

FACTUAL HISTORY

This is the second appeal in this case before this Board. The facts and the law of the Board's June 5, 2007 decision are hereby incorporated by reference.¹ The relevant facts are briefly set forth below.

Appellant's May 13, 2004 claim was accepted by the Office for bilateral carpal tunnel syndrome. On May 16, 2006 Dr. George L. Rodriguez, a Board-certified physiatrist, rated appellant's impairment as a 27 percent impairment of the left upper extremity and a 37 percent impairment of the right upper extremity. 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 rated impairment as 16 percent of the right upper extremity and 4 percent of the left upper extremity. In a decision dated November 13, 2006, the Office issued schedule awards for 16 percent loss of the right upper extremity and 4 percent loss to the left upper extremity.

In the June 5, 2007 decision,² the Board found that the impairment ratings of Dr. Rodriguez and Hanley were in conflict. The Board noted that 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 any impairment. The Board remanded the case to the Office for further development of the medical evidence.

By letter dated August 1, 2007, the Office referred appellant to Dr. Joseph J. Mesa, a Board-certified orthopedic surgeon, for an impartial medical examination. The Office instructed Dr. Mesa to resolve the conflict in medical opinion regarding the extent of permanent impairment to each upper extremity. In an opinion dated August 29, 2007, Dr. Mesa stated:

“With regard [sic] to his overall impairment rating, he calculates as follows: With regard to his range of motion, he has near normal range of motion of both hands and has no evidence for any impairment rating with regards to his range of motion. With regard to his right median nerve impairment, the patient has a right median nerve sensory deficit, which corresponds to a Grade 3 deficit as defined by Table 16-10 on the fifth edition of the [A.M.A., *Guides*]. I rate the present sensory deficit as 40 percent, and using the maximal upper extremity impairment with regard to the median nerve below the forearm from Table 16.15, gives a 39 percent upper extremity impairment, which when multiplied, the 40 by 39 percent get a 15.6 impairment rating for the right upper extremity. The second criteria for determination of his impairment is his grip strength. Evaluation of his grip strength by dynameter gives a score of 20. The normal grip strength and the normal average grip strength in a male 50 to 59 in the dominant hand which is his right hand is 45.9. Determination of strength loss index percentage, the grip strength, is taken from Table 16-32. The determination of strength loss index percentage is normal strength minus the limited strength divided by the normal

¹ L.H., Docket No. 07-339 (issued June 5, 2007).

² L.H., *supra* note 1.

strength, which comes to 5, and in using Table 16-34, gives a 20 percent upper extremity impairment. Combine that to the 15.6 and the total right upper extremity impairment is 35.6 with regards to the right upper extremity. With regards to the left upper extremity, he has left medial nerve impairment, which I agree is Grade 4, which I have given as a 10 percent deficit multiplied by 39 gives a 3.9 percent of upper extremity impairment. However, he has grip strength loss on that side as well. With his measurement being 20 and the normal measurement in the nondominant arm is 43.5, which when using the strength loss index percentage calculation gives a percentage strength loss index of 54 percent which again is 20 percent upper extremity impairment. Combine that with the 4 percent from the sensory loss and it is a 24 percent impairment of the upper extremity impairment with regards to the left upper extremity.

In a decision dated October 12, 2007, the Office denied appellant's claim for an additional schedule award. The Office noted that Dr. Mesa's findings regarding impairment of the median nerves established 15.6 percent impairment of the right upper extremity and a 3.9 percent impairment of the left upper extremity. The Office further noted that Dr. Mesa included ratings for loss of grip strength that could not be used under the A.M.A., *Guides*.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act³ 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.⁴ 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.⁵ The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.⁶

The standards for evaluation of the permanent impairment of an extremity under the A.M.A., *Guides* are based on loss of range of motion, together with all factors that prevent a limb from functioning normally, such as pain, sensory deficit and loss of strength. All of the factors should be considered together in evaluating the degree of permanent impairment.⁷ Chapter 16 of the fifth edition of the A.M.A., *Guides* provides a detailed grading scheme and procedure for determining impairments of the upper extremities due to pain, discomfort, loss of sensation or loss of strength.⁸ However, loss of grip strength impairment is used only in rare cases.⁹

³ 5 U.S.C. §§ 8101-8193.

⁴ 5 U.S.C. § 8107.

⁵ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

⁶ 20 C.F.R. § 10.404.

⁷ *See Paul A. Toms*, 28 ECAB 403 (1987).

⁸ A.M.A., *Guides* 433-521, Chapter 16, *The Upper Extremities* (5th ed. 2001).

⁹ *Id.* at 508.

Additionally, decreased strength is not to be rated in the presence of decreased motion painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated.¹⁰

The Act provides that, if there is a disagreement between a physician making an examination for the United States and the physician of the employee, the Office will appoint a third physician to make an examination.¹¹ The implementing regulation provides that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser or consultant, the Office must appoint a third physician to make an examination. This is called a referee examination and the Office is required to select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.¹² It is well established that when 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 proper factual and medical background, must be given special weight.¹³

ANALYSIS

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

The Board remanded this case to resolve a conflict between appellant's physician, Dr. Rodriguez, and the second opinion physician, Dr. Hanley, with regard to extent of impairment to appellant's upper extremities. Accordingly, the Office referred appellant to Dr. Mesa for an impartial medical examination.

Dr. Mesa rated appellant's impairment with regard to median nerve sensory deficit in the right and left upper extremities. As to the right upper extremity, Dr. Mesa noted that appellant had a right median nerve sensory deficit which corresponded to a Grade 3 deficit as defined by Table 16-10, page 482 of the A.M.A., *Guides*. Table 16-10 allows between 20 and 60 percent for a Grade 3 sensory deficit. Dr. Mesa determined that he would rate appellant with a sensory deficit of 40 percent. By applying Table 16-5, page 447 of the A.M.A., *Guides*,¹⁴ which allows a maximum impairment of the upper extremity of 39 percent for sensory deficit to the median nerve, Dr. Mesa determined that appellant had 15.6 percent impairment of his right upper extremity. With regard to the left upper extremity, utilizing the same tables, he determined that appellant had a Grade 4 impairment, for which the A.M.A., *Guides* allow a 1 to 25 percent sensory deficit. Dr. Mesa concluded that appellant had a 10 percent sensory impairment. He multiplied 10 percent by the 39 percent maximum for sensory deficit to the median nerve to find

¹⁰ *Id.*

¹¹ 5 U.S.C. §§ 8101-8193, 8123(a).

¹² 20 C.F.R. § 10.321.

¹³ *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

¹⁴ Although Dr. Mesa refers to Table 16.5, it is evident that he properly utilized Table 16-15 of the A.M.A., *Guides*.

that appellant had a 3.9 percent impairment to his left upper extremity due to sensory impairment of the median nerve.

However, Dr. Mesa also rated impairment with regard to grip strength. He combined findings of grip strength loss with his findings on sensory impairment of the median nerve. He concluded that appellant had a 35.6 percent impairment of the right upper extremity and a 24 percent impairment of the left upper extremity. The Board has noted that, in accordance with the A.M.A., *Guides*, impairment arising from carpal tunnel syndrome should be rated only on motor and sensory deficits.¹⁵ The A.M.A., *Guides* provide that, in compression neuropathies, additional impairment values are not given for decreased grip strength.¹⁶ Carpal tunnel syndrome is an entrapment/compression neuropathy of the median nerve.¹⁷ Therefore, Dr. Mesa's impairment ratings were not consistent with the A.M.A., *Guides*. When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in the original report.¹⁸ Accordingly, the Board finds that the case must be remanded for further clarification of Dr. Mesa's opinion on permanent impairment. Dr. Mesa should be asked to clarify whether appellant has any motor loss involving his upper extremities. After such development as the Office deems necessary, an appropriate merit decision shall be issued.

CONCLUSION

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

¹⁵ A.M.A., *Guides* 494; *Robert V. Disalvatore*, 54 ECAB 351 (2003).

¹⁶ *Id.* at 494; *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

¹⁷ *Id.* at 492.

¹⁸ *See Adrienne L. Currey*, 53 ECAB 750 (2002).

ORDER

IT IS HEREBY ORDERED THAT the October 12, 2007 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further proceedings consistent with this decision.

Issued: June 17, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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