

gardening duties. He did not stop work. The Office accepted appellant's claim for bilateral carpal tunnel syndrome and right hand tenosynovitis. It authorized a right carpal tunnel release which was performed on February 5, 2002.

Appellant came under the treatment of Dr. Scott M. Fried, an osteopath, from March 10, 1993 to November 14, 2001, who diagnosed flexor tenosynovitis of the right hand, median neuropathy on the right side, ulnar neuropathy of the left elbow and bilateral de Quervain's tenosynovitis and opined that these conditions were directly related to his work activities as a gardener. Dr. Fried noted that conservative treatment was unsuccessful and recommended surgical intervention. On February 5, 2002 he performed decompression of the right median nerve, neurolysis of the medial nerve, neurolysis palmar cutaneous branch of the median nerve, neurolysis of motor and digital branches of the median nerve, flexor tenosynovectomy, lysis palmar arch, decompression and lysis of the ulnar nerve, lysis ulnar artery and flexor tenosynovectomy extensive. Dr. Fried diagnosed median neuropathy of the right upper extremity. An electromyography (EMG) dated October 2, 2000 revealed significant right median nerve neuropathy at the wrist, significant left ulnar neuropathy at the elbow, bilateral radial nerve neuropathies at the dorsal elbow levels and right brachial plexus neuropathy.

Appellant submitted a report from Dr. David Weiss, an osteopath, dated April 1, 2003, who noted that appellant reached maximum medical improvement on April 1, 2003. Dr. Weiss stated that physical examination of the right wrist revealed a well-healed mid palmar surgical scar and a positive Phalen's sign. Examination of the left wrist revealed positive Tinel's and Phalen's signs. Dr. Weiss further noted grip strength testing on the right *via* Jamar hand dynamometer at Level III revealed 32 kilograms (kg) of force strength versus 24 kg of force strength on the left. He diagnosed cumulative and repetitive trauma disorder with bilateral carpal tunnel syndrome, status post right carpal tunnel release, chronic de Quervain's tenosynovitis to the left wrist, flexor tenosynovitis to the left hand, left ulnar nerve neuropathy at the cubital tunnel, status post decompression and lysis of the ulnar nerve of the left wrist, status post lysis of the ulnar artery and flexor tenosynovectomy to the right hand. Based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,¹ (A.M.A., *Guides*) appellant had 20 percent impairment on the left for grip strength deficit² and 3 percent for pain-related impairment.³ With regard to the right arm, appellant had 20 percent impairment for grip strength deficit⁴ and 3 percent for pain-related impairment.⁵

On June 20, 2003 appellant filed a claim for a schedule award.

On February 24, 2004 the Office referred appellant for a second opinion to Dr. Robert A. Smith, a Board-certified orthopedic surgeon, for an evaluation of the extent of permanent

¹ A.M.A., *Guides* (5th ed. 2001).

² Table 16-34, page 509 (A.M.A., *Guides*).

³ Figure 18-1, page 574 (A.M.A., *Guides*).

⁴ Table 16-34, page 509 (A.M.A., *Guides*).

⁵ Figure 18-1, page 574 (A.M.A., *Guides*).

impairment in accordance with the A.M.A., *Guides*. In a report dated April 16, 2004, Dr. Smith noted no deformity or atrophy of either the forearms or the hands, normal motor examination of the bilateral hands, positive Tinel's and Phalen's signs and grip strength was reduced based on lack of effort. He diagnosed bilateral carpal tunnel syndrome which was caused by appellant's diabetes and not his work activities. Dr. Smith advised that appellant had five percent permanent impairment to each arm based on page 495 of the A.M.A., *Guides*.

Appellant submitted reports from Dr. Fried dated April 12 and October 4, 2004, who diagnosed flexor tenosynovitis of the right hand, median neuropathy on the right side, ulnar neuropathy of the left elbow, bilateral de Quervain's tenosynovitis and proximal radiculitis.

In a report dated December 16, 2004, an Office medical adviser opined that appellant had five percent impairment of the right arm and no impairment of the left arm. He opined that with regard to the left arm appellant did not undergo surgery and therefore page 495 of the A.M.A., *Guides* would not apply. The Office medical adviser indicated that there is no award for grip strength deficit in a compression neuropathy under the A.M.A., *Guides*. He noted that appellant reached maximum medical improvement on April 16, 2004.

In a decision dated December 23, 2004, the Office granted appellant a schedule award for five percent permanent impairment of the right arm. The period of the award was from April 10 to July 28, 2004.

Appellant requested an oral hearing before an Office hearing representative which was held on December 16, 2005. In an October 12, 2005 report, Dr. Fried advised that appellant experienced intermittent numbness and soreness in his hands and diagnosed flexor tenosynovitis of the right hand and median neuropathy on the right side.

In a decision dated February 6, 2006, the hearing representative vacated the December 23, 2004 decision and remanded the case for further development. The hearing representative found that a conflict of medical opinion arose between Dr. Weiss, appellant's treating physician, and Dr. Smith, the Office referral physician, regarding the degree of permanent partial impairment of the upper extremities due to his work-related injury.

On March 13, 2006 the Office referred appellant to Dr. Barry A. Silver, a Board-certified orthopedic surgeon, selected as the impartial referee, who indicated, in a report dated March 31, 2006, that he reviewed the records provided to him and performed a physical examination of appellant. Dr. Silver noted a history of appellant's work-related injury and advised that he had reached maximum medical improvement on March 16, 2006. He noted findings upon physical examination on the right of normal range of motion, dorsiflexion of 50 degrees, volar flexion of 50 degrees, normal supination, negative Tinel's test and normal sensation. Examination of the left side revealed normal range of motion of the elbow, wrist and finger function, normal motor and grip strength and decreased sensation in the distal volar thumb, index and middle finger. Dr. Silver opined that appellant's condition was related to his employment and diabetes. With regard to the right arm, he opined that appellant sustained five percent impairment of the right arm, noting in accordance with the A.M.A., *Guides*, page 495, scenario two provides that normal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles infers a residual carpal tunnel syndrome was present and an impairment rating not to exceed five percent may be

justified. Dr. Silver opined that, with respect to the left arm, appellant had an unoperated carpal tunnel and the A.M.A., *Guides* recommend the use of sensory and motor deficits in evaluating impairment. He noted findings upon physical examination of sensory loss on the radial and ulnar part of the left thumb, index finger, middle finger and ring finger and opined that the full percentage of impairment would be 39 percent of the arm. However, Dr. Silver noted that appellant did not have full sensory loss and he would therefore award a 20 percent loss of function of the left arm due to sensory deficit.

In a report dated April 13, 2006, the Office medical adviser concurred in Dr. Silver's determination that appellant had 5 percent permanent impairment of the right arm and 20 percent impairment of the left arm.

In a decision dated April 26, 2006, the Office granted appellant a schedule award for 20 percent permanent impairment of the left upper extremity. The period of the award was from March 31, 2006 to June 10, 2007.

On September 28, 2006 appellant requested reconsideration. Appellant submitted a September 8, 2006 report from Dr. Weiss, who indicated that Figure 18-1 of the A.M.A., *Guides* provides that, if pain-related impairment appears to increase the burden of a condition slightly, the examiner can increase the percentage by three percent. Dr. Weiss noted that at the time of the examination appellant's pain level was graded at 5/10 in the right wrist and hand and 7/10 for the left wrist and hand and appellant had difficulties with activities of daily living. Therefore, appellant would be entitled to an additional three percent for pain-related impairment. Also submitted was a September 14, 2006 report from Dr. Fried who noted appellant's complaints of pain in the left plexus and shoulder in the left ulnar nerve distribution.

In a decision dated December 22, 2006, the Office denied modification of the prior decisions, finding that there was no additional permanent impairment to either arm.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act⁶ and its implementing regulations⁷ 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.⁸

⁶ 5 U.S.C. § 8107.

⁷ 20 C.F.R. § 10.404 (1999).

⁸ *See id.*; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

ANALYSIS

On appeal, appellant contends that he has greater than 5 percent permanent impairment of the right arm and 20 percent impairment of the left arm. The Office accepted appellant's claim for bilateral carpal tunnel syndrome and right hand tenosynovitis and authorized a right carpal tunnel release which was performed on February 5, 2002. The Office found that a conflict in the medical evidence arose between Dr. Weiss, appellant's attending physician, who disagreed with Dr. Smith, an Office referral physician, concerning impairment to his right and left arms. The Office referred appellant to Dr. Silver to resolve the conflict.

Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.⁹

The Board finds that the opinion of Dr. Silver is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight. Dr. Silver found that appellant sustained no more than a five percent impairment of the right upper extremity.

Dr. Silver reviewed appellant's history, reported findings and diagnosed carpal tunnel syndrome. He noted on physical examination of the right arm, a normal range of motion, dorsiflexion of 50 degrees, volar flexion of 50 degrees, normal supination, negative Tinel's test and normal sensation. Dr. Silver opined that appellant sustained a five percent impairment of the right upper extremity based on the A.M.A., *Guides*, page 495, scenario two. It provides that normal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles infers a residual carpal tunnel syndrome was present and an impairment rating not to exceed five percent. In an April 13, 2006 report, an Office medical adviser indicated that Dr. Silver's determination of five percent impairment of the right arm was consistent with the A.M.A., *Guides*.

The Board finds that Dr. Silver properly determined that there was no basis under the A.M.A., *Guides* for an award greater than the five percent impairment previously granted. This evaluation conforms to the A.M.A., *Guides* and establishes that appellant has no more than a five percent impairment of the right upper extremity.

However, the Board finds that Dr. Silver did not fully explain his rating of appellant's left upper extremity impairment in his March 31, 2006 report. Dr. Silver determined that appellant had 20 percent impairment due to sensory deficit or pain of the radial and ulnar part of the left thumb, index finger, middle finger and a portion of the ring finger. He advised that the full percentage of the upper extremity impairment would be 39 percent of the arm "based on this table," but noted that appellant's findings were incomplete, without full sensory loss, and would be awarded 20 percent loss of function of the left upper extremity due to sensory deficit. The Office medical adviser agreed. He copied the text of Dr. Silver's March 31, 2006 report into his report and noted, "I have reviewed the information presented and I agree with this impairment rating exam[ination]." Although Dr. Silver found sensory deficit impairments of "radial and ulnar part of the left thumb, index finger, middle finger and a portion of the right finger" he did

⁹ *Aubrey Belnavis*, 37 ECAB 206 (1985). See 5 U.S.C. § 8123(a).

not identify a grade of sensory deficit between 1 and 5 as set forth in the A.M.A., *Guides*¹⁰ and did not explain how he derived at the impairment values using Table 16-15 on pages 492 of the A.M.A., *Guides*.¹¹ He did not adequately explain how his assessment of permanent impairment for the left arm was derived in accordance with the A.M.A., *Guides*. Dr. Silver's opinion does not resolve the medical conflict with regard to the left arm.

The record, therefore, contains insufficient clinical information to determine the extent of appellant's permanent impairment with regard to the left arm. The Office should obtain clarification from Dr. Silver this rating.¹² The Board will set aside the Office's April 26 and December 22, 2006 decisions and remand the case for proper development of the medical evidence. After such further development as may be required, the Office shall issue an appropriate final decision on appellant's left upper extremity impairment.

CONCLUSION

The Board finds that this case is not in posture for decision regarding appellant's entitlement to a schedule award for the left upper extremity.¹³ Appellant has no greater than five percent impairment of his right upper extremity.

¹⁰ Table 16-10a, page 482, (A.M.A., *Guides*).

¹¹ Table 16-15, page 492, (A.M.A., *Guides*).

¹² See *Richard R. LeMay*, 56 ECAB 341(2005) (where the Board found that if a referee physician's opinion required clarification, the Office should request a supplemental opinion); see also *Harry T. Mosier*, 49 ECAB 688, 693 (1998).

¹³ The Board notes that appellant submitted a report from Dr. Weiss dated September 8, 2006 who indicated that appellant would be entitled to an additional 3 percent for pain-related impairment pursuant to 18-1 of the A.M.A., *Guides*. The Board has noted that physicians should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*. *Linda Beale*, 57 ECAB ____ (Docket No. 05-1536, issued February 15, 2006). Dr. Weiss did not explain why appellant's condition was not adequately rated in other chapters of the A.M.A., *Guides*; see *Frantz Ghassan*, 57 ECAB ____ (Docket No. 05-1947, issued February 2, 2006).

ORDER

IT IS HEREBY ORDERED THAT the December 22 and April 26, 2006 decisions of the Office of Workers' Compensation Programs be affirmed with respect to the schedule award for the right upper extremity and set aside with respect to the left upper extremity and the case remanded for further action consistent with this opinion.

Issued: March 14, 2008
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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