United States Department of Labor
Employees' Compensation Appeals Board

L.H., Appellant	)	
and	)	**Docket No. 07-339**
	)	**Issued: June 5, 2007**
U.S. POSTAL SERVICE, NORTH PHILADELPHIA STATION, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On November 20, 2006 appellant filed a timely appeal of the November 13, 2006 merit decision of the Office of Workers' Compensation Programs granting schedule awards for a 16 percent impairment of the right upper extremity and a 4 percent impairment of the left upper extremity. 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 has established impairment greater than 16 percent of her right upper extremity and 4 percent of her left upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On May 13, 2004 appellant, then a 62-year-old letter carrier, filed an occupational disease claim alleging that he sustained from carpal tunnel syndrome as a result of his federal duties. On

March 16, 2004 he underwent a right carpal tunnel release with palmar fasciectomy performed by Dr. John S. Taras, a Board-certified orthopedic surgeon specializing in hand surgery. On June 22, 2004 Dr. Taras performed a "[r]ight release right middle and ring finger stenosing flexor tenosynovitis with partial palmar fasciectomy and flexor tenosynovectomy." By letter dated July 30, 2004, the Office accepted appellant's claim for bilateral carpal tunnel syndrome and bilateral trigger finger.

On April 1, 2005 and March 23, 2006 appellant filed claims for a schedule award.

On September 13, 2005 Dr. Taras performed a left ring finger release stenosing flexor tenosynovitis with partial palmar fasciectomy.

In a medical report dated May 16, 2006, Dr. George L. Rodriguez, a Board-certified physiatrist, rated appellant's impairment. He diagnosed bilateral carpal tunnel syndrome; calorific tenosynovitis for which appellant had surgery on March 16 and June 22, 2004; bilateral calorific tenosynovitis in his hands; and dysfunction in his activities of daily living. Dr. Rodriguez indicated that appellant was suffering significantly from bilateral wrist pain and that maximum medical improvement had been reached on March 31, 2006. Utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, he concluded that appellant had 27 percent impairment of his left upper extremity due to combined motor and sensory impairment in his median nerve below the forearm.[1] With regard to appellant's right upper extremity, Dr. Rodriguez found that he had 27 percent impairment due to combined motor and sensory deficit in the median nerve below the midforearm.[2] With regard to range of motion impairment, he concluded that appellant had a 52 percent deficit of the 3rd finger, which equaled 9 percent impairment to the upper extremity. Dr. Rodriguez noted that appellant also had a 52 percent deficit of the 4th finger, which amounted to a 5 percent impairment of the upper extremity.[3] He combined the 9 percent range of motion impairment and the 5 percent range of motion impairment to find 14 percent impairment to the right arm. Dr. Rodriguez then combined the 27 impairment motor and sensory impairment and the 14 percent range of motion impairment to find a total 37 percent combined right upper extremity impairment.

On September 18, 2006 the Office referred appellant to Dr. Kevin F. Hanley, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a report dated October 5, 2006, Dr. Hanley diagnosed bilateral carpal tunnel syndrome, surgically treated on the right and triggering of the right middle and ring finger and left ring finger, surgically, treated and resolved. He concluded:

> "First of all with regard to the trigger fingers, he clearly has resolved all triggering and, therefore, has no impairment according to the [A.M.A., *Guides*]. I refer to Table 16-29 on page 507, where the patient must have at least inconstant

[1] A.M.A., *Guides* at 482, Table 16-10; 484, Table 16-11; and 492, Table 16-15.

[2] *Id.*

[3] A.M.A., *Guides* at 464, Figure 16-25; 438, Table 16-1; 439, Tables 16-2 and 16-3.

triggering to have any digit impairment. He has none. Relative to his carpal tunnel syndrome, that will be rated on both sides using Tables 16-10, 16-11 and 16-15. On the right where he has disordered [two]-point discrimination, he has a [G]rade [3] sensory loss. I would suggest that the sensory deficit is 40 percent. Multiplying 50 percent by the number found on Table 16-15 for median neuropathy, gives one a 16 percent right upper extremity impairment. On the left side, he has a [G]rade [4] classification with only a 10 percent sensory deficit that would give him a 4 percent impairment on the left upper extremity. There is no additional impairment for range of motion loss or any other findings that would be his attributable impairment according to the [A.M.A., *Guides*] for his industrial injury. [Appellant] does continue to suffer residuals of the carpal tunnel injury, not of the trigger finger injury. There are still objective findings as outlined above."

On October 18, 2006 the Office forwarded appellant's case to the Office medical adviser. In a medical report dated October 20, 2006, the Office medical adviser agreed with Dr. Hanley finding that appellant's right upper extremity impairment was 16 percent and his left upper extremity impairment was 4 percent. The Office medical adviser stated:

"*Right Median Nerve Impairment*

Upper Extremity Impairment Due to Sensory/Pain Deficit-Median Nerve
Grade median nerve sensory deficit using Table 16-10, page 482
I agree with Grade 3 which corresponds to 40 percent Upper Extremity Impairment.

"*Maximum Upper Extremity Impairment Due to Sensory Deficit Median Nerve-Using Table 16-15, page 492*
Maximum Sensory Deficit for Median Nerve below midforearm equals 39 percent Upper Extremity Impairment.
Total Sensory Median Nerve Impairment … Upper Extremity Impairment equals 39 percent Upper Extremity Impairment….

"*Left Median Nerve Impairment*
Upper Extremity Impairment Due to Sensory/Pain Deficit-Median Nerve
Grade median nerve sensory deficit using Table 16-10, page 482
I agree with Grade 4 which corresponds to 10 percent Upper Extremity Impairment.

"*Maximum Upper Extremity Impairment due to Sensory Deficit Median Nerve-Using Table 16-15, page 492*
Maximum Sensory Deficit for Median Nerve below midforearm equals 39 percent Upper Extremity Impairment.
Total Sensory Median Nerve Impairment
Grade [multiplied by] Maximum Upper Extremity Impairment for Median Nerve Sensory Deficit

> 10 percent [multiplied by] 39 percent upper extremity impairment equals 3.9 percent Upper Extremity Impairment equals 4 percent Upper Extremity Impairment."

On November 13, 2006 the Office issued schedule awards for a 16 percent impairment of the right upper extremity and a 4 percent impairment of the left upper extremity.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[4] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[5] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[6] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[7]

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.[8] 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.[9]

ANALYSIS

The Board finds that the case is not in posture for decision due to a conflict in medical opinion between Dr. Rodriguez, appellant's physician, and Dr. Hanley, the second opinion physician.

In a report dated May 16, 2006, Dr. Rodriguez applied the A.M.A., *Guides* and determined that appellant had a 27 percent impairment of the left upper extremity due to combined motor and sensory impairments in his forearm. With regard to the right upper extremity, he determined that appellant sustained 37 percent impairment due to combined motor and sensory impairment and range of motion impairment in his right 3rd and 4th fingers. The Office referred appellant to Dr. Hanley who also applied the A.M.A., *Guides* finding that there

[4] 5 U.S.C. §§ 8101-8193.

[5] 5 U.S.C. § 8107.

[6] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[7] 20 C.F.R. §10.404.

[8] 5 U.S.C. § 8123(a).

[9] *See Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980).

was no impairment with regard to appellant's trigger fingers. Dr. Hanley found 16 percent right upper extremity impairment based on sensory deficit. With regard to the left upper extremity he found that appellant had four percent impairment due to sensory deficit. The Office medical adviser agreed with Dr. Hanley's findings.

Both Dr. Rodriguez and Dr. Hanley used the A.M.A., *Guides* in reaching their conclusions. However, their opinions conflict as to the ratings provided following physical examination of appellant. Dr. Rodriguez found a range of motion impairment to appellant's right 3rd and 4th fingers whereas Dr. Hanley concluded that appellant's trigger finger condition had resolved without impairment. The Board finds that there is a conflict in medical opinion requiring further development of the medical evidence.

The case will be remanded to the Office to refer appellant to an appropriate impartial medical specialist for a determination regarding the extent of impairment to his upper extremities. After such development as the Office deems necessary, an appropriate decision should be issued regarding the extent of any impairment to his upper extremities.

CONCLUSION

The Board finds that this case is not in posture for decision due to a conflict in the medical evidence.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 13, 2006 is set aside and the case is remanded for further action consistent with this decision.

Issued: June 5, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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