United States Department of Labor
Employees' Compensation Appeals Board

T.B., Appellant	)	
and	)	**Docket No. 09-562**
	)	**Issued: October 27, 2009**
U.S. POSTAL SERVICE, NEW JERSEY INTERNATIONAL & BULK MAIL CENTER, Jersey City, 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:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 23, 2008 appellant filed a timely appeal from schedule award decisions of the Office of Workers' Compensation Programs dated February 1 and August 18, 2008. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determinations in this case.

ISSUE

The issue is whether appellant has more than a five percent impairment of the right upper extremity and more than a five percent impairment of the left upper extremity for which she received schedule awards.

On appeal appellant, through her attorney, contends that she has preexisting cervical radiculitis that should be considered in the impairment rating, that the electromyographic (EMG) studies demonstrate residuals of carpal tunnel syndrome, and that the report of Dr. Evan Kovalsky, a Board-certified orthopedic surgeon, who provided an impartial evaluation, is not entitled to special weight because he did not perform Semmes-Weinstein testing, as required by

the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[1]

FACTUAL HISTORY

On March 27, 1997 appellant, then a 57-year-old maintenance support clerk, submitted a Form CA-2, occupational disease claim, alleging that repetitive work on a keypunch and at a computer caused tendinitis. She was first aware of her condition and its relationship to her employment on March 27, 1997. Appellant did not stop work. A May 21, 1997 medical report with an illegible signature noted a history of cervical disc herniation in 1983. On May 25, 1997 Dr. Clifton Howell, a Board-certified internist, noted complaints of pain in the hands; however, EMG testing on June 5, 1997 was reported as normal. Dr. John Carmody, Board-certified in orthopedic surgery, diagnosed tendinitis on June 24, 1997. On September 15, 1997 the Office accepted that appellant sustained employment-related bilateral tendinitis of the hand and wrists. EMG and nerve conduction (NCS) studies on March 9, 1998 demonstrated bilateral median nerve entrapment across the wrists and no evidence of ulnar neuropathy. On June 24, 1999 bilateral carpal tunnel syndrome was accepted.

In a March 19, 1999 report, Dr. Mark A. Filippone, a Board-certified physiatrist, noted appellant's history of bilateral wrist pain and diagnosed carpal tunnel syndrome and de Quervain's syndrome. A May 26, 1999 EMG demonstrated bilateral carpal tunnel syndrome, mild left Guyon canal syndrome and left C5-6 cervical radiculopathy. On May 4, 2000 Dr. Stephen Hall, Board-certified in plastic surgery, performed left carpal tunnel release. Appellant stopped work that day and was placed on the periodic rolls. Dr. Hall performed carpal tunnel release on the right on September 14, 2000. Dr. Filippone submitted monthly reports advising that appellant was totally disabled.

Appellant retired on June 2, 2006 and submitted a schedule award claim. In an August 30, 2006 report, Dr. David Weiss, an osteopath, noted his review of records from Dr. Filippone, including EMG and NCS reports, the history of injury, appellant's work and past medical history, and her complaints of bilateral wrist and hand pain, numbness and tingling. He opined that in accordance with the fifth edition of the A.M.A., *Guides*, appellant had a left upper extremity impairment of 37 percent and a right upper extremity impairment of 36 percent. In reports dated December 6 and 13, 2006, Dr. Filippone agreed with the impairment rating of Dr. Weiss. On July 6, 2007 he performed EMG and NCS testing and advised that there was abnormal showing of the calculated median sensories over the carpal canals bilaterally and that there was evidence of partial denervation in the muscles innervated by the left C5-6 cervical nerve roots and mild partial denervation in the left abductor pollicis brevis. On April 18, 2007 Dr. Filippone advised that appellant had continued complaints of pain in the right wrist and forearm and tingling in the fingers bilaterally.

In an August 2, 2007 report, Dr. Arnold T. Berman, Board-certified in orthopedic surgery and an Office medical adviser, reviewed the medical record. He advised that maximum medical

[1] A.M.A., *Guides* (5th ed. 2001).

improvement was reached on August 30, 2006 and that Dr. Weiss' report could not be accepted as submitted because it did not conform with the A.M.A., *Guides*. Dr. Berman advised that appellant had 10 percent impairment of each upper extremity.

In an August 21, 2007 report, Dr. Stephen Huish, a Board-certified physiatrist, noted that bilateral hand and wrist examination demonstrated continued but improved weakness of the abductor pollicis brevis and sensory deficits in the median distribution, more profound on the right. In reports dated August 9 and September 13, 2007, Dr. Filippone advised that appellant's symptoms of numbness and tingling in both hands persisted and was unchanged.

The Office found that a conflict in medical opinion had arisen between Dr. Weiss and Dr. Berman, the Office medical adviser, regarding the extent of appellant's upper extremity impairments. It referred her to Dr. Kovalsky, a Board-certified orthopedic surgeon, for another impartial medical evaluation. In a November 9, 2007 report, Dr. Kovalsky reviewed the medical record and noted appellant's complaints of constant hand and wrist pain and numbness and tingling in the fingertips of all five digits, worse on the right. He provided findings on physical examination, advising that there was mild inappropriate illness behavior and inconsistencies during her examination. There was no swelling or discoloration of the finger, hands or wrists. Cervical motion was good. Motion of elbows and shoulders was full and painless. Wrist motion was full although the extremes of flexion and extension caused some discomfort and with both ulnar and radial deviation. Finger interphalangeal joint motion was full with no contractures. Manual motor testing revealed give-out weakness on resisted palmar abduction of the right thumb with no sign of thenor or intrinsic atrophy. Dr. Kovalsky noted that appellant did not give full effort on Jaymar grip testing. Phalen's test was positive, reverse Phalen's negative, Tinel's positive on the right and negative on the left, and Finkelstein's equivocal on the right. There was mild tenderness in the right wrist diffusely and no tenderness on the left. Sensory testing revealed nonanatomical and nondermatomal findings with a stocking glove type of loss of sensation to sharp in the right arm, starting in the mid-forearm and going globally distally involving patterns not involving the carpal or nerve entrapment at the wrist or ulnar and radial nerve loss in the right hand. The left hand also demonstrated a glove type of sensory loss starting at the wrist and going distally. Dr. Kovalsky also noted varied findings on repeated two point discrimination testing. He noted that appellant's hands were well groomed, opining that one would normally expect that, if she had a decrease in global sensation and lack of feeling to the extent that she complained of, there would be some sign of trauma to the fingers or skin from loss of protective sense but that none was present.

Dr. Kovalsky further advised that appellant had a significant amount of subjective symptoms but no significant objective findings, noting that she had no atrophy to indicate any ongoing muscle denervation, no indication of any significant objective abnormalities suggestive of any progressive problems, no indication of clinically significant radiculopathy, no significant evidence of any residual tendinitis and, based on her history, no significant loss of ability to do activities of daily living. He reported that she seemed to have good protected sensation throughout the hands and that, although her subjective symptoms would not correlate to isolated carpal tunnel problems and were nondermatomal, she had a positive Tinel's and Phalen's on the right but no clinical indication to suggest a severe carpal tunnel problem. Dr. Kovalsky advised that there were no objective findings on the left with a negative Tinel's and intact sensory findings and no atrophy. He advised that, based on his findings and utilizing page 495 of the

A.M.A., *Guides*, appellant would fall under Category 2, which yielded bilateral upper extremity impairments of five percent each, based on appellant's EMG findings. Dr. Kovalsky explained that he did not think she was entitled to an impairment rating greater than five percent because additional sensory findings could not be substantiated due to significant invalid efforts on testing and the nondermatomal pattern of her complaints. He advised that maximum medical improvement was reached on January 26, 2006, as provided by Dr. Filippone.

On December 20, 2007 Dr. Henry J. Magliato, an Office medical adviser and Board-certified orthopedic surgeon, reviewed the medical evidence and Dr. Kovalsky's November 9, 2007 report of no objective sensory or motor findings on physical examination with positive EMG findings. He advised that maximum medical improvement was reached on January 26, 2006 and agreed with Dr. Kovalsky's application of the A.M.A., *Guides*. Dr. Magliato stated that, because appellant had EMG changes, he would accept Dr. Kovalsky's conclusion that she had a five percent impairment to each upper extremity.

By decision dated February 1, 2008, appellant was granted schedule awards for five percent impairment of each upper extremity, for a total of 31.2 weeks, to run from January 26 to September 1, 2006.

On February 15, 2008 appellant's attorney requested a hearing that was held on June 19, 2008. At the hearing, appellant testified concerning her work history and stated that she had no preexisting conditions when she began work at the employing establishment in 1976 as a keypunch operator. She disagreed with Dr. Kovalsky's report and described her current physical condition, stating that she could not grasp anything and had a pins and needles sensation. Appellant enumerated the activities of daily living that she could no longer perform and advised that she wore splints at night and sometimes during the day. Appellant's attorney noted that Dr. Kovalsky's opinion was not sufficient to resolve the conflict in medical evidence.

By decision dated August 18, 2008, an Office hearing representative credited the opinion of Dr. Kovalsky and affirmed the February 1, 2008 schedule award decision.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulations,[3] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

A.M.A., *Guides*[4] has been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5]

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[6] Office procedures provide that to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred ("date of maximum medical improvement") describes the impairment in sufficient detail to include, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment, and the percentage of impairment should be computed in accordance with the fifth edition of the A.M.A., *Guides*. The procedures further provide that after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for opinion concerning the nature and percentage of impairment, and the Office medical adviser should provide rationale for the percentage of impairment specified.[7]

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.[8] Regarding carpal tunnel syndrome, the A.M.A., *Guides* provide:

> "If, after an *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 CTS [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 EMG testing of the thenar muscles: a residual CTS is still present, and an impairment rating not to exceed five percent of the upper extremity may be justified.

[4] A.M.A., *Guides*, *supra* note 1.

[5] *See Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[6] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(d) (August 2002).

[8] A.M.A., *Guides*, *supra* note 1 at 433-521.

> 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."[9] (Emphasis in the original.)

Section 16.5d of the A.M.A., *Guides* provide that in compression neuropathies, additional impairment values are not given for decreased grip strength. Carpal tunnel syndrome is an entrapment/compression neuropathy of the median nerve, and the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory deficits only and that in the absence of a complex regional pain syndrome, additional impairment values are not given for decreased motion.[10]

Section 16.8a provides that in a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods, the loss of strength may be rated separately. An example of such situation would be loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. Decreased strength cannot 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.[11]

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 shall appoint a third physician who shall make an examination.[12] When 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 on a proper factual background, must be given special weight.[13]

ANALYSIS

The Office determined that a conflict in the medical evidence had been created between the opinions of Dr. Weiss, an attending osteopath, and Dr. Berman, an Office medical adviser, regarding the extent of appellant's upper extremity impairments. It properly referred appellant to Dr. Kovalsky, Board-certified in orthopedic surgery, for an impartial evaluation.[14] In a comprehensive report dated November 9, 2007, Dr. Kovalsky described the employment injury, his review of the medical record, and appellant's complaints of constant hand and wrist pain and numbness and tingling in the fingertips of all five digits, worse on the right. He also noted varied findings on repeated two-point discrimination testing. Dr. Kovalsky reported that, while

[9] A.M.A., *Guides*, *supra* note 1 at 495.

[10] *Id*. at 494; *Kimberly M. Held*, 56 ECAB 670 (2005).

[11] A.M.A., *Guides*, *supra* note 1 at 508; *see Cerita J. Slusher*, 56 ECAB 532 (2005).

[12] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[13] *Manuel Gill*, 52 ECAB 282 (2001).

[14] *See id.*.

appellant had a significant amount of subjective symptoms, she had no significant objective findings, noting no atrophy to indicate any ongoing muscle denervation, no indication of any significant objective abnormalities suggestive of any progressive problems, no indication of clinically significant radiculopathy, no significant evidence of any residual tendinitis and, based on her history, no significant loss of ability to do activities of daily living. He advised that, based on his findings, appellant would fall under Category 2, as described on page 495 of the A.M.A., *Guides*, for bilateral upper extremity impairments of five percent each, based on appellant's EMG findings. Appellant was not entitled to a greater impairment rating because additional sensory findings could not be substantiated due to significant invalid efforts on testing and the nondermatomal pattern of her complaints. Dr. Kovalsky advised that maximum medical improvement was reached on January 26, 2006, as provided by Dr. Filippone.

Office procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from the attending physician is obtained.[15] On December 20, 2007 Dr. Magliato, an Office medical adviser who is a Board-certified orthopedist, noted his review of the medical evidence and Dr. Kovalsky's November 9, 2007 report of no objective sensory or motor findings on physical examination with positive EMG findings. Dr. Magliato advised that maximum medical improvement was reached on January 26, 2006 and agreed with Dr. Kovalsky's application of the A.M.A., *Guides* and his conclusion that appellant had a five percent impairment of each upper extremity.

The Board finds that Dr. Kovalsky provided a comprehensive, well-rationalized evaluation in which he clearly explained his impairment rating. His report is entitled to the special weight accorded an impartial examiner and constitutes the weight of the medical opinion evidence.[16] Appellant did not establish that she has greater impairment than that awarded.

The Board notes that there is no evidence of record to support appellant's contention that she had preexisting cervical radiculopathy. While the record contains a May 21, 1997 report with an illegible signature that noted a history of cervical disc herniation in 1983, this does not constitute competent medical evidence.[17] Furthermore, an EMG of June 5, 1997 was reported as normal. It was not until May 26, 1999, more than two years after appellant filed her claim, that an EMG demonstrated left C5-6 cervical radiculopathy. Therefore, she did not meet her burden of proof to establish cervical radiculopathy as a preexisting condition.

The Board further finds that, contrary to appellant's contention there is no requirement in the A.M.A., *Guides* that Semmes-Weinstein testing be done. Rather, section 16.5d of the A.M.A., *Guides* provides that Semmes-Weinstein testing may be indicated but is not required.[18]

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[15] *Supra* note 7.

[16] *See Sharyn D. Bannick*, 54 ECAB 537 (2003).

[17] *See K.W.*, 59 ECAB ___ (Docket No. 07-1669, issued December 13, 2007).

[18] A.M.A., *Guides*, *supra* note 1 at 493.

CONCLUSION

The Board finds that appellant did not establish that she has more than a five percent impairment of the right upper extremity and a five percent impairment of the left upper extremity for which she received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated August 18 and February 1, 2008 be affirmed.

Issued: October 27, 2009
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