United States Department of Labor
Employees' Compensation Appeals Board

C.F., Appellant	)	
and	)	**Docket No. 08-1176**
	)	**Issued: November 26, 2008**
U.S. POSTAL SERVICE, TRENTON PROCESSING & DISTRIBUTION CENTER, Monroe, NJ, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 12, 2008 appellant, through counsel, filed a timely appeal of the Office of Workers' Compensation Programs' merit decisions dated February 23 and October 3, 2007, finding that he had no more than a 30 percent impairment of the left upper extremity and a 20 percent impairment of the right 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 more than a 30 percent impairment of the left upper extremity and more than a 20 percent impairment of the right upper extremity, for which he received schedule awards.

FACTUAL HISTORY

On May 19, 2004 appellant, then a 50-year-old clerk, filed a claim for an occupational disease. He alleged that on March 28, 2003 he first became aware of his bilateral carpal tunnel syndrome and bilateral shoulder tendinitis, and first realized that his conditions were caused by

his federal employment. By letter dated July 1, 2004, the Office accepted the claim for bilateral carpal tunnel syndrome and shoulder tendinitis.

On July 29, 2005 appellant filed a claim for a schedule award. He submitted a February 10, 2005 medical report of Dr. Nicholas P. Diamond, a Board-certified pain management specialist, who stated that appellant sustained bilateral carpal tunnel syndrome, left C5-6 radiculopathy, rotator cuff tendinitis, subacromial bursitis and bilateral wrist tenosynovitis. Dr. Diamond opined that appellant sustained a 43 percent impairment of the left upper extremity and a 34 percent impairment of the right upper extremity based on the A.M.A., *Guides*. He concluded that appellant reached maximum medical improvement on February 10, 2005.

On August 18, 2005 Dr. Henry Megliato, an Office medical adviser, reviewed appellant's case record. He opined that appellant sustained a 30 percent impairment of the left upper extremity and a 13 percent impairment of the right upper extremity.

By letter dated October 18, 2005, the Office referred appellant, together with a statement of accepted facts, the case record and a list of questions to be addressed, to Dr. Dean L. Carlson, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict in the medical opinion evidence.[1] In an October 25, 2005 report, Dr. Carlson opined that appellant sustained a 30 percent impairment of the left upper extremity and an 18 percent impairment of the right upper extremity based on the A.M.A., *Guides*.

On November 13, 2005 an Office medical adviser reviewed appellant's case record. The medical adviser agreed with Dr. Carlson's finding that appellant sustained a 30 percent impairment of the left upper extremity and an 18 percent impairment of the right upper extremity. The medical adviser stated that appellant reached maximum medical improvement on October 25, 2005.

By decision dated November 16, 2005, the Office granted appellant a schedule award for a 30 percent impairment of the left upper extremity and an 18 percent impairment of the right upper extremity. In a November 21, 2005 letter, appellant, through counsel, requested an oral hearing before an Office hearing representative.

Following the March 29, 2006 hearing, appellant's attorney, contended in an April 20, 2006 letter, that Dr. Carlson was not selected from the PDS and, thus, his report was not sufficient to carry the weight of the medical opinion evidence as an impartial medical specialist in determining appellant's permanent impairment.

By decision dated June 13, 2006, an Office hearing representative set aside the November 16, 2005 decision and remanded the case to the Office. She could not determine whether the Office followed its procedures in selecting Dr. Carlson as an impartial medical specialist from the PDS. The hearing representative stated that, if the Office was unable to present records demonstrating that his selection was proper, then it must select a new impartial

[1] The Office stated that Dr. Daniel A. Shaw, a Board-certified orthopedic surgeon, who was originally selected from the PDS to conduct appellant's impartial medical examination, was unable to do so because sufficient notice of the examination was not provided.

medical specialist in accordance with its procedures. She instructed the Office to issue a *de novo* decision after further development of the case record.

On October 26, 2006 the Office determined that Dr. Carlson was not properly selected as an impartial medical specialist. By letter dated November 17, 2006, it referred appellant to Dr. Robert Dennis, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a December 1, 2006 report, Dr. Dennis reviewed a history of appellant's accepted employment-related injuries, medical treatment, and social and employment background. On physical examination, he reported some minimal loss of motion in the planes of flexion and abduction of both shoulders. Dr. Dennis found no evidence of biceps or triceps dysfunction or any other abnormalities. There was almost perfect symmetry. Dr. Dennis reported complete symmetry between appellant's right and left wrists. He found some minimal loss of flexion and extension of both wrists. Dr. Dennis stated that appellant's left upper extremity, which was the dominant upper extremity, had greater sensory deficit throughout multiple fingers just beyond the medial nerve, than the right upper extremity. He reported no difference in grip strength. There was a slight deficit that was equal in both upper extremities regarding pinch strength. Dr. Dennis found no deficits in either extremity regarding the deltoid, biceps and triceps muscles. He stated that an unbundling of appellant's impairment did not allow for a separate determination for carpal tunnel syndrome based on page 494 of the A.M.A., *Guides*. Dr. Dennis determined that he sustained an additional one percent impairment for pain in deference to the intermittent discomforts he described. He diagnosed appellant as having mild and spontaneous bilateral carpal tunnel syndrome that had improved from a prior examination, bilateral shoulder impingement and tendinitis with minimal current residual and degenerative changes of the left elbow that had resolved and were no longer producing any findings or symptoms. Dr. Dennis stated that his tenosynovitis of the wrists had also resolved for the most part.

Dr. Dennis opined that appellant sustained a 30 percent impairment of the left upper extremity. His range of motion measurements for the left shoulder indicated 165 degrees of flexion which constituted a one percent impairment (A.M.A., *Guides* 476, Figure 16-40) and 150 degrees of abduction which constituted a one percent impairment (A.M.A., *Guides* 477, Figure 16-43), resulting in a two percent impairment. Regarding the left wrist, Dr. Dennis reported 55 degrees of flexion and 55 degrees of extension which each constituted a one percent impairment (A.M.A., *Guides* 467, Figure 16-28), resulting in a three percent impairment. He stated that a measurement for grip strength was not applicable as the median nerve was not involved. Dr. Dennis determined that 6.5 kilograms of lateral pinch strength represented a 10 percent impairment (A.M.A., *Guides* 509, Figure 16-34). He combined the impairment ratings for loss of range of motion and pinch strength to calculate a 14 percent impairment. Dr. Dennis determined that appellant sustained a 16 percent impairment for sensory deficit, greater on the left than on the right (A.M.A., *Guides* 482, Figure 16-10a). He combined this impairment rating with the 14 percent impairment rating for loss of motion and pinch strength to calculate a 28 percent impairment of the left upper extremity (A.M.A., *Guides* 604, Combined Values Chart). Dr. Dennis stated that appellant sustained an additional 2 percent impairment for pain which he added to the 28 percent impairment rating, resulting in a 30 percent impairment of the left upper extremity.

Regarding the right shoulder, Dr. Dennis reported 165 degrees of flexion which constituted a one percent impairment (A.M.A., *Guides* 476, Figure 16-40) and 150 degrees of abduction which constituted a one percent impairment (A.M.A., *Guides* 477, Figure 16-43), resulting in a two percent impairment. Regarding the right wrist, he determined that 55 degrees of flexion and 55 degrees of extension each constituted a one percent impairment (A.M.A., *Guides* 467, Figure 16-28), resulting in a three percent impairment. Dr. Dennis reiterated that an impairment rating for grip strength was not applicable. He determined that 6.0 kilograms of lateral pinch strength constituted a 10 percent impairment (A.M.A., *Guides* 509, Figure 16-34). Dr. Dennis combined his impairment ratings for loss of range of motion and pinch strength to calculate a 14 percent impairment. He determined that appellant sustained a five percent impairment for sensory deficit (A.M.A., *Guides* 482, Figure 16-10a). Dr. Dennis combined this impairment rating with the 14 percent impairment rating noted above to calculate an 18 percent impairment. He determined that appellant sustained an additional 2 percent impairment for pain which he added to the 18 percent impairment rating, resulting in a 20 percent impairment of the right upper extremity. Dr. Dennis concluded that appellant reached maximum medical improvement on October 25, 2005.

In a January 10, 2007 report, Dr. Morley Slutsky, an Office medical adviser, reviewed Dr. Dennis' December 1, 2006 report. He agreed with Dr. Dennis that appellant reached maximum medical improvement on October 25, 2005. Dr. Slutsky, however, disagreed with Dr. Dennis' finding that appellant sustained a 30 percent impairment of the left upper extremity and a 20 percent impairment of the right upper extremity. He opined that appellant sustained an 18 percent impairment of the right upper extremity and a 19 percent impairment of the left upper extremity.

Dr. Slutsky stated that appellant had a Grade 4 sensory impairment of both wrists due to his very mild residual symptoms of bilateral carpal tunnel syndrome. He determined that, since appellant did not meet the full criteria of a Grade 4 impairment, he sustained a 13 percent deficit of the right wrist and a 15 percent deficit of the left wrist (A.M.A., *Guides* 482, Table 16-10). Dr. Slutsky noted that Dr. Dennis assigned significantly more impairment for carpal tunnel syndrome of the left wrist although his examination findings did not justify such a difference between the wrists. He determined that the maximum sensory deficit for median nerve below the mid-forearm was 39 percent for each wrist (A.M.A., *Guides* 492, Table 16-15). Dr. Slutsky multiplied the 39 percent impairment rating with the 13 percent sensory deficit to calculate a 5 percent impairment for sensory median nerve impairment of the right wrist. He multiplied the 39 percent impairment by the 15 percent sensory deficit of the left wrist to calculate a 5.85 or 6 percent impairment. Regarding the left upper extremity, Dr. Slutsky subtracted 6.5 kilograms of measured pinch strength from 7.5 kilograms, the normal pinch strength, multiplied by 100 and divided by 7.5 kilograms to calculate a 13.3 percent impairment which represented a 10 percent impairment (A.M.A., *Guides* 509, Table 16-34). Regarding the right upper extremity, he subtracted 6.0 kilograms of measured pinch strength 7.1 kilograms, the normal grip strength, multiplied by 100 and divided by 7.1 kilograms to calculate a 15.49 percent impairment which represented a 10 percent impairment (A.M.A., *Guides* 509, Table 16-34).

Dr. Slutsky did not agree with Dr. Dennis' finding that an additional one percent impairment for appellant's intermittent discomforts was warranted. He stated that, since such discomforts were not permanent impairments which affected the activities of daily living, they

were not ratable impairments based on the A.M.A., *Guides*. Dr. Slutsky further stated that pain was already addressed when appellant was rated for median nerve sensory impairment according to the A.M.A., *Guides*. He stated that his impairment rating was consistent with Chapter 3.0800 of the Office's procedures which provided that pain may not be rated while using methods which measure impairment due to sensory pain as in the case of median nerve sensory impairments.

Regarding the right wrist, Dr. Slutsky determined that 55 degrees of flexion and 55 degrees of extension each constituted a one percent impairment, resulting in a two percent impairment (A.M.A., *Guides* 467, Figure 16-28). He determined that 165 degrees of flexion and 150 degrees of abduction of the right shoulder each constituted a one percent impairment, resulting in a two percent impairment (A.M.A., *Guides* 476, Figure 16-40). Dr. Slutsky combined the range of motion impairment ratings for the wrist and shoulder to calculate a four percent impairment. He combined the 4 percent impairment with the 5 percent impairment for sensory deficit of the median nerve and 10 percent impairment due to loss of pinch strength to calculate an 18 percent impairment of the right upper extremity.

Regarding the left wrist, Dr. Slutsky determined that 165 degrees[2] of flexion and 55 degrees of extension each constituted a one percent impairment, resulting in a two percent impairment (A.M.A., *Guides* 467, Figure 16-28). He further determined that 165 degrees of flexion and 150 degrees abduction of the left shoulder each constituted a one percent impairment, resulting in a two percent impairment. Dr. Slutsky combined the impairment ratings for the wrist and shoulder to calculate a four percent impairment. He combined the 4 percent impairment for loss of range of motion with the 6 percent impairment for sensory deficit of the median nerve and 10 percent impairment due to loss of pinch strength to calculate a 19 percent impairment of the left upper extremity.

By decision dated February 23, 2007, the Office granted appellant a schedule award for a 30 percent impairment of the left upper extremity and 20 percent impairment of the right upper extremity. In a letter dated March 6, 2007, appellant, through counsel, requested an oral hearing before an Office hearing representative.

By decision dated October 3, 2007, an Office hearing representative affirmed the February 23, 2007 decision, finding that appellant was not entitled to an additional schedule award for his left and right upper extremities. She accorded special weight to Dr. Dennis's medical opinion as an impartial medical specialist. The hearing representative also found that his opinion was supported by Dr. Slutsky's findings.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulation[4] set forth the number of weeks of compensation to be paid for

[2] The Board notes that Dr. Dennis reported 55 degrees of flexion and not 165 degrees as stated by Dr. Slutsky.

[3] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[4] 20 C.F.R. § 10.404.

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 of loss of use.[5] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[6]

The fifth edition of the A.M.A., *Guides*, regarding carpal tunnel syndrome, provides:

> "If, after optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias and/or difficulties in performing certain activities, three possible scenarios can be present --
>
> > 1. Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual [carpal tunnel syndrome] is rated according to the sensory and/or motor deficits as described earlier.
> >
> > 2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal [electromyogram] testing of the thenar muscles: a residual [carpal tunnel syndrome] is still present and an impairment rating not to exceed five 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."[7]

The Board has found that, in accordance with the fifth edition of the A.M.A., *Guides*, impairment arising from carpal tunnel syndrome should be rated on motor and sensory deficits only.[8] The A.M.A., *Guides* provides that, in compression neuropathies, additional impairment values are not given for decreased motion strength in the absence of a complex regional pain syndrome.[9] Carpal tunnel syndrome is an entrapment/compression neuropathy of the median nerve.[10]

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[5] 5 U.S.C. § 8107(c)(19).

[6] 20 C.F.R. § 10.404.

[7] A.M.A., *Guides* 495; *Silvester DeLuca*, 53 ECAB 500 (2002).

[8] *Id.* at 494; *Robert V. Disalvatore*, 54 ECAB 351 (2003).

[9] *Id.* at 494; *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); *Kimberly M. Held*, 56 ECAB 670 (2005).

[10] *Id.* at 492.

Section 8123 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.[11] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[12]

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 his original report.[13] However, when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[14]

ANALYSIS

The Office granted appellant a schedule award for 20 percent impairment of the right upper extremity and a 30 percent impairment of the left upper extremity due to his employment-related bilateral carpal tunnel syndrome and shoulder tendinitis. On appeal, appellant contends that he is entitled to greater than the schedule award he previously received. The Board, however, finds that the case is not in posture for decision.

The Board finds that a conflict in the medical opinion existed between Dr. Diamond, an attending physician, and Dr. Megliato, an Office medical adviser, as to the extent of permanent impairment of appellant's right and left upper extremities. Dr. Diamond opined that appellant sustained a 43 percent impairment of the left upper extremity and a 34 percent impairment of the right upper extremity based on the A.M.A., *Guides*. Dr. Megliato opined that appellant sustained a 30 percent impairment of the left upper extremity and a 13 percent impairment of the right upper extremity based on the A.M.A., *Guides*.

The Office referred appellant to Dr. Dennis, selected as the impartial medical specialist, but the Board finds that Dr. Dennis provided inadequate rationale for his impairment ratings.

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[11] 5 U.S.C. § 8123.

[12] *James F. Weikel*, 54 ECAB 660 (2003); *Beverly Grimes*, 54 ECAB 543 (2003); *Sharyn D. Bannick*, 54 ECAB 537 (2003); *Daniel F. O Donnell, Jr.*, 54 ECAB 456 (2003); *Phyllis Weinstein (Elliot H. Weinstein)*, 54 ECAB 360 (2003); *Robert V. Disalvatore*, *supra* note 8; *Bernadine P. Taylor*, 54 ECAB 336 (2003); *Karen L. Yeager*, 54 ECAB 317 (2003); *Barry Neutuch*, 54 ECAB 313 (2003); *David W. Pickett*, 54 ECAB 272 (2002).

[13] *Raymond A. Fondots*, 53 ECAB 637, 641 (2002); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

[14] *Nancy Keenan*, 56 ECAB 687 (2005); *Roger W. Griffith*, 51 ECAB 491 (2000); *Talmadge Miller*, 47 ECAB 673 (1996).

The Board has held that a medical opinion lacking in rationale is of diminished probative value.[15] Dr. Dennis incorrectly included separate ratings for range of motion, loss of pinch strength and pain. As noted, the A.M.A., *Guides* indicate that only sensory and motor deficits are to be considered when rating impairment due to carpal tunnel syndrome.[16] Further, in determining that appellant sustained an additional two percent impairment for pain, Dr. Dennis did not reference the A.M.A., *Guides*. Moreover, he did not explain how or why appellant was entitled to an additional impairment for pain when he had already determined his impairment for sensory loss. Therefore, the Board finds that Dr. Dennis' total impairment ratings are insufficient to form the basis for a schedule award.

Similarly, the Board finds that the impairment ratings of Dr. Slutsky, an Office medical adviser, are of diminished probative value because he did not properly apply the A.M.A., *Guides*.

While Dr. Slutsky correctly stated that appellant was not entitled to an additional one percent impairment for his intermittent discomforts as they were not considered ratable impairments based on the A.M.A., *Guides* or additional impairment rating for pain because it was already addressed in the impairment rating for median nerve sensory impairment according to the A.M.A., *Guides*,[17] he calculated impairment ratings based on loss of range of motion and pinch strength which as stated, are not allowed in rating compression neuropathy such as, carpal tunnel syndrome.[18]

For the stated reasons, the case should be remanded to the Office for a proper evaluation of appellant's claim for an additional schedule award in accordance with the above-described standards. The Office should request a supplemental opinion from Dr. Dennis. If he is unwilling or unavailable to render such, the Office should select another impartial medical specialist for an evaluation of appellant and an opinion as to whether appellant has more than a 20 percent impairment of the right upper extremity and a 30 percent impairment of the left upper extremity. After such development it deems necessary, the Office should issue an appropriate decision.[19]

CONCLUSION

The Board finds that the conflict in the medical evidence was not properly resolved and the case requires further development.

[15] *Cecilia M. Corley*, 56 ECAB 662 (2005); *see Tara L. Hein*, 56 ECAB 431 (2005) (medical consultant's failure to explain selection of sensory deficit value on Table 16-10, page 482, basis for remand of case).

[16] *See supra* note 8.

[17] *See e.g.*, A.M.A., *Guides* 571, section 18.3b

[18] *See supra* note 9.

[19] *See* cases cited in *supra* note 15.

ORDER

IT IS HEREBY ORDERED THAT the October 3 and February 23, 2007 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further action consistent with this decision.

Issued: November 26, 2008
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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