U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOHN R. FENSTERMACHER and U.S. POSTAL SERVICE,
POST OFFICE, San Francisco, PA

Docket No. 01-1536; Submitted on the Record;
Issued December 23, 2002

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant sustained greater than a 31 percent permanent impairment of the right upper extremity for which he received a schedule award.

The Office of Workers' Compensation Programs accepted that on or before May 1, 1990, appellant, then a 38-year-old letter carrier, developed bilateral carpal tunnel syndrome, right thumb tendinitis, right elbow tendinitis, cervical radiculopathies and focal dystonia.[1] He underwent a left carpal tunnel release in March 1993 and a right carpal tunnel release in July 1993. The Office also accepted recurrences of disability beginning on March 29 and September 13, 1994 and April 14, 1997.[2] Appellant received appropriate compensation. He submitted numerous medical reports from 1990 through 1997 documenting continuing treatment for bilateral wrist and arm complaints, a right thumb twitch and neck pain.

On October 19, 1998 appellant filed a claim for a schedule award for permanent impairment of both upper extremities.

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[1] Appellant had two compensation claims: No. A03-0163715, for bilateral carpal tunnel syndrome, tendinitis of the right thumb extensor, right elbow tendinitis and a focal dystonia of the right upper extremity; No, 03-0228608 for right wrist tendinitis. The Office appears to have doubled these claims.

[2] By decision dated July 16, 1997, the Office denied appellant's claim for an April 1, 1996 recurrence of disability. At a February 24, 1998 oral hearing, he asserted that he continued to be disabled for his date-of-injury job due to overuse conditions of both upper extremities. In an April 14, 1998 report, Dr. Thomas Ward, an orthopedic surgeon and second opinion physician, opined that appellant did not demonstrate objective evidence of neurologic abnormality in either upper extremity or any "neuropathy in his right forearm or hand or wrist." In a May 18, 1998 report, Dr. Scott M. Fried, an attending osteopath, noted that appellant experienced "twitching" in his right thumb, aggravated by repetitive motion. By decision dated August 6, 1998, an Office hearing representative reversed the Office's July 16, 1997 decision and accepted that appellant had sustained a recurrence of disability effective April 1, 1996, based on Dr. Fried's opinion as the weight of the medical evidence.

In support of his claim, appellant submitted a September 10, 1998 narrative report from Dr. Nicholas Diamond, an attending osteopath, who provided a detailed history of condition and treatment and reviewed numerous medical reports. On examination he found bilateral paracervical muscle spasm and tenderness, tenderness in the right shoulder and elbow with full range of motion, a ganglion cyst of the right wrist, bilaterally negative Tinel's and Phalen's signs, moderate loss of grip strength in the right hand and a neurological examination of the upper extremities within normal limits. Dr. Diamond diagnosed status post bilateral carpal tunnel releases, "[s]tatus post right first dorsal compartment release, right thumb with neurolysis of radial nerve," "[r]efractory de Quervain's tenosynovitis, right thumb" and "[r]efractory right entensoic tend[i]nitis, right elbow."

Referring to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (fourth edition, 1993) (hereinafter, the A.M.A., *Guides*), Table 16, page 57,[3] Dr. Diamond found a 40 percent impairment of the right upper extremity due to median nerve entrapment at the wrist, a 10 percent impairment due to ulnar nerve entrapment at the wrist, a 10 percent impairment due to entrapment of the right radial nerve at the wrist. Referring to Table 15, page 54[4] and Table 12, page 49,[5] Dr. Diamond found a four percent impairment for loss of strength, and a one percent impairment due to limited motion at the wrist according to Figure 29, page 38.[6] He totaled these percentages to equal a 53 percent impairment of the right upper extremity. Dr. Diamond also found a 20 percent impairment of the left upper extremity due to entrapment of the median nerve at the wrist.

In a November 20, 1998 report, Dr. Michael J. Quinlan, a district medical director for the Office, noted that Dr. Diamond used the A.M.A., *Guides* correctly, but that "the internal descriptions of his evaluation do not correlate with his selection of severity on Table 16, page 57. He recommended a second opinion examination and repeat electromyogram (EMG) studies of both upper extremities.

In a December 30, 1998 EMG, Dr. Cynthia A. Farrell, an osteopath to whom appellant was referred by the Office, identified deficits demonstrating bilateral carpal tunnel syndrome without denervation and chronic bilateral C5-6 radiculopathies without an acute radicular process.

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[3] According to Table 16, page 57, entitled "Upper Extremity Impairment Due to Entrapment Neuropathy," severe entrapment of the median nerve at the wrist is equal to a 40 percent impairment of the upper extremity and a mild entrapment of the ulnar nerve at the wrist is equal to a 10 percent permanent impairment of the upper extremity.

[4] Table 15, page 54, entitled "Maximum Upper Extremity Impairments Due to Unilateral Sensory or Motor Deficits or Combined Deficits of the Major Peripheral Nerves," provides percentages of impairment due to sensory or motor deficits of the median and ulnar nerves. Dr. Diamond did not indicate his precise method of calculation using this table.

[5] Table 12, page 49, entitled "determining Impairment of the Upper Extremity Due to Loss of Power and Motor Deficits Resulting from Peripheral Nerve Disorders Based on Individual Muscle Rating," provides grades of impairment for different degrees of muscle function in the upper extremities. Dr. Diamond did not provide his precise method of calculation.

[6] Figure 29, page 38 is entitled "Upper Extremity Impairments Due to Abnormal Radial and Ulnar Deviations of Wrist Joint."

By decision dated March 2, 1999, the Office granted appellant a schedule award for a 24 percent impairment of the right upper extremity and a 20 percent impairment of the left upper extremity.

Appellant disagreed with this decision and in a March 5, 1999 letter requested an oral hearing before a representative of the Office's Branch of Hearings and Review, held September 23, 1999. At the hearing, appellant's attorney representative asserted that the Office was incorrect to issue the March 2, 1999 schedule award based on the calculations of the Office's district medical director, rather than that provided by Dr. Diamond.[7]

By decision dated December 15, 1999, the Office hearing representative vacated the March 2, 1999 decision and remanded the case to the Office to obtain a second opinion regarding the percentage of permanent impairment to the upper extremities. The hearing representative noted that there was a significant discrepancy between Dr. Diamond's determination of a 53 percent permanent impairment and the 24 percent calculated by Dr. Quinlan for the Office. The hearing representative also directed the Office to conduct further development to determine if appellant's C5 and C6 radiculopathies should be included in calculating the schedule award.

On remand of the case, the Office referred appellant, the medical record and a statement of accepted facts to Dr. Robert Aiken, a Board-certified neurologist. In a January 25, 2000 report, he provided a history of condition and noted that appellant's father had Parkinson's disease. Dr. Aiken described the 1990 onset of involuntary movements in appellant's right thumb. These involuntary movements spread into the other fingers of his right hand, interfering with activities of daily living. On examination Dr. Aiken observed "a predominant dystonic quality to movements of his right thumb and other fingers," with a "significant degree of terminal atheotosis of the fingers of his right hand." He noted that the dystonic movements were "aggravated with purposeful rapid movements of the right hand. Dr. Aiken reviewed the EMG studies and opined that appellant had bilateral carpal tunnel syndrome, as well as bilateral C5 and C6 neuropathies without radiculopathy. He instead diagnosed a focal dystonia with athetoid features, producing a loss of right wrist motion. Dr. Aiken recommended a "thorough neurological investigation into the cause of and then will require other treatment for his focal/segmental dystonia." He did not provide an impairment rating referring to the A.M.A., *Guides*.

In a January 31, 2000 supplemental report, Dr. Aiken stated that appellant's focal dystonia was aggravated by factors of his federal employment.

In a February 22, 2000 letter, the Office requested that Dr. Quinlan, the Office's district medical director, determine if a further medical opinion should be obtained regarding whether appellant had a cervical radiculopathy and whether it was work related. The Office noted that Dr. Aiken did not answer the questions provided to him regarding percentage of permanent impairment or the presence of cervical radiculopathy.

[7] Appellant also submitted medical records documenting the presence of the right thumb dystonia in 1990 and 1991.

In a March 3, 2000 note, Dr. Quinlan replied that there was a conflict between Dr. Aiken and Dr. Diamond regarding the presence of cervical radiculopathy.

Thus, the Office found a conflict of medical opinion between Dr. Diamond and Dr. Aiken regarding the cause and degree of upper extremity impairment. To resolve this conflict, the Office referred appellant, the record and a statement of accepted facts to Dr. Richard Buckler, a Board-certified neurologist. In a March 23, 2000 letter, the Office instructed Dr. Buckler to explain whether or not appellant had focal dystonia, whether it was related to factors of his federal employment and whether it caused or affected any permanent impairment of the right upper extremity. The Office did not request Dr. Buckler to perform a schedule award calculation.

In a May 4, 2000 report, Dr. Buckler provided a history of condition and treatment, noting that appellant's father had Parkinson's disease and reviewed the medical record. On examination Dr. Buckler observed "intermittent involuntary movements of his right thumb with flexion across the palm," aggravated by "repetitive movements with his right hand" at work. He diagnosed bilateral carpal tunnel syndrome, right ulnar neuropathy and elbow tendinitis related to work, nonoccupational "[f]ocal dystonia of the right thumb" and "[c]hronic neck pain and pain in both trapezius muscles, etiology unclear," but possibly related to an occupational myofascial syndrome. Dr. Buckler explained that appellant did not have "any evidence of a C5-6 radiculopathy … [as] he has normal strength, normal reflexes and normal sensation in his upper extremities." He noted that appellant had reached maximum medical improvement. Dr. Buckler did not provide an impairment rating.[8]

In a June 5, 2000 letter, the Office referred the case back to Dr. Quinlan for "comment on whether the aggravation of the tremors has an effect on the percentage of impairment. If so, please give the percentage of impairment and date of [maximum medical impairment]." The Office advised that Dr. Aiken diagnosed a focal dystonia as opposed to cervical radiculopathy, and that the focal dystonia was aggravated by work factors. The Office noted that Dr. Buckler had also opined that appellant did not have a cervical radiculopathy. The Office also noted that appellant's "father had Parkinson's disease. I presume that if Dr. Buckler felt that was [appellant's] problem also, he would have said so."

In a June 12, 2000 note, Dr. Quinlan stated that focal dystonia was "not specifically mentioned in the A.M.A., *Guides* fourth edition. This is a strictly motor condition." He stated that the thumb was enervated by the radial nerve and that Table 15, page 54 of the A.M.A., *Guides* allowed a maximum of 35 percent "for motor impairment at (or below) the elbow. Since involuntary movement is described by Dr. Buckler as intermittent but does not interfere with repetitive activity, [Dr. Quinlan] classif[ied] it as Grade 4 even though there is no loss of muscle strength." Dr. Quinlan multiplied 25 percent for the Grade 4 motor impairment by 35 percent for the radial nerve, resulting in 8.75 percent, which he rounded up to 9 percent for dystonia. He also provided a zero percent impairment for cervical radiculopathy, stating that there was "none present." Dr. Quinlan then referred to the Combined Values Chart, combining the 24 percent previously awarded for right upper extremity impairment, with the 9 percent impairment due to

[8] In a May 7, 2000 work capacity evaluation, Dr. Buckler limited pushing, pulling and lifting with the right hand to 10 pounds or less and limited repetitive movements of the right hand and wrist.

dystonia, to arrive at a 31 percent impairment of the right upper extremity, representing an additional 7 percent impairment. He opined that appellant had reached maximum medical improvement as of May 4, 2000, the date of Dr. Buckler's examination.

By decision dated June 21, 2000, the Office modified its March 2, 1999 decision, increasing the schedule award for the right upper extremity from 24 to 31 percent. The Office found that "Dr. Buckler opined that [appellant] does not have clinical evidence of cervical radiculopathy in that he has normal strength, reflexes and sensation in the upper extremities. The etiology of his neck and trapezius pain was felt to be unclear. With respect to cervical radiculopathy the weight of the medical evidence rests with the opinion of the impartial specialist Dr. Buckler, especially since the prior EMG was negative for cervical radiculopathy." The Office found that based on the opinion of Dr. Buckler as the impartial medical examiner, appellant sustained a focal dystonia of the right thumb due to keying and writing for six hours per day in the performance of duty.

Appellant disagreed with this decision and in a June 26, 2000 letter requested an oral hearing before a representative of the Office's Branch of Hearings and Review, held on November 29, 2000. At the hearing, appellant's attorney representative agreed that Dr. Buckler's opinion was insufficient to resolve the conflict of medical opinion between Dr. Aiken and Dr. Diamond. Appellant asserted that the Office should have either obtained a supplemental report from Dr. Buckler containing an impairment rating according to the A.M.A., *Guides* or referred appellant to another impartial specialist. Appellant contended that it was improper for the Office to have allowed the Office medical adviser to represent the weight of the medical evidence and, in effect, resolve the conflict.

By decision dated February 22, 2001 and finalized February 23, 2001, the Office affirmed the June 4, 2000 decision finding that appellant had no greater than a 31 percent impairment of the right upper extremity and a 20 percent impairment of the left upper extremity. The hearing representative found that Dr. Buckler's report, although it did not refer to the A.M.A., *Guides*, "was based on a proper factual and medical history in that he had the benefit of an accurate and up-to-date statement of accepted facts, provided a thorough factual and medical history and accurately summarized the relevant medical evidence." The hearing representative noted that Dr. Buckler found "no evidence of a C5-6 radiculopathy … in his report of May 4, 2000. Dr. Aiken had also stated this opinion in his report of January 25, 2000." The hearing representative found that the referral to the Office medical adviser was proper, as medical advisers are "responsible for taking the calculations provided by the examining physician and arriving at an overall impairment percentage rating."

The Board finds that appellant has not established that he sustained greater than a 31 percent impairment of his right upper extremity, for which he received a schedule award.

The schedule award provisions of the Federal Employees' Compensation Act and its implementing regulation[9] set forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule.[10] However, the

[9] 20 C.F.R. § 10.404.

[10] 5 U.S.C. §§ 8107-8109.

Act does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such a determination is a matter which rests in the sound discretion of the Office.[11] The Board has held, however, that for consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitate the use of a single set of tables so that there may be uniform standards applicable to all claimants. The Office has adopted the A.M.A., *Guides* (fourth edition, 1993), as an appropriate standard for evaluating schedule losses and to ensure equal justice for all claimants.[12] The Board has concurred with the adoption of the A.M.A., *Guides*.

The Board notes that as of February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides*, published in November, 2000. However, as the June 21, 2000 schedule award was calculated prior to February 1, 2001, the use of the fourth edition of the A.M.A., *Guides* was appropriate.[13]

In the fourth edition of the A.M.A., *Guides*, the standards for evaluating the percentage of impairment of extremities 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*.[14] All factors that prevent a limb from functioning normally should be considered, such as pain and weakness, together with loss of motion, in evaluating the degree of permanent impairment. This was correctly done by Dr. Quinlan, the Office's district medical director, in appellant's case.

The determination of a 31 percent impairment of the right upper extremity was based primarily on the opinion of appellant's attending osteopath, Dr. Diamond, who provided a September 10, 1998 narrative report describing appellant's upper extremity impairments in great detail, and referred to the appropriate tables and figures in the A.M.A., *Guides* in determining that appellant had a 53 percent permanent impairment of the right upper extremity.

However, Dr. Quinlan, an Office district medical director, found in a November 20, 1998 report, that Dr. Diamond's clinical findings on examination indicated that appellant had less than a 53 percent permanent impairment of the right upper extremity. Dr. Quinlan questioned the presence of the C5-6 radiculopathy diagnosed by Dr. Diamond. After a December 30, 1998 EMG study confirmed the absence of an active C5-6 radiculopathy affecting either upper

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[11] *Danniel C. Goings*, 37 ECAB 781 (1986); *Richard Beggs*, 28 ECAB 387 (1977).

[12] FECA Bulletin No. 89-30 (issued September 28, 1990).

[13] *Joseph Lawrence, Jr.*, 53 ECAB ___ (Docket No. 01-1361, issued February 4, 2002). Arguendo, the Board notes that Chapter 13 of the fifth edition of the A.M.A., *Guides*, entitled "The Central and Peripheral Nervous System," provides whole person impairment ratings for focal dystonia of one upper extremity at Table 13-6, page 338, entitled "Criteria for Rating Impairment of One Upper Extremity." As the Act does not recognize whole person impairments, Table 13-6 is not relevant to this case. As the fifth edition of the A.M.A., *Guides* does not differ in any other respect regarding the method of calculation set forth in the fourth edition of the A.M.A., *Guides*, the Board finds that the Office's use of the fourth edition was proper under the facts and circumstances of this case.

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

extremity, on March 2, 1999, the Office awarded appellant a schedule award equal to a 24 percent permanent impairment of the right upper extremity and a 20 percent permanent impairment of the left upper extremity.

Following a September 23, 1999 oral hearing, the Office issued a December 15, 1999 decision vacating the March 2, 1999 schedule award, finding that further development was needed to determine whether or not appellant had a C5-6 radiculopathy and whether it was work related. The Office referred the case to Dr. Robert Aiken, a Board-certified neurologist, for a second opinion examination. Dr. Aiken provided January 25 and 31, 2000 reports diagnosing an occupationally aggravated focal dystonia of the right thumb as opposed to a cervical radiculopathy.

The Office then found a conflict between Dr. Diamond, for appellant and Dr. Aiken, for the government, regarding the presence of cervical radiculopathy. To resolve this conflict, the Office referred the case to Dr. Buckler for the sole purpose of determining whether appellant had a cervical radiculopathy or a focal dystonia, whether such a condition was work related and, if so, how it affected the percentage of permanent impairment of the upper extremities.

Dr. Buckler provided a May 4, 2000 report diagnosing a focal dystonia of the right thumb aggravated by work factors and ruled out a C5-6 radiculopathy. Based on Dr. Buckler's clinical observations, Dr. Quinlan, the district medical director, found that appellant sustained an additional seven percent impairment of the right upper extremity due to focal dystonia.

By decision dated June 21, 2000, based on Dr. Quinlan's interpretation of Dr. Buckler's findings, the Office granted appellant a schedule award for an additional seven percent permanent impairment of the right upper extremity. Appellant disagreed with this decision and requested an oral hearing, held November 29, 2000, at which his attorney contended that Dr. Buckler's opinion was inadequate as it did not contain a schedule award calculation. By decision dated February 22, 2001 and finalized February 23, 2001, the Office hearing representative affirmed the June 21, 2000 schedule award.

On appeal, appellant's attorney again asserted that Dr. Buckler's opinion was inadequate as he did not provide a schedule award calculation according to the A.M.A., *Guides*. However, the Board finds that the Office's mandate to Dr. Buckler was that he provide an opinion regarding whether appellant had cervical radiculopathy or a focal dystonia, if either condition was work related and, if so, how did it affect the percentage of permanent impairment. The Office did not ask Dr. Buckler to recalculate the schedule award. Thus, appellant's argument that Dr. Buckler's opinion is deficient as he did not recalculate the entire schedule award is without merit, as the Office never asked that Dr. Buckler do so. Additionally, the Board finds that there was no procedural need for Dr. Buckler to have recalculated the schedule award in the absence of a direction from the Office to do so.

Appellant has not submitted any persuasive medical evidence demonstrating that he sustained greater than a 31 percent impairment of the right upper extremity. Also, appellant has not asserted that Dr. Buckler or Dr. Quinlan made factual or medical errors in obtaining and interpreting the clinical findings and calculating the schedule award. His only contention is that the Office should have sent appellant to a second impartial medical examiner for the sole

purpose of obtaining a new schedule award calculation. As stated above, the Board finds that there was no procedural need or requirement for a second impartial medical examiner to have been appointed in this case. The Board finds that Dr. Buckler's clinical findings used for schedule award calculations were accurate and appropriate.

Thus, appellant has not established that he sustained greater than a 31 percent impairment of the right upper extremity, for which he received a schedule award.

The decisions of the Office of Workers' Compensation Programs dated February 22, 2001 and finalized February 23, 2001 and dated June 21, 2000 are hereby affirmed.

Dated, Washington, DC
December 23, 2002

Alec J. Koromilas
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member