United States Department of Labor
Employees' Compensation Appeals Board

B.P., Appellant	)	
and	)	**Docket No. 08-1457**
	)	**Issued: February 2, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, PA, 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 April 23, 2008 appellant filed a timely appeal from a December 12, 2007 decision of the Office of Workers' Compensation Programs denying her claim for an additional 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 more than 10 percent permanent impairment of her right upper extremity.

FACTUAL HISTORY

On May 18, 2000 appellant, then a 71-year-old mail handler, filed an occupational disease claim alleging that she developed right carpal tunnel syndrome due to repetitive hand and wrist movements. On August 22, 2000 the Office accepted her claim for right carpal tunnel

syndrome and surgical release on September 26, 2000.[1] Appellant subsequently filed a claim for a schedule award.

On March 7, 2001 Dr. Anthony W. Salem, a Board-certified orthopedic surgeon and an Office referral physician, provided findings on physical examination and found that appellant had no impairment of her right upper extremity. He stated that she had fully recovered from her carpal tunnel surgery.

In a March 12, 2002 report, Dr. David Weiss, an osteopathic physician specializing in orthopedic medicine, provided findings on physical examination and determined that appellant had 33 percent impairment of her right upper extremity, including 30 percent for grip strength deficit based on Tables 16-31 and 16-34 at page 509 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) fifth edition and 3 percent for pain based on Figure 18-1 at page 574. He found that she had 23 percent impairment of the left upper extremity, including 20 percent for grip strength deficit and 3 percent for pain.

On January 10, 2003 an Office medical adviser found a conflict in the medical opinion evidence between Dr. Salem and Dr. Weiss as to appellant's work-related right upper extremity impairment. He recommended an examination by an impartial medical specialist. The Office referred appellant, together with a statement of accepted facts, a list of questions and the case file, to Dr. William H. Spellman, a Board-certified orthopedic surgeon.

In a February 8, 2005 report, Dr. Spellman reviewed the history of appellant's condition and provided findings on physical examination. He stated that she had right upper extremity impairment because of ongoing median nerve neuropathy. Dr. Spellman noted that he could not determine whether the neuropathy represented a recurrence of appellant's right carpal tunnel syndrome or was secondary to her diabetes. He indicated that he could not determine the cause of her right upper extremity neuropathy without seeing the results of a diagnostic electromyogram (EMG). Dr. Spellman stated that appellant had no impairment due to decreased range of motion in her right wrist. A slight loss of range of motion in her right hand was due to age-related degenerative changes, not a work-related impairment.

By decision dated September 21, 2005, the Office denied appellant's claim for a schedule award causally related to her accepted May 1, 1999 right carpal tunnel syndrome. On January 25, 2006 an Office hearing representative set aside the September 21, 2005 decision and remanded the case for further development of the medical evidence. The hearing representative noted that Dr. Spellman requested an EMG of appellant's right upper extremity impairment so that he could determine the cause of her median nerve impairment. The hearing representative instructed the Office to schedule an EMG and provide the results to Dr. Spellman.

In a September 8, 2006 report, Dr. Yan Qi, a Board-certified neurologist and psychiatrist, stated that an EMG revealed bilateral median neuropathy in appellant's wrists caused by moderate-to-severe carpal tunnel syndrome. On January 10, 2007 the Office provided a new statement of accepted facts and Dr. Qi's EMG report to Dr. Spellman and requested a rating of appellant's right upper extremity impairment.

[1] The record reflects that appellant has underlying diabetic neuropathy on the right side.

In a February 28, 2007 report, Dr. Spellman stated that the September 8, 2006 EMG was consistent with severe bilateral carpal tunnel syndrome. He noted that the median nerve often does not fully recover following carpal tunnel release in patients who have diabetes. Dr. Spellman stated that he was unable to determine the role that diabetes played in appellant's right upper extremity condition, *i.e.*, whether she had significant recovery from her surgery but had developed carpal tunnel syndrome again due to compression of the median nerve or whether she did not experience significant recovery from her surgery. He found that appellant had 10 percent impairment of her right upper extremity and 6 percent impairment of the whole person based on a Grade 3 sensory impairment of the right median nerve and the A.M.A., *Guides*.

On April 2, 2007 Dr. Morley Slutsky, a Board-certified specialist in preventive medicine and an Office medical adviser, calculated that appellant had 10 percent right upper extremity impairment based on the February 28, 2007 report of Dr. Spellman.[2] He indicated that he agreed with Dr. Spellman's finding of a Grade 3 sensory deficit of appellant's right upper extremity and he indicated that 26 percent impairment according to Table 16-10 at page 482 of the A.M.A., *Guides*, multiplied by 39 percent for maximum impairment of the median nerve from Table 16-15 at page 494, yielded 10.14 percent (26 percent multiplied by 39 percent), rounded down to 10 percent.

By decision dated April 3, 2007, the Office granted appellant a schedule award based on 10 percent impairment of her right upper extremity for 31.20 weeks from February 8 to September 14, 2005.[3]

Appellant requested an oral hearing before an Office hearing representative that was held on September 28, 2007.

By decision dated December 12, 2007, the Office hearing representative denied appellant's claim for an additional schedule award.

[2] *See* Federal (FECA) Procedural Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[3] The Federal Employees' Compensation Act provides for 312 weeks of compensation for 100 percent loss or loss of use of the upper extremity. 5 U.S.C. § 8107(c)(10). Multiplying 312 weeks by 10 percent equals 31.20 weeks of compensation.

LEGAL PRECEDENT

Section 8107 of the 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]

Chapter 16 of the fifth edition of the A.M.A, *Guides* provides the framework for assessing upper extremity impairments.[6] Office procedures[7] provide that upper extremity impairment secondary to carpal tunnel syndrome and other entrapment neuropathies should be calculated using section 16.5d and Tables 16-10, 16-11 and 16-15.[8]

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

> "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--
>
> > (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 [in Tables 16-10a and 16-11a].
> >
> > (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."[9]

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[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

[6] A.M.A., *Guides* 433-521.

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

[8] A.M.A., *Guides* 491, 482, 484, 494, respectively.

[9] *Id*. at 495.

The Board has found that the fifth edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory deficits only.[10]

It is well established that in determining the amount of the schedule award for a member of the body that sustained an employment-related impairment, preexisting impairments are to be included in the evaluation of permanent impairment.[11]

Section 8123(a) of the Act provides that, "if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary [of Labor] shall appoint a third physician who shall make an examination."[12] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.

Board case precedent provides that, 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 deficiency in his original report. Only when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is incomplete, vague, speculative or lacking in rationale, should the Office refer the claimant to a second impartial specialist.[13]

ANALYSIS

Dr. Salem found that appellant had no right upper extremity impairment causally related to her accepted right carpal tunnel syndrome. Dr. Weiss found that she had 33 percent impairment, including 30 percent for grip strength deficit based on Tables 16-31 and 16-34 at page 509 of the A.M.A., *Guides* and 3 percent for pain based on Figure 18-1 at page 574.[14] Due to the conflict in the medical opinion evidence between the two physicians as to appellant's right upper extremity impairment, the Office properly referred her to Dr. Spellman for an impartial medical examination.

[10] *Kimberly M. Held*, 56 ECAB 670 (2005).

[11] *See Beatrice L. High*, 57 ECAB 329, 332 (2006).

[12] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

[13] *See Nancy Keenan*, 56 ECAB 687 (2005).

[14] The A.M.A., *Guides* provides that, "In compression neuropathies, additional impairment values are not given for decreased grip strength. A.M.A., *Guides* 494. Dr. Weiss erred in including grip strength in his impairment rating. He found that appellant had three percent impairment due to pain based on Chapter 18 of the A.M.A., *Guides*. However, the A.M.A., *Guides* warns that examiners should not use Chapter 18 to rate pain-related impairment for any condition that can be adequately rated on the basis of the body and organ impairment rating systems given in other chapters. A.M.A, *Guides* 571. Moreover, as the A.M.A., *Guides* explains: "The impairment ratings in the body organ system chapters make allowance for expected accompanying pain." *Id*. at 20. Dr. Weiss did not adequately explain why appellant's condition could not be rated in other chapters of the A.M.A., *Guides* or how her condition falls within one of the several situations identified under Chapter 18.3a. *Id*. at 570-71.

In his February 8, 2005 report, Dr. Spellman stated that he could not determine whether appellant's right upper extremity median nerve neuropathy represented a recurrence of her right carpal tunnel syndrome or was secondary to her diabetes unless he could review the results of a diagnostic EMG. A September 8, 2006 EMG revealed bilateral median neuropathy in appellant's wrists caused by moderate-to-severe carpal tunnel syndrome. In a February 28, 2007 report, Dr. Spellman stated that the EMG was consistent with severe bilateral carpal tunnel syndrome. He noted that the median nerve often does not fully recover following carpal tunnel release in patients who have diabetes. Dr. Spellman stated that he was unable to determine the role that diabetes played in appellant's right upper extremity condition, *i.e.*, whether she had significant recovery from her surgery but had developed carpal tunnel syndrome again due to compression of the median nerve or whether she did not experience significant recovery from her surgery. He found that appellant had 10 percent impairment of her right upper extremity based on a Grade 3 sensory impairment of the right median nerve and the A.M.A., *Guides*.[15] However, Dr. Spellman did not explain, with reference to specific sections of the A.M.A., *Guides*, how he determined appellant's 10 percent impairment. Additionally, as noted, preexisting impairments are to be included in the evaluation of permanent impairment. Dr. Spellman stated that he was unable to determine the contribution of appellant's diabetes to her right upper extremity impairment. Because his impairment rating does not include a consideration of how her diabetic condition affected her right upper extremity impairment and an explanation as to how he determined that she had 10 percent impairment of her right upper extremity, the rating is incomplete and is not sufficient to establish appellant's right upper extremity impairment.

Dr. Slutsky found that appellant had 10 percent right upper extremity impairment based on the February 28, 2007 report of Dr. Spellman. He indicated that he agreed with Dr. Spellman's finding of a Grade 3 sensory deficit of her right upper extremity and stated that a 26 percent impairment according to Table 16-10 at page 482 of the A.M.A., *Guides*, multiplied by 39 percent for maximum impairment of the median nerve from Table 16-15 at page 494, yielded 10.14 percent (26 percent multiplied by 39 percent), rounded down to 10 percent. However, Table 16-10 provides for a range of 26 to 60 percent impairment for Grade 3. Dr. Slutsky did not explain why he selected the lowest percentage of Grade 3 impairment, although one could infer that he applied 26 percent to the process of determining impairment based on Tables 16-10 and 16-15 because using 26 percent is consistent with Dr. Spellman's 10 percent impairment rating. However, neither physician provided a rationale for using the low end of the impairment percentage for a Grade 3 sensory deficit in Table 16-10. Further, the impairment ratings of Dr. Spellman and Dr. Slutsky do not appear to take into account any contribution of appellant's preexisting diabetic condition to her right upper extremity impairment. For these reasons, this case must be remanded for further development of the medical evidence. On remand, the Office should ask Dr. Spellman for a supplementary report explaining the contribution of appellant's preexisting diabetes to her right upper extremity impairment, a rationale for his choice of sensory deficit grade from Table 16-10 and an explanation for his choice of a specific percentage from the range of impairment percentage from Table 16-10. If Dr. Spellman is unwilling or unable to provide a supplementary report, the

[15] As noted, Dr. Spellman also stated that appellant had six percent whole person impairment. However, whole person impairment is not permitted under the Act. *See Guiseppe Aversa*, 55 ECAB 164, 167 (2003).

Office should refer appellant to another Board-certified medical specialist for an examination and impairment rating.

On appeal, appellant asserts that Dr. Spellman was not properly selected as the impartial medical specialist. She alleged that no reason was given for the cancellation of an examination by a Dr. Barry Silver prior to her examination by Dr. Spellman. A physician selected by the Office to serve as an impartial medical specialist should be wholly free to make a completely independent evaluation and judgment. To achieve this, the Office has developed specific procedures for the selection of impartial medical specialists designed to provide safeguards against any possible appearance that the selected physician's opinion is biased or prejudiced. The procedures contemplate that impartial medical specialists will be selected from Board-certified specialists in the appropriate geographical area on a strict rotating basis in order to negate any appearance that preferential treatment exists between a particular physician and the Office.[16] The Federal (FECA) Procedure Manual (the procedure manual) provides that the selection of referee physicians (impartial medical specialists) is made through a strict rotational system using appropriate medical directories. The procedure manual provides that the Physicians Directory System (PDS) should be used for this purpose wherever possible.[17] The PDS is a set of stand-alone software programs designed to support the scheduling of second opinion and referee examinations.[18] The PDS database of physicians is obtained from the American Board of Medical Specialties (ABMS) which contains the names of physicians who are Board-certified in certain specialties. In this case, the record contains a memorandum indicating that the Office could not reach agreement with Dr. Silver's staff regarding a written contract for appellant's examination. Therefore, there is an explanation of record for the cancellation of appellant's appointment with Dr. Silver. The Board finds that appellant failed to establish that the Office did not properly follow its procedures in selecting Dr. Spellman as the impartial medical specialist.

The Board notes appellant's assertion that bilateral carpal tunnel syndrome is the accepted condition in this case, rather than right carpal tunnel syndrome. The FECA Nonfatal Summary indicates that only right carpal tunnel syndrome has been accepted. The August 22, 2000 Office acceptance letter states that right carpal tunnel syndrome and related surgery is accepted. A January 10, 2007 statement of accepted facts states that right carpal tunnel syndrome is the accepted condition and highlights the word "right." The September 21, 2005 Office decision states that the accepted condition is right carpal tunnel syndrome and related surgery. A March 28, 2007 memorandum from a claims examiner to an Office medical adviser states that the accepted condition is right carpal tunnel syndrome with surgery. The September 28, 2000 and January 30, 2001 statements of accepted facts do not indicate what specific medical condition is accepted. Regarding appellant's assertion that the accepted condition is bilateral carpal tunnel syndrome, Office decisions dated January 25, 2006 and

[16] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4b (May 2003). *See also Willie M. Miller*, 53 ECAB 697 (2002); *Arden E. Butler*, 53 ECAB 680 (2002).

[17] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4b (May 2003).

[18] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.7 (September 1995, May 2003).

December 12, 2007 state that bilateral carpal tunnel syndrome has been accepted in this case. In the transcript of the September 28, 2007 hearing, the hearing representative stated that the Office accepted appellant's claim for bilateral carpal tunnel syndrome. A January 9, 2003 memorandum from a claims examiner to an Office medical director states that the accepted condition is bilateral carpal tunnel syndrome. Dr. Qi noted in his September 8, 2006 EMG report that appellant's condition was bilateral. In his February 28, 2007 report, Dr. Spellman stated that the EMG was consistent with moderately severe bilateral carpal tunnel syndrome. Due to the conflicting evidence, the Board finds that the record is unclear as to the accepted condition in this case. On remand, the Office should determine whether the accepted condition is right carpal tunnel syndrome or bilateral carpal tunnel syndrome. If bilateral carpal tunnel syndrome is the accepted condition, it should develop the medical evidence on the issue of appellant's entitlement to a schedule award for left carpal tunnel syndrome.

CONCLUSION

The Board finds that this case is not in posture for a decision. On remand, the Office should ask Dr. Spellman for a supplementary report explaining the contribution of appellant's preexisting diabetes to her right upper extremity impairment, a rationale for his choice of sensory deficit grade from Table 16-10 and an explanation for his choice of a specific percentage from the range of impairment percentage from Table 16-10. If it cannot obtain a supplementary report from Dr. Spellman, it should refer appellant to another Board-certified medical specialist for an examination and impairment rating. The Office should also determine whether appellant has work-related left carpal tunnel syndrome and, if so, whether she has any permanent impairment causally related to that condition.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 12, 2007 is set aside and the case remanded for further action consistent with this decision.

Issued: February 2, 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