United States Department of Labor
Employees' Compensation Appeals Board

W.B., Appellant	)	
and	)	**Docket No. 07-1548**
	)	**Issued: February 25, 2008**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Southeastern, PA, Employer	)	

Appearances:
Thomas 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
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 21, 2007 appellant, through counsel, filed a timely claim from a December 8, 2006 decision of an Office of Workers' Compensation Programs' hearing representative who affirmed an April 19, 2006 schedule award. 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 is whether appellant has established that she has more than 28 percent permanent impairment to her left arm and 10 percent permanent impairment to her right arm. On appeal, appellant contends that the Office should have referred her to an impartial medical examiner, as the opinion of the Office medical adviser created a conflict with that of her attending physician.

FACTUAL HISTORY

On August 10, 2000 appellant, then a 41-year-old postal clerk, filed a traumatic injury claim alleging that she had sharp pain and numbness in her hands and elbows after pulling

bundles of heavy magazines. The Office accepted her claim for bilateral carpal tunnel syndrome and bilateral adhesive capsulitis.

On September 28, 2005 appellant submitted a claim for a schedule award. She submitted the report of Dr. Nicholas Diamond, a Board-certified osteopathic physician specializing in pain management, who evaluated her upper extremities on June 16, 2005. Dr. Diamond noted that appellant had undergone a carpal tunnel release for her right hand in July 2001 and for her left hand in October 2001. He stated that an electromyogram and nerve conduction study from October 2002 revealed mild residual median neuropathy of the left wrist. Appellant reported stiffness and pain in both hands that waxed and waned. She reported numbness, weakness and hypersensitivity in her left wrist, especially at night. Appellant also reported that her pain was exacerbated by working, shopping and cooking and that she had difficulty with styling her hair, sleeping, fine dexterity, gripping, pushing, pulling and prolonged driving. Dr. Diamond stated that appellant's disability score on the self-reporting QuickDASH test was 47.5 percent.

On examination, Dr. Diamond found that appellant's right hand had palmar tenderness and that the Tinel's sign, one-minute Phalen's sign and carpal compression test were positive in the right wrist. He noted that her right wrist had dorsiflexion of 60 out of 75 degrees, palmar flexion of 60 out of 75 degrees, full radial deviation, and ulnar deviation of 30 out of 35 degrees. Appellant's left hand had palmar tenderness and the Tinel's sign, one-minute Phalen's sign and carpal compression test were positive in the left wrist. Dr. Diamond noted that appellant's left wrist had dorsiflexion of 50 out of 75 degrees, palmar flexion of 50 out of 75 degrees, full radial deviation, and ulnar deviation of 30 out of 35 degrees. He stated that she had pain with palmar flexion on the left. Semmes-Weinstein monofilament testing revealed diminished light-touch sensibility at 3.61 milligrams in the third and fourth fingers on the right hand and at 4.56 milligrams in the third and fourth fingers on the left hand. Grip strength testing using the Jamar Hand Dynamometer at level three showed seven kilograms of force strength on the right and three and a half kilograms on the left. Pinch key testing measured strength of two and a quarter kilograms in the right hand and one kilogram on the left. Appellant's upper arm circumferential measurements were 32 centimeters on the right and 33 on the left. The lower arm circumferential was 27.5 centimeters on the right and 27 on the left.

Dr. Diamond diagnosed repetitive use trauma resulting in carpal tunnel syndrome for both wrists and status post carpal tunnel release for both hands. He stated that appellant's cumulative and repetitive employment-related injury was competent to cause her subjective and objective findings. Using Figure 16-28, page 467 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A.., *Guides*) (5th ed. 2001), Dr. Diamond found that the range of motion deficit in appellant's left wrist dorsiflexion indicated an upper extremity impairment of two percent and that the deficit in left wrist palmar flexion indicated impairment of two percent, for a total of four percent. He stated that the sensory deficit caused by the left median nerve equaled 31 percent arm impairment using Table 16-15, page 492, in conjunction with Table 16-10, page 482. The left pinch deficit indicated an arm impairment of 30 percent on Table 16-33 and Table 16-34, page 509. Dr. Diamond found a pain-related impairment of three percent using Figure 18-1, page 574. He opined that the total left upper extremity impairment was 57 percent. Dr. Diamond reported that the sensory deficit caused by the right median nerve equaled 31 percent arm impairment using Table 16-15, page 492 in conjunction with Table 16-10, page 482. The right pinch deficit indicated an impairment of

20 percent on Tables 16-33 and 16-34, page 509. Dr. Diamond found a pain-related impairment of three percent using Figure 18-1, page 574. He opined that the total right upper extremity impairment was 48 percent. Dr. Diamond found that appellant reached maximum medical improvement on June 16, 2005. He made no findings related to adhesive capsulitis in appellant's shoulder.

On November 23, 2005 the Office submitted the medical evidence to the Office medical adviser for a determination of whether appellant was entitled to a schedule award. The Office medical adviser stated that Dr. Diamond's impairment rating incorrectly included pinch deficit on the left and right. He stated that the A.M.A., *Guides*, section 16.8A, page 508, indicates that strength loss could not be combined with other impairments in appellant's situation because the sensory deficit took precedence. The Office medical adviser also found that Dr. Diamond's assignment of three percent impairment for pain in the right and left extremities under Chapter 18 was incorrect because the sensory deficits identified on Table 16-10, page 482, of the A.M.A., *Guides*, already incorporated pain into the impairment estimate.

In rating appellant's permanent impairment, the Office medical adviser rated the range of motion deficits with the sensory deficit. Using Table 16-15, page 492, he found that an impairment of the median nerve before the mid forearm has a maximum upper extremity impairment of 39 percent. Applying this percentage to Table 16-10, page 482, he found that appellant's 60 percent Grade 3 sensory deficit yielded a left arm sensory impairment of 24 percent. The Office medical adviser found that appellant had a normal nerve conduction study and fewer symptoms in the right arm. He found that her sensory deficit was 25 percent, Grade 4 which resulted in a rating of 10 percent impairment when combined with the 39 percent impairment maximum for the median nerve. The Office medical adviser agreed with Dr. Diamond's range of motion impairment rating of four percent of the left arm. He utilized the Combined Values Chart to find a total left arm impairment rating of 28 percent. The right arm impairment was rated as 10 percent.

By decision dated April 19, 2006, the Office granted appellant schedule awards for 28 percent permanent impairment of her left upper extremity and 10 percent permanent impairment of her right upper extremity.

On May 3, 2006 appellant requested an oral hearing, which was held on October 16, 2006. She reported that she had no history of hand, arm or shoulder problems before working at the employing establishment. After her carpal tunnel releases and physical therapy, appellant continued to experience stiffness, tingling and pain in her finger, which sometimes radiated up her arms with nighttime pain and stiffness in her shoulders. Counsel contended that, although the Office medical adviser presented an alternative way to measure her impairment, appellant was entitled to the higher of the impairment ratings. He also contended that the Office medical rating created a conflict of medical opinion with Dr. Diamond.

By decision dated December 8, 2006, the Office hearing representative affirmed the Office's May 3, 2006 decision. He found that, because the Office medical adviser applied Dr. Diamond's findings on examination to the A.M.A., *Guides* and explained how he reached the impairment ratings, the Office properly relied on his opinion in rendering the schedule award.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulations[2] 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 should be determined. For consistent results and to ensure equal justice under the law for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standards applicable to all claimants.[3] Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[4]

The fifth edition of the A.M.A., *Guides*, regarding carpal tunnel syndrome, provides:

> "If, after 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 --
>
> > 1. Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual [carpal tunnel syndrome] is rated according to the sensory and/or motor deficits as described earlier.
> >
> > 2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal [electromyogram] testing of the thenar muscles: a residual [carpal tunnel syndrome] is still present and an impairment rating not to exceed five percent of the upper extremity may be justified.
> >
> > 3. 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 found that, in accordance with the fifth edition of the A.M.A., *Guides*, impairment arising from carpal tunnel syndrome should be rated on motor and sensory deficits only.[6] The A.M.A., *Guides* provides that, in compression neuropathies, additional impairment

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[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

[3] *Id*. at § 10.404(a).

[4] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[5] A.M.A., *Guides* 495; *Silvester DeLuca*, 53 ECAB 500 (2002).

[6] *Id*. at 494; *Robert V. Disalvatore*, 54 ECAB 351 (2003).

values are not given for decreased grip strength.[7] Carpal tunnel syndrome is an entrapment/compression neuropathy of the median nerve.[8]

ANALYSIS

The Board finds that this case is not in posture for a decision because the opinion of the Office medical adviser is insufficient to establish appellant's permanent impairment rating.

To determine appellant's impairment rating, the Office medical adviser combined her range of motion deficits with her sensory deficits. He noted that Table 16-15, page 492, limited the maximum upper extremity sensory deficit of the median nerve before the mid-forearm to 39 percent. Applying this percentage to Table 16-10, page 482, the Office medical adviser found that appellant's 60 percent sensory deficit yielded a left arm sensory impairment of 24 percent. He found that appellant's right arm had a normal nerve conduction study and fewer symptoms. The Office medical adviser therefore opined that her right median sensory deficit was 25 percent, or Grade 4 which resulted in a rating of 10 percent impairment when combined with the 39 percent impairment maximum from Table 16-15, page 492. He agreed with Dr. Diamond's range of motion impairment rating of four percent of the left arm. The Office medical adviser applied the Combined Values Chart to the left arm sensory and range of motion impairments to find a total left arm impairment of 28 percent. He found a right arm impairment of 10 percent.

The Board had held that, in schedule award cases where an examining physician has provided a description of physical findings but failed to properly apply the A.M.A., *Guides*, a detailed opinion by the Office medical adviser giving an impairment rating based on the reported findings and the A.M.A., *Guides* may constitute the weight of the medical evidence.[9] The Office procedures state that, when an Office medical adviser explains his or her opinion, shows values and computation of impairment based on the A.M.A., *Guides* and considers each of the reported findings of impairment, his or her opinion may constitute the weight of the medical opinion evidence.[10]

The Board finds that the impairment rating provided by the Office medical adviser is not sufficiently rationalized to constitute the weight of medical opinion.[11] When determining the left arm rating, the Office medical adviser provided no explanation for assigning a 60 percent sensory deficit to appellant's median nerve. He did not address Dr. Diamond's findings or state why he rejected Dr. Diamond's rating, which placed appellant's sensory deficit at 80 percent.

[7] *Id*. at 494; *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[8] *Id*. at 492.

[9] *James Massenburg*, 29 ECAB 850 (1978).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(h) (April 1993).

[11] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002) ("As a matter of course, the [Office medical adviser] should provide rationale for the percentage of impairment specified").

The Office medical adviser's assignment of 25 percent sensory deficit to appellant's right median nerve was also not adequately explained. He stated that the right arm rating was lower than the left because appellant had normal nerve conduction studies and fewer symptoms in that arm, but failed to explain which of Dr. Diamond's findings supported the percentage of the right median nerve deficit. Without adequate rationale, the Office medical adviser's medical opinion is of diminished probative value.[12] The Board notes that the Office medical adviser incorrectly included a rating for range of motion deficits in appellant's left wrist. The A.M.A., *Guides* states that impairment for carpal tunnel syndrome may be rated solely on motor and sensory deficits.[13] The Board finds that the impairment rating provided by the Office medical adviser is an insufficient basis for the Office's schedule award.

The impairment rating provided by Dr. Diamond is also of diminished probative value because he did not properly apply the A.M.A., *Guides*. Dr. Diamond found that appellant reached maximum medical improvement on June 16, 2005. He found that her right wrist had dorsiflexion of 60 degrees, palmar flexion of 60 degrees and ulnar deviation of 30 degrees. Appellant's left wrist had dorsiflexion of 50 degrees, palmar flexion of 50 degrees and ulnar deviation of 30 degrees. Dr. Diamond conducted Semmes-Weinstein monofilament testing, which revealed diminished light-touch sensibility at 3.61 milligrams and 4.56 milligrams, respectively, in the third and fourth fingers of the right hand and left hand. He reported that pinch key testing measured strength of 2.25 kilograms in the right hand and 1 kilogram on the left.

Dr. Diamond provided impairment ratings for both upper extremities. Based on Figure 16-28, page 467, of the A.M.A., *Guides*, he found that appellant's left wrist range of motion deficits for dorsiflexion and palmar flexion rated two percent each, for a total of four percent impairment.[14] Dr. Diamond stated that the sensory deficit caused by the left median nerve equaled 31 percent arm impairment using Table 16-15, page 492 and Table 16-10, page 482. He found 30 percent impairment for appellant's left pinch deficit based on Tables 16-33 and 16-34, page 509. Dr. Diamond found a left arm pain related impairment of three percent using Figure 18-1, page 574. For the right upper extremity, he referenced the same tables he did for the left upper extremity. Dr. Diamond rated the sensory deficit caused by the right median nerve as 31 percent arm impairment, the right pinch deficit as 20 percent impairment and a pain-related impairment as 3 percent.

Dr. Diamond provides inadequate rationale for his impairment rating. The Board has held that a medical opinions lacking in rationale is of diminished probative value.[15] Dr. Diamond incorrectly included separate ratings for range of motion, loss of pinch strength and

[12] *See* A.M.A., *Guides* 482 (method for determining impairment ratings).

[13] *Id*. at 495, section 16.5d; *see Kimberly M. Held*, 56 ECAB 670 (2005) (appellant with carpal tunnel syndrome incorrectly awarded for range of motion deficits).

[14] The Board notes that dorsiflexion is called extension in the A.M.A., *Guides* and palmar flexion is called extension.

[15] *Cecilia M. Corley*, 56 ECAB 662 (2005); *see Tara L. Hein*, 56 ECAB 431 (2005) (medical consultant's failure to explain selection of sensory deficit value on Table 16-10, page 482, basis for remand of case).

pain. As noted, however, the A.M.A., *Guides* indicate that only sensory and motor deficits are to be considered when rating impairment due to carpal tunnel syndrome.[16] Dr. Diamond impairment elements such as loss of range of motion and opinion through which are not allowed in rating compression neuropathy. The Board finds that his total impairment rating is insufficient to form the basis for a schedule award.

On remand, the Office should conduct the medical development necessary to determine the permanent impairment of appellant's upper extremities in accordance with the A.M.A., *Guides*. Following such development, the Office shall issue a *de novo* decision on appellant's schedule award.

CONCLUSION

The Board finds that this case is not in posture for a decision because the opinion of the Office medical adviser is insufficient to establish appellant's permanent impairment rating. The case is remanded for further medical development followed by an appropriate decision.

ORDER

IT IS HEREBY ORDERED THAT the December 8, 2006 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for action consistent with this decision.

Issued: February 25, 2008
Washington, DC

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

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

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

[16] A.M.A., *Guides* 495, section 16.5d.