

an increased schedule award beyond 14 percent permanent impairment previously awarded for each arm.² The Board found that an Office medical adviser did not adequately explain how he reached his impairment rating. The Board remanded the case for the Office to request clarification from its medical adviser. In an April 22, 2009 decision, the Board set aside the Office's June 24, 2008 decision, which denied appellant's claim for an increased schedule award.³ The Board found that the Office's medical adviser's supplemental report did not adequately explain why appellant would have bilateral pain impairment rating based on a decreased sensation to the ulnar nerve as opposed to the median nerve. The Board noted that appellant's physician, Dr. James R. Moitoza, a Board-certified orthopedic surgeon, found that appellant's numbness and tingling and dysesthesias and loss of sensation arose from the median nerve distribution. The Board remanded the case to the Office for further medical development. The facts and circumstances of the case as set forth in the Board's prior decisions are incorporated herein by reference.

On remand the Office determined a conflict in medical evidence existed between Dr. Moitoza, appellant's attending physician, and the Office's medical adviser, with regard to whether a neurologic deficit in the upper extremities existed and what kind of neurologic deficit.⁴ The Office referred appellant, together with the case record and a statement of accepted facts, to Dr. Edwin B. Fuller, a Board-certified orthopedic surgeon, for an impartial medical examination.

In an April 2, 2010 report, Dr. Fuller reviewed appellant's history and medical records and reported findings on examination. Diagnoses provided were: bilateral carpal tunnel syndrome with surgical releases of both right and left carpal tunnel; bilateral ulnar neuropathy at the elbow with postoperative status anterior transposition of both left and right ulnar nerve at the elbow; bilateral de Quervain's tenosynovitis with postoperative status release of both right and left first dorsal compartment; no electromyogram (EMG) or nerve conduction evidence of persistent ulnar nerve neuropathy; and electrodiagnostic evidence of improved median nerve pathology at the wrist. Dr. Fuller advised that appellant reached maximum medical improvement on or about December 20, 2006. Under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (hereinafter A.M.A., *Guides*), Dr. Fuller opined that appellant had 7 percent total impairment of the right arm and 11 percent impairment of the left arm. Under Table 15-3, page 395, he found appellant at maximum medical improvement due to de Quervain's tenosynovitis and assigned class 1 or one percent impairment to the right wrist and class 1 or one percent impairment to the left wrist. Under Table 15-21, page 443, Dr. Fuller assigned each elbow class 1 category due to moderate sensory deficit verified on physical examination or 2 percent impairment of the arm. Under Table 15-21,

² Docket No. 08-13 (issued May 22, 2008).

³ Docket No. 08-1995 (issued April 22, 2009).

⁴ In his March 22, 2007 report, Dr. Moitoza opined that appellant's numbness and tingling and dysesthesias and loss of sensation arose from the median nerve distribution with no ulnar nerve symptoms present. In later evaluations, he opined that appellant continued to have a neurologic deficit in either upper extremity. In his June 9, 2008 report, the Office medical adviser disagreed on the extent of appellant's bilateral median nerve sensory impairment. The medical adviser concluded that appellant's chronic problems with bilateral median nerve/median neuropathy and bilateral cubital tunnel/ulnar neuropathy, with no evidence of a neurologic deficit in either arm, would cause her symptoms to wax and wane with time.

page 439, he assigned class 1 impairment class for median nerve below the forearm and assigned four percent impairment of the arms for both the right and left wrists due to moderate sensory deficit of the hands. Under Table 15-32, page 473, Dr. Fuller also assigned four percent impairment due to loss of ulnar deviation in the left wrist.

On June 25, 2010 another Office medical adviser reviewed the file and used Dr. Fuller's April 2, 2010 report to determine the impairment of the right and left upper extremities. She advised date of maximum improvement was April 2, 2010. The medical adviser found the total impairment for the right arm was six percent and for the left arm was six percent. For impairment due to bilateral carpal tunnel syndrome, she found four percent impairment to each arm. Under Table 15-23, page 449, the medical adviser found grade modifier 1 for test findings; grade modifier 3 for history; and grade modifier 2 for physical findings with an average grade modifier of 2. She then used the functional scale value 1, mild, as a modifier. For impairment due to cubital tunnel syndrome, the medical adviser found two percent impairment to each arm. Under Table 15-23, page 449, she indicated grade modifier 1 for test findings, grade modifier 3 for history, grade modifier 2 for physical findings, with an average grade modifier of 2. Using the functional scale value 1, mild, as a modifier, the medical adviser found the upper extremity impairment was four percent. Because the cubital tunnel syndrome was a second entrapment neuropathy, she found the A.M.A., *Guides* only allowed half the value or two percent impairment for each arm. The Office medical adviser advised that Dr. Fuller incorrectly applied Table 15-21 as Table 15-23, the entrapment neuropathy table, should have been applied. She also noted that the A.M.A., *Guides* do not allow for the addition of range of motion deficit and de Quervain's disease.

By decision dated June 28, 2010, the Office denied appellant's claim for an increased schedule award. Determinative weight was accorded to the Office's medical adviser.

LEGAL PRECEDENT

The schedule award provision of the Act and its implementing regulations⁵ 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. The Act, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of the Office.⁶ For consistent results and to ensure equal justice under the law to 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 A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.⁷ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁸

⁵ 20 C.F.R. § 10.404.

⁶ *Linda R. Sherman*, 56 ECAB 127 (2004); *Daniel C. Goings*, 37 ECAB 781 (1986).

⁷ *Ronald R. Kraynak*, 53 ECAB 130 (2001).

⁸ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

For evaluating impairment related to dysfunction of the median nerves, the sixth edition of the A.M.A., *Guides* contains Appendix 15-B (Electrodiagnostic Evaluation of Entrapment Syndromes). It provides that the criteria for carpal tunnel syndrome include distal motor latency longer than 4.5 milliseconds for an 8 centimeter (cm) study; distal peak sensory latency longer than 4.0 cm for a 14 cm distance; and distal peak compound nerve latency of longer than 2.4 milliseconds for a transcarpal or midpalmar study of 8 cm. If different distances were used in testing, correction to the above-stated distances could be accomplished by assuming each 1 cm of distance required 0.2 milliseconds.⁹

If carpal tunnel syndrome is found under the standards of Appendix 15-B, impairment is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.¹⁰ In Table 15-23, grade modifiers are described for test findings, history and physical findings. A survey completed by a given claimant, known by the name *QuickDASH*, is used to further modify the grade and to choose the appropriate numerical impairment rating.¹¹ If carpal tunnel syndrome is not found under the standards of Appendix 15-B, impairment due to median nerve dysfunction is evaluated under the scheme found in Table 15-21 (Peripheral Nerve Impairment: Upper Extremity Impairments).¹² Under Table 15-21, observed conditions are placed into classes (ranging from class 0 to class 4) based on diagnosis and the severity of the condition. After the class is identified, the precise degree of the impairment can be modified by various factors, including functional history, physical examination and clinical studies.¹³

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.¹⁴ 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.¹⁵ 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.¹⁶

⁹ A.M.A., *Guides* 487, Appendix 15-B.

¹⁰ *See id.* at 449, Table 15-23.

¹¹ *Id.* at 448.

¹² *Id.* at 437-40, Table 15-21 (portion relating to median nerves).

¹³ *Id.* at 406-09.

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

¹⁵ *Manuel Gill*, 52 ECAB 282 (2001).

¹⁶ *See Nathan L. Harrell*, 41 ECAB 402 (1990).

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.¹⁷ The Board has held that, to properly resolve a conflict in medical opinion, it is the impartial medical specialist who should provide a reasoned opinion as to a permanent impairment to a scheduled member of the body in accordance with the A.M.A., *Guides*. An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.¹⁸

ANALYSIS

The Office accepted appellant's claim for bilateral carpal tunnel syndrome, bilateral lesion of the ulnar nerve and right radial styloid tendinitis and granted her schedule awards for 14 percent impairment of each arm. After she claimed an increased schedule award, the Office determined that a conflict in the medical evidence was created between Dr. Moitoza, an attending Board-certified orthopedic surgeon, and an Office medical adviser regarding the nature and degree of appellant's impairment. It properly referred appellant to Dr. Fuller, Board-certified in orthopedic surgery, for an impartial evaluation.

On April 2, 2010 Dr. Fuller examined appellant and found that she reached maximum medical improvement on or about December 20, 2006. Under the sixth edition of the A.M.A., *Guides*, he opined that appellant had 7 percent impairment of the right arm and 11 percent impairment of the left arm. This was based on a diagnosis-based impairment rating using the wrist regional grid, Table 15-3 page 395, wrist range of motion Table 15-32, page 473, and Table 15-21, Peripheral Nerve Impairment: Upper Extremity Impairments, pages 439 and 443. The Office medical adviser reviewed Dr. Fuller's examination findings and applied them to the A.M.A., *Guides* and opined that appellant had six percent impairment of each arm. This was based on Table 15-23, Entrapment/Compression Neuropathy Impairment, for impairment due to bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. Appellant disagreed with certain of Dr. Fuller's findings. The Office found that the weight of the medical evidence rested with the Office medical adviser. This was error. As noted, to properly resolve a conflict in medical opinion, it is the impartial medical specialist who should provide a reasoned opinion as to a permanent impairment to a scheduled member of the body in accordance with the A.M.A., *Guides*. An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.¹⁹ If there were errors perceived by the medical adviser in Dr. Fuller's report, the Office should have obtained a supplemental report from Dr. Fuller.²⁰

The Board also finds that Dr. Fuller's impairment rating is incomplete. As noted, with respect to evaluating impairment related to dysfunction of the median nerves, Appendix 15-B

¹⁷ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

¹⁸ See *Richard R. LeMay*, 56 ECAB 341 (2005); *Thomas J. Fragale*, 55 ECAB 619 (2004).

¹⁹ See *supra* note 18.

²⁰ See *supra* note 16.

(Electrodiagnostic Evaluation of Entrapment Syndromes) contains criteria for evaluating whether carpal tunnel syndrome is present. If carpal tunnel syndrome is found under the standards of Appendix 15-B, impairment is evaluated under the schedule found in Table 15-23. If carpal tunnel syndrome is not found under the standards of Appendix 15-B, impairment due to median nerve dysfunction is evaluated under the scheme found in Table 15-21. There is no indication that Dr. Fuller considered Appendix 15-B or sufficiently explained why he chose to evaluate appellant's case under the separate criteria of Table 15-21 or Table 15-23, respectively.²¹

As further clarification is required from Dr. Fuller, the Board will set aside the Office's June 28, 2010 decision and remand the case for further development of the medical evidence. The Office shall request a supplemental report from Dr. Fuller resolving whether carpal tunnel or cubital tunnel syndrome is found under the standards of Appendix 15-B so an impairment determination may be evaluated under the correct criteria. The physician shall obtain any further diagnostic testing as he deems appropriate and shall provide a reasoned opinion regarding permanent impairment to appellant's arms under the applicable provisions of the A.M.A., *Guides*. After such development as it deems necessary, the Office shall issue an appropriate merit decision regarding appellant's entitlement to schedule award compensation.

While appellant asserts on appeal that she should be entitled to an increased schedule award, the case is not in posture for decision on this matter as the Board is remanding the case for further medical development.

CONCLUSION

The Board finds that clarification is required from the impartial specialist and the case requires further development.

²¹ The Board notes that section 15.4f page 432-33 advises that, if the impairment is calculated under an entrapment neuropathy, then additional impairment values are not permitted for decreased grip strength, loss of motion or pain.

ORDER

IT IS HEREBY ORDERED THAT the June 28, 2010 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded to the Office for proceedings consistent with this decision of the Board.

Issued: July 11, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board