United States Department of Labor
Employees' Compensation Appeals Board

S.N., Appellant	)	
and	)	**Docket No. 11-1548**
	)	**Issued: March 8, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 17, 2011 appellant filed a timely appeal from the April 8, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) concerning a schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met her burden of proof to establish that she has a permanent impairment of her right or left upper extremity warranting a schedule award.

FACTUAL HISTORY

OWCP accepted appellant's March 16, 2007 occupational disease claim for radial styloid tenosynovitis, bilateral carpal tunnel syndrome (CTS) and de Quervains disease of the right hand

[1] 5 U.S.C. § 8101 *et seq.*

and wrist.[2] On September 14, 2007 appellant underwent right carpal tunnel release, de Quervain's release and ganglion cyst surgery of the right wrist. On February 22, 2008 she underwent left CTS release surgery. On May 15, 2008 appellant was released to full duty with no restrictions by Dr. Anton Fakhouri, a Board-certified orthopedic surgeon.

On September 18, 2008 appellant sustained a recurrence of disability and she was placed on the periodic rolls.

In a May 22, 2009 second opinion report, Dr. R.M. Ubilluz, a Board-certified neurologist, opined that appellant's accepted conditions had resolved and there was no objective evidence of residuals. Periodic reports from her treating physician, Dr. Jacob Salomon, a Board-certified surgeon, continued to reflect that she was disabled as a result of her accepted conditions.

Appellant submitted a May 28, 2009 report from Dr. Axal Varges, a treating physician, which suggested bilateral median nerve neuropathy, as well as complex regional pain syndrome (CRPS) manifested by obvious sympathetic mediated pain components, *i.e.*, allodynia, hyperpathia, hyperalgesia dysesthesia. Dr. Varges stated that appellant would benefit from stellate ganglion nerve blocks, aimed at restoring the functionality of her hands.

On June 5, 2009 Dr. Salomon diagnosed CRPS and opined that appellant was totally incapacitated.

OWCP found a conflict in medical opinion as to whether appellant continued to experience residuals from the accepted injury and referred her to Dr. Charles C. Wang, a Board-certified neurologist, in order to resolve the conflict. In a December 2, 2009 report, Dr. Wang found her intrinsic hand coordination to be compromised bilaterally. Appellant had reduced strength of bilateral abductor pollicis brevis muscles. There was reduced sensation to pinprick in the digits 1, 2 and 3. Dr. Wang detected no abnormal hair growth or hair loss, no abnormal color change and no increased sensitivity to touch. He diagnosed bilateral CTS, status post carpal tunnel release, which was likely related to the accepted work injury. Dr. Wang opined that appellant continued to experience residuals from the accepted injury.

On June 29, 2010 Dr. Salomon released appellant to work with restrictions effective July 12, 2010. On July 1, 2010 appellant filed a claim for a schedule award. In a letter dated July 20, 2010, OWCP requested that she submit additional medical evidence in support of her schedule award claim.

Appellant submitted a September 3, 2010 impairment rating from Dr. Salomon, who provided a history of injury and treatment. Dr. Salomon diagnosed CRPS based on his findings of hand swelling and changes of temperatures and coolness of the fingers, with clinically obvious decrease grip, which measured an average of 18 pounds of pressure on the right sided and 35 pounds of pressure on the left side after three repetitive measurements creating a true bell-shaped curve. Appellant also had some mild thenar muscle loss in both hands. Using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*

[2] On October 14, 2010 appellant filed a traumatic injury claim alleging that she sustained a back injury as a result of lifting tubs of mail at work. The claim was accepted for displacement of lumbar intervertebral disc.

(A.M.A., *Guides*), Dr. Salomon concluded that she met the standard of Table 15-24 under diagnostic criteria for CRPS, based on her reports of continuing pain and at least one symptom of the various categories all of which were confirmed by Dr. Vargas. Referring to Table 15-25, objective diagnostic criteria for CRPS, appellant met multiple objective diagnostic criteria such as skin temperature change, coldness, edema, joint stiffness and decreased passive motion. She also underwent a bone scan which showed increased uptake in numerous joints suggestive of CRPS. Under functional history, appellant met criteria 15-7, adjustment of her extremity describing symptoms consistent with grade modifier 3, such as pain and symptoms with less than normal activity. She required assistance to perform self-care activities such as getting dressed, feeding herself and going to the bathroom. Physical examination such as decreased grip strength and muscle loss equated to grade modifier 3 per Table 15-9. Clinical studies (a positive bone scan) were suggestive of diffuse joint inflammation, a consistent grade modifier 3. Applying his findings to Table 15-26 (CRPS 1), Dr. Salomon concluded that appellant was in class 3, which resulted in a 49 percent upper extremity impairment using the net adjustment formula. He opined that the date of maximum medical improvement was July 12, 2010, the date appellant was removed from limited duty and allowed to return to work with no restrictions.

On October 12, 2010 OWCP routed the medical file to a district medical adviser (DMA) for review and an opinion as to whether appellant had a measurable permanent impairment to her upper extremities. In an October 18, 2010 report, the DMA expressed concern about the discrepancy between Dr. Salomon's September 3, 2010 opinion that appellant had a 49 percent upper extremity impairment based on the diagnosed CRPS and Dr. Fakhouri's May 15, 2008 opinion that her paresthesias had resolved and that she had full strength and motion of both wrists. The DMA recommended that an impartial medical examination be performed to determine whether there was any ongoing evidence of CRPS.

On December 6, 2010 OWCP referred appellant to Dr. Vikram Gandhi, a Board-certified orthopedic surgeon, for a second opinion examination and an opinion as to whether there was any ongoing evidence of CRPS. In a report dated January 11, 2011, Dr. Gandhi noted no significant findings related to the diagnosed CTS. On examination, appellant had weak grip strength in both hands. Her wrist and elbow muscles and shoulders were also weakened. Appellant had decreased sensation of ulnar and radial nerve areas of both hands. She had Tinel's sign present in the suprascapular area and along the radial nerves of both sides in the forearm area, as well as along the right ulnar nerve in the elbow area. Appellant's forearm muscles had decreased tone and strength. She had no abnormal hair loss or atrophy of the nails or any excessive sweating of the hands. Dr. Gandhi opined that appellant's symptoms were unrelated to her accepted injury. He stated that her findings were not consistent with a CRPS and that most of her numbness and tingling was not consistent with carpal tunnel problem, but rather stemmed from a cervical disease.

OWCP again routed appellant's case file to the DMA for review and an opinion as to whether she had any permanent impairment to her upper extremities. In a March 23, 2011 report, the DMA referred to Dr. Gandhi's January 11, 2011 report as an "IME [impartial medical examiner]" report. The DMA disagreed with Dr. Salomon's impairment rating because it was based on the diagnosis of CRPS. He stated that there was no clinical evidence that appellant had CRPS, no consistent findings of CTS and no median nerve sensory neuropathy after surgery.

The DMA recommended that appellant receive a zero percent impairment rating for each upper extremity based on no carpal tunnel or radial tenosynvotic symptoms.

By decision dated April 8, 2011, OWCP denied appellant's request for a schedule award based on Dr. Gandhi's January 11, 2011 referee report and the March 23, 2011 report of the DMA.

LEGAL PRECEDENT

The schedule award provision of FECA[3] and its implementing regulations[4] 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, FECA 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 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.[5] For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.[6] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[7]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. The A.M.A., *Guides* does provide a separate, stand alone method for a CRPS impairment that is not to be combined with any other method for the same extremity.[8] The A.M.A., *Guides* note, however, that an accurate diagnosis is difficult and the diagnostic criteria under Table 15-24 must be met, as well as other conditions, before an impairment rating based on CRPS can be made.[9]

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] *Id.*

[6] *See* FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5th ed. 2001) is used.

[7] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b (June 1993). This portion of OWCP procedure provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

[8] A.M.A., *Guides* 452.

[9] *Id.* at 451. The other conditions include that the diagnosis has been present for a year, verified by more than one physician and other differential diagnoses have been ruled out.

Impairment due to CTS is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[10] In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories test findings, history and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[11]

Section 8123(a) of FECA 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 there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[13]

ANALYSIS

The Board finds that there exists an unresolved conflict in medical opinion as to whether appellant has any permanent impairment of her upper extremities. Therefore, this case is not in posture for a decision and must be remanded for further development of the medical evidence.

OWCP determined that appellant was not entitled to a schedule award based on Dr. Gandhi's January 11, 2011 referee report and the March 23, 2011 report of the DMA, who found that appellant did not have any permanent impairment of her upper extremities under the standards of the sixth edition of the A.M.A., *Guides*. The Board finds, however, that OWCP improperly relied on the opinion of Dr. Gandhi as that of an impartial medical examiner.

In a September 3, 2010 report, Dr. Salomon opined that appellant had a 49 percent permanent impairment of her upper extremities based on her diagnosed CRPS. He provided detailed examination findings, which he applied to the sixth edition of the A.M.A., *Guides*. Dr. Salomon concluded that appellant met the standard of Table 15-24 under diagnostic criteria for CRPS. Under Table 15-25, he opined that she met multiple objective diagnostic criteria such as skin temperature change, coldness, edema, joint stiffness and decreased passive motion. Under functional history, appellant met the criteria of Table 15-7, adjustment of her extremity describing symptoms consistent with grade modifier 3, such as pain and symptoms with less than normal activity. She required assistance to perform self-care activities such as getting dressed, feeding herself and going to the bathroom. Applying his findings to Table 15-26 (CRPS type 1), Dr. Salomon rated appellant's condition as a class 3, which resulted in a 49 percent upper extremity impairment using net adjustment formula. He opined that the date of maximum medical improvement was July 12, 2010, the date she was removed from limited duty and allowed to return to work with no restriction.

[10] *Id*. at 449, Table 15-23.

[11] *Id*. at 448-50.

[12] 5 U.S.C. § 8123(a).

[13] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

In contrast, Dr. Gandhi stated in his January 11, 2011 second opinion report that appellant's findings were not consistent with CRPS and that most of her numbness and tingling were related to nerves that were not consistent with the carpal tunnel problem, but rather stemmed from a cervical disease.[14] In summary, he opined that her symptoms were unrelated to her accepted injury.

On March 23, 2011 the DMA concluded that appellant had no upper extremity impairment, based on Dr. Gandhi's second opinion report, which he improperly referred to as an a "IME" report. He stated that there was no clinical evidence that she had CRPS, no consistent findings of CTS and no median nerve sensory neuropathy after surgery. In its April 8, 2011 decision, OWCP also erroneously relied upon Dr. Gandhi's second opinion report in determining that appellant demonstrated no evidence of CRPS and was not entitled to a schedule award for an upper extremity impairment.

The Board finds that there is a conflict in medical opinion between Dr. Salomon and Dr. Gandhi regarding the nature of appellant's current condition and as to whether she has a permanent impairment of either upper extremity. Consequently, the case must be referred to an impartial medical specialist to resolve the conflict. On remand, OWCP should refer appellant, along with the case file and the statement of accepted facts, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion on this matter. After such further development as it deems necessary, OWCP should issue an appropriate decision regarding appellant's claim.

CONCLUSION

The Board finds that, due to a conflict in the medical opinion evidence, the case is not in posture for decision regarding whether appellant has permanent impairment of an upper extremity.

[14] On October 18, 2010 the DMA recommended that OWCP obtain a referee report to determine whether or not there was any ongoing evidence of CRPS. As there did not exist a conflict in medical opinion at that time, OWCP sought a second opinion report from Dr. Gandhi.

ORDER

IT IS HEREBY ORDERED THAT the April 8, 2011 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further proceedings consistent with this decision of the Board.

Issued: March 8, 2012
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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