United States Department of Labor
Employees' Compensation Appeals Board

BRENDA HILL, Appellant	)	
and	)	**Docket No. 06-258**
	)	**Issued: June 15, 2006**
U.S. POSTAL SERVICE, MARKET STREET POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On November 14, 2005 appellant filed a timely appeal of a November 8, 2005 decision of the Office of Workers' Compensation Programs, awarding a five percent impairment of the right upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501(d)(3), the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has established that she sustained more than a five percent impairment of the right upper extremity, for which she received a schedule award. On appeal, appellant contends that she sustained a nine percent impairment of the right upper extremity, as determined by Dr. Evan Kovalsky, an impartial medical examiner, Board-certified in orthopedic surgery.

FACTUAL HISTORY

The Office accepted that, on or before November 1994, appellant, then a 47-year-old clerk, sustained bilateral carpal tunnel syndrome requiring bilateral median nerve release surgeries. The Office accepted and authorized surgery for stenosing tenosynovitis with "trigger

finger" of the thumb, third and fourth digits of both hands. Appellant received appropriate wage-loss compensation for intermittent work absences and recurrences of disability through May 2005.[1]

Dr. Joseph J. Thoder, an attending Board-certified orthopedic surgeon specializing in surgery of the hand, treated appellant for the accepted conditions beginning in 1995. On the right hand, he performed a median nerve release on February 22, 2000 and a release of the proximal interphalangeal (PIP) joints of the third and fourth fingers on April 23, 2002. On the left hand, Dr. Thoder performed a median nerve release on January 28, 2003, a release of stenosing tenosynovitis of the thumb on March 4, 2003 and a release of stenosing tenosynovitis of the third finger on April 22, 2003.

On July 30, 2003 appellant claimed a schedule award. The Office obtained a second opinion from Dr. Richard J. Mandel, a Board-certified orthopedic surgeon, who submitted an October 2, 2003 report, reviewing the medical record and a statement of accepted facts. On examination he found no impairments of the fingers, mild ulnar neuropathy at the right elbow, resolved right carpal tunnel syndrome and a mild left median neuropathy. Dr. Mandel diagnosed status post bilateral carpal tunnel releases and status post release of multiple trigger fingers bilaterally. Referring to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*), he found a nine percent left upper extremity impairment due to carpal tunnel syndrome demonstrable on electrodiagnostic testing. Dr. Mandel explained that the 9 percent impairment was based on a 10 percent sensory deficit according to Table 16-10[2] and a 10 percent motor deficit according to Table 16-11.[3] "Combining this with Table 16-15, which assigns the median nerve in the distal forearm by a 45 percent upper extremity impairment and multiplying the 10 percent motor and sensory deficits by 45 percent and summing the result, yields a total left upper extremity impairment of 9 percent."[4] Dr. Mandel found a zero percent impairment of the right upper extremity as electrodiagnostic testing no longer demonstrated median neuropathy and the clinical examination was unremarkable.

In an October 16, 2003 report, Dr. George L. Rodriguez, an attending Board-certified physiatrist, performed a schedule award evaluation for Dr. Thoder. Dr. Rodriguez reviewed the medical records, provided a history of the accepted conditions and performed a clinical

[1] By decision dated September 2, 2003, the Office initially denied compensation from July 2 to 27, 2003. By decision dated December 15, 2003, an Office hearing representative vacated the Office's September 2, 2003 decision, finding that appellant established entitlement to wage-loss compensation from July 2 to 27, 2003. These decisions are not before the Board on the present appeal.

[2] Table 16-10, page 482 of the fifth edition of the A.M.A., *Guides* is entitled "Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting From Peripheral Nerve Disorders."

[3] Table 16-11, page 484 of the fifth edition of the A.M.A., *Guides* is 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."

[4] Table 16-15, page 492 of the fifth edition of the A.M.A., *Guides* is entitled "Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to *Combined* 100% Deficits of the Major Peripheral Nerves."

examination. He found nodules "along the flexor aspects of the metacarpophalangeal (MCP) joints of the second, third and fourth digits of the R[ight] hand" and decreased sensation in the ulnar aspect of the left index finger. Dr. Rodriguez diagnosed degenerative joint disease of the carpometacarpal (CMC) joint of the left thumb, status post release of bilateral carpal tunnel syndrome and status post multiple surgeries for stenosing flexor tenosynovitis. He noted that flexion of the proximal interphalangeal joint of the right second, third, fourth and fifth fingers to 95 degrees equaled a 4 percent impairment of the right upper extremity according to Tables 16-2,[5] 16-15 and 16-23[6] of the A.M.A., *Guides*. Dr. Rodriguez also found a 3 percent impairment of the right upper extremity due to a Grade 4 or 25 percent loss of strength in the median nerve distribution, according to Tables 16-11 and 16-15. He combined the four and three percent impairments to equal a seven percent impairment of the right upper extremity. Dr. Rodriguez noted the same impairments in the left upper extremity, with an additional one percent impairment for limited motion in the PIP joint of the fourth finger, and a one percent impairment due to a Grade 4 sensory deficit in the left ulnar nerve distribution. He concluded that appellant had a nine percent impairment of the left upper extremity.[7]

In a March 10, 2004 report, an Office medical adviser agreed with the nine percent impairment rating for the left upper extremity. Regarding the right upper extremity, the medical adviser found a zero percent impairment based on Dr. Mandel's opinion.

By decision dated May 5, 2004, the Office granted appellant a schedule award for a nine percent impairment of the left upper extremity. Following a review of the written record, the Office issued a February 14, 2005 decision vacating the May 5, 2004 decision on the grounds that there was a conflict between Dr. Mandel, for appellant, and Dr. Rodriguez, for the government, regarding the percentage of impairment to the right upper extremity. The Office remanded the case for preparation of a statement of accepted facts, appointment of an impartial medical examiner and issuance of an appropriate decision.

On remand of the case, the Office referred appellant, a statement of accepted facts and the medical record to Dr. Kovalsky for an impartial medical examination. In a June 17, 2005 report, he provided a history of injury and treatment, reviewed the medical record and statement of accepted facts. Dr. Kovalsky noted findings on examination of tenderness in both hands, a possibly positive shrug test, pain at the CMC joint, worse on the right. He found full extension and flexion of all the interphalangeal joints, full range of motion of the thumbs and "no triggering in any of the fingers." Dr. Kovalsky opined that, under the fifth edition of the A.M.A., *Guides*, appellant had no upper extremity impairments due to restricted motion. As recent studies confirmed bilateral median nerve involvement at the wrist, he agreed with Dr. Mandel's nine percent rating for the left upper extremity. Regarding the right upper extremity,

[5] Table 16-2, page 439 of the fifth edition of the A.M.A., *Guides* is entitled "Conversion of Impairment of the Hand to Impairment of the Upper Extremity."

[6] Table 16-23, page 502 of the fifth edition of the A.M.A., *Guides* is entitled "Joint Impairment Due to Excessive Passive Mediolateral Instability."

[7] January 27, 2004 EMG (electromyography) and NCV (nerve conduction velocity) studies showed left carpal tunnel syndrome and bilateral C5-6 radiculopathy.

Dr. Kovalsky found a nine percent impairment due to ongoing median nerve symptoms at the wrist, according to Table 16-10a.[8]

On August 4, 2005 the Office requested that an Office medical adviser review Dr. Kovalsky's report and explain whether or not he concurred with the nine percent impairment rating "of the right hand." In an October 17, 2005 report, the Office medical adviser opined that appellant's clinical presentation most closely resembled page 495, paragraph 2 of the fifth edition of the A.M.A., *Guides*.[9] He explained that appellant's "clinical picture [did] not meet with the criteria that would utilize Table 16-10A as suggested by Dr. Kovalsky. It is therefore, [the medical adviser's] recommendation of zero SA [schedule award] and we reject both Dr. Rodriguez and Dr. Kovalsky's recommendation of nine percent." The medical adviser then recommended a five percent impairment rating of the right upper extremity.

By decision dated November 8, 2005, the Office awarded appellant a schedule award for a five percent impairment of the right upper extremity.

LEGAL PRECEDENT

The schedule award provisions of the Federal Employees' Compensation Act[10] 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.[11] As of February 1, 2001, schedule awards are calculated according to the fifth edition of the A.M.A., *Guides*, published in 2000.[12]

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[8] Table 16-10, page 482 of the fifth edition of the A.M.A., *Guides* is entitled "Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting from Peripheral Nerve Disorders." Section a. of Table 16-10 classifies impairment by grade according to the description of sensory deficit or pain and gives ranges for converting the grade of deficit into a percentage of impairment. A Grade 4 impairment, representing a sensory deficit of 0 to 25 percent, is characterized as "Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations of pain, that is forgotten during activity."

[9] Paragraph 2, page 495 of the fifth edition of the A.M.A., *Guides* provides that following an optimal recovery time after median nerve release, residual carpal tunnel syndrome with "[n]ormal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles" equaled "an impairment rating not to exceed 5 percent of" the upper extremity.

[10] 5 U.S.C. §§ 8101-8193.

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

[12] *See* FECA Bulletin No. 01-05 (issued January 29, 2001) (schedule awards calculated as of February 21, 2001 should be evaluated according to the fifth edition of the A.M.A., *Guides*. Any recalculations of previous awards which result from hearings, reconsideration or appeals should, however, be based on the fifth edition of the A.M.A., *Guides* effective February 1, 2001).

The standards for evaluation of the permanent impairment of an extremity under the A.M.A., *Guides* are based on loss of range of motion, together with all factors that prevent a limb from functioning normally, such as pain, sensory deficit and loss of strength. All of the factors should be considered together in evaluating the degree of permanent impairment.[13] Chapter 16 of the fifth edition of the A.M.A., *Guides* provides a detailed grading scheme and procedure for determining impairments of the upper extremities due to pain, discomfort, loss of sensation or loss of strength.[14]

Section 8123 of the Act 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.[15] In situations where there exist opposing medical reports of virtually equal weight and rationale and 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, must be given special weight.[16] However, in a situation where the Office secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[17]

ANALYSIS

The Office accepted that appellant sustained right carpal tunnel syndrome and stenosing tenosynovitis of the thumb, third and fourth digits, necessitating surgical release of the median nerve and the third and fourth "trigger fingers." A second opinion physician found no impairment of the right upper extremity whereas an attending physician found a nine percent impairment of the right upper extremity due to residual median neuropathy and restricted finger motion. Dr. Kovalsky, the impartial medical examiner, opined that appellant had a nine percent impairment of the right upper extremity due to residual median neuropathy according to Table 16-10a of the A.M.A., *Guides*. Table 16-10a sets forth percentages of sensory impairment due to peripheral nerve disorders. A 9 percent sensory impairment is encompassed by the 0 to 25 percent range of the Grade 4 classification, described as "[d]istorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity." However, Dr. Kovalsky did not use Table 16-15 to convert this nine percent sensory impairment to an upper extremity impairment due to median nerve involvement. Thus,

[13] *See Paul A. Toms*, 28 ECAB 403 (1987).

[14] A.M.A., *Guides*, Chapter 16, "The Upper Extremities," pages 433-521 (5th ed. 2001).

[15] 5 U.S.C. § 8123; *see Charles S. Hamilton*, 52 ECAB 110 (2000).

[16] *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[17] *Margaret M. Gilmore*, 47 ECAB 718 (1996).

his report was incomplete and required clarification.[18] But the Office did not request a supplemental report from Dr. Kovalsky.

The Office submitted Dr. Kovalsky's report to an Office medical adviser for review. However, the medical adviser did not discuss the incomplete nature of Dr. Kovalsky's opinion. Rather, he rejected Dr. Kovalsky's reasoning and opined that appellant had both a zero percent and a five percent impairment of the right upper extremity according to another grading scheme of the A.M.A., *Guides*. The Board has held that, while an Office medical adviser may review the opinion of an impartial medical specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility.[19] The Office issued the November 8, 2005 schedule award finding a five percent impairment of the right upper extremity, based on the Office medical adviser's opinion, without attempting to obtain a supplemental report from Dr. Kovalsky.

The Board finds that the conflict in medical opinion is unresolved and the Office should obtain a supplemental report from Dr. Kovalsky as to the percentage of permanent impairment of the right upper extremity.[20] Following this and all other development deemed necessary, the Office shall issue an appropriate decision in the case.

CONCLUSION

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

[18] *Id*.

[19] *See, e.g., Willie C. Howard*, 55 ECAB ___ (Docket Nos. 04-342 & 04-464, issued May 27, 2004) (where the Office medical adviser concurred that the impartial medical specialist's impairment rating was appropriate under the fifth edition of the A.M.A., *Guides*).

[20] *See, e.g., Elmer K. Kroggel*, 47 ECAB 557 (1996) (the Board remanded the case for the Office to obtain a supplemental report from the impartial medical specialist).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 8, 2005 is set aside and the case remanded to the Office for further development consistent with this decision.

Issued: June 15, 2006
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board