United States Department of Labor
Employees' Compensation Appeals Board

D.C., Appellant	)	
	)	
and	)	**Docket No. 06-541**
	)	**Issued: September 15, 2006**
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of the Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 10, 2006 appellant filed a timely appeal from an Office of Workers' Compensation Programs' merit decision dated August 30, 2005. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award decision.

ISSUE

The issue is whether appellant has more than a 16 percent impairment to her left upper extremity.

FACTUAL HISTORY

This is the second appeal before the Board. The Office accepted a claim for left carpal tunnel syndrome (CTS) and appellant filed a Form CA-7 claim for a schedule award based on partial loss of use of her left arm. After development of the medical evidence, the Office, on August 12, 1997, granted appellant an award under the schedule for a 10 percent impairment of the left arm for the period May 7 through December 11, 1997, for a total of 31.20 weeks of compensation. By decision dated July 6, 1998, an Office hearing representative affirmed the

Office's previous decision. In a January 9, 2001 decision,[1] the Board set aside the Office decisions. The Board found that there was an unresolved conflict in the medical evidence between the Office referral physician, Dr. Lawrence H. Schneider, a Board-certified orthopedic surgeon and Dr. Ronald J. Potash, a Board-certified surgeon, regarding the percentage of impairment in appellant's left upper extremity used under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (fifth edition) (A.M.A., *Guides*). The Board also found that there was a conflict of medical opinion regarding the method of evaluation of the permanent impairment. To resolve these conflicts of medical opinion, the Board remanded the case to the Office for referral of appellant to an appropriate impartial medical specialist. The complete facts of this case are set forth in the Board's January 9, 2001 decision and are herein incorporated by reference.

The Office referred appellant, the case file and a statement of accepted facts to Dr. Randall N. Smith, Board-certified in orthopedic surgery, for an impartial medical examination. In a report dated March 12, 2001, Dr. Smith stated:

> "As far as percentage of impairment, there is no significant loss of movement, ankylosis or other findings to suggest any document[ed] impairment rating. She would need an impairment rating test to determine anything beyond that."

The Office referred appellant for functional capacity testing, which occurred on August 6, 2001. In a report dated September 10, 2001, Dr. Smith reiterated his diagnoses of cervical radiculopathy and left CTS.

In an impairment evaluation dated September 27, 2001, an Office medical adviser found that appellant had a 10 percent impairment of her left upper extremity based on the A.M.A., *Guides*. He noted that her original award had been calculated in accordance with the fourth edition of the A.M.A., *Guides*, which had been superceded by the updated, fifth edition of the A.M.A., *Guides* in calculating impairments. The Office medical adviser found that appellant had an eight percent loss of use due to loss of motion, the standards of which were unchanged from the fourth edition of the A.M.A., *Guides*. He noted further that the fifth edition of the A.M.A., *Guides*, deleted the table of "upper extremity impairment duty to nerve entrapment," which provided the basis for the 10 percent award the Office previously granted appellant.

By decision dated September 27, 2001, the Office found that appellant was not entitled to an award greater than the 10 percent already awarded. By letter dated October 2, 2001, her attorney requested an oral hearing which was held on March 27, 2002. Counsel argued that Dr. Smith failed to provide an impairment rating in accordance with the A.M.A., *Guides* and failed to calculate an impairment based on appellant's preexisting cervical radiculopathy.

By decision dated May 9, 2002, an Office hearing representative set aside the September 27, 2001 Office decision. He found that Dr. Smith had authorized additional functional capacity testing but had failed to review the results of these tests. The hearing representative further found that Dr. Smith did not provide his own estimate of appellant's left upper extremity impairment and that the Office, contrary to the Board's instruction in its

[1] Docket No. 99-178 (issued January 9, 2001).

January 9, 2001 decision, had improperly relied on the Office medical adviser's impairment evaluation. The hearing representative, therefore, instructed the Office on remand to refer the case back to Dr. Smith to review the August 6, 2001 functional capacity evaluation, state the degree of impairment of the left upper extremity and explain his calculation pursuant to the applicable tables of the fifth edition of the A.M.A., *Guides*. The hearing representative further instructed the Office to ask Dr. Smith to describe any impairment of the limb related to the preexisting cervical radiculopathy and include it in his calculation.

In a report dated June 28, 2002, Dr. Smith stated that he had reviewed appellant's electromyogram (EMG), nerve conduction study and functional capacity evaluation (FCE), as requested. He did not offer any findings or conclusions regarding these tests. Dr. Smith did report regarding his findings as follows:

> "After reviewing the FCE, it is my opinion, based on the impairment report, that [appellant] does indeed have 15 degrees of left wrist flexion, 26 degrees of left wrist extension, 15 degrees of left wrist radial deviation, 23 degrees of left wrist ulnar deviation. This leads to an impairment rating of 751 and 1 percent respectfully, a total of 8 percent of the whole person. The left shoulder, she has 119 degrees of flexion, 19 degrees of extension, 43 degrees of abduction, 19 degrees of adduction, 41 degrees of internal rotation and 83 degrees of external rotation leading to an impairment of 41613 and 0 percent for a total of 9 percent impairment rating. In the cervical spine [appellant] has 50 degrees of flexion, 60 degrees of extension, 45 degrees of right and left rotation. This leads to an impairment of 24224 and 4 leading to a total impairment of the cervical spine contributing the whole body impairment of 18 percent.
>
> "Based strictly on the list, there would be a 16 percent permanent partial impairment of the left upper extremity and an 18 percent impairment of the cervical spine. I do not see the preexisting cervical radiculopathy leading to any limb impairments, thus, concluding there is a 16 percent impairment of the left upper extremity."

On February 4, 2003 the Office granted appellant a schedule award for an additional 6 percent impairment of the left upper extremity, totaling an overall 16 percent impairment for the period June 28 to November 6, 2002, for an additional 18.72 weeks of compensation.

By letter dated February 5, 2003, appellant's attorney requested a hearing, which was held on September 23, 2003. Counsel argued at the hearing that Dr. Smith's opinion was flawed because he failed to factor in all of her preexisting conditions, including failed to calculate an impairment based on appellant's preexisting cervical radiculopathy, in his overall impairment rating, in accordance with Federal (FECA) Procedure Manual, Part 3 -- Schedule Awards, *Determining Schedule Awards* Chapter 3.600 (April 1995).

In a decision dated December 15, 2003, an Office hearing representative affirmed the April 24, 2003 Office decision and denied appellant's claim for a greater additional award. He found that Dr. Smith's referee medical opinion was sufficiently well reasoned to represent the weight of the medical evidence.

Appellant thereafter appealed to the Board. By decision dated June 6, 2005, the Board remanded the case for reconstruction of the record to include the September 23, 2003 hearing transcript from the decision of the Office hearing representative dated December 15, 2003. By decision dated August 30, 2005, the Office reissued its February 4, 2003 decision granting appellant an award for a 16 percent left upper extremity impairment.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] sets 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. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[3] However, the Act does not specify the manner in which the percentage of loss of use of a member is to be determined. For consistent results and to insure equal justice under the law to all claimants, the Office has adopted the A.M.A., *Guides* (fifth edition) as the standard to be used for evaluating schedule losses.[4]

Regarding CTS, the A.M.A., *Guides* provide:

> "If, after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias and/or difficulties in performing certain activities, three possible scenarios can be present:
>
> "Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTS is rated according to the sensory and/or motor deficits as described earlier.
>
> "Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: [A] residual CTS is still present and an impairment rating not to exceed 5 percent of the upper extremity may be justified.
>
> "Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies: there is no objective basis for an impairment rating.[5]

The Board has previously stated:

> "When the Office an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires

[2] 5 U.S.C. §§ 8101-8193*; see* 5 U.S.C. § 8107(c).

[3] 5 U.S.C. § 8107(c)(19).

[4] 20 C.F.R. §10.404.

[5] A.M.A., *Guides* 495 (5th ed. 2001).

clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report. When the impartial medical specialist's statement of clarification or elaboration is not forthcoming or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative or lacks rational, the Office must submit the case record together detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question. Unless this procedure is carried out by the Office, the intent of section 8123(a) will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence."[6]

ANALYSIS

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

In the present case, the Office found that appellant was not entitled to an award greater than the 16 percent for left upper extremity impairment already awarded based on Dr. Smith's referee medical opinion. The Board finds, however, that the Office improperly relied on his opinion, which contains findings and conclusions that are insufficiently clear and comprehensible upon which to render a judgment. Dr. Smith appeared to rate appellant's motor deficits, but failed to identify any positive clinical findings of median nerve dysfunction and electrical conduction delay, which is prerequisite to rating CTS motor deficits. In addition, he failed to indicate the applicable tables and figures of the A.M.A., *Guides* upon which he relied in calculating his impairment rating. Regarding the left wrist, Dr. Smith's conclusion that appellant's motor deficits "leads to an impairment rating of 751 and 1 percent respectfully, a total of 8 percent of the whole person" in not explained and as such is nonsensical. Due to this lack of clarity, the Board is unable to render an informed judgment as to whether Dr. Smith's impairment was in conformance with the standards enunciated in the A.M.A., *Guides*.[7] The Board, therefore, finds that the Office erred in relying on Dr. Smith's June 28, 2002 report. On appeal, as well as before the Office, appellant's representative has continued to assert that all preexisting impairments of the scheduled member must be considered in the permanent

[6] *Roger W. Griffith*, 51 ECAB 491 (2000).

[7] With regard to impairment for decreased flexion/extension for the left wrist, section 16.4(g) of the A.M.A., *Guides*, sets out the procedure for rating impairments based on loss of wrist motion. The relative upper extremity functional value is converted pursuant to the guidelines presented in Figures 16-28 at page 467 and 16-31 at page 469. The specific procedure for calculating an impairment rating based on loss of flexion and extension is outlined at page 467 of the A.M.A., *Guides*, which states that ankylosis in functional positions corresponds to a 21 percent lower extremity impairment. The procedure for obtaining an impairment rating for radial and ulnar deviation is discussed at page 468-469 of the A.M.A., *Guides*. In order to render an upper extremity impairment rating based on radial and ulnar deviation, the examiner is instructed to use Figure 16-31 at page 469 for decreased left wrist radial/ulnar deviation ankylosis pursuant to Figure 16-31, at page 469.

impairment evaluation. Counsel is correct in his assertion. Pursuant to the Federal (FECA) Procedure Manual.[8]

> "Percentage of Impairment. A percentage evaluation of impairment is provided in terms of the affected member or function of the body (not the body as a whole, except where impairment to the lungs and other internal organs is at issue; see paragraph 4 below). The percentage should include those conditions accepted by [the Office] as job-related and any preexisting permanent impairment of the same member or function."

Accordingly, the Board will set aside the Office's August 30, 2005 decision and remand the case to the Office for further development of the medical evidence and determine whether appellant is entitled to a schedule award for impairment of the left upper extremity. On remand, the Office should refer her to a second impartial medical specialist for a well-rationalized, updated medical opinion, to specifically refer to the applicable tables and standards of the A.M.A. *Guides* in making his findings and conclusions and in rendering his impairment rating and to clearly indicate the specific background upon which he based his opinion.[9] After such development as it deems necessary, the Office shall issue a *de novo* decision.

CONCLUSION

The Board vacates and remands for further development the Office's determination that appellant is not entitled to any additional award based on impairment to her left upper extremity.

[8] Federal (FECA) Procedure Manual, Part 3 -- *Schedule Awards*: *Percentage of Impairment*, Chapter 3.700.3(a) (3) (February 1991).

[9] The Board notes that Dr. Smith's most recent report was issued on June 28, 2002 and that in order to provide accurate findings regarding appellant's current condition an updated medical evaluation and report is required. The Office should instruct the impartial medical specialist, on remand, to issue his impairment in accordance with the fifth edition of the A.M.A. *Guides*.

ORDER

IT IS HEREBY ORDERED THAT the August 30, 2005 decision of the Office of Workers' Compensation Programs be set aside and the case remanded to the Office for further action consistent with this decision of the Board.

Issued: September 15, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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