

employment.¹ On May 3, 1994 this case was combined with the Office File No. xxxxxx325, which was accepted for right radial styloid tenosynovitis and a right ganglion and cyst of the synovium, tendon and bursae sustained on April 6, 1992. On September 6, 1994 appellant underwent left wrist arthroscopy. On August 12, 2006 she filed a claim for a schedule award.²

In a report dated November 17, 2005, Dr. David Weiss, a Board-certified family practitioner and osteopathic physician, reviewed appellant's medical history and provided findings on physical examination.³ He stated that her right wrist and hand revealed no thenar or hypothenar atrophy. Range of motion was normal. Tinel's, Phalen's, Finkelstein's and carpal compressions tests were positive. There was tenderness in the first dorsal compartment and along the abductor pollicis longus and extensor pollicis brevis muscles. Resistive thumb abduction was graded 3+/5. Resistive 4th and 5th finger flexion was graded at 4/5. Fist presentation was normal to the distal palmar crease. Appellant was able to touch her thumb to the distal palmar crease of the 5th digit. For the left wrist and hand, Tinel's, Phalen's and carpal compression tests were positive but Finkelstein's test was negative. Resistive thumb abduction was graded at 5/5. Resistive 4th and 5th finger flexion was 4/5. There was no thenar or hypothenar atrophy. Range of motion was normal. There was tenderness along the first dorsal compartment and along the abductor pollicis longus and extensor pollicis brevis muscles. Fist presentation was normal and appellant could touch her thumb to the distal palmar crease of the 5th digit. Grip strength testing performed via Jamar Dynamometer at Level III revealed 8 kilograms (kg) of force strength on the right and 10kg on the left. Pinch key testing revealed 5kg in both hands. Semmes-Weinstein Monofilament testing revealed a diminished light touch sensibility over both the median and ulnar nerve distribution of both the right hand and left hand. Subjective findings included daily bilateral wrist pain and stiffness, numbness and tingling and swelling. Dr. Weiss calculated 45 percent combined impairment to the right upper extremity, including 31 percent and 6 percent, respectively, for Grade 2 sensory deficit of the median nerve and ulnar nerve, based on Table 16-10 at page 482 and Table 16-15 at page 492 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) and 10 percent for lateral pinch deficit, based on Table 16-33 and Table 16-34 at page 509 (Per Table 16-33: 6kg for the dominant hand in a normal female performing manual work, minus appellant's 5 kg for her right hand, divided by 6kg, equates to 16.6 percent strength loss index. Per Table 16-34: a strength loss index between 10 and 30 constitutes 10 percent upper extremity impairment). Dr Weiss calculated 35 percent impairment

¹ The condition of de Quervain's disease, also called de Quervain's syndrome, is a tenosynovitis (inflammation of a tendon sheath) due to relative narrowness of the common tendon sheath of the abductor pollicis longus and extensor pollicis brevis muscles of the thumb. See DORLAND'S, *Illustrated Medical Dictionary* (30th ed. 2003) 531, 1865.

² The Board notes that the accepted conditions in this case are unclear. The Office's May 3, 1994 acceptance letter and the July 3, 2008 decision state that bilateral de Quervain's disease and bilateral ganglion cysts are the accepted conditions. However, in a statement of accepted facts dated July 10, 2007, a July 10, 2007 memorandum from a claims examiner to Dr. Arnold T. Berman and Dr. Berman's July 20, 2007 impairment rating, the accepted conditions are listed as bilateral synovitis and tenosynovitis, bilateral ganglion cysts and radial styloid tenosynovitis on the right. The latter two conditions are accepted in the combined cases. However, it is unclear why the July 10, 2007 statement of accepted facts includes bilateral synovitis and bilateral tenosynovitis.

³ In February 2008, Dr. Weiss corrected his original November 17, 2005 report because he had misstated that appellant's right upper extremity impairment was 35 percent and left upper extremity was 45 percent.

for the left upper extremity for the same Grade 2 sensory deficit of the median and ulnar nerves as in the right upper extremity. He did not indicate any pinch strength deficit in the left wrist.⁴

On July 20, 2007 Dr. Berman, a Board-certified orthopedic surgeon and an Office medical adviser, reviewed the November 17, 2005 report from Dr. Weiss. He disagreed with Dr. Weiss' determination of Grade 2 sensory deficit, stating that this grade was not consistent with a December 5, 2001 report from a Dr. A. Lee Osterman who found borderline median neuropathy on the right and no neuropathy on the left. Dr. Berman calculated 17 percent combined right upper extremity impairment, including 6 percent for loss of range of motion of the right shoulder, based on the physical findings in Dr. Weiss' report, for 160 degrees of flexion, (1 percent), 110 degrees of abduction (3 percent) and 60 degrees of internal rotation (2 percent), based on Figures 16-40, 16-43 and 16-46 at pages 476, 477 and 479, respectively, of the A.M.A., *Guides*, 10 percent for Grade 4 median nerve sensory deficit, based on Table 16-10 at page 482 and Table 16-15 at page 492 and 2 percent for Grade 4 sensory deficit of the ulnar nerve, based on Table 16-10 and Table 16-15.⁵ Dr. Berman calculated two percent left upper extremity impairment for Grade 4 sensory deficit of the ulnar nerve, based on Tables 16-10 and 16-15.

By decision dated October 4, 2007, the Office granted appellant a schedule award based on 17 percent right upper extremity impairment and 2 percent left upper extremity impairment, for 414.96 days or 59.28 weeks, from November 17, 2005 to January 5, 2007.⁶

On October 9, 2007 appellant requested a hearing that was held on February 27, 2008. By decision dated July 3, 2008, the Office hearing representative affirmed the October 4, 2007 schedule award decision.

LEGAL PRECEDENT

Section 8107 of the Act⁷ authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as

⁴ Dr. Weiss provided an impairment rating for appellant's right shoulder. However, the Office has not accepted a right shoulder condition in this case.

⁵ See Federal (FECA) Procedural Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (October 2005) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

⁶ The Federal Employees' Compensation Act provides for 312 weeks of compensation for 100 percent loss or loss of use of the upper extremity. 5 U.S.C. § 8107(c)(1). Multiplying 312 weeks by 19 percent equals 59.28 weeks of compensation.

⁷ 5 U.S.C. § 8107.

permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.⁸

Section 8123(a) 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 [of Labor] shall appoint a third physician who shall make an examination.”⁹ Where 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 a proper factual and medical background, must be given special weight.

ANALYSIS

The Board finds that this case is not in posture for a decision. Further development of the medical evidence is required due to a conflict in the medical evidence between Dr. Weiss and Dr. Berman.

Dr. Weiss reviewed appellant’s medical history and provided findings on physical examination which included positive Tinel’s, Phalen’s, Finkelstein’s and carpal compressions tests. There was tenderness in the first dorsal compartment and along the abductor pollicis longus and extensor pollicis brevis muscles. Resistive thumb abduction was graded 3+/5. Resisted 4th and 5th finger flexion was graded at 4/5. For the left wrist and hand, Tinel’s, Phalen’s and carpal compression tests were positive but Finkelstein’s test was negative. Resistive thumb abduction was graded at 5/5. Resisted 4th and 5th finger flexion was 4/5. There was tenderness along the first dorsal compartment and along the abductor pollicis longus and extensor pollicis brevis muscles. Pinch key testing revealed 5kg in both hands. Semmes-Weinstein Monofilament testing revealed a diminished light touch sensibility over both the median and ulnar nerve distribution of both the right hand and left hand. Subjective findings included daily bilateral wrist pain, stiffness, numbness, tingling and swelling. Dr. Weiss calculated 45 percent combined impairment to the right upper extremity, including 31 percent and 6 percent, respectively, for Grade 2 sensory deficit of the median nerve and ulnar nerve and 10 percent for lateral pinch deficit. He calculated 35 percent impairment for the left upper extremity for the same Grade 2 sensory deficit of the median and ulnar nerves as in the right upper extremity. Dr. Weiss did not indicate any pinch strength deficit in the left wrist.

Dr. Berman disagreed with Dr. Weiss’ determination of Grade 2 sensory deficit. He calculated 17 percent combined right upper extremity impairment, including 6 percent for loss of range of motion of the right shoulder,¹⁰ 10 percent for Grade 4 sensory deficit of the right median nerve and 2 percent for Grade 4 sensory deficit of the right ulnar nerve. Dr. Berman calculated two percent left upper extremity impairment for Grade 4 sensory deficit of the left ulnar nerve.

⁸ 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

⁹ 5 U.S.C. § 8123(a); *see also* *Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

¹⁰ As noted, a right shoulder condition is not accepted.

The Board finds that there is a conflict in the medical opinion evidence between Dr. Weiss and Dr. Berman regarding appellant's right and left upper extremity impairment. Therefore, the issue of appellant's impairment requires further development. Accordingly, the Office should refer her to an appropriate impartial medical specialist for a thorough physical examination and evaluation of her right and left upper extremity impairment. On remand, the Office should also clarify the conditions that are accepted as causally related to appellant's July 21, 1993 employment injury. After such further development as it deems necessary, the Office should issue an appropriate decision.

CONCLUSION

The Board finds that this case is not in posture for a decision. Further development of the medical evidence is required on the issue of appellant's right and left upper extremity impairment. On remand, the Office should refer her to an appropriate impartial medical specialist to resolve the conflict in the medical evidence. After such further development as it deems necessary, it should issue an appropriate decision on appellant's schedule award claim.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 3, 2008 is set aside and the case is remanded for further development consistent with this decision of the Board.

Issued: July 15, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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