United States Department of Labor
Employees' Compensation Appeals Board

H.G., Appellant	)	
and	)	**Docket No. 09-631**
	)	**Issued: October 8, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Westville, 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 January 5, 2009 appellant, through her representative, filed a timely appeal from the August 18, 2008 merit decision of an Office of Workers' Compensation Programs hearing representative who affirmed a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant has a 15 percent permanent impairment of her right upper extremity causally related to her August 25, 2005 employment injury.

FACTUAL HISTORY

On August 25, 2005 appellant, then a 53-year-old window/distribution clerk, sustained an injury in the performance of duty when her hand became caught between two all purpose containers. The Office accepted her claim for tenosynovitis of the right hand, crushing injury to the right hand and right-sided cubital tunnel syndrome. On May 22, 2006 she underwent a right carpal tunnel release and a right ulnar nerve neurolysis with subcutaneous transposition.

On April 22, 2007 appellant filed a claim for a schedule award. To resolve a conflict in medical opinion, the Office referred her, together with the medical record and a statement of accepted facts, to Dr. Robert Dennis, a Board-certified orthopedic surgeon, for an impartial medical evaluation.

On October 10, 2007 Dr. Dennis reviewed appellant's history of injury, medical treatment and her current subjective complaints. He described findings on physical examination of her upper extremities. After reviewing the statement of accepted facts and the medical records, he diagnosed: 1. Resolved carpal tunnel, postsurgery and markedly improved right cubital tunnel syndrome (improved with some residual); and 2. Status right ulnar nerve transposition and status post median nerve release for carpal tunnel syndrome.

Dr. Dennis found sensory and motor deficits in the right median and ulnar nerves. He graded the "slight" sensory deficit of the median nerve at 10 percent, for an upper extremity impairment of 3.9 percent. Dr. Dennis graded the sensory deficit of the ulnar nerve at 25 percent, for 1.8 percent impairment. He graded the motor deficits of both nerves at 10 percent, for impairments of one and 4.6 percent respectively. Dr. Dennis added a 3 percent pain-related impairment for a total right upper extremity impairment of 14.3 percent. An Office medical adviser reviewed the calculations and determined, after rounding Dr. Dennis' figures, that appellant had a 15 percent impairment of the right upper extremity.

On February 19, 2008 the Office issued a schedule award for a 15 percent impairment of appellant's right upper extremity. On August 18, 2008 an Office hearing representative affirmed, finding that the weight of the medical evidence rested with Dr. Dennis, the impartial medical specialist.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[1] 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 permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2]

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.[3] When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report. When the

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

[3] 5 U.S.C. § 8123(a).

impartial medical specialist's statement of clarification or elaboration is not forthcoming or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative or lacks rationale, the Office must submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question.[4] Unless this procedure is carried out by the Office, the intent of section 8123(a) will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[5]

ANALYSIS

Dr. Dennis, a Board-certified orthopedic surgeon and impartial medical specialist, examined appellant and found a mild or slight sensory deficit in the median nerve, which, using clinical judgment, he graded at 10 percent under Table 16-10, page 482 of the A.M.A., *Guides*. Following proper procedure, he multiplied this figure by the maximum impairment value of the median nerve below the midforearm or 39 percent, from Table 16-15, page 492.

Dr. Dennis found that the sensory deficit of the ulnar never a little more severe at 25 percent. He properly multiplied this figure by the maximum impairment value of the ulnar nerve above the midforearm or seven percent, also from Table 16-15, page 492.

Following the similar grading scheme and procedure for motor loss at Table 16-11, page 484, Dr. Dennis found a 10 percent deficit in both the median and ulnar nerves, for upper extremity impairments of one and 4.6 percent, respectively.

For a structure with mixed sensory and motor fibers, sensory and motor impairments are combined. When more than one nerve structure is involved, the respective impairments are also combined.[6] Rounding Dr. Dennis' figures to whole numbers and using the Combined Values Chart on page 604 of the A.M.A., *Guides*, the Board finds that appellant has a 12 percent impairment of her right upper extremity due to sensory and motor deficits resulting from peripheral nerve disorders.

Using Chapter 18, Figure 18-1, page 574 of the A.M.A., *Guides*, both Dr. Dennis and the Office medical adviser increased appellant's rating by three percent. It is not clear whether such an increase is warranted. Discussing the difficulties associated with integrating pain-related impairment into an impairment rating system, the A.M.A., *Guides* states:

> "Finally, at a practical level, a chapter of the [A.M.A.,] *Guides* devoted to pain-related impairment should not be redundant of or inconsistent with principles of impairment rating described in other chapters. The [A.M.A.,] *Guides'* impairment ratings currently include allowances for the pain that individuals typically experience when they suffer from various injuries or diseases, as articulated in Chapter 1 of the [A.M.A.,] *Guides*: 'Physicians recognize the local

[4] *See Nathan L. Harrell*, 41 ECAB 402 (1990).

[5] *Harold Travis*, 30 ECAB 1071 (1979).

[6] A.M.A., *Guides* 481.

> and distant pain that commonly accompanies many disorders. Impairment ratings in the [A.M.A.,] *Guides* already have accounted for pain. For example, when a cervical spine disorder produces radiating pain down the arm, the arm pain, which is commonly seen, has been accounted for in the cervical spine impairment rating' (p. 10). Thus, if an examining physician determines that an individual has pain-related impairment, he or she will have the additional task of deciding whether or not that impairment has already been adequately incorporated into the rating the person has received on the basis of other chapters of the [A.M.A.,] *Guides*."[7]

Examiners should not use Chapter 18 to rate pain-related impairment for any condition that can be adequately rated on the basis of the body and organ impairment rating systems give in other chapters of the A.M.A., *Guides*.[8] Adding a pain-related impairment to the ratings Dr. Dennis provided for sensory deficits or pain under Chapter 16, appears duplicative.[9] He graded the sensory deficit or pain in the median nerve as slight. Dr. Dennis graded the sensory deficit or pain in the ulnar nerve as Grade 4, the lowest ratable grade, reflecting minimal pain. The Board will set aside the Office hearing representative's August 18, 2008 decision and remand the case for a reasoned supplemental opinion from the impartial medical specialist addressing whether a Chapter 18 pain-related impairment is appropriate in light of the sensory rating provided under Chapter 16. After such further development as may be necessary, the Office will issue an appropriate final decision on appellant's claim for a schedule award.

On appeal, appellant's representative suggested that the Office did not properly select the impartial medical specialist. The Board finds his objection untimely. Appellant's representative did not raise the objection prior to the date of the scheduled examination.[10]

The representative also objected that Dr. Dennis impermissibly compared physical findings of the right and left upper extremity. The A.M.A., *Guides* allows this when grading motor loss or loss of power. Muscle strength testing is voluntary and remains somewhat subjective. Muscle atrophy can be a more objective sign of motor dysfunction.[11] Dr. Dennis took girth measurements of both arms and forearms. Any comparison of right and left grip and pinch strength or range of motion was inconsequential. In compression neuropathies, additional impairment values are not given for decreased grip strength.[12] In the absence of complex regional pain syndromes, additional impairment values are not given for decreased motion.

[7] *Id*. at 570.

[8] *Id*. at 571.

[9] *See id.* at 570 ("When This Chapter Should Be Used to Evaluate Pain-Related Impairment," discussing several situations wherein the body and organ system impairment rating may not adequately address impairment).

[10] *M.A.*, 59 ECAB ___ (Docket No. 07-1344, issued February 19, 2008) (claimant raised a timely objection to the selection of the impartial medical specialist prior to the scheduled examination and provided sufficient reason to require the Office to demonstrate that it properly followed its selection procedures).

[11] A.M.A., *Guides* 484.

[12] *Id*. at 494.

Dr. Dennis properly assigned no rating for loss of grip or pinch strength and no rating for loss of motion.

Lastly, appellant's representative contended that Dr. Dennis reported no measurements for his sensory deficit rating. But such ratings do not depend solely on millimeters of two-point discrimination. The examining physician must use clinical judgment.[13]

CONCLUSION

The Board finds that this case is not in posture for decision on whether appellant has more than a 15 percent permanent impairment of her right upper extremity causally related to her August 25, 2005 employment injury. Further development of the medical evidence is warranted.

ORDER

IT IS HEREBY ORDERED THAT the August 18, 2008 decision of the Office of Workers' Compensation Programs is set aside and case remanded for further action consistent with this opinion.

Issued: October 8, 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

[13] Sensory deficits or pain associated with peripheral nerve disorders are evaluated according to the following criteria: (1) How does the sensory deficit or pain interfere with the individual's performance of daily activities? (2) To what extent does the sensory deficit or pain follow the defined anatomic pathways of the spinal nerves, brachial plexus or peripheral nerves? (3) To what extent is the description of the sensory deficit or pain consistent with characteristics of peripheral nerve disorders? (4) To what extent does the sensory deficit or pain correspond to other disturbances (motor, trophic, vasomotor, etc.) of the involved nerve structure? *Id*. at 482.