United States Department of Labor
Employees' Compensation Appeals Board

LEMUEL ANDERSON, Appellant	)	
and	)	**Docket No. 04-1964**
	)	**Issued: January 24, 2005**
DEPARTMENT OF THE AIR FORCE, KEESLER AIR FORCE BASE, MS, Employer	)	

Appearances:
Lemuel Anderson, pro se,
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
MICHAEL E. GROOM, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On August 2, 2004 appellant filed a timely appeal from the Office of Workers' Compensation Programs' decisions dated July 15, 2004, denying his requests for modification of schedule awards granting him 45 percent impairment of the left upper extremity and 15 percent impairment of the right upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue on appeal is whether appellant sustained greater than a 45 percent impairment of the left upper extremity and a 15 percent impairment of the right upper extremity, for which he received schedule awards. On appeal, appellant asserts that the Office did not allow the full impairment rating estimated by Dr. Purser, a Board-certified orthopedic surgeon appointed as impartial medical examiner. Appellant also contended that the Office attempted to improperly influence Dr. Purser's opinion by submitting the Office medical adviser's critique of his schedule award calculation. Appellant argues that the Office should have relied on the opinion of

Dr. M.F. Longnecker, Jr., an attending Board-certified orthopedic surgeon, who found a 100 percent permanent impairment of the left hand due to sensory loss.

FACTUAL HISTORY

This is the second appeal before the Board in this case. By decision and order issued February 1, 2004,[1] the Board remanded the case to the Office to resolve an outstanding conflict of medical opinion evidence between Dr. Longnecker, an attending physician and two Office medical advisers, regarding the appropriate percentage of impairment to his upper extremities.

On remand, the Office referred appellant, the medical record and a statement of accepted facts, to Dr. Thomas Purser, III, a Board-certified orthopedic surgeon, to resolve the conflict of medical opinion. In a May 25, 2004 report, Dr. Purser provided a history of injury and treatment. On examination of the right hand, Dr. Purser found poor grasp strength and medial hypesthesia. On the left, Dr. Purser found a positive Tinel's sign, full but paretic extension, poor strength on abduction and adduction, poor grasp strength and hypoesthesia in the medial distribution. Dr. Purser obtained nerve conduction velocity studies of both upper extremities showing severe carpal tunnel syndrome on the left. Dr. Purser diagnosed severe, persistent carpal tunnel syndrome on the left with median nerve deficit, with maximum medical improvement attained as of March 16, 2001. He opined that, according to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*), appellant sustained an 80 percent permanent impairment of the left upper extremity due to sensory deficit in the entire hand, and a "100 percent loss of left upper extremity" due to weakness. Regarding the right hand, Dr. Purser opined that appellant had reached maximum medical improvement in June 2000 and exhibited an 18 percent permanent impairment of the hand, with a 20 percent impairment of the right upper extremity due to sensory loss in the palm and fingers.[2] Dr. Purser found appellant unable to perform his "usual job" due to a total, permanent median nerve deficit in the left hand which prevented him from performing repetitive wrist motions, pushing, pulling or lifting.

In a June 25, 2004 report, an Office medical adviser stated that Dr. Purser had not correctly applied the fifth edition of the A.M.A., *Guides*. He explained that the maximum rating for motor loss of the median nerve was 10 percent and the maximum percentage of impairment for sensory loss of the median nerve was 39 percent, based on Table 16-15, page 492 of the A.M.A., *Guides*.[3] On the left, the medical adviser calculated that, according to Table 15-16, page 424, the motor loss described was Grade 1, equaling 76 percent, multiplied by the

[1] Docket No. 03-2284.

[2] Dr. Purser reiterated these impairment ratings in accompanying schedule award worksheets.

[3] Table 16-15 is entitled "Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to *Combined* 100 percent Deficits of the Major Peripheral Nerves." Table 16-15 provides that the maximum percent of upper extremity impairment due to pain resulting from median nerve impairment is 39 percent. The maximum percentage of upper extremity impairment due to a motor deficit of the median nerve is 10 percent. The maximum combined motor and sensory deficit for median nerve impairment is a 45 percent impairment of the upper extremity.

maximum 10 percent grade for motor loss of the median nerve was 7.6 percent.[4] Multiplying the 95 percent Grade 1 sensory loss in the median nerve equaled by the maximum sensory loss for the median nerve of 39 percent resulted in a 37 percent impairment according to Table 15-15, page 424.[5] The medical adviser then used the Combined Values Chart of page 604 of the A.M.A., *Guides* to combine 37 percent and 8 percent, equaling 42 percent. On the right, the Office medical adviser found that a Grade 4 motor loss in the median nerve equaled 18 percent multiplied by the maximum 10 percent value for the median nerve, resulting in a 1.8 percent loss according to Table 15-16, page 424.[6] Grade 4 sensory loss equaled 20 percent of 10 percent for a result of 2 percent according to Table 15-15, page 424. The Office medical adviser then combined the 2 percent loss with the 1.8 percent loss, rounded up to 2 percent, to equal a 4 percent impairment of the right upper extremity. The Office medical adviser thus concluded that appellant had a 42 percent impairment of the left upper extremity and a 4 percent permanent impairment of the right upper extremity.

In a June 25, 2004 letter, the Office requested that Dr. Purser clarify the percentages of permanent impairment offered as his recommendations were unclear. The Office enclosed the Office medical adviser's June 25, 2004 report. In response, Dr. Purser submitted a July 7, 2004 report. Regarding the left upper extremity, he noted that, according to the Table 16-15, page 492, of the A.M.A., *Guides*, a total motor loss of the median nerve equaled a 10 percent permanent impairment of the left upper extremity, and a total sensory loss in the median nerve equaled a 39 percent impairment of the left upper extremity. Dr. Purser noted that, according to Table 15-16,[7] a Grade 1 motor loss in the median nerve equaled a 76 percent motor deficit, multiplied by the 10 percent maximum value for motor loss in the median nerve resulted in 7.6 percent permanent impairment, rounded up to 8 percent. Dr. Purser then calculated a Grade 1 sensory loss at 95 percent, multiplied by the 39 percent value for the median nerve equaled a 3.7

[4] Table 15-16 is entitled "Determining Impairment Due to Loss of Power and Motor Deficits." According to Table 15-16, a Grade 1 motor loss, described as "[s]light contraction and no movement," is equal to a 76 to 99 percent impairment.

[5] Table 15-15 is entitled "Determining Impairment Due to Sensory Loss." Table 15-15 provides that a Grade 4 sensory loss, described as "[d]istorted superficial tactile sensibility (diminished light touch) with or without minimal abnormal sensations or pain, that is forgotten during activity," is equal to a 1 to 25 percent sensory deficit.

[6] Table 15-16 describes a Grade 4 motor loss as "[a]ctive movement against gravity with some resistance," equal to a 1 to 25 percent motor deficit.

[7] The Board notes that, according to the instructions provided by the A.M.A., *Guides* for using Table 16-15, the severity of motor deficits is to be determined by reference to Table 16-11a, page 484, entitled "Determining Impairment of the Upper Extremity Due to Motor and Loss-of-Power Deficits Resulting From Peripheral Nerve Disorders Based on Individual Muscle Rating." Instead Dr. Purser relied on Table 15-16, page 424, entitled "Determining Impairment Due to Loss of Power and Motor Deficits." The Board notes, however, that the grading scheme and percentages provided by both Table 16-11a and 15-16 are virtually identical and would not have provided a different result. Thus, Dr. Purser's reliance on Table 15-16 and not Table 16-11a is harmless error.

percent impairment of the upper extremity according to Table 16-15.[8] Dr. Purser then used the Combined Values Chart to combine the 37 percent impairment for sensory loss with the 8 percent impairment for motor loss, resulting in a 45 percent permanent impairment of the left upper extremity. On the right, Dr. Purser found that, according to Table 15-16, a Grade 4 motor loss in the median nerve equaled an 18 percent impairment that when multiplied by the 10 percent maximum value for the median nerve, equaled a 1.8 percent. Dr. Purser then rounded up the 1.8 percent impairment to 2 percent. Dr. Purser then found that, according to Table 15-15, a Grade 4 sensory loss was equal to a 20 percent impairment, multiplied by the 10 percent maximum value for the median nerve, equaled a 2 percent impairment. Dr. Purser then used the Combined Values Chart to combine 2 percent and 3.8 percent (rounded up to 4 percent) to equal a 4 percent impairment of the right upper extremity.

The Office then referred Dr. Purser's July 7, 2004 schedule award calculation to an Office medical adviser for review. In a July 15, 2004 report, an Office medical adviser found that Dr. Purser had properly applied the A.M.A., *Guides* and had correctly utilized Table 16-15. The medical adviser concurred with the offered percentages of permanent impairment.

By decision dated July 15, 2004, the Office denied modification of the April 5, 2002 decision on the grounds that the medical evidence did not demonstrate a greater percentage of impairment than 45 percent for the left arm and 15 percent for the right arm. The Office found that Dr. Purser's final report indicated a 41 percent permanent impairment of the left upper extremity and a 4 percent permanent impairment of the right upper extremity. The Office noted that these percentages were less than those previously awarded. The Office also found that Dr. Purser's opinion as impartial medical examiner outweighed that of Dr. Longnecker.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[9] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. 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 determination is a mater which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[10]

[8] The Board notes that the A.M.A., *Guides'* instructions for Table 16-15 provide that sensory deficits are to be determined using Table 16-10a, page 482, entitled "Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting from Peripheral Nerve Disorders." Instead, Dr. Purser referred to Table 15-15, "Determining Impairment due to Sensory Loss." The Board notes, however, that the grading scheme and percentages of impairment provided by both Table 16-10a and Table 15-15 are identical and thus would not have resulted in a different percentage of impairment. Thus, Dr. Purser's reliance on Table 15-15 and not Table 16-10a is harmless error.

[9] 5 U.S.C. §§ 8101-8193.

[10] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

Utilization of the A.M.A., *Guides* requires that a detailed description of appellant's impairment be obtained from appellant's attending physician,[11] in sufficient detail so that the claims examiner and others reviewing the file, such as a physician examining the claimant or the case file on behalf of the government, will be able to clearly visualize the impairment with its restrictions and limitations.[12] Should there be a disagreement between the claimant's physician and an examiner for the United States, section 8123 of the Act[13] provides that the Office shall appoint a third physician who shall make an examination. Where 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, is entitled to special weight.[14]

ANALYSIS

The Office accepted that appellant sustained bilateral carpal tunnel syndrome. A conflict of medical opinion then arose between appellant's attending physician and two Office medical advisers regarding the percentage of permanent impairment. Therefore, to resolve this conflict, the Office referred appellant to Dr. Purser, a Board-certified orthopedic surgeon, to ascertain the appropriate percentage of permanent impairment attributable to the accepted bilateral carpal tunnel syndrome.

Dr. Purser provided a May 25, 2004 report noting detailed findings on examination of both upper extremities, including electrodiagnostic test results. However, Dr. Purser did not indicate which tables and grading schemes of the A.M.A., *Guides* he applied to arrive at his assessment of a 100 percent impairment of the left upper extremity and a 20 percent impairment of the right upper extremity. An Office medical adviser reviewed Dr. Purser's initial report and noted that Dr. Purser had misapplied the A.M.A., *Guides*. Using Dr. Purser's clinical findings, the Office medical adviser referred to the A.M.A., *Guides* and determined that appellant had sustained a 42 percent permanent impairment of the left upper extremity and a 4 percent permanent of the right upper extremity. The Office then requested that Dr. Purser submit a supplemental report correctly utilizing the A.M.A., *Guides*.

In response, Dr. Purser submitted a July 7, 2004 report finding that appellant sustained a 41 percent permanent impairment of the left upper extremity and a 4 percent impairment of the right upper extremity due to the accepted carpal tunnel syndrome. On the left, Dr. Purser found a total motor loss of the median nerve, equaling an 8 percent impairment of the left upper extremity according to Tables 15-16 and 16-15. Dr. Purser also found a total sensory loss of the median nerve, equaling a 39 percent impairment of the left upper extremity according to Tables 15-15 and 16-15. He then combined these percentages to equal a 45 percent impairment of the left upper extremity. On the right, Dr. Purser found a two percent upper extremity impairment

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(c) (August 2002).

[12] *Noe L. Flores*, 49 ECAB 344 (1998).

[13] 5 U.S.C. § 8123(a).

[14] *Leanne E. Maynard*, 43 ECAB 482 (1992).

due to motor loss in the median nerve and an additional two percent impairment for sensory loss in the median nerve, based on the same tables and grading schemes used to calculate the percentages of impairment for the left arm. He combined these percentages to equal a four percent impairment of the right upper extremity. The Board finds that Dr. Purser properly applied the grading schemes of the A.M.A., *Guides* in assessing the percentage of permanent impairment of the upper extremities.[15] Dr. Purser's evaluation conforms to the A.M.A., *Guides* and establishes that appellant has no greater than the 45 percent impairment of the left upper extremity and 15 percent impairment of the right upper extremity previously awarded. The Board further finds that Dr. Purser's opinion as impartial medical examiner is entitled to special weight as his opinion is based on a complete and accurate factual and medical history and properly applied the A.M.A., *Guides* to his clinical findings on examination.[16]

On appeal, appellant asserts that the Office only awarded part of the impairment rating intended by Dr. Purser. However, the Board finds that the Office awarded appellant the entire percentage of impairment calculated by Dr. Purser in his July 7, 2004 report, which was based on a proper application of the A.M.A., *Guides*. Appellant also asserted that the Office attempted to improperly influence Dr. Purser by providing him with the Office medical adviser's critique of his schedule award calculation. The Office did so in order to obtain clarification from Dr. Purser regarding several errors in his initial schedule award rating. The Office's procedures provide that the Office may request a clarifying report from an impartial medical specialist if there is a deficiency in the original report.[17] As Dr. Purser had not properly applied the A.M.A., *Guides* in his initial report, the Office advised him of the deficiencies in his report, as explained by the Office medical adviser, and requested a supplemental report. The Board finds that the Office properly requested a supplemental report and forwarded the Office medical adviser's calculations to Dr. Purser to confirm the rating was appropriate under the A.M.A., *Guides*.

CONCLUSION

The Board finds that appellant has not established that he sustained greater than a 45 percent impairment of the left upper extremity and a 15 percent impairment of the right upper extremity, for which he received schedule awards.

[15] The fifth edition of the A.M.A., *Guides* at page 494 provides that impairment for carpal tunnel syndrome be rated on motor and sensory impairments only. *See also Robert V. DiSalvatore*, 54 ECAB ___ (Docket No. 02-2256, issued January 17, 2003) (where the Board found that the fifth edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory impairments only, without additional impairment values for decreased grip strength).

[16] *Leanne E. Maynard*, *supra* note 14.

[17] Federal (FECA) Procedure Manual, Part 3 -- *Medical*, Chapter 3.0500.5.b(2) Referee Examinations, Actions of Completion of Referral (March 1994). This section of the Office's Procedure Manual provides that the Office claims examiner "will review the specialist's report to ensure that it meets the tests for a referee examination and that it addresses all issues posed." If the claims examiner determines that clarification or additional information is needed, the claims examiner "will write to the specialist to obtain it." *See also Guiseppe Aversa*, 55 ECAB ___ (Docket No. 03-2042, issued December 12, 2003) (the Board held that where the Office obtains an opinion from a referee medical specialist to resolve a conflict of medical opinion evidence and the specialist's report requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist to correct the deficiency in the original opinion).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 15, 2004 is affirmed.

Issued: January 24, 2005
Washington, DC

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member