



returned to work on January 6, 1997. Appellant stopped work again on May 28, 1997 and did not return. The Office accepted her claim for bilateral wrist tendinitis, bilateral carpal tunnel syndrome, bilateral lesions of the ulnar nerve and adhesive capsulitis of the bilateral shoulders. It also accepted that appellant sustained a consequential depressive disorder.

Appellant underwent a right carpal tunnel release on June 18, 1997 and a left carpal tunnel release on August 6, 1997. On June 21, 2001 she underwent a subacromial decompression of the right shoulder and on December 19, 2001 she underwent a subacromial decompression of the left shoulder.

On April 21, 2008 appellant filed a claim for a schedule award.<sup>1</sup> In an impairment evaluation dated March 24, 2008, Dr. John W. Ellis, an osteopath who is Board-certified in family practice, discussed her complaints of pain and loss of range of motion of the bilateral shoulders, elbows and wrists worse on the right upper extremity. He diagnosed bilateral impingement syndrome of the shoulders, status post surgery, bilateral radial tunnel syndrome and bilateral carpal and cubital tunnel syndrome status post surgery. Dr. Ellis found diminished two point discrimination in the radial, ulnar and median nerves bilaterally and a positive Tinel's test. Citing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5<sup>th</sup> ed. 2001), he found a 41 percent impairment of the right upper extremity and a 36 percent permanent impairment of the left upper extremity due to loss of range of motion of the wrists, elbows and shoulders.<sup>2</sup> Dr. Ellis found that, according to Tables 16-10 and 16-15 on pages 482 and 492 of the A.M.A., *Guides*, appellant had a bilateral impairment of 12 percent of the median nerve, 3 percent of the ulnar nerve and 1 percent of the radial nerve due to sensory loss. In evaluating appellant's impairment due to motor loss of the affected nerves on the right side, he utilized Tables 16-11 and 16-15 on pages 484 and 492 to find a 6 percent impairment of the median nerve, an 18 percent impairment of the ulnar nerve and a 4 percent impairment of the radial nerve. For the left side, Dr. Ellis determined that appellant had a 3 percent impairment due to motor loss of the median nerve, a 12 percent impairment due to motor loss of the ulnar nerve and a 4 percent impairment due to motor loss of the median nerve. He combined the impairments due to motor loss and pain to find a 37 percent impairment on the right side and a 32 percent impairment on the left side. In determining appellant's total right upper extremity impairment, Dr. Ellis combined the 37 percent impairment due to peripheral nerve roots with the 41 percent impairment due to loss of range of motion to find a 63 percent permanent impairment. For the left upper extremity, he combined the 32 percent impairment due to peripheral nerve roots with the 36 percent impairment due to loss of range of motion to find a 57 percent permanent impairment.

On July 28, 2008 an Office medical adviser reviewed the findings of Dr. Ellis. Citing the A.M.A., *Guides*, he found that appellant had a 12 percent permanent impairment of the right wrist and a 10 percent impairment of the left wrist due to loss of motion<sup>3</sup> and a 5 percent bilateral

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<sup>1</sup> On September 27, 2004 appellant filed a claim for a schedule award.

<sup>2</sup> A.M.A., *Guides* at 469, 472, 476, 477, 479, Figures 16-28, 16-31, 16-34, 16-40, 16-43, 16-46.

<sup>3</sup> *Id.* at 467, 469, Figures 16-28, 16-31.

impairment due to residual carpal tunnel.<sup>4</sup> The Office medical adviser determined that appellant had a 28 percent impairment due to loss of range of motion for the right elbow, a 15 percent impairment due to loss of range of motion of the left elbow, a 26 percent impairment for loss of range of motion of the right shoulder and a 15 percent impairment due to loss of range of motion of the left shoulder.<sup>5</sup> He applied Table 16-10 on page 482 in finding that she had a four percent impairment due to sensory loss of the ulnar nerve bilaterally and a one percent impairment due to sensory loss of the radial nerve bilaterally. The Office medical adviser combined the 28 percent impairment due to loss of elbow motion with the 4 percent impairment due to sensory loss to find a 31 percent right elbow impairment. He then combined the 15 percent impairment due to loss of elbow motion on the left side with the 4 percent impairment due to sensory loss to find an 18 percent left elbow impairment. The medical adviser combined the 16 percent right wrist impairment, the 31 percent right elbow impairment, the 26 percent right shoulder impairment and the 1 percent impairment for loss of sensation of the radial nerve to find a 58 percent right upper extremity impairment. He combined the 15 percent left wrist impairment, the 18 percent left elbow impairment, the 15 percent left shoulder impairment and the 1 percent impairment of the radial nerve to find a 42 percent left upper extremity impairment. The Office medical adviser stated:

“It should be noted that there were some differences in the impairment calculated by myself and Dr. Ellis, most notably with regard to [appellant’s] residual carpal tunnel symptoms. In discussing impairment for residual carpal tunnel symptoms status post carpal tunnel release, the A.M.A., *Guides* do not discuss impairment for [claimants] with residual symptoms that have normal electrodiagnostic studies [EMGs]. It is noted that preoperatively, [appellant] did have normal [EMG] studies and has not had [EMG] studies to document objective evidence of residual carpal tunnel symptoms. As such, the A.M.A., *Guides*, do not provide a clear cut description of impairment for patients who have residual symptoms following carpal tunnel release with abnormal physical findings without positive [EMG] studies, such is the case in this claimant.”

The Office medical adviser found that a five percent impairment bilaterally “for residual symptoms following carpal tunnel release would be appropriate.”

By decision dated August 27, 2008, the Office granted appellant schedule awards for a 58 percent right upper extremity impairment and a 42 percent left upper extremity impairment. The period of the awards ran for 312 weeks from August 31, 2008 to August 23, 2014.

On October 29, 2008 appellant, through her representative, requested reconsideration. In a report dated October 15, 2008, Dr. Ellis concurred with the Office medical adviser’s finding that she had a 27 percent impairment due to loss of right elbow flexion for a total impairment of

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<sup>4</sup> *Id.* at 495.

<sup>5</sup> *Id.* at 472, 476, 477, 479, Figures 16-34, 16-40, 16-43, 16-46.

the right elbow due to loss of range of motion of 29 percent.<sup>6</sup> Dr. Ellis disagreed with the Office medical adviser's finding that appellant did not sustain motor loss of the nerves. He stated:

“[The Office medical adviser] has made some incorrect assumptions. He has not examined [appellant]. [The Office medical adviser] cannot go retroactively back to preoperative EMGs and determine that only sensory loss has occurred. He has ignored the motor loss of the impingement of the nerves in her upper extremities. Ignoring them does not make them go away. Obviously, my examination after the surgeries, with time and the scarring that occurs after the surgeries is going to be more accurate than a physician arbitrarily ignoring motor loss and changing sensory loss. [The Office medical adviser] cannot change sensory loss unless he examines [appellant].”

Dr. Ellis further found that appellant had three percent impairment for radial deviation of the wrist rather than four percent. He stated:

“In the second paragraph on page 4, [the Office medical adviser] states [that appellant] only has [five percent] impairment of having a satisfactory result following carpal tunnel release. Based on my examination of [appellant] and not an arbitrary review of records, it is obvious that she has not had a satisfactory result and does not have normal sensory and motor latencies and, therefore, does not fit into [category] [two] carpal tunnel syndrome, page 495. One would have to get another EMG to put her in that status. You cannot use the EMG before surgery and then the physical findings on my examination to show non satisfactory results. Instead, one would use Table 16-15, Maximum Upper Extremity Impairment due to Unilateral Sensory or Motor Deficits or to Major Peripheral Nerves, page 492. It goes into great detail about how to use the specific nerves, such as the median nerve at the wrist, ulnar nerve at the elbow and radial nerve at the arm.”

On February 14, 2009 the Office medical adviser reviewed Dr. Ellis' October 15, 2008 report. He noted that Dr. Ellis found that appellant had a 29 percent impairment due to loss of motion of the right elbow as well as additional impairment for muscle weakness in both upper extremities resulting from problems with the radial nerve, ulnar nerve and medial nerve. The Office medical adviser concurred with Dr. Ellis' finding of a 29 percent loss of motion for the right elbow and modified her total right upper extremity impairment to 59 percent. He found that appellant had pain and limited range of motion of the shoulders, elbows, hands and wrists. The Office medical adviser determined that under the A.M.A., *Guides* at page 508, decreased strength could not be rated in the presence of decreased motion or painful conditions. He also noted that a December 1, 2007 report from a second opinion examiner found normal muscle

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<sup>6</sup> Dr. Ellis noted that the Office medical adviser combined appellant's right elbow impairments due to loss of range of motion to find a 28 percent impairment rather than adding the impairments to find a 29 percent impairment.

testing and sensation on examination.<sup>7</sup> The Office medical adviser found that Dr. Ellis had not documented muscle weakness. He concluded:

“Based on the above, I do not wish to change any previously expressed opinions, other than to increase the claimant’s right upper extremity impairment to 59 percent, as I would agree with Dr. Ellis that the claimant is entitled to an additional 1 percent impairment for loss of elbow motion.

“If this report does not adequately resolve this matter, then I would recommend the claimant be referred to a physician not previously connected to the case for evaluation of residual problems with both upper extremities and documentation of physical examination.”

By decision dated February 26, 2009, the Office modified its August 27, 2008 decision to find that appellant was entitled to an additional 1 percent right upper extremity impairment, for a total right upper extremity impairment of 59 percent. It found that she had no additional left upper extremity impairment.

### **LEGAL PRECEDENT**

The schedule award provision of the Federal Employees’ Compensation Act<sup>8</sup> and its implementing federal regulations,<sup>9</sup> 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 for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.<sup>10</sup> Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.<sup>11</sup>

Section 8123(a) 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.<sup>12</sup> The implementing regulations state that, if a conflict exists between the medical opinion of the employee’s physician and the medical opinion of either a second opinion physician or an Office medical adviser, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select

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<sup>7</sup> In a report dated December 1, 2007, Dr. Paul F. Howard, a Board-certified internist who provided a second opinion examination on the issue of appellant’s current condition and work restrictions, found no gross weakness or loss of motor strength and normal sensation to light touch.

<sup>8</sup> 5 U.S.C. § 8107.

<sup>9</sup> 20 C.F.R. § 10.404.

<sup>10</sup> *Id.* at § 10.404(a).

<sup>11</sup> Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

<sup>12</sup> 5 U.S.C. § 8123(a).

a physician who is qualified in the appropriate specialty and who has no prior connection with the case.<sup>13</sup>

### ANALYSIS

The Office accepted that appellant sustained bilateral wrist tendinitis, bilateral carpal tunnel syndrome, bilateral lesions of the ulnar nerve and adhesive capsulitis of both shoulders due to factors of her federal employment. Appellant underwent bilateral carpal tunnel releases in 1997 and bilateral subacromial decompressions of the shoulders in 2001. On April 21, 2008 she filed a claim for a schedule award.

In a March 24, 2008 impairment evaluation, Dr. Ellis found that appellant had a 63 percent permanent impairment of the right upper extremity and a 57 percent permanent impairment of the left upper extremity. He calculated her bilateral impairment of the upper extremities by combining impairments due to loss of range of motion of the wrists, elbows and shoulders with impairments due to sensory and motor loss of the median, ulnar and radial nerves.

On July 28, 2008 an Office medical adviser reviewed Dr. Ellis' findings. He opined that appellant had a 58 percent right upper extremity impairment and a 42 percent left upper extremity impairment. The Office medical adviser explained that the primary difference between his impairment determination and the findings of Dr. Ellis was the evaluation of her impairment due to residual carpal tunnel syndrome. He found that appellant was not entitled to sensory or motor loss of the median nerve as she did not have EMG studies postoperatively. The Office medical adviser further found that she was not entitled to an additional award for motor loss.

In a report dated October 15, 2008, Dr. Ellis disagreed with the Office medical adviser's finding that appellant had no impairment due to motor loss. He asserted that, under the A.M.A., *Guides*, abnormal sensory and motor latencies following carpal tunnel releases should be evaluated by using the tables and pages relevant to determining impairments of peripheral nerves.<sup>14</sup>

On February 14, 2009 an Office medical adviser reviewed the October 15, 2008 report of Dr. Ellis. He found that decreased strength could not be rated in the presence of decreased motion. The Office medical adviser cited section 16.8(a) of the A.M.A., *Guides*, which limits grip strength evaluations except in rare cases and states that decreased strength cannot be rated in the presence of decreased motion or other condition that prevents the application of maximal force in the evaluated region.<sup>15</sup> This section, however, would not preclude a motor deficit for an identified peripheral nerve.<sup>16</sup> The Office medical adviser further questioned Dr. Ellis' findings

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<sup>13</sup> 20 C.F.R. § 10.321.

<sup>14</sup> A.M.A., *Guides* at 495.

<sup>15</sup> *Id.* at 508.

<sup>16</sup> *See A.M.*, Docket No. 06-1962 (issued February 2, 2007).

of loss of sensory and motor deficits in view of the discrepancies between his findings on examination and those of other examining physicians.

The Board finds a conflict in medical opinion between Dr. Ellis and the Office medical adviser regarding the extent of appellant's permanent impairment of the bilateral upper extremities. Section 8123(a) of the Act provides that if there is a 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.<sup>17</sup> Accordingly, the case must be remanded for further development. On remand, the Office should refer appellant for an impartial medical examination to determine the extent of her bilateral upper extremity impairment. After such further development as it deems necessary, the Office shall issue a *de novo* decision.

**CONCLUSION**

The Board finds that the case is not in posture for decision.

**ORDER**

**IT IS HEREBY ORDERED THAT** the decisions of the Office of Workers' Compensation Programs dated February 26, 2009 and August 27, 2008 are set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: March 12, 2010  
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

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<sup>17</sup> 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002).