United States Department of Labor
Employees' Compensation Appeals Board

D.C., Appellant	)	
and	)	**Docket No. 09-1129**
	)	**Issued: June 7, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, PA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 24, 2009 appellant filed a timely appeal from an Office of Workers' Compensation Programs' merit decision dated January 29, 2009. Under 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 has more than a 16 percent permanent impairment to her left upper extremity.

FACTUAL HISTORY

This is the third appeal before the Board. The Office accepted a claim for left carpal tunnel syndrome. It granted appellant an award for 10 percent permanent impairment of the left arm on August 12, 1997; it affirmed this award by decision dated July 6, 1998. In a January 9, 2001 decision,[1] the Board set aside the Office's decisions. The Board found that there was an

[1] Docket No. 99-178 (issued January 9, 2001).

unresolved conflict in the medical evidence regarding the percentage of impairment in appellant's left upper extremity used under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001). The Board remanded the case to the Office for referral of appellant to an impartial medical specialist to resolve the outstanding conflict in medical evidence regarding the appropriate percentage of impairment in her left arm.

The Office referred appellant to Dr. Randall N. Smith, Board-certified in orthopedic surgery, for an impartial medical examination. Relying on Dr. Smith's findings, the Office, by decision dated September 27, 2001, found that appellant was not entitled to an award greater than the 10 percent already awarded. By decision dated May 9, 2002, an Office hearing representative set aside the September 27, 2001 Office decision; it remanded the case and instructed that it be referred back to Dr. Smith to explain his calculation pursuant to the applicable tables of the fifth edition of the A.M.A., *Guides*. By decision dated February 4, 2003, relying on Dr. Smith's supplemental June 28, 2002 report, the Office granted appellant a schedule award for an additional 6 percent permanent impairment of the left upper extremity, totaling an overall 16 percent impairment. In a decision dated December 15, 2003, an Office hearing representative affirmed the April 24, 2003 Office decision and denied appellant's claim for a greater award. By decision dated August 30, 2005, the Office reissued its February 4, 2003 decision granting appellant an award for a 16 percent left upper extremity impairment.

In a decision dated September 15, 2006,[2] the Board set aside the August 30, 2005 decision. It found that the Office improperly relied on Dr. Smith's opinion, which contained insufficiently clear and comprehensible findings upon which to render a judgment and that he failed to indicate the applicable tables and figures of the A.M.A., *Guides* upon which he relied in calculating his impairment rating. The Board remanded the case and instructed the Office to refer appellant to a second impartial medical specialist for a well-rationalized, updated medical opinion, to specifically refer to the applicable tables and standards of the A.M.A., *Guides* in rendering his impairment rating and to clearly indicate the specific background upon which he based his opinion. The complete facts of this case are set forth in the Board's January 9, 2001 and September 15, 2006 decisions and are herein incorporated by reference.

The Office scheduled appellant for an impartial medical examination with Dr. Evan S. Kovalsky, Board-certified in orthopedic surgery. In a December 1, 2006 report, Dr. Kovalsky found that she had no additional permanent impairment under the A.M.A., *Guides*. He stated that appellant had good motor strength, a five out of five, with no weakness in the upper extremities. Dr. Kovalsky advised that there was no evidence of any restricted range of motion in the upper extremity on which to base impairment. He also noted no objective loss of strength or sensation, no gross atrophy and no indication of ankylosis in the left upper extremity. Dr. Kovalsky stated that appellant's subjective pain in the left hand at worst was 3 out of 10. He indicated that the most severe pain she had was in the neck area, but that this was not at issue. Dr. Kovalsky stated that appellant had a positive Tinel's bilaterally over the carpal tunnels, as well as positive Phalen's. He also indicated that she underwent an electromyelogram (EMG) on July 25, 2006, which showed evidence of moderate right brachial plexus compromise, left radial

[2] Docket No. 06-150 (issued September 15, 2006).

nerve compromise, right median nerve compromise and bilateral ulnar nerve compromise. Dr. Kovalsky stated:

> "In regards to the A.M.A., *Guides*, she would have several different impairment ratings based upon the accepted facts. I will not comment upon the impairment ratings due to the myofascial pain syndrome which involves the thoracic and trapezial regions. In regards to the cervical radiculopathy and its aggravation, I cannot attribute a specific component to the left upper extremity. If there was significant weakness or sensory changes as a result of this, this could be delineated to the left upper extremity. Based upon the cervical spine impairment rating due to cervical disorders in Table 15-5, she would have approximately a five to eight percent impairment of the whole person based upon her symptomatology and findings. Once again, I cannot necessarily attribute a portion of this to the left upper extremity.
>
> "This leaves the only accepted diagnosis of a left carpal tunnel to determine the impairment of the left upper extremity. Given the fact that she does not have any significant objective sensory loss at this time but intermittent subjective sensory symptoms, I would place her impairment of the left upper extremity at [five] percent. This is based on the guidelines for carpal tunnel syndrome on page 495. Under Item #2, the guidelines indicate in the patient with normal sensibility and opposition strength with an abnormal [EMG], a residual carpal tunnel syndrome an impairment rating not to exceed five percent of the upper extremity may be justified. I feel that this would be the maximum amount of her impairment based upon her objective findings."

In a January 4, 2007 report, an Office medical adviser agreed with Dr. Kovalsky's opinion that appellant had a five percent impairment of her left upper extremity. He rejected any additional impairment for aggravation of the cervical radiculopathy or myofascial pain syndrome. The Office medical adviser stated that there was no applicable rating for myofascial syndrome under the A.M.A., *Guides*, which does not permit awards based on spinal impairments. He further stated that since there was no clinical evidence of C6 radiculopathy there was no impairment for this condition.

With regard to appellant's left-sided carpal tunnel syndrome, the Office medical adviser noted that Dr. Kovalsky had found that she had intermittent subjective sensory symptoms but did not have any significant objective sensory loss. He concurred with Dr. Kovalsky's assessment that appellant had a five percent left upper extremity impairment for carpal tunnel syndrome, based on paragraph number 2 at page 495 of the A.M.A., *Guides*. As appellant had already been granted an award for 16 percent impairment, the Office medical adviser found that she was not entitled to an additional award for the left upper extremity than the she already received.

By decision dated January 4, 2007, the Office denied appellant's claim for a schedule award. It found that Dr. Kovalsky's referee medical opinion represented the weight of the medical evidence.

By letter dated January 9, 2007, appellant's attorney requested an oral hearing, which was held on April 2, 2007.

By decision dated June 19, 2007, an Office hearing representative affirmed the January 4, 2007 Office decision.

In a February 22, 2008 report, Dr. Scott Fried, an osteopath, stated that appellant had ongoing dysfunction and disability, which was much higher than that found by Dr. Kovalsky and the Office medical adviser. He asserted that her accepted diagnoses were still quite symptomatic and that she was substantially dysfunctional. Dr. Fried stated that appellant underwent a March 7, 2008 EMG nerve conduction study, which was consistent with bilateral brachial plexus thoracic outlet nerve involvement, in addition to bilateral ulnar neuropathies at the elbows and radial nerve involvement at the left and right forearm. He also stated that there was evidence of bilateral median nerve carpal tunnel involvements at the wrist levels, again consistent with her median nerve carpal tunnel diagnosis; the proximal brachial plexus involvements were consistent also with her cervical nerve root involvements.

Dr. Fried stated that appellant's findings were consistent with a 16 percent impairment of the left arm secondary to the carpal tunnel and the dysfunction of the hand. He also stated that she had evidence of cervical radiculopathy and brachial plexus involvement, adding another 16 percent impairment to her proximal extremity. Dr. Fried indicated that the brachial plexus cervical radicular component, in addition to the carpal tunnel and thoracic component, would amount to a 35 percent impairment of her left upper extremity secondary to her carpal tunnel, cervical radiculopathy and myofascial pain syndrome, as well as thoracic degenerative disease.

By letter dated March 13, 2008, appellant's attorney requested reconsideration.

By decision dated January 29, 2009, the Office denied modification of the June 19, 2007 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] 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 loss of use.[4] However, the Act does not specify the manner in which the percentage of loss of use of a member is to be determined. For consistent results and to insure equal justice under the law to all claimants, the Office has adopted the A.M.A., *Guides* (fifth edition) as the standard to be used for evaluating schedule losses.[5]

[3] 5 U.S.C. §§ 8101-8193*; see* 5 U.S.C. § 8107(c).

[4] *Id*. at § 8107(c)(19).

[5] 20 C.F.R. § 10.404.

ANALYSIS

In this case, the Office referred appellant to Dr. Kovalsky, the impartial examiner, who determined that she had no additional permanent impairment applicable to the A.M.A., *Guides*. It determined that appellant was not entitled to an additional schedule award in its June 19, 2007 and January 29, 2009 decisions, finding that Dr. Kovalsky's opinion represented the weight of the medical evidence.[6] Dr. Kovalsky noted that she still showed residual findings, including a positive Tinel's bilaterally over the carpal tunnels, a positive Phalen's test and EMG results which showed evidence of moderate right brachial plexus compromise, left radial nerve compromise, right median nerve compromise and bilateral ulnar nerve compromise. He found, however, that these findings did not provide a basis for an additional permanent impairment greater than the 16 percent already awarded. Dr. Kovalsky found that appellant had intermittent subjective sensory symptoms but did not have any significant objective sensory loss. He found that appellant had a five percent left upper extremity impairment for carpal tunnel syndrome based on paragraph number 2 at page 495 of the A.M.A., *Guides*, which states:

> "Normal sensibility and opposition strength with an abnormal sensory and/or motor latencies or abnormal EMG 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."[7]

The Office medical adviser reviewed Dr. Kovalsky's report and rejected any additional award for left lower extremity impairment. He properly noted that there was no applicable rating for myofascial syndrome under the A.M.A., *Guides*, which does not permit awards based on spinal impairments. The Office medical adviser further found that, given the fact that there was no clinical evidence of C6 radiculopathy, there was no ratable impairment for this condition. He concurred with Dr. Kovalsky's assessment that appellant had a five percent left upper extremity impairment for carpal tunnel syndrome based on paragraph number 2 at page 495 of the A.M.A., *Guides*. As appellant had already been granted an award for a 16 percent left upper extremity impairment, the Office properly found in its June 19, 2007 decision that she had no additional permanent impairment of the left upper extremity based on the reports from Dr. Kovalsky and the Office medical adviser, which were rendered in conformance with the applicable protocols of the A.M.A., *Guides*.

Appellant thereafter submitted the February 22, 2008 report from Dr. Fried, who found that she had a 35 percent left upper extremity impairment based on residual left carpal syndrome, cervical radiculopathy, myofascial pain syndrome and thoracic degenerative disease. The Board finds that Dr. Fried's report was not sufficient to negate the Office's finding that Dr. Kovalsky' s referee report represented the weight of the medical evidence. Dr. Fried did not relate any of his findings to the applicable tables and charts of the A.M.A., *Guides*. The Office properly

[6] It is well established that the opinion of an impartial medical specialist is to be given special weight. *See Anna M. Delaney*, 53 ECAB 384 (2002).

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

determined that Dr. Fried's report did not provide a basis for a schedule award under the Act.[8] His report does not provide adequate medical rationale in support of his opinion that appellant is entitled to an additional schedule award for the left upper extremity.[9]

There is no other probative medical evidence establishing that appellant sustained any additional permanent impairment. The Board finds that the Office medical adviser properly applied the A.M.A., *Guides* to rate appellant's left upper extremity impairments based on Dr. Kovalsky's opinion, which constitutes the weight of medical opinion. The Board will affirm the January 29, 2009 decision.

CONCLUSION

The Board finds that appellant has no additional impairment of her left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the January 29, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 7, 2010
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[8] The Board notes that a description of appellant's impairment must be obtained from appellant's physician, which must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations. *See Peter C. Belkind*, 56 ECAB 580, 585 (2005).

[9] *William C. Thomas*, 45 ECAB 591 (1994).