United States Department of Labor
Employees' Compensation Appeals Board

B.P., Appellant	)	
	)	**Docket No. 08-2236**
and	)	**Issued: May 8, 2009**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 12, 2008 appellant filed a timely appeal of a July 8, 2008 schedule award decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than 10 percent permanent impairment of the left and right upper extremities, for which she received schedule awards.

FACTUAL HISTORY

On April 1, 2006 appellant, then a 44-year-old mail handler, filed an occupational disease claim alleging that she developed bilateral carpal tunnel syndrome from repetitive duties at work. She became aware of her condition in August 2005 and realized it was caused by her employment in September 2005. Appellant stopped work on April 15, 2006 and worked intermittently thereafter. The Office accepted the claim for bilateral carpal tunnel syndrome and paid appropriate compensation benefits.

A January 16, 2006 electromyogram (EMG) revealed findings compatible with minimal incipient compression of the median nerves at the flexor retinaculum (carpal tunnel syndrome) with no evidence of diffuse large fiber neuropathy, brachial plexopathy, cervical radiculopathy or other nerve entrapment neuropathy. From March 16 to May 11, 2006 appellant came under the treatment of Dr. Stuart L. Trager, a Board-certified orthopedic surgeon, who diagnosed mild carpal tunnel syndrome and recommended wrist splints. He was also treated by Dr. John S. Taras, a Board-certified orthopedic surgeon, from June 1 to July 20, 2006, for bilateral hand numbness, tingling and pain. Dr. Taras noted a history of injury with progressively worsening of symptoms. He noted findings upon physical examination of positive Tinel's sign over both carpal tunnels, negative Phalen's test bilaterally and normal sensation to light touch present in all digits. Dr. Taras diagnosed bilateral carpal tunnel syndrome and recommended splints and physical therapy. In a work capacity evaluation dated July 20, 2006, he diagnosed bilateral carpal tunnel syndrome and noted maximum medical improvement had not been reached.

On July 2, 2006 appellant filed a claim for a schedule award. On July 31, 2006 Dr. Taras diagnosed bilateral carpal tunnel syndrome and noted maximum medical improvement had not been reached. In a letter dated August 7, 2006, the Office advised appellant that the medical evidence in her case did not demonstrate that she reached maximum medical improvement and could not be considered for a schedule award. In a September 25, 2006 work capacity evaluation, Dr. Taras diagnosed bilateral carpal tunnel syndrome and advised that appellant reached maximum medical improvement.

On October 13, 2006 the Office requested that appellant submit a report from her physician providing an impairment rating in conformance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[1] (A.M.A., *Guides*). In a September 25, 2006 report, Dr. Taras reiterated that she reached maximum medical improvement and had permanent impairment to both her arms. In a November 20, 2006 report, he noted that appellant was a candidate for bilateral carpal tunnel release surgery but that she had chosen not to have surgery. Dr. Taras opined that appellant had permanent impairment.

By letter dated February 9, 2007, the Office requested that Dr. Taras provide an impairment rating. On a February 26, 2007 Dr. Taras noted work restrictions. He did not address any permanent impairment of her upper extremities.

By decision dated May 4, 2007, the Office denied appellant's claim for a schedule award.

On March 25, 2008 appellant requested reconsideration. In reports dated September 24 and November 26, 2007, Dr. Taras noted findings upon physical examination of full active range of motion of the bilateral wrist and digits, normal manual muscle test for all muscle groups in the bilateral upper extremities and positive Phalen's test and positive Tinel's sign at her bilateral carpal tunnels. He diagnosed bilateral carpal tunnel syndrome and noted appellant had no appreciable progression of her carpal tunnel syndrome and should be able to work full duty.

In an October 23, 2007 impairment rating, Dr. Daisy A. Rodriguez, a Board-certified physiatrist, advised that appellant reached maximum medical improvement on

[1] A.M.A., *Guides* (5th ed. 2001).

November 20, 2006. She noted that physical examination of the hands revealed mild atrophy of the thenar eminences, positive Tinel's sign on the right, moderate decrease in sensation to light touch from the index, middle and ring fingers bilaterally with sensation to light touch was decreased in the left hand at the index, middle and radial fourth digits. Dr. Rodriguez advised that grip strength testing on the right via Jamar Hand Dynamometer at Level III revealed 12.1 kilogram (kg) of force strength on the right versus 10 kg of force strength on the left which equated into a 48 percent strength deficit to the right hand and 53 percent strength deficit on the left hand. She diagnosed bilateral carpal tunnel syndrome, functional activity decrease, osteoarthrosis of the hand bilaterally and chronic pain. Based on the A.M.A., *Guides*, appellant had 24 percent deficit of the right arm, Grade 3 sensory deficit, for pain in the distribution of the median nerve below the midforearm, under Table 16-10 of the A.M.A., *Guides*.[2] Dr. Rodriguez noted that, for sensory deficit or pain, appellant would be classified as Grade 3, for a 60 percent sensory deficit or pain,[3] in the distribution of median nerve below the midforearm.[4] The A.M.A., *Guides* provides that the maximum allowed for total impairment of the median nerve below the midforearm is 39 percent. Dr. Rodriguez noted that, when the maximum for the median nerve, 39 percent, is multiplied by the 60 percent allowed for a Grade 3 sensory deficit, this yields 23.4 rounded to 24 percent, for sensory loss.[5] She further noted appellant had 20 percent impairment for grip strength deficit[6] and 2 percent impairment due to abnormal motion at the metacarpophalangeal (MP) joint,[7] for 40 percent impairment of the right upper extremity. For the left arm, Dr. Rodriguez noted that appellant had 24 percent impairment for a Grade 3 sensory deficit or pain of the median nerve below the midforearm, as noted above, 20 percent for grip strength deficit, and 2 percent impairment due to abnormal motion at the MP joint for 40 percent impairment of the left upper extremity. She opined that the diagnosis was attributable to appellant's work injuries.

Dr. Rodriguez's report of October 23, 2007 and the case record were referred to the Office medical adviser. In a report dated June 23, 2008, the Office medical adviser determined that appellant had 10 percent impairment for both the right and left upper extremities. The medical adviser indicated that Dr. Rodriguez found decreased sensation to light touch over the left index, middle and ring fingers, decreased grip strength bilaterally and decreased range of motion for the MP joints; however, these observations were in direct conflict with Dr. Taras' findings who noted normal light touch, no grip strength deficit and no decreased range of motion of the digits. The medical adviser noted that Dr. Taras was the treating physician and a well known hand surgeon and his opinion was the weight of the evidence. The medical adviser further noted that carpal tunnel syndrome was a compression neuropathy and Dr. Rodriguez's determination of impairment for decreased grip strength was not valid because there was no

[2] *Id.* at 482, 492, Table 16-10, 16-15.

[3] *Id.* at 482, Table 16-10.

[4] *Id.* at 492, Table 16-15.

[5] *Id.* at 482, 492, Table 16-10, 16-15.

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

[7] *Id.* at 464, Table 16-25.

award for grip strength deficit in a compression neuropathy under the A.M.A., *Guides*.[8] He noted appellant had 10 percent impairment on the right for Grade 4 sensory deficit or pain of the median nerve below the midforearm,[9] and 10 percent impairment on the left for Grade 4 sensory deficit or pain of the median nerve below the midforearm.[10]

In a decision dated July 8, 2008, the Office granted appellant a schedule award for 10 percent impairment of the right upper extremity and 10 percent impairment of the left upper extremity. The period of the award was from October 23, 2008 to January 1, 2009.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[11] and its implementing regulations[12] 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 regulations as the appropriate standard for evaluating schedule losses.[13]

ANALYSIS

On appeal, appellant asserts that she is entitled to a schedule award greater than 10 percent permanent impairment of the right and left upper extremities. The Board finds that there is a conflict in medical opinion between the Office medical adviser and Dr. Rodriguez, appellant's treating physician.

The Office medical adviser, on June 23, 2008, opined that based on the A.M.A., *Guides* appellant sustained 10 percent impairment of both the right and left upper extremity. He noted that appellant would be entitled to a schedule award for 10 percent impairment on the right for a Grade 4 sensory deficit or pain involving the median nerve below the midforearm,[14] and 10 percent impairment on the left for Grade 4 sensory deficit or pain of the median nerve below the midforearm.[15] By contrast, Dr. Rodriguez in her report dated October 23, 2007 also applied the A.M.A., *Guides* and found that appellant sustained a 24 percent impairment bilaterally for

[8] *Id.* at 508.

[9] *Id.* at 482, 492, Table 16-10, 16-15.

[10] *Id.* at 482, 492, Table 16-10, 16-15.

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404 (1999).

[13] *See id.*; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

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

[15] *Id.* at 482, 492, Table 16-10, 16-15.

Grade 3 sensory deficit or pain of the median nerve below the midforearm[16] and noted findings of moderate decrease in sensation to light touch from the index, middle and ring fingers bilaterally to support her determination. She supported a higher impairment rating of each arm while the Office medical adviser opined that appellant had no more than a 10 percent permanent impairment of both the right and left upper extremity.[17]

Section 8123(a) of the Act provides in pertinent part: "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."[18] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.[19] The Board finds that the Office should have referred appellant to an impartial medical specialist to resolve the medical conflict regarding the extent of permanent impairment arising from appellant's accepted employment injury.

Therefore, to resolve the conflict in the medical opinions, the case will be remanded to the Office for referral of appellant, the case record and a statement of accepted facts, to an impartial medical specialist for a determination regarding the extent of appellant's upper extremity impairment in accordance with the relevant standards of the A.M.A., *Guides*.[20] After such further development as the Office deems necessary, an appropriate decision should be issued regarding the extent of appellant's impairment of each arm.

CONCLUSION

The Board finds that this case is not in posture for decision.

[16] *Id.* at 482, 492, Table 16-10, 16-15.

[17] The Board notes that Dr. Rodriguez incorrectly found impairment for grip strength deficit and lost range of motion. There generally is no award for grip strength deficit or decreased motion in a compression neuropathy under the A.M.A., *Guides. See* A.M.A., *Guides* 494. 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. *T.A.*, 59 ECAB ___ (Docket No. 07-1836, issued November 20, 2007).

[18] 5 U.S.C. § 8123(a).

[19] *William C. Bush*, 40 ECAB 1064 (1989).

[20] *See Harold Travis*, 30 ECAB 1071, 1078-79 (1979).

ORDER

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

Issued: May 8, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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