U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ROBERT F. NELSON and U.S. POSTAL SERVICE,
POST OFFICE, Durango, CO

Docket No. 00-2726; Submitted on the Record;
Issued February 26, 2002

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether appellant has established greater than a 12 percent impairment of his right upper extremity.

On January 11, 1996 appellant, then a 54-year-old clerk/carrier, filed a notice of occupational disease and claim for compensation, alleging that he sustained a ganglion cyst within the tendons on the back of his right hand as a result of factors of his employment. In a medical report dated December 5, 1995, Dr. Mark Kircher, a Board-certified orthopedic surgeon, noted that appellant had a ganglion cyst on the right side and that the extensor tendons appeared to be somewhat involved.[1] The claimant underwent excision of the cyst on December 8, 1995. By letter dated January 22, 1996, appellant's claim was accepted for ganglion cyst of the right hand.

By letter dated January 16, 1998, the Office of Workers' Compensation Programs referred appellant to Dr. Russell Compton, a Board-certified orthopedic surgeon, for a second opinion. Dr. Compton conducted a physical examination and reviewed appellant's medical records and, in a report dated February 16, 1998, found no sensory deficit in appellant's upper extremities and no atrophy of the upper extremities. He diagnosed appellant as status post "excision of reactive synovitis," right wrist and history of mild osteoarthritis, right wrist, on bone scan. Dr. Compton noted that the "excision of the ganglion cyst was necessary for the accepted condition of ganglion cysts of the right hand, which was caused by the patient's federal employment as a postal clerk."

[1] Dr. Kirchner also noted no neurologic complaints and that appellant's wrist appeared to have no evidence of carpal instability.

On October 20, 1998 the Office medical adviser reviewed appellant's file, including the February 16, 1998 report of Dr. Compton. She noted:

> "The accepted conditions are ganglion cyst of the right wrist and excision. The treating physician notes at the time of surgery that the fluid and tissue excised was not typical for a ganglion cyst; he felt that there was a reactive synovitis on the basis of underlying degenerative arthritis of the carpal area, visible only on bone scan.
>
> "According to the A[merican M[edical] A[ssociation], *Guides to the Evaluation of Permanent Impairment*, [f]ourth [e]dition, the right upper extremity impairment can be determined as follows.
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> "Impairment due to arthritic changes and carpal instability, moderate, is 12 percent, as per Table 27, page 61.
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> "On page 61, the following notes seem applicable in this case: 'certain patients may have wrist pain and the loss of strength related to a dynamic or nondissociative carpal instability that cannot be measured by changes of angles on roentgenograms … pain and loss of strength are not rated separately.'
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> "The total impairment for the right upper extremity equals 12 percent.
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> "The date of maximal improvement is February 10, 1998."

In a statement of accepted facts dated May 26, 1998, the Office noted that appellant was required to perform work not within his restrictions as outlined by his treating physician and that appellant retired from his employment on May 15, 1997.

In a decision dated December 18, 1998, the Office granted appellant a schedule award for 12 percent impairment of the right upper extremity (arm).

By letter dated January 12, 1999, appellant requested an oral hearing.

In a medical report dated April 20, 1999, Dr. David A. Friscia, a Board-certified orthopedic surgeon and appellants primary treating physician, stated:

> "With reference to the A.M.A., *Guides*, fourth edition evaluation of permanent impairment, I would estimate that he has a 24 percent impairment of the upper extremity and a 14.4 percent impairment of the entire body from this injury. This takes into account joint discomfort and crepitation with range of motion in addition to joint swelling and synovitis. Doing these percentages is complicated and this does not necessarily take into account his degree of pain. An experienced [w]orkers' [c]omp[ensation] evaluator should be able to review the report and better arrive at the exact rating, however, these would be my estimate based on physical examination. These may need to be modified based on his pain and soft tissue damage. This needs to be factored in also. This rating can be quite complex. Based on the objective findings my rating would be listed above."

A hearing was held on June 23, 1999. Appellant testified that he worked for the employing establishment from November 1987 until he retired in 1996 and described the duties of a clerk/carrier.

At the hearing, appellant also submitted a June 18, 1999 report by Dr. Luigi Galloni, an orthopedic surgeon. Dr. Galloni stated that it was his opinion that appellant's right upper extremity condition was due to his employment as a postal clerk/carrier, because of the repetitive nature of his duties.

In a decision dated October 8, 1999, the hearing representative affirmed the Office's decision of December 18, 1998.

By letter dated May 1, 2000, appellant requested reconsideration and submitted a medical report by Dr. Jacob E. Tauber, a Board-certified orthopedic surgeon, dated March 27, 2000. Dr. Tauber stated:

> "The patient has objective findings of examination of carpal and cubital tunnel syndrome, which correlate with the patient's clinical examination and are clearly attributable to his repetitive motion work activities.
>
> "Using Table 15 of the A.M.A., *Guides*, ([f]ourth [e]dition), this patient is documented to have a sensory deficit and pain and a motor deficit due to this carpal and cubital tunnel syndromes.
>
> "Utilizing the [C]ombined [V]alues [C]hart, the patient would have a 36 percent impairment of his right upper extremity due to his peripheral nerve entrapments."

Dr. Tauber noted that he disagreed with Dr. Compton's February 16, 1998 report, as Dr. Tauber noted substantial differences from the physical findings of Dr. Compton. He noted that Dr. Compton found that the handgrip was equal, which was contrary to his findings. Furthermore, Dr. Tauber noted that Dr. Compton made no mention of having performed Tinel's testing, elbow flexion testing, Phalen's sign or carpal compression and that, therefore, Dr. Compton's examination was not complete. He also noted, in discussing Dr. Compton's report:

> "What does not make sense to me, however, is the fact that the patient was noted to have pain extending into his hands and fingers and yet he was not evaluated for a peripheral nerve entrapment, when this is a classic complaint for peripheral nerve entrapment."
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> * * *
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> "Thus, in summary, the patient likely had an aggravation of his underlying arthritic condition of his wrist and hand as a result of his repetitive motion activities and if this is accepted, it would add an increment of several percent due to the patient's limited motion of his upper extremity. However, the reason he has radiating pain into his hand is because he has peripheral nerve entrapments is the repetitive motion activities carried out in the course of his employment."

On May 28, 2000 the Office medical adviser noted:

> "The new report dated March 27, 2000 from Jacob Tauber, MD, gives additional impairment due to carpal and cubital tunnel syndrome and submits findings of same on [nerve conduction velocity] testing from February 2000. He notes that the report of Dr. Compton, on which the previous rating was based, does not specifically mention testing or these conditions. Dr. Tauber, however, concludes that the tunnel syndromes were due to the repetitive work activities. However, the claimant retired in 1996. The report of Dr. Kirchner dated December 5, 1995 specifically notes no evidence of [computerized tomography] or ulnar nerve compression. There is no additional permanent impairment based on the accepted condition."

By decision dated June 1, 2000, the Office reviewed appellant's case on the merits but found that the evidence submitted in support of the application was not sufficient to modify the prior decision. The Office noted that appellant retired in 1996 and the report of Dr. Kirchner dated December 5, 1995 specifically found no evidence of carpal tunnel syndrome or ulnar nerve compression. The Office also noted that appellant did not file his Form CA-2 for anything beyond a ganglion cyst and medical evidence submitted following his filing failed to establish the condition that Dr. Tauber now diagnosed.

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

Section 8107 of the Federal Employee's Compensation Act provides that, "if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the schedule member or function.[2] Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[3]

In this case, the Office medical adviser concluded that there was no additional permanent impairment based on the accepted condition. However, the Office medical adviser relied on an inaccurate medical history in reaching his opinion. The Office medical adviser stated that Dr. Kirchner's December 5, 1995 report specifically found no evidence of carpal tunnel syndrome or ulnar nerve compression and that as appellant retired in 1996, there could be no additional impairment. Although appellant did testify that he retired in 1996, in the statement of accepted facts dated May 26, 1998, the claims examiner indicated that appellant retired from his employment on May 15, 1997 and that, at the time he retired, he was required to perform work that was not within his restrictions as outlined by his treating physician. In light of this evidence which is, at best, contradictory, an unresolved question arises as to whether the Office medical

[2] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found at 20 C.F.R. § 10.404(a).

[3] *Mary L. Henninger*, 52 ECAB ____ (Docket No. 00-552, issued June 20, 2001).

adviser relied on an accurate history in formulating his opinion. The Board notes that an accurate history of injury is critical to any medical opinion with regard to appellant's claim. Medical conclusions based on inaccurate or incomplete histories are of little probative value.[4]

This case will be remanded for further consideration consistent with this opinion. On remand, the Office should further develop the evidence and determine when appellant retired, whether he was working outside of his restrictions at the time of his retirement and whether he had any additional impairment due to his employment.

The June 1, 2000 and October 8, 1999 decisions of the Office of Workers' Compensation Programs are hereby set aside and the case is remanded to the Office for proceedings consistent with this opinion.

Dated, Washington, DC
February 26, 2002

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member

[4] *See James A. Wyrick*, 31 ECAB 1805 (1980) (physician's report was entitled to little probative value because the history was both inaccurate and incomplete). *See generally Melvina Jackson*, 38 ECAB 443, 450 (1987) (addressing factors that bear on the probative value of medical opinions).