United States Department of Labor
Employees' Compensation Appeals Board

DEBORAH D. DUNN, Appellant	)	
and	)	**Docket No. 04-1509**
	)	**Issued: October 6, 2005**
U.S. POSTAL SERVICE, POST OFFICE, St. Louis, MO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
WILLIE T.C. THOMAS, Alternate Judge

JURISDICTION

On May 19, 2004 appellant filed a timely appeal from an Office of Workers' Compensation Programs' merit decision dated February 12, 2004 and the decision dated November 12, 2003. 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 four percent permanent impairment to her right and left upper extremities.

FACTUAL HISTORY

Appellant, a 41-year-old city letter carrier, filed a Form CA-2 claim for benefits on October 24, 2000, alleging that she developed a bilateral carpal tunnel condition and de Quervain's tenosynovitis causally related to factors of her employment. The Office accepted the claim for bilateral carpal tunnel syndrome and right hand tenosynovitis. Appellant underwent surgery for right carpal tunnel release on October 16, 2001, and for left carpal tunnel release on October 30, 2001.

In a report dated March 24, 2002, Dr. Richard E. Coin, a Board-certified surgeon and the attending physician, determined that appellant had a five percent impairment of the right and left upper extremities. Dr. Coin, however, did not calculate his rating in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (fifth edition), (the A.M.A., *Guides*).

On April 7, 2002 appellant filed a Form CA-7 claim for a schedule award based on a partial loss of use of his right and left upper extremities.

The Office referred appellant for a second opinion examination with Dr. John Gragnani, Board-certified in both physical medicine and rehabilitation and preventive medicine, who submitted a report dated September 19, 2002. Dr. Gragnani determined that appellant had a four percent permanent impairment in his right and left upper extremities.

Using a goniometer, Dr. Gragnani stated that active range of motion for the right wrist was 58 degrees on the right and 72 degrees on the left. He measured extension at 62 degrees on the right and 58 degrees on the left; ulnar deviation of 50 degrees on the right and 52 degrees on the left; and radial deviation of 38 degrees on the right and 30 degrees on the left. He recorded a positive Tinel's sign at both wrists. Dr. Gragnani concluded:

> "Using the A.M.A., *Guides*, a rating was developed for both of the upper extremities due to the carpal tunnels at the wrist level as follows. For the right upper extremity at the wrist from Figure 16-28, extension of 62 degrees is 0 percent. Flexion of 58 is 0 percent. The radial and ulnar deviation are assessed from Figure 16-31 as follows. Radial deviation of 38 degrees is a 0 percent impairment, and ulnar deviation of 50 degrees is 0 percent impairment. Tables 16-10 and 16-11 were considered for pain and/or weakness. There is no substantial weakness Grade [5] for the upper extremities at the hand level based on the results of the Jamar readings. Therefore, no rating from Table 16-11 is offered. Since pain and discomfort were not addressed through range of motion, this examiner felt that abnormal sensation of pain were given. Therefore, this would be at least a Grade [4] from Table 16-10 for 10 percent sensory deficit. This 10 percent sensory deficit was compared against Table 16-15 for median nerve below mid forearm, which is 39 percent multiplied by the 10 percent. Therefore, the sensory and pain deficit estimated for the right upper extremity is 3.9 percent, which is rounded to the next integer, yielding 4 percent impairment for the right upper extremity due to the carpal tunnel at the wrist.
>
> "For the left upper extremity, the rating was evolved in exactly the same manner. From Figure 16-28, extension of 58 degrees is 0 percent impairment. From Figure 16-31, radial deviation of 30 degrees is 0 percent impairment, and ulnar deviation of 52 percent is also 0 percent impairment. Grip strength was at least Grade [5], therefore no rating is offered from Table 16-11. Sensory impairment was Grade [4] from Table 16-10 for 10 percent sensory impairment, which is compared against Table 16-15 for 39 percent due to median nerve below mid forearm, yielding a 3.9 percent, rounded to 4 percent impairment for pain and sensory changes of the left upper extremity. Therefore, the bilateral ratings for

[appellant] are four percent of the right upper extremity and four percent of the right upper extremity."

In an impairment evaluation dated February 13, 2002, an Office medical adviser found that appellant had a four percent impairment of his left and right lower extremities based on the A.M.A., *Guides*, in accordance with the findings and conclusions of Dr. Gragnani.

On October 11, 2002 the Office granted appellant a schedule award for a four percent permanent impairment of the right and left upper extremities for the period February 13 to August 6, 2002, for a total of 24.96 weeks of compensation.

By letter dated November 5, 2002, appellant requested an oral hearing, which was held on August 18, 2003.

Appellant submitted a January 12, 2003 report from Dr. Jerome Levy, a general practitioner, who opined that she had a 20 percent permanent impairment of the right upper extremity and a 25 percent impairment of the left upper. He did not calculate this rating in accordance with the A.M.A., *Guides*. In a letter dated August 18, 2003, Dr. Levy expressed his disagreement with the methods outlined in the A.M.A., *Guides* to calculate impairment.

Dr. Coin submitted a report dated August 14, 2003, but did not provide an impairment rating.

In a decision dated November 12, 2003, an Office hearing representative affirmed the April 1, 2002 Office decision and denied appellant's claim for a greater additional award.

Dr. Coin submitted a report dated October 27, 2003 in which he stated that appellant had a one percent impairment of the right wrist and a one percent impairment of the left wrist based on her work-related tenosynovitis. He did not calculate this rating in accordance with the A.M.A., *Guides*.

By letter dated January 23, 2004, appellant requested reconsideration.

Appellant submitted a December 22, 2003 report from Dr. Bruce Schlafly, a Board-certified orthopedic surgeon, who calculated a 14 percent permanent impairment of the right and left upper extremities. Dr. Schlafly stated that appellant's grip strength measured 61 pounds in the right hand compared to 65 pounds in the left hand; repeat testing rendered a measurement of 56 pounds in the right hand compared to 68 pounds in the left hand; and a third test yielded 56 in the right hand as compared with 62 pounds in the left hand. Dr. Schlafly stated:

"[Appellant] has normal median nerve motor function, and therefore has a zero percent motor deficit of the median nerve, and therefore has no impairment on the basis of a motor deficit. With regard to upper extremity impairment on the basis of sensory deficit or pain, the reader is referred to Table 16-11 and Table 16-15. Using Table 16-10 on page 482, my clinical judgment is that [appellant] has a Grade 3 category of sensory deficit and pain, with an estimated sensory loss determined with two-point discrimination testing, as given in Table 16-5 on page 447 'cannot be used in Table 16-10 as a substitute for selecting the grade of

> severity of sensory deficits or pain resulting from peripheral nerve disorders.' The reader will also note that, on page 482, the A.M.A., *Guides* state that '[h]owever, in conditions such as radiculitis, causalgia, and entrapment or compression neuropathy, normal two-point discrimination does not exclude the presence of abnormal light-to-touch/deep-pressure thresholds and abnormal conduction studies.' Using Table 16-15 on page 492, I find that [appellant] has an upper extremity impairment due to sensory deficit or pain of 35 percent of 39, that is, 13.65 percent. This rounds off to 14 percent permanent partial impairment of each upper extremity due to her work-related bilateral carpal tunnel syndrome, since there is no additional impairment on the basis of any motor deficit."

In a memorandum dated February 6, 2004, an Office medical adviser rejected Dr. Schlafly's opinion because, in his opinion, Dr. Schlafly incorrectly cited out of context a comment at page 447 of the A.M.A., *Guides*. The Office medical adviser stated that the actual text in this portion of the A.M.A., *Guides* is used in context with Table 16-5 on that page and states, "the sensory quality impairment ratings derived from Table 16-5 are to be used only for impairment due to lesions of digital nerves. They cannot be used in Table 16-10 as a substitute for selecting the grade of severity of sensory deficits or pain resulting peripheral nerve disorder." The Office medical adviser opined that Dr. Schlafly reported examination findings of normal strength and normal two-point discrimination when in fact appellant's examination findings do not meet the requirements for the grade offered for pain from Table 16-10.

By decision dated February 12, 2004, the Office denied reconsideration.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] sets 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.[2] 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.[3]

ANALYSIS

The Board finds that the case is not in posture for decision.

In the instant case, appellant sought an additional award for her impairment based on carpal tunnel syndrome. The A.M.A., *Guides* outline the manner by which an award for carpal

[1] 5 U.S.C. §§ 8101-8193*; see* 5 U.S.C. § 8107(c).

[2] 5 U.S.C. § 8107(c)(19).

[3] 20 C.F.R. §10.404.

tunnel syndrome is rated on page 495, where the following scenarios for rating impairment are discussed:

> "(1) Positive clinical findings of media nerve dysfunction and electrical conduction delay(s); the impairment due to residual carpal tunnel syndrome [CTS] is rated according to the sensory and /or motor deficits as describe earlier.
>
> "(2) Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal electromyelogram [EMG] testing of the thenar muscles: a residual CTS is still present, and an impairment rating not to exceed 5 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."

In the instant case, the only physician of record who made findings with regard to median nerve dysfunction was Dr. Schlafly, who stated that appellant had normal median nerve motor function, a zero percent motor deficit of the median nerve, and therefore has no impairment on the basis of a motor deficit. Dr. Schlafly then considered whether appellant had an upper extremity impairment on the basis of sensory deficit or pain, and cited Tables 16-10, 16-11 and Table 16-15, which deal with peripheral nerve disorders. Relying on Table 16-10 on page 482, Dr. Schlafly calculated a Grade 3 category of sensory deficit and pain, with an estimated sensory loss determined with two-point discrimination testing.[4] After stating that the A.M.A., *Guides* at page 482 indicated that a normal two-point discrimination does not exclude the presence of abnormal light-to-touch/deep-pressure thresholds and abnormal conduction studies, Dr. Schlafly found that appellant had an upper extremity impairment due to sensory deficit or pain of 35 percent of 39, that is, 13.65 percent, pursuant to Table 16-15 at page 492. This rounded off to a 14 percent permanent impairment of each upper extremity due to her work-related bilateral carpal tunnel syndrome as there was no additional impairment on the basis of any motor deficit.

Dr. Gragnani, who calculated a rating for the right wrist based on carpal tunnel syndrome by deriving a Grade 4 from Table 16-10 for 10 percent sensory deficit. This 10 percent sensory deficit was compared against Table 16-15 for median nerve below mid forearm, which is 39 percent multiplied by the 10 percent. Therefore, the sensory and pain deficit estimated for the right upper extremity is 3.9 percent, which is rounded to the next integer, yielding 4 percent impairment for the right upper extremity due to the carpal tunnel at the wrist. Dr. Gragnani employed the same method for the left wrist, stating that "For the left upper extremity, the rating was evolved in exactly the same manner. From Figure 16-28, extension of 58 degrees is 0 percent impairment. From Figure 16-31, radial deviation of 30 degrees is 0 percent impairment, and ulnar deviation of 52 percent is also 0 percent impairment. Grip strength was at least Grade

[4] Dr. Schlafly noted that this rating "as given in Table 16-5 on page 447 'cannot be used in Table 16-10 as a substitute for selecting the grade of severity of sensory deficits or pain resulting from peripheral nerve disorders.'" The Office medical advisor discredited Dr. Schlafly's opinion on this basis. While the direct relation of Table 16-5 to a rating based on peripheral nerve disorder is questionable, the Board finds that Dr. Schlafly's citation of this Table does not detract from the probative value of his overall impairment rating, which was properly based on Tables 16-10, 16-11 and 16-15.

5, therefore no rating is offered from Table 16-11. Sensory impairment was Grade 4 from Table 16-10 for 10 percent sensory impairment, which is compared against Table 16-15 for 39 percent due to median nerve below mid forearm, yielding a 3.9 percent, rounded to 4 percent impairment for pain and sensory changes of the left upper extremity. Therefore, the bilateral ratings for [appellant] are four percent of the right upper extremity and four percent of the right upper extremity."

In the present case, there was disagreement between the Office medical adviser, Dr. Gragnani, and Dr. Schlafly regarding the degree of impairment in her upper extremities to which appellant was entitled due to her work-related condition. Both Dr. Gragnani and Dr. Schlafly submitted impairment ratings and evaluations which were thorough and well rationalized. While both physicians relied on Table 16-10 on page 482 to calculate a peripheral nerve disorder in appellant's upper extremities, Dr. Schlafly calculated a Grade 3 category based on sensory deficit and pain, deriving a 14 percent impairment; in contrast, Dr. Gragnani calculated a Grade 4 category impairment based on sensory deficit and pain under Table 16-10 for a total 4 percent impairment. When such conflicts in medical opinion arise, 5 U.S.C. § 8123(a) requires the Office to appoint a third or "referee" physician, also known as an "impartial medical examiner."[5] It was therefore incumbent upon the Office to refer the case to a properly selected impartial medical examiner, using the Office procedures, to resolve the existing conflict. As the Office did not refer the case to an impartial medical examiner, there remains an unresolved conflict in medical opinion.[6]

Accordingly, the case is remanded to the Office for referral of appellant, the case record and a statement of accepted facts to an appropriate impartial medical specialist selected in accordance with the Office's procedures, to resolve the outstanding conflict in medical evidence regarding the appropriate percentage of impairment in appellant's upper extremities. On remand, the Office should instruct the new impartial medical examiner to provide a well-rationalized opinion, to specifically refer to Table 16-10 at page 482 of the A.M.A., *Guides* in making his findings and conclusions and in rendering his impairment rating, and to clearly indicate the specific background upon which he based his opinion. After such further development of the record as it deems necessary, the Office shall issue a *de novo* decision.

The Office's decision of February 12, 2004 is therefore set aside and the case is remanded to the Office of Workers' Compensation Programs for further action consistent with this decision of the Board.

CONCLUSION

The Board finds that the case is not in posture for decision.

[5] Section 8123(a) of the Act provides in pertinent part, "(i)f there is a 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." *See Dallas E. Mopps*, 44 ECAB 454 (1993).

[6] *See Shirley L. Steib*, 46 ECAB 309 (1994); *Vernon E. Gaskins*, 39 ECAB 746 (1988).

ORDER

IT IS HEREBY ORDERED THAT the February 12, 2004 decision of the Office of Workers' Compensation Programs be set aside and the case is remanded to the Office for further action consistent with this decision of the Board.

Issued: October 6, 2005
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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