CRPS, rendering the diagnosis as speculative.[11] The Board finds that Dr. Turner's report is of diminished probative value. Dr. Turner did not provide a rationalized medical opinion based on proper application of the A.M.A., *Guides* regarding the extent of permanent impairment to appellant's left upper extremity.

As the Office attempted development of the medical evidence, it has a responsibility to see that justice is done.[12] The case will be remanded to the Office for appropriate development of the medical evidence. After this and such further development as may be necessary, the Office shall issue an appropriate final decision on appellant's claim for a schedule award for her left arm.

CONCLUSION

The Board finds that the case is not in posture for a decision as to whether appellant sustained permanent impairment of her left arm.

[10] A.M.A., *Guides* 495.

[11] *L.R. (E.R.)*, 58 ECAB 369 (2007); *D.D.*, 57 ECAB 734 (2006); *Cecelia M. Corley*, 56 ECAB 662 (2005).

[12] *See Peter C. Belkind*, 56 ECAB 580 (2005).

ORDER

IT IS HEREBY ORDERED THAT the April 30, 2009 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: August 12, 2010
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