U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PATRICK KANE and DEPARTMENT OF THE NAVY, PHILADELPHIA NAVAL SHIPYARD, Philadelphia, PA

Docket No. 99-2200; Submitted on the Record;
Issued January 23, 2001

DECISION and ORDER

Before WILLIE T.C. THOMAS, BRADLEY T. KNOTT, VALERIE D. EVANS-HARRELL

The issue is whether appellant has more than a 10 percent permanent impairment of each upper extremity for which he received a schedule award.

On April 2, 1996 the Office of Workers' Compensation Programs granted appellant a schedule award for a 10 percent permanent impairment of the left and right hand, after it accepted that appellant developed bilateral carpal tunnel syndrome in the performance of duty. Appellant disagreed with the April 2, 1996 decision and by decision dated September 6, 1996, the case was remanded to the Office to resolve a conflict in the medical evidence.[1] By decision dated January 17, 1997, the Office determined that, based on the evidence, appellant was not entitled to an increased schedule award.

By letter dated January 29, 1997, appellant, through his attorney, requested an oral hearing before a representative of the Office. A hearing was held on September 24, 1997. By decision dated November 14, 1997, the Office hearing representative remanded the case to the

[1] A conflict in the medical evidence existed between Dr. David Weiss, appellant's treating physician, who found that appellant had a 30 percent permanent impairment of both upper extremities and the second physician, Dr. Andrew Sattel, who found that appellant had a 10 percent permanent impairment of both hands. To resolve the conflict, appellant was later referred to Dr. Michael Okin, an impartial medical examiner who found that appellant only had a 10 percent upper extremity impairment for both hands.

Office to refer appellant and the case record to a second opinion orthopedist for an evaluation and determination of any permanent impairment of the upper extremities.[2]

The Office later referred appellant to Dr. Samuel Broudo, a Board-certified orthopedic surgeon, who examined appellant on January 19, 1998 and thereafter submitted his findings to the Office. Dr. Broudo stated:

> "The range of motion of both wrists revealed that dorsiflexion is of the order of 50 degrees on both right and left wrists. Palmar flexion is of the order of 80 degrees on the right and 70 degrees on the left. Radial deviation is of the order of 30 degrees in both wrists and ulnar deviation is of the order of 45 degrees in both wrists. [Appellant] is capable of making a full fist with both hands … with full 90 degrees flexion of the MP joints bilaterally, 80 degrees flexion at the proximal interphalangeal joints and 45 degrees of flexion at the distal interphalangeal joints bilaterally. Radial thumb abduction is of the order of 65 degrees on the right and 60 degrees on the left. Thumb opposition from the flexor crease at the 3rd MP joint measured 5 cm. on the right and 4.2 cm. on the left. The grind test was negative bilaterally and there was no clicking of the navicular bilaterally. There was no pain on active motion of either wrist. Two-point discrimination was tested and though appellant at various times discriminated two-point testing at six, seven or eight mm. yet the results obtained were inconsistent for valid conclusions. Grip strength was measured with a Jamar Dynamometer and various readings were obtained. …[S]ince both extremities were involved, the strength measurements were compared to the average normal strength of grip by age listed in Table 21, page 53, [A.M.A.,] *Guides*, third edition and corresponding with the same figures to Table 32, Page 3/65 for [A.M.A.,] *Guides*, fourth edition. The two tables are identical and … the average strength of grip for his age in the … left [hand] is of the order of 49 kg and in the … right it is of the order of 47.3 kg. …[t]he 49 kg. would correspond to 107.8 pounds and the 47.3 kg would correspond to a 104.06 pounds.

[2] The Office hearing representative found that no physician of record had supplied sufficient medical evidence upon which to render an accurate determination of appellant's degree of permanent partial impairment experienced, as a result of the accepted employment condition and resulting surgeries. The Office hearing representative indicated that, in his October 24, 1995 report, Dr. Weiss, appellant's treating physician, properly utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, fourth edition; however, he failed to indicate the calculations used in reaching his determination that appellant had a 30 percent permanent impairment of both upper extremities. The Office hearing representative found that, in a February 27, 1996 report, Dr. Sattel, the second opinion physician, failed to indicate that he utilized A.M.A., *Guides* in determining that appellant had a 10 percent permanent impairment in both his left and right hands. The Office hearing representative further found that, although Dr. Okin, the impartial medical examiner, mentioned the A.M.A., *Guides* in his November 5, 1996 report, he indicated that he could not utilize such for the impairment experienced by appellant. Dr. Okin did not evaluate appellant's fine discriminatory function or address grip strength in accordance with such, nor did he address grip strength or indicate that any measurements were taken with a Jamar dynamometer. Therefore, due to a lack of sufficient evidence, the Office hearing representative remanded the case to the Office for referral of appellant and the case to a second opinion orthopedist for an evaluation and determination utilizing the A.M.A., *Guides*.

"Based on the formula … documented [on] page 54, [A.M.A.,] *Guides* third edition revised and page 3/65 [A.M.A.,] *Guides* fourth edition, the percentage of strength loss index would be equivalent to:

Position 2- 18 percent on the left and 5.5 percent on the right.

Position 3- 16 percent on the left and 18 percent on the right.

[A.M.A.,] *Guides* third edition revised, Table 23/page 54 and [A.M.A.,] *Guides* fourth edition, Table 34/page 3/65 indicates that upper extremity impairment for loss of strength of 10 to 30 percent results in an impairment of 10 percent of the upper extremity."

* * *

"We documented above that two-point discrimination was tested but the results obtained were inconsistent for valid conclusions. …Dr. Weiss in his report dated [October 24, 1995] stated, 'Neurological examination, sensory examination was intact bilaterally over the median nerve distribution.' Dr. Sattel in his report dated February 7, 1996 describes 'two-point discrimination is intact.' Dr. Okin in his report dated November 5, 1996 was of the opinion that [appellant] has no decreased sensation and '…that his two-point discrimination test revealed he can discriminate two points at 7mm on both hands in the median nerve distribution. This is also present in the ulnar nerve distribution as well but this is above normal.'"

* * *

"As a conclusion … were we to consider only the upper extremity impairment for loss of strength with sensory evaluation invalid, then the upper extremity impairment would be of the order of 10 percent for each of the right and left upper extremity. On the other hand, should we consider accepting a partial transverse sensory loss for each hand, then the maximum sensory impairment of the hand would amount to 5 percent of the upper extremity…. Hence, on an empiric basis, the sensory impairment of the hand would be estimated of the order of 2½ percent of the upper extremity and if such 2½ percent of the upper extremity would be added to the 10 percent impairment from loss of strength, then the resulting permanent partial impairment of each upper extremity would be of the order of 12½ percent."

On March 3, 1998 an Office medical adviser reviewed the case record, including Dr. Broudo's January 19, 1998 report.[3] He stated:

> "Although Dr. Fabriani referenced the third edition of the A.M.A., *Guides*, the tables he used have the exact equivalent in the current edition of the 4th edition. For grip strength, Table 23, page 54 of the third edition equals Table 34, page 65 of the fourth edition. His calculations are in accordance with the current edition.
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> "Dr. Fabriani's opinion is 10 percent impairment of each upper extremity for loss of strength. Dr. Fabriani's further opinion was that the results of the [two]-point discrimination for sensory impairment were inconsistent for valid conclusions. Therefore, a schedule award for permanent impairment for sensory loss is not applicable at this time."

The Office medical adviser concluded in his report that appellant had a 10 percent impairment of the right arm and a 10 percent impairment of the left arm.

By decision dated March 11, 1998, the Office issued appellant an amended schedule award for 10 percent impairment to the right and left upper extremity.[4]

Appellant disagreed with the decision and requested another oral hearing. A hearing was held on October 28, 1998, at which, appellant's counsel represented him in his absence. Appellant's counsel argued that Dr. Broudo, the second opinion physician gave some of appellant's measurements using the third edition of the A.M.A., *Guides* and that he should have given some measurements in accordance with the fourth edition. He also argued that Dr. Weiss, appellant's attending physician, took measurements with a Jamar dynamometer and determined that appellant had a 30 percent impairment of each upper extremity and, therefore, his report should carry the weight of the medical evidence.

By decision dated March 29, 1999 and finalized April 1, 1999, the Office hearing representative affirmed the March 11, 1998 decision, finding that appellant sustained no more than a 10 percent permanent impairment to his right and left upper extremity, for which he received a schedule award. The Office hearing representative found that the Office medical adviser applied the proper edition of the A.M.A., *Guides* to the information provided in Dr. Broudo's report in order to reach appellant's impairment rating of 10 percent of both upper extremities.

[3] The Board notes that the medical adviser mistakenly referred to the opinion of a physician named Dr. Fabrini, in his March 3, 1998 report, although the record clearly indicates that he actually reviewed the January 19, 1998 second opinion examination performed by Dr. Broudo.

[4] Appellant was also granted additional weeks of compensation with his March 11, 1998 amended schedule award. A memorandum to the file indicated that appellant's award included additional weeks of compensation, since appellant's previous award was based on the hands and an award for an arm would be greater.

The Board finds that this case is not in posture for a decision regarding whether appellant has more than a 10 percent permanent impairment of each upper extremity, for which he received schedule award.

The schedule award provisions of the Federal Employees' Compensation Act[5] set forth the number of weeks of compensation to be paid for permanent loss of use of the members listed in the schedule. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determinations is a matter, which rests in the sound discretion of the Office. However, as a matter of administrative practice and to ensure consistent results to all claimants, the Office has adopted and the Board has approved of the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6]

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*.[7] However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.

The Office's procedure manual notes that some objective and subjective impairments, such as pain, atrophy, deformity, loss of sensation, loss of strength, sensitivity to heat or cold and soft tissue damage, cannot easily be measured by the A.M.A., *Guides*, but that the effects of any such factors should be explicitly considered along with measurable impairments and correlated as closely as possible with factors set forth in the A.M.A., *Guides*.[8]

In this case, the Office medical adviser correctly applied the tables of the A.M.A., *Guides* to the findings reported by Dr. Broudo, the impartial medical specialist, in his January 19, 1998 report and concluded that appellant had a 10 percent impairment of each upper extremity for loss of strength. The Board notes that appellant's strength measurements reported by Dr. Broudo were compared to the average strength of grip by age found in Table 32 on page 65 of the A.M.A., *Guides* to determine appellant's grip strength. Those figures were then applied to the percentage strength loss index in Table 34 on page 65 to determine that appellant's upper extremity impairment for loss of strength both fell within the range of 10 to 30 percent, which results in an impairment of 10 percent of each upper extremity.

With regard to sensory impairment, the Office medical adviser found that an award for permanent impairment for sensory loss was not applicable at that time. He related Dr. Broudo's

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[5] *See* 5 U.S.C. §§ 8101-8193.

[6] *Jimmy B. Newell*, 39 ECAB 181 (1987).

[7] *William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

[8] Federal (FECA) Procedure Manual, Part 2 -- *Claims, Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a)(2) (March 1995).

findings that the results of the two-point discrimination for sensory impairments were inconsistent for valid reasons. Given the medical evidence of record, the Board notes that appellant did at times have normal sensory function and at other times appellant was found to have a loss of sensory function. According to Chapter three of the A.M.A., *Guides*, which discusses the evaluation of sensory loss, any sensory loss or deficit that is believed to contribute to permanent impairment must be unequivocal and permanent.[9] Therefore, as inconsistent results have been reported regarding appellant's sensory function, the Office medical adviser properly found that a permanent impairment for sensory loss was not applicable at that time.

The Office medical adviser did not attempt to rate a permanent impairment due to loss of range of motion or thumb opposition. Dr. Broudo also failed to rate impairments for loss of range of motion and thumb opposition, although he reported findings in his January 19, 1998 report, which seem to suggest that appellant has some impairment in both areas.[10] As such, it appears that appellant may be entitled to a greater schedule award for permanent impairment of each upper extremity.

The Office medical adviser properly determined, based on Dr. Broudo's report, that appellant had a 10 percent permanent impairment of both upper extremities due to loss of strength. He further determined correctly that a rating for sensory loss could not be given at that time; however, he did not discuss whether appellant had any impairment due to loss of range of motion or thumb opposition. Dr. Broudo seems to suggest in his January 19, 1998 report that appellant may have further impairment due to loss of range of motion and thumb opposition; however, he did not identify any impairment ratings for either area. When the Office secures an opinion from an impartial medical specialist and the opinion of the specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original report.[11] The case therefore will be remanded to the Office to obtain a supplemental report from Dr. Broudo, explaining why he did not provide an impairment rating for loss of range of motion and thumb opposition related to appellant's accepted employment condition, supported by complete medical rationale and in accordance with the A.M.A., *Guides*. After further development as it may find necessary, the Office should issue a *de novo* decision.

[9] A.M.A., *Guides* 3/20.

[10] Dr. Broudo indicated in his January 19, 1998 report that range of motion of both wrists revealed a dorsiflexion (extension) of 50 degrees of both wrists. According to Figure 26 on page 36, a loss of extension of 50 degrees would appear to result in a 2 percent impairment. With regard to thumb impairments, Dr. Broudo reported that appellant measured at 5 cm on the right and 4.2 cm on the left. According to Table 7 on page 29 of the A.M.A., *Guides*, thumb opposition measured at 5 cm on the right is equivalent to a 5 percent impairment and thumb opposition measured at 4.2 cm on the left is equivalent to a 9 percent impairment.

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

The decision of the Office of Workers' Compensation Programs, dated March 29, 1999, is hereby set aside and the case remanded for further development as set forth in this decision.

Dated, Washington, DC
January 23, 2001

Willie T.C. Thomas
Member

Bradley T. Knott
Alternate Member

Valerie D. Evans-Harrell
Alternate Member