United States Department of Labor
Employees' Compensation Appeals Board

F.M., Appellant	)	
and	)	**Docket No. 08-1205**
	)	**Issued: November 19, 2008**
U.S. POSTAL SERVICE, DALLAS BULK MAIL CENTER, Dallas, TX, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On March 17, 2008 appellant filed a timely appeal from the August 9, 2007 and February 25, 2008 schedule award decisions of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of these schedule award decisions.

ISSUE

The issue is whether appellant has more than a four percent impairment of the left upper extremity and a nine percent impairment of the right upper extremity, for which he received a schedule award.

FACTUAL HISTORY

Appellant's June 13, 2005 occupational disease claim was accepted by the Office for a bilateral carpal tunnel syndrome and bilateral lesion of the ulnar nerves. The Office approved right and left carpal tunnel release surgeries, which occurred on October 6 and December 1, 2005, respectively. Appellant returned to light duty, eight hours per day, on March 20, 2006.

On December 27, 2006 appellant filed a claim for a schedule award. In a November 21, 2006 report, Dr. Ronnie D. Shade, a Board-certified orthopedic surgeon, advised that appellant had reached maximum medical improvement as of that date. Examination of the upper extremities revealed mild synovitis of the right wrist dorsally and tenderness over the A-1 pully of the right middle finger. Tinel's sign was positive bilaterally. Phalen's was positive on the right. Grip strength on the right was 10 kilogram (kg), 8 kg and 6 kg; grip strength on the left was 6 kg, 5 kg and 5 kg. Dr. Shade diagnosed bilateral carpal tunnel syndrome and cubital tunnel syndrome. Under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[1] he provided an 11 percent impairment rating for both the right and left median nerves. Specifically, Dr. Shade awarded a three percent motor deficit (10 X .30) and an eight percent sensory deficit (39 X .20) for each nerve. He provided 10 percent impairment for both the right and left ulnar nerves, pursuant to appellant's cubital tunnel syndrome. Specifically, Dr. Shade awarded a nine percent motor deficit (46 X .20) and a one percent sensory deficit (7 X .20) for each nerve. Applying the Combined Values Chart on page 604 of the A.M.A., *Guides*, Dr. Shade concluded that appellant had a 20 percent impairment of each upper extremity.

In a September 27, 2006 report of an electromyography and nerve conduction study, Dr. Frank Morrison, a physiatrist, found no electromyographic evidence of a significant neuropathic process. On April 26, 2007 the district medical adviser recommended that the Office obtain a second opinion examination regarding the degree of appellant's permanent impairment.

In a June 19, 2007 second opinion report, Dr. Richard N. Brown, a Board-certified physiatrist, opined that appellant had a 15 percent permanent impairment of the right wrist and a 23 percent impairment of the left wrist. He stated that diagnostic studies revealed moderate neuropathy of the right wrist and mild median neuropathy of the left wrist. Right wrist range of motion was as follows: flexion -- 60 degrees; extension -- 40 degrees; radial deviation -- 20 degrees; and ulnar deviation -- 23 degrees. Left wrist range of motion was as follows: flexion -- 30 degrees; extension -- 40 degrees; radial deviation -- 12 degrees; and ulnar deviation -- 15 degrees. Sensation in the median nerve distribution was decreased in both hands. The claimant's impairment rating was calculated utilizing section 16.9 at page 511 of the A.M.A., *Guides.* Dr. Brown determined that appellant's impairment for loss of range of motion for the right and left wrists was 7 and 20 percent, respectively. He found a 20 percent sensory deficit, as well as a 20 percent strength deficit on the right. Utilizing Table 16-15 on page 492, Dr. Brown concluded that appellant had a nine percent motor and sensory deficit on the right and a four percent sensory deficit on the left. (Ten percent times the maximal sensory deficit of 39 percent) Using the Combined Values Chart on page 605, Dr. Brown found a right wrist impairment of 15 percent and a left wrist impairment of 23 percent.

On July 23, 2007 an Office medical adviser reviewed Dr. Brown's report and found that appellant had a four percent impairment of the left upper extremity and a nine percent impairment of the right upper extremity under the A.M.A., *Guides*. Referring to Table 16-15 at page 492 of the A.M.A., *Guides*, he concluded that appellant had a 39 percent sensory deficit and

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

a 10 percent motor deficit bilaterally (median below midforearm). According to Table 16-10 at page 482 (pain or sensory deficit), Dr. Brown determined that appellant had a 4 percent left upper extremity impairment, based upon a Grade 4 pain or sensory deficit classification (10 percent X 39 percent = 4 percent). Referring to Table 16-11 at page 484 (motor deficit), he found that appellant had a 9 percent right upper extremity impairment, based upon a Grade 4 motor deficit (20 percent X 45 percent = 9 percent). The medical adviser stated that no consideration is given for the limited wrist range of motion in addition to the median nerve impairment pursuant to page 494 of the A.M.A., *Guides*. He opined that the date of maximum medical improvement was June 19, 2007.

On August 9, 2007 the Office granted appellant a schedule award for a four percent permanent impairment of the left upper extremity and for a nine percent impairment of the right upper extremity. The period of the award was from June 19, 2007 to March 28, 2008.

Appellant requested reconsideration. He submitted an August 8, 2007 report from Dr. Shade, who noted appellant's ongoing complaints of hand pain, numbness and tingling. On October 23, 2007 Dr. Shade reiterated his opinion that appellant had a 20 percent impairment of both upper extremities.

In a decision dated February 25, 2008, the Office denied modification of the August 9, 2007 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulation[3] 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 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 regulation as the appropriate standard for evaluating schedule losses.

Section 8123(a) of the Act provides that 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.[4] 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.[5]

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] 5 U.S.C. § 8123(a).

[5] *Id. See also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

ANALYSIS

The Board finds that this case is not in posture for a decision due to a conflict in medical opinion between Dr. Shade and Dr. Brown as to the extent of appellant's upper extremity impairment.

In his November 21, 2006 report, Dr. Shade concluded that appellant had a 20 percent impairment of each upper extremity, pursuant to the A.M.A., *Guides*. He found mild synovitis of the right wrist dorsally and tenderness over the A-1 pully of the right middle finger. Tinel's sign was positive bilaterally and Phalen's was positive on the right. Grip strength on the right was 10 kg, 8 kg and 6 kg; grip strength on the left was 6 kg, 5 kg and 5 kg. Dr. Shade provided an 11 percent impairment rating for both the right and left median nerves, awarding a 3 percent motor deficit (10 X .30) and an 8 percent sensory deficit (39 X .20) for each nerve. He provided 10 percent impairment for both the right and left ulnar nerves, pursuant to appellant's cubital tunnel syndrome, awarding a 9 percent motor deficit (46 X .20) and an 1 percent sensory deficit (7 X .20) for each nerve. Dr. Shade arrived at a 20 percent impairment rating for each upper extremity by applying the Combined Values Chart on page 604 of the A.M.A., *Guides*.

In a June 19, 2007 second opinion report, Dr. Brown opined that appellant had a 15 percent permanent impairment of the right wrist and a 23 percent impairment of the left wrist, pursuant to section 16.9 at page 511 of the A.M.A., *Guides.* Noting that diagnostic studies revealed moderate neuropathy of the right wrist and mild median neuropathy of the left wrist, he stated that sensation in the median nerve distribution was decreased in both hands. Testing revealed decreased range of motion in both wrists, which Dr. Brown determined translated into a rating for loss of range of motion for the right and left wrists of 7 and 20 percent, respectively. He found a 20 percent sensory deficit, as well as a 20 percent strength deficit on the right. Utilizing Table 16-15 on page 492, Dr. Brown concluded that appellant had a nine percent motor and sensory deficit on the right and a four percent sensory deficit on the left. (Ten percent times the maximal sensory deficit of 39 percent). Using the Combined Values Chart on page 605, Dr. Brown found a right wrist impairment of 15 percent and a left wrist impairment of 23 percent.

An Office medical adviser reviewed Dr. Brown's report and found that appellant had a four percent impairment of the left upper extremity and a nine percent impairment of the right upper extremity. However, he did not address Dr. Shade's November 21, 2006 report or the conflict in medical opinion between Dr. Shade and Dr. Brown. Although the medical adviser stated that he had given no consideration for the limited wrist range of motion, he did not explain why he had relied solely on and accorded more weight to, the report of the second opinion examiner. The Board finds that there is an unresolved conflict between the medical opinions of Dr. Shade and Dr. Brown. Therefore, the case must be remanded to the Office for an impartial medical examination to resolve the conflict as to the degree of permanent impairment to appellant's upper extremities, followed by an appropriate *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision due to a conflict in the medical opinion evidence between Dr. Shade and Dr. Brown as to the degree of appellant's

upper extremity impairment. On remand, the Office should refer appellant, together with a statement of accepted facts and the case record, to an appropriate impartial medical specialist, for an examination and evaluation in order to resolve the conflict.

ORDER

IT IS HEREBY ORDERED THAT the February 25, 2008 and August 9, 2007 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further action consistent with this opinion.

Issued: November 19, 2008
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board