United States Department of Labor
Employees' Compensation Appeals Board

G.T., Appellant	)	
and	)	**Docket No. 08-621**
	)	**Issued: September 10, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Bellmawr, 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:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 26, 2007 appellant filed a timely appeal from the February 7, 2007 merit decision of the Office of Workers' Compensation Programs, which denied an increased schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case. The Board also has jurisdiction to review the Office hearing representative's August 1, 2007 decision affirming the Office's denial.

ISSUE

The issue is whether appellant has more than a 25 percent permanent impairment of her right upper extremity.

FACTUAL HISTORY

On May 14, 1994 appellant, then a 45-year-old letter carrier, injured her right thumb when she tripped over a tray and put her hand out to stop her fall. The Office accepted her claim for right thumb sprain and de Quervain's disease, right wrist. Appellant received a schedule award for a 25 percent permanent impairment of her right upper extremity.

On the prior appeal,[1] the Board set aside the Office's June 4, 2004 decision affirming the denial of an increased schedule award and remanded the case for further development. The Board found that the opinion of the impartial medical specialist did not permit a proper application of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001):

> "Dr. Zeidman, the impartial medical specialist, reported that appellant had 'good motion' in both hands; it was symmetrical bilaterally. He also noted 'good residual motion' following her de Quervain's release. Although the Office interpreted these remarks to mean no loss of motion, Dr. Zeidman reported no actual measurements. This prevents the Board from using the A.M.A., *Guides* to determine as a matter of fact whether appellant has an impairment of her right upper extremity due to loss of motion.… A physician's description of 'full' or 'normal' or 'good' range of motion may well be accurate, but as a reviewing and adjudicatory body, the Board must be able to determine whether the clinical findings show any impairment under the protocols of the A.M.A., *Guides*.… The Board therefore cannot accept Dr. Zeidman's descriptions as 'full' or 'normal' or 'good' range of motion without specific range of motion findings to support this stated conclusion."[2]

After obtaining a supplemental report from the impartial medical specialist, the Office again denied an increased schedule award. An Office hearing representative found, however, that the impartial medical specialist still failed to provide the necessary clinical information. She remanded the case for referral to a second impartial medical specialist.

The Office referred appellant, together with the case record and a statement of accepted facts, to Dr. Stanley R. Askin, a Board-certified orthopedic surgeon, for an impartial medical evaluation. On October 20, 2006 Dr. Askin related appellant's history, reviewed medical evidence and described his findings on examination. He reported no objective clinical evidence of any right upper extremity impairment. Appellant had no objective restriction of motion for thumb or wrist. There was no atrophy, and appellant's reports of incredible insensitivity were not corroborated by abnormal skin appearance, lack of sweat or the presence of ulcerations that would occur in an insensate hand. Dr. Askin noted that appellant's complaints did not have the indicia of reliability, as she smiled while reporting she was hurting.

Dr. Askin explained the nature of de Quervain's disease -- a form of tendinitis affecting the abductor pollicis longus and extensor pollicis brevis tendons. Noting the applicable portion of the A.M.A., *Guides*, he reported that appellant "does not have objective findings of any other factor that would warrant a permanent impairment rating at this late date and tend[i]nitis is not an ipso facto determinant of permanent impairment." Dr. Askin concluded that appellant's condition did not present any justification based on the A.M.A., *Guides* for accepting that she still had a permanent condition pertaining to her accepted work injury. He added that appellant's

[1] Docket No. 05-1107 (issued September 20, 2005).

[2] The facts of this case, as set forth in the Board's prior decisions, are hereby incorporated by reference.

clinical presentation in 1997, as reported by her attending physician, was no longer an accurate depiction of her current musculoskeletal status.[3]

Following review by its medical adviser, the Office issued a decision on February 7, 2007 finding that Dr. Askin's opinion represented the weight of the medical evidence and established that appellant had no permanent impairment of the right upper extremity in excess of the 25 percent previously awarded. After an oral hearing on June 12, 2007, an Office hearing representative issued a decision on August 1, 2007 affirming the denial of an increased schedule award.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[4] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[5]

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.[6] When 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.[7]

When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires 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 rationale, the Office must submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question.[8] Unless this procedure is carried out by the Office, the intent of

[3] In 1997 appellant's physician reported a 58 percent impairment of the right upper extremity due to loss of thumb motion, various sensory nerve losses and loss of grip strength.

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999).

[6] 5 U.S.C. § 8123(a).

[7] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

[8] *See Nathan L. Harrell*, 41 ECAB 402 (1990).

the Act will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[9]

ANALYSIS

Dr. Askin, the orthopedic surgeon and impartial medical specialist, properly evaluated the impairment of appellant's right upper extremity due to loss of wrist motion. He reported 80 degrees dorsiflexion (extension) and 80 degrees palmar flexion (flexion) of the right wrist. According to Table 16-28, page 467 of the A.M.A., *Guides*, appellant has no impairment due to loss of wrist flexion or extension. Dr. Askin reported 35 degrees ulnar deviation and 20 degrees radial deviation, or no impairment under Table 16-31, page 469. Supination of 90 degrees and pronation of 80 degrees (measures of forearm rotation) show no impairment under Table 16-37, page 474.

Dr. Askin offered medical rationale sufficient to establish that appellant has no objective sensory loss. He noted the lack of reliability in reporting pain, the absence of atrophic or dystrophic changes about either hand and the lack of confirmation from sweat pattern or skin tone or ulcerations.

Dr. Askin reported thumb adduction to within one centimeter of the fifth metacarpal head, which represents no impairment under Table 16-8b, page 459. But his other findings relating to thumb motion require clarification. He reported "full" motion of thumb interphalangeal (IP), metacarpophalangeal (MP) and carpometacarpal (CMC) joints. As the Board explained on the prior appeal, such vaguely described findings as "full" motion of the thumb do not permit a proper application of the A.M.A., *Guides*. If appellant is able to flex her right thumb's IP joint to 80 degrees and extend it to at least +10 degrees,[10] if she is able to flex the MP joint to 60 degrees and extend it to 0, or the neutral position,[11] if she has at least 45 degrees radial abduction[12] and at least eight centimeters measured thumb opposition,[13] Dr. Askin should so report. Neither the Office nor the Board may assume that is what he means by "full" motion of the IP, MP and CMC joints.

Dr. Askin reported thumb abduction away from the index tip as 14½-17 cm. But Figure 16-16, page 458 of the A.M.A., *Guides*, measures thumb radial abduction in terms of the angle of separation formed between the first and second metacarpal in the coronal plane, not in terms of distance from the index tip. Dr. Askin did not report a finding for thumb opposition, measured in

[9] *Harold Travis*, 30 ECAB 1071 (1979).

[10] A.M.A., *Guides* 456 (Figure 16-12).

[11] *Id*. at 457 (Figure 16-15).

[12] *Id*. at 459 (Table 16-8a).

[13] *Id*. at 460 (Table 16-9).

centimeters as the largest achievable distance between the flexor crease of the thumb IP joint to the distal palmar crease directly over the third MP joint.[14]

Additional clarification is required for Dr. Askin's findings on grip strength: "Grip strength on the hand dynamometer is 10/14 at I; 12/18 at III, and 10/15 pounds at V." The Board can convert the reported pounds to the required kilograms, but Dr. Askin should make clear whether he means 10 pounds right/14 pounds left at Level I, 12 pounds right/18 pounds left at Level III and 10 pounds right/15 pounds left at Level V. It is important for the Office to note that decreased strength cannot be rated in the presence of decreased motion.[15]

Because Dr. Askin's findings for thumb motion pose the same problem as the findings of the previous impartial medical specialist, the Board must again set aside the Office decisions denying an increased schedule award and remand the case for a supplemental report that provides specific goniometric readings and linear distance measurements. The Office should ask Dr. Askin to compare his clinical measurements to the appropriate tables and figures in the A.M.A., *Guides*, not only for the six remaining units of thumb motion but for grip strength in Chapter 16.8b, pages 508 and 509. This will help ensure a proper evaluation of impairment under the A.M.A., *Guides*.

CONCLUSION

The Board finds that this case is not in posture for decision. The opinion of the impartial medical specialist requires clarification.

ORDER

IT IS HEREBY ORDERED THAT the August 1 and February 7, 2007 decisions of the Office of Workers' Compensation Programs are set aside. The case is remanded for further action consistent with this opinion.

Issued: September 10, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

[14] *Id*. at 459-60.

[15] *Id*. at 508.

Michael E. Groom, Alternate Judge, dissenting:

In the prior appeal, Dr. Zeidman found no permanent impairment to appellant's right arm caused by the accepted de Quervain's tenosynovitis. Examination by the physician was reported as somewhat inconsistent on sensory examination, with good residual motion and healing following surgery. Dr. Zeidman noted no objective signs of permanent impairment. In critiquing the report, the Board relied upon the Office procedure manual to find the report deficient as no actual range of motion measurements were reported. In this regard, the procedure manual provides:

"The report of the examination must always include the following:

> (1) A detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment."[16]

Based on the Board's remand, the Office referred appellant for a second impartial medical evaluation performed by Dr. Askin, a Board-certified orthopedic surgeon specializing in the hand. His examination of appellant also found no permanent impairment to the right upper extremity. Dr. Askin found no restriction of the right thumb or wrist, no atrophy of the right arm musculature and opined that appellant's complaints of "incredible insensitivity" were not corroborated and had no indicia of reliability. He noted full motion of the IP, MCP and CMC joints of both thumbs. Finkelstein's test for de Quervain's was negative bilaterally, although appellant reported a diffuse discomfort over the radial side of her right distal forearm. Dr. Askin addressed the nature of the accepted condition affecting the abductor pollicis longus and extensor pollicis brevis tendons that extend from the wrist into the thumb.[17] He reviewed the medical evidence from 1995, noting that repeat electromyograms were at best "borderline" for right carpal tunnel syndrome. Dr. Askin stated that Dr. Jani had suggested surgical release "out of frustration" in light of the lack of clear corroborative evidence. Upon surgery, he noted that Dr. Jani had injected the presumably affected area but that appellant did not get any relief. This inferred that either the injection did not reach the affected area or that appellant did not have de Quervain's. However, Dr. Askin recognized that he was guided by the statement of accepted facts in accepting the diagnosis of de Quervain's syndrome. He advised that there was no objective clinical evidence of any right upper extremity impairment and that appellant was capable of returning to full-duty work without restriction. With regard to the restriction of motion in terms of degrees of active retained motion, Dr. Askin's stated: "[Appellant] has no objective restriction of motion for the digits, thumbs, wrists, forearms, elbows, shoulders and neck. She did actively limit her thumb motion insofar as terminal adduction and abduction but this is not based upon any joint limitation but rather lack of exertion."

[16] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 8.808.6(c)(1) (August 2002).

[17] The function of the abductor pollicis longus is to abduct the thumb at the carpometacarpal (CMC) joint, thereby advancing the digit anterior relative to the palm of the hand.

As noted, the procedure manual simply provides that the report of an examination include, *where applicable, the loss* in degrees of motion of the affected member. When a physician finds no evidence of permanent impairment to the member and characterizes range of motion as "full," no applicable "loss" has been found. In this case, Dr. Askin set forth relevant range of motion measurements for the wrist and right thumb, the measurements reflecting no permanent impairment under the A.M.A. *Guides*. He identified the tendons which extend from the wrist into the thumb, advising that the nature of the accepted condition was an inflammation of the tendons which had resolved and did not warrant any permanent impairment rating. Dr. Askin is a Board-certified specialist in the applicable field. Having joined in the prior remand, I believe the medical evidence to be sufficiently developed to affirm the Office's determination that appellant has not established impairment greater than the 25 percent previously awarded. I would affirm the Office's decision denying an additional schedule award.

Michael E. Groom
Employees' Compensation Appeals Board