United States Department of Labor
Employees' Compensation Appeals Board

A.K., Appellant	)	
and	)	**Docket No. 07-72**
	)	**Issued: April 12, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Edison, NJ, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 10, 2006 appellant timely appealed an April 27, 2006 merit decision of a hearing representative of the Office of Workers' Compensation Programs concerning her entitlement to schedule award compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2), the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has established more than a 30 percent impairment of her right upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On January 10, 2003 appellant, then a 40-year-old mail carrier, filed an occupational disease claim stating that she had developed nerve damage to her right wrist and hand which she attributed to the repetitive activities required by her job duties. The Office accepted the claim for compression neuropathy of the right medial nerve and a right wrist opponensplasty, which appellant underwent on June 13, 2003. Appellant worked limited duty until her surgery. After

her surgery, she returned to limited duty on October 20, 2003. The Office paid all appropriate compensation.

On October 26, 2004 appellant filed a claim for a schedule award. In an April 1, 2004 report, Dr. Nicholas Diamond, a family practitioner, noted the history of injury, appellant's medical treatment and presented his examination findings. Utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*), he evaluated appellant's impairment and opined that she had a 64 percent right upper extremity impairment. Dr. Diamond found that appellant had a combined right upper extremity deficit of 61 percent, which comprised of: a 31 percent sensory deficit of the right median nerve;[1] a 30 percent right lateral pinch strength deficit;[2] and an 18 percent impairment for a 3/5 motor strength deficit right thumb abduction.[3] He additionally found that appellant had a three percent pain-related impairment.[4]

The record indicates that on December 20, 2004 an Office medical adviser reviewed the medical evidence and determined that appellant had an 11 percent right arm impairment for compression of the median nerve. It was reported that the Office medical adviser did not think the nerve in the left ring finger and its excision had any connection to the compression neuropathy. It was further reported that the Office medical adviser noted that the A.M.A., *Guides* did not provide for additional impairment ratings due to combined motor and sensory deficits to the median nerve or additional impairments for a pinch strength rating.

The Office found that a conflict in medical opinion had been created between Dr. Diamond and the Office medical adviser. On June 9, 2005 the Office referred appellant to Dr. Robert Dennis, a Board-certified orthopedic surgeon, to resolve the conflict in medical opinion on the extent of her permanent impairment of the right upper extremity.

In a report dated June 21, 2005, Dr. Dennis noted his review of the medical records, including a statement of accepted facts and provided his examination findings. He found that under the A.M.A., *Guides* appellant sustained 30 percent impairment to her right arm. Dr. Dennis advised that under the A.M.A., *Guides* appellant fell into a special category because she did not have a simple carpal tunnel syndrome which was decompressed before motor involvement occurred; rather, her motor involvement had occurred prior to surgical intervention. He noted that appellant had a severe median nerve compression with complete atrophy and flatness of the thenar eminence by the time surgical intervention was considered. Dr. Dennis opined that this situation altered the way appellant's permanent impairments were determined because it was appropriate to consider grip strength and pinch strength. He noted that appellant had not plateaued after undergoing the carpal tunnel release as anticipated by the A.M.A., *Guides* on this issue. Additionally, appellant's surgery, which required a tendon from the index finger to be transferred and rerouted to perform some of the functions of the opponens muscle, had

[1] A.M.A., *Guides* 492, Table 16-15 and 482, Table 16-10.

[2] *Id*. at 509, Table 16-34.

[3] *Id.* at 492, Table 16-15 and 484, Table 16-11.

[4] *Id.* at 574, Table 18-1.

permitted appellant to regain partial function of the thumb, but lose partial function of the index finger. Because of this unique surgical procedure, Dr. Dennis opined that the additional impairment which resulted from the moving of the tendon, superceded the statement on page 494 of the A.M.A., *Guides* which advises that decreased grip and pinch strength should not be considered in this impairment evaluation. Accordingly, he opined that the impairment evaluation should include the loss of grip and pinch strength in addition to the sensory loss from the neuropathy in this case, which he opined was a 30 percent impairment of the right upper extremity.

Dr. Dennis agreed with Dr. Diamond that appellant reached maximum medical improvement on April 1, 2004. Under Tables 16-6 and 16-7, page 448 of the A.M.A., *Guides*, the sensory loss of the thumb was valued at a 20 percent sensory impairment for the total radial digital nerve and a 10 percent sensory impairment for the partial loss to the index and ring finger. Under Tables 16-1 and 16-2, pages 438 and 439 of the A.M.A., *Guides*, Dr. Dennis converted the sensory impairment values to an impairment of the hand, combined such values and found a four percent total hand impairment, which converted to four percent upper extremity impairment. Under Tables 16-1, 16-2 and Figures 16-10, 16-11 and 16-12, pages 438, 439, 455 and 456 of the A.M.A., *Guides*, 50 degrees loss of flexion at the interphalangeal (IP) joint equated to a 10 percent motion unit impairment of the IP joint of the thumb which converted to a 2 percent upper impairment. Under Tables 16-1, 16-2 and Figure 16-15, pages 438, 439 and 457 of the A.M.A., *Guides*, 40 degrees loss of flexion at the metaphalangeal (MP) joint equated to a two percent thumb impairment, which converted to one percent upper extremity. Under Figure 16-18, page 459 of the A.M.A., *Guides*, a four centimeter radial adduction equated to a 20 percent motion unit loss which converted to a 4 percent thumb impairment under Table 16-8b, page 459 of the A.M.A., *Guides.* This converted to two percent upper extremity impairment under Tables 16-1, 16-2, pages 438, 439 of the A.M.A., *Guides*. Under Table 16-9, page 460 of the A.M.A., *Guides* a three centimeter thumb opposition loss equated to a 13 percent thumb impairment which, under Tables 16-1, 16-2, pages 438 and 439 of the A.M.A., *Guides*, equated to a 5 percent upper extremity impairment. Under Figure 16-21, page 461 of the A.M.A., *Guides*, Dr. Dennis found a zero percent impairment due to abnormal motion at the distal interphalangeal joint (DIP). Under Figure 16-23, page 463 and Tables 16-1, 16-2, pages 438 and 439 of the A.M.A., *Guides*, a 90 degree flexion of the proximal interphalangeal (PIP) joint equaled a six percent finger impairment which converted to a one percent upper extremity impairment. Under Table 16-34, page 509 of the A.M.A., *Guides*, a 20 percent loss of grip strength equaled 8 percent upper extremity impairment and a 40 percent loss of pinch strength equaled 7 percent upper extremity impairment, for a total impairment of 15 percent. Dr. Dennis further opined that, as a result of the diminished grip and pinch strength due to the tendon transfers, appellant had another 15 percent impairment.

In an August 6, 2006 report, an Office medical adviser reviewed Dr. Dennis' June 21, 2005 report and concurred with his impairment findings.

By decision dated September 14, 2005, the Office granted a schedule award for a 30 percent impairment of the right upper extremity. The period of the award ran for 93.60 weeks, from June 21, 2005 to April 7, 2007.

On September 19, 2005 appellant disagreed with the Office's September 14, 2005 decision and requested an oral hearing, which was held on February 24, 2006.

By decision dated April 27, 2006, an Office hearing representative affirmed the September 14, 2005 schedule award decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulation[6] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. However, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates 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 implementing regulation as the appropriate standard for evaluating schedule losses.[7]

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.[8] 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.[9] However, loss of grip strength impairment is used only in rare cases.[10] Additionally, decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated.[11]

Section 8123(a) of the Act[12] 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.[13] When 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 on a proper factual background, must be

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999).

[7] *Id.*

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

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

[10] *Id.* at 508. Loss of strength is rated separately only in a rare case where the examiner believes the impairment has not been considered adequately by other methods.

[11] *Id.* at 508.

[12] 5 U.S.C. §§ 8101-8193.

[13] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

given special weight.[14] When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in the original report.[15]

Office procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from a physician is obtained.[16]

ANALYSIS

The Board finds that this case is not in posture for decision. The Office found that a conflict had been created regarding appellant's degree of impairment. Dr. Diamond, appellant's treating physician, found 64 percent right arm impairment while the initial Office medical adviser reportedly found 11 percent right arm impairment. On June 9, 2005 the Office referred appellant to Dr. Dennis for an impartial evaluation. In a report dated June 21, 2005, Dr. Dennis advised that appellant reached maximum medical improvement on April 1, 2004 and concluded that she had 30 percent right upper extremity impairment. In an August 6, 2006 report, a second Office medical adviser assessed appellant's right upper extremity impairment based on Dr. Dennis' physical findings and the A.M.A., *Guides* and agreed that appellant was entitled to a 30 percent right arm impairment.

The Board finds, however, that Dr. Dennis' examination findings are not consistent with the A.M.A., *Guides* and requires further clarification. For example, Dr. Dennis found a 4 percent hand impairment which comprised of a 20 percent sensory loss of the thumb for the total radial digital nerve and a 10 percent sensory loss of the index finger. Under Tables 16-6, 16-1 and 16-2, pages 448 and 438-39 of the A.M.A., *Guides*, a 20 percent sensory loss of the thumb for the total radial digital nerve equals an 8 percent hand impairment or a 7 percent upper extremity impairment. Dr. Dennis found a 10 percent sensory impairment for partial loss to the index and ring finger. However, he did not identify which nerve was affected. Under Tables 16-1, 16-2 and 16-7, pages 438, 439 and 448 of the A.M.A., *Guides*, a partial sensory deficit of the radial digital nerve would result in a 15 percent digit impairment or 3 percent upper extremity impairment, while a partial sensory deficit of the ulnar digital nerve would result in a 10 percent digit impairment or a 2 percent upper extremity impairment. Thus, the combined sensory impairments for the thumb and the index finger would result in greater than the four percent upper extremity impairment found by Dr. Dennis, who also found that appellant had two percent upper extremity impairment due to a 40 degree loss of flexion at the MP joint. Under Tables 16-1, 16-2 and Figure 16-15, page 438, 439 and 457 of the A.M.A., *Guides*, 40 degree loss of flexion at the MP joint equals a 2 percent finger impairment, which converts to a 1 percent upper extremity impairment, not the 2 percent impairment found. Additionally, while Dr. Dennis explained why it would be appropriate in this case to include pinch and grip strength as part of

[14] *Barry Neutuch*, 54 ECAB 313 (2003); *David W. Pickett*, 54 ECAB 272 (2002).

[15] *See Adrienne L. Curry*, 53 ECAB 750 (2002).

[16] *See Thomas J. Fragale*, 55 ECAB 619 (2004). Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (August 2002).

appellant's impairment rating, the A.M.A., *Guides* specifically state decreased strength cannot be rated in the presence of decreased motion.[17]

Dr. Dennis' report along with the subsequent opinion of the Office medical adviser are of diminished probative value as Dr. Dennis' medical opinion is not based on proper application of the A.M.A., *Guides*. As previously noted, when the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in the original report.[18] Accordingly, the Board finds that the case must be remanded for further clarification of Dr. Dennis' opinion and the issuance of a supplemental report for a determination as to whether she is entitled to an increased schedule award based on her accepted work-related conditions. After such development as the Office deems necessary, an appropriate merit decision shall be issued.

CONCLUSION

The Board finds that this case is not in posture for decision to determine whether appellant is entitled to more than a 30 percent impairment of the right upper extremity, which the Office awarded.

ORDER

IT IS HEREBY ORDERED THAT the April 27, 2006 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further proceedings consistent with this decision.

Issued: April 12, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[17] *Supra* note 1 at 508. The remainder of Dr. Dennis' examination findings comport with the A.M.A., *Guides*.

[18] *See Adrienne L. Curry*, *supra* note 15.