United States Department of Labor
Employees' Compensation Appeals Board

M.P., Appellant	)	
and	)	**Docket No. 09-451**
	)	**Issued: August 26, 2009**
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 December 4, 2008 appellant, through her representative, filed a timely appeal from the August 8, 2008 merit decision of the Office of Workers' Compensation Programs' hearing representative, which affirmed the schedule award for her left upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant has more than a 14 percent permanent impairment of her left upper extremity causally related to her December 28, 2000 employment injury.

FACTUAL HISTORY

On December 28, 2000 appellant, then a 29-year-old clerk, sustained a left arm injury while pitching mail in the performance of duty. The Office accepted her claim for left shoulder impingement and left carpal tunnel syndrome.

On May 10, 2005 appellant, through her representative, requested a schedule award. She submitted a February 23, 2005 rating from Dr. Nicholas P. Diamond, an osteopath, who related

appellant's history, including an electromyogram and nerve conduction study (EMG/NCV) from July 16, 2002 showing mild left carpal tunnel syndrome. Dr. Diamond described her complaints and his findings on physical examination. He reported positive clinical findings of median nerve dysfunction. Dr. Diamond diagnosed cumulative and repetitive trauma disorder, left shoulder impingement syndrome and bursitis and left carpal tunnel syndrome per EMG/NCV.

Dr. Diamond rated a 52 percent impairment of the left upper extremity: 2 percent for loss of shoulder motion, 6 percent for loss of wrist motion, 20 percent for left lateral pinch deficit, 31 percent for sensory deficit of the left median nerve and 3 percent for pain.

On April 1, 2006 an Office medical adviser reviewed Dr. Diamond's findings and determined that appellant had an 11 percent impairment of the left upper extremity. The medical adviser based this rating on Dr. Diamond's estimates for loss of shoulder and wrist motion and for pain. The medical adviser reported that the estimates for pinch deficit and sensory deficit of the median nerve did not correlate with the EMG findings of mild carpal tunnel syndrome and so he could not award those percentages.

The Office determined that a conflict in medical opinion existed between Dr. Diamond and the Office referral physician and referred appellant to Dr. David Rubinfeld, a Board-certified orthopedic surgeon, for an impartial medical evaluation. Dr. Rubinfeld found no permanent impairment.

On March 20, 2007 the Office denied appellant's claim for a schedule award. But on July 18, 2007 an Office hearing representative set aside that decision on grounds that the Office did not properly select Dr. Rubinfeld through the Physicians Directory System (PDS) and therefore his report had no probative value. The hearing representative remanded the case for a new impartial medical specialist.

The Office referred appellant to Dr. Norman M. Heyman, a Board-certified orthopedic surgeon. On November 29, 2007 Dr. Heyman related her history, reviewed her medical records and described his findings on physical examination. He explained that there were no physical findings with respect to any carpal tunnel syndrome. But Dr. Heyman did find a 14 percent impairment of the left upper extremity due to loss of shoulder motion.

On February 7, 2008 the Office issued a schedule award for a 14 percent permanent impairment of appellant's left upper extremity. In a decision dated August 8, 2008, an Office hearing representative affirmed, finding that Dr. Heyman's opinion represented the weight of the medical evidence. The hearing representative returned the case to the District Office to recalculate the schedule award based on evidence developed on a recurrent pay rate.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[1] 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

[1] 5 U.S.C. § 8107.

American Medical Associations, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2]

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.[3]

ANALYSIS

Appellant's representative argues that the Office failed to show that it used the PDS to select Dr. Heyman, a Board-certified orthopedic surgeon serving as impartial medical specialist. He argues that Dr. Heyman did not account for the EMG findings on July 16, 2002, which identified a mild left carpal tunnel syndrome. The representative argues that Dr. Heyman failed to provide any motor strength or grip strength or lateral pinch strength testing. He argues that the Office should have used a recurrent pay rate.

The argument raised by appellant's representative concerning Dr. Heyman's selection as the impartial medical specialist presupposes a conflict in medical opinion warranting such a selection through the PDS. The Board finds no conflict between appellant's osteopath and the Office medical adviser who reviewed his findings. Dr. Diamond's February 23, 2005 rating has such little probative value that it cannot support a finding of conflict warranting further development of the evidence. Further, the Office medical adviser was simply exercising his interpretative function to verify the correct application of the A.M.A., *Guides* and confirm the percentage of permanent impairment supported by Dr. Diamond's findings.

Every evaluation of impairment due to carpal tunnel syndrome starts with the three scenarios listed on page 495 of the A.M.A., *Guides*.[4] Each of these scenarios requires a comparison of clinical findings with EMG and NCV studies. Dr. Diamond reported positive clinical findings and he relied on an NCV study from three years earlier to proceed under Scenario 1.

In rating impairment of entrapment/compression neuropathies, such as carpal tunnel syndrome, sensory and motor deficits are evaluated according to the impairment determination method described in section 16.5b of the A.M.A., *Guides*. Additional impairment values are not given for decreased grip strength. In the absence of complex regional pain syndromes, additional

[2] 20 C.F.R. § 10.404.

[3] 5 U.S.C. § 8123(a).

[4] If, after optimal recovery time following surgical decompression for carpal tunnel syndrome, an individual continues to complain of pain, paresthesias 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 motor deficits as described in Chapter 16-5b. 2. Normal sensibility and opposition strength with abnormal sensory 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 NCVs. There is no objective basis for an impairment rating. A.M.A., *Guides* 495.

impairment values are not given for decreased motion.[5] Yet Dr. Diamond reported a 20 percent impairment for left lateral pinch strength deficit and a 6 percent impairment for loss of wrist motion. These ratings are inconsistent with the proper application of the A.M.A., *Guides* and cannot be considered in appellant's schedule award.

Dr. Diamond did report a 31 percent impairment due to sensory deficit of the left median nerve and he cited Table 16-15, page 492 and Table 16-10, page 482. But he did not show how he applied these tables. Table 16-15 gives the maximum upper extremity impairment due to unilateral sensory deficits. The Board assumes Dr. Diamond must have used 39 percent for the median nerve below the midforearm, but he did not so report. Table 16-10 provides a grading scheme and procedure for determining upper extremity impairment due to sensory deficits and Dr. Diamond may properly use that table to evaluate impairment due to carpal tunnel syndrome. But he did not report how he graded appellant's sensory deficit and what findings supported that grade and he did not report what percentage he used to multiply the percentage he obtained from Table 16-15. All Dr. Diamond's report shows is a rating of 31 percent with footnotes to tables and no explanation on how he applied them. This does not allow a reviewer to determine whether his rating for sensory deficit comports with the A.M.A., *Guides*. The Board finds, therefore, that Dr. Diamond's rating for sensory deficit of the left median nerve carries little weight.

Finally, there is Dr. Diamond's three percent rating for pain-related impairment. Discussing the difficulties associated with integrating pain-related impairment into an impairment rating system, the A.M.A., *Guides* states:

> "Finally, at a practical level, a chapter of the [A.M.A.,] *Guides* devoted to pain-related impairment should not be redundant of or inconsistent with principles impairment rating described in other chapters. The [A.M.A.,] *Guides'* impairment ratings currently include allowances for the pain that individuals typically experience when they suffer from various injuries or diseases, as articulated in Chapter 1 of the [A.M.A.,] *Guides*: 'Physicians recognize the local and distant pain that commonly accompanies many disorders. Impairment ratings in the [A.M.A.,] *Guides* already have accounted for pain. For example, when a cervical spine disorder produces radiating pain down the arm, the arm pain, which is commonly seen, has been accounted for in the cervical spine impairment rating' (p[age] 10). Thus, if an examining physician determines that an individual has pain-related impairment, he or she will have the additional task of deciding whether or not that impairment has already been adequately incorporated into the rating the person has received on the basis of other chapters of the [A.M.A.,] *Guides*."[6]

[5] A.M.A., *Guides* 494.

[6] *Id*. at 570.

So without a sound explanation for incorporating pain-related impairment,[7] Dr. Diamond's opinion does not justify a three percent increase in appellant's rating.

After one discounts Dr. Diamond's ratings for loss of wrist motion and lateral pinch deficit, which are not allowed and his rating for sensory deficit of the median nerve, which is not explained and his rating for pain-related impairment, which is not supported, there is nothing left on which to base a schedule award for left carpal tunnel syndrome. The only impairment rating Dr. Diamond provided that appears proper is his two percent rating for loss of shoulder flexion and abduction. His measurements and ratings are consistent with Table 16-40 and Table 16-43, pages 476-77.

When the Office medical adviser reviewed Dr. Diamond's evaluation and observed that significant upper extremity impairments of 20 percent for pinch deficit and 31 percent for sensory deficit of the median nerve did not correlate with the earlier EMG finding of mild carpal tunnel syndrome, he was simply noting a deficiency in Dr. Diamond's report, an apparent inconsistency and lack of medical reasoning. When he reported that Dr. Diamond's findings supported only an 11 percent impairment of the left upper extremity, he was not rendering a medical opinion in his own right. The Office medical adviser was simply reviewing another physician's report to verify the correct application of the A.M.A., *Guides* and to confirm the percentage of permanent impairment.[8] Such interpretive reviews are seldom if ever a basis for declaring a conflict under section 8123 of the Act. Indeed, it is well established that when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his opinion is of diminished probative value in establishing the degree of permanent impairment and the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[9]

Because there was no true conflict in medical opinion between Dr. Diamond and the Office medical adviser, Dr. Heyman is not considered an impartial medical specialist and his opinion does not carry special weight. He is, instead, an Office second-opinion physician, whose opinion may constitute the weight of the medical evidence.

Dr. Heyman, a Board-certified orthopedic surgeon, examined appellant on November 29, 2007 and made the following findings: shoulder flexion of 120 degrees; extension of 20 degrees; abduction of 100 degrees; adduction of 10 degrees; external rotation of 40 degrees and internal rotation of 60 degrees. These all add up to a 14 percent impairment of

[7] *See id*. ("When This Chapter Should Be Used to Evaluate Pain-Related Impairment").

[8] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Functions of the Medical Unit*, Chapter 3.200.4 (October 1990).

[9] *Linda Beale*, 57 ECAB 429, 434 (2006). In *Beale*, the attending physician reported a 43 percent impairment of the left upper extremity. An Office medical adviser reviewed the physician's findings and determined that the evidence did not demonstrate a loss of shoulder motion but did demonstrate a 10 percent impairment due to arthroplasty of the distal clavicle. The Board found that the medical adviser's findings constituted the weight of the medical evidence. Although the claimant's representative contended that a conflict existed between the attending physician and the Office medical adviser, the Board held that the evaluation by the attending physician did not conform to the A.M.A., *Guides* and was thus of diminished probative value.

the left upper extremity under Figures 16-40, 16-43 and 16-46, pages 476-79 of the A.M.A., *Guides*. This is what the Office awarded and appellant's representative does not dispute that percentage as far as it goes.

Appellant's representative argues, however, that it was improper for Dr. Heyman not to give a rating for median nerve deficiency, since a left carpal tunnel syndrome was identified on July 16, 2002. But Dr. Heyman reported no sign of carpal tunnel syndrome. There was no sign of peripheral nerve compression or entrapment. There was a negative Tinel's test over the median nerve at the wrist and Phalen I and II tests were negative. These findings are not necessarily inconsistent with the EMG/NCV study obtained five years earlier, which showed only a mild carpal tunnel syndrome.

But even claimants who lack positive clinical findings of carpal tunnel syndrome may be entitled to a schedule award for such if there are abnormal sensory or motor latencies or if there is an abnormal EMG testing of the thenar muscles. Under Scenario 2, page 495 of the A.M.A., *Guides*, such findings would indicate that a residual carpal tunnel syndrome was still present and an impairment rating not to exceed five percent of the upper extremity may be justified. Dr. Heyman did not obtain an EMG/NCV study and he did not have a reasonably current study to review. The Board therefore finds that clarification is warranted on whether appellant is entitled to a schedule award for residual carpal tunnel syndrome under Scenario 2.[10] The Board will set aside the Office's August 8, 2008 decision and remand the case for a supplemental report from Dr. Heyman on whether EMG/NCV findings support the presence of a residual carpal tunnel syndrome even in the absence of positive clinical findings. After such further development of the evidence as may be necessary, the Office shall issue an appropriate final decision on appellant's claim for a schedule award.[11]

CONCLUSION

The Board finds that this case is not in posture for decision on whether appellant has more than a 14 percent permanent impairment of her left upper extremity causally related to her December 28, 2000 employment injury. Although Dr. Heyman's opinion supports a 14 percent impairment of the left upper extremity due to loss of shoulder motion, further development is warranted on the issue of residual carpal tunnel syndrome.

[10] The Office has developed a checklist to provide guidance with respect to whether carpal tunnel syndrome is still present. Among the clinical findings the medical report should contain are decreased NCV, as measured during nerve conduction testing and decreased muscle motor activity, as measured by EMG. Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.8.c (September 1995).

[11] Because the hearing representative remanded the case to the Office to recalculate the schedule award in light of the evidence developed on a recurrent pay rate, the issue is in an interlocutory posture and not currently subject to review by the Board. 20 C.F.R. § 10.501.2(c)(2).

ORDER

IT IS HEREBY ORDERED THAT the August 8, 2008 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: August 26, 2009
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