United States Department of Labor
Employees' Compensation Appeals Board

P.H., Appellant	)	
and	)	**Docket No. 09-229**
	)	**Issued: September 29, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Westville, 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 October 30, 2008 appellant filed a timely appeal from November 27, 2007 and July 30, 2008 decisions of the Office of Workers' Compensation Programs adjudicating his claim for a 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 11 percent impairment to his left upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On August 29, 2000 appellant, then a 45-year-old letter carrier, filed a claim for left carpal tunnel syndrome and a left elbow condition sustained on August 14, 2000 due to holding mail for long periods of time and repetitive twisting, turning and pulling motions. On July 3, 2001 his claim was accepted for tendinitis (inflammation of a tendon), tenosynovitis (tendinitis with tendon sheath inflammation) and synovitis (inflammation of the synovial membrane lining

the joints) of the left wrist and left elbow. On March 3, 2004 appellant filed a claim for a schedule award.[1]

In an October 10, 2003 report, Dr. Nicholas Diamond, an osteopathic physician specializing in pain management, reviewed appellant's medical history and provided findings on physical examination. He diagnosed left carpal tunnel syndrome and left elbow lateral epicondylitis. Dr. Diamond stated that there was olecranon and lateral epicondyle tenderness of the left elbow. Tinel's sign was negative. Flexion-extension range of motion was 0 to 145 degrees, pronation was 80 degrees with pain, supination was 80 degrees. Left wrist hyperextension sign was negative. Left wrist range of motion was 65 degrees of dorsiflexion, 65 degrees of palmar flexion, radial deviation of 20 degrees with pain and ulnar deviation of 35 degrees with pain. Grip strength testing with a Jamar Hand Dynamometer at level three revealed 36 kilograms (kg) of force in the dominant right hand and 28 kg in the left. Manual muscle strength testing revealed a grade of 4-4+/5 in the left upper extremity. Sensory examination revealed decreased sensation to light touch and pin prick over the median nerve distribution of the left upper extremity. Subjective complaints included left elbow medial aspect tenderness and left wrist and hand pain and weakness. Dr. Diamond calculated 48 percent combined impairment to the left upper extremity, including 20 percent for left grip strength deficit, based on Table 16-32 and 16-34 at page 509 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), 31 percent for sensory deficit of the left median nerve, based on Table 16-10 at page 482 and 3 percent for pain-related impairment, based on Figure 18-1 at page 574.[2]

In reports dated March 26 and April 20, 2004, an Office medical adviser calculated 11 percent left upper extremity impairment based on Dr. Diamond's report and appellant's accepted left carpal tunnel syndrome.[3]

By decision dated July 27, 2004, the Office granted appellant a schedule award based on 11 percent left upper extremity for 34.32 weeks, from October 30, 2003 to June 26, 2004 at the two-thirds rate for employees without dependents.[4]

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[1] Appellant has a claim accepted for left elbow tendinitis, synovitis and tenosynovitis and left carpal tunnel syndrome sustained on September 28, 1999. The Office combined these two cases.

[2] Combining 31 percent, 20 percent and 3 percent according to the Combined Values Chart at page 604 of the fifth edition of the A.M.A., *Guides*, equals 47 percent combined impairment, not 48 percent (31 combined with 20 according to the chart is 45 percent combined impairment, 45 combined with 3 is 47).

[3] *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).

[4] 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 11 percent equals 34.32 weeks of compensation.

On August 17, 2005 an Office hearing representative remanded the case for further development of the medical evidence. He stated that Dr. Diamond provided insufficient explanation as to how he calculated appellant's left upper extremity impairment. Additionally, it was not clear whether the Office medical adviser included appellant's accepted left elbow conditions in his calculation of 11 percent left upper extremity impairment.

By decision dated December 21, 2005, the Office denied appellant's claim for more than 11 percent left upper extremity impairment. By decision dated July 11, 2006, an Office hearing representative remanded the case for further development of the medical evidence. She found that reports dated October 19, November 28 and December 21, 2005 from an Office medical adviser who reviewed Dr. Diamond's report were insufficient to establish appellant's left upper extremity impairment. On November 7, 2006 the Office found that his schedule award compensation should be based on the augmented three-fourths compensation rate for employees with dependents.

On March 12, 2007 Dr. Henry J. Magliato, a Board-certified orthopedic surgeon and an Office medical adviser, calculated 28 percent left upper extremity impairment, including 10 percent for sensory deficit of the median nerve, based on Table 16-15 at page 492 and Table 16-10 at page 482 of the fifth edition of the A.M.A., *Guides* (39 percent maximum for the median nerve multiplied by 25 percent for Grade 4 deficit equals 9.75 percent, rounded to 10 percent[5]) and 20 percent for grip strength deficit, based on Tables 16-32 and 16-34 at page 509 (47.3 kg normal grip strength for the nondominant hand of a male between the ages of 40 and 49, minus appellant's 28 kg strength, divided by 47.3 kg, equals a 40 percent strength loss index which equals 20 percent upper extremity grip strength deficit). According to the Combined Values Chart at page 604 of the A.M.A., *Guides*, 20 percent combined with 10 percent results in 28 percent combined impairment.

By letter dated March 16, 2007, the Office asked Dr. Diamond to explain how he calculated 31 percent left upper extremity impairment for sensory loss in his October 10, 2003 report. There was no response from Dr. Diamond.

The Office found a conflict in the medical opinion evidence between Dr. Diamond and Dr. Magliato. On September 7, 2007 it referred appellant, together with a statement of accepted facts, a list of questions and the medical record, to Dr. Zohar Stark, a Board-certified orthopedic surgeon, for an examination and an independent evaluation of his left upper extremity impairment.[6]

In a September 27, 2007 report, Dr. Stark reviewed the medical history and provided findings on physical examination. The medical history revealed that an electromyogram (EMG)

[5] Dr. Magliato indicated that Dr. Diamond's calculation of 31 percent sensory deficit was incomplete because he did not specify a grade from Table 16-10 in his report or reference Table 16-15 at page 492 regarding the median nerve. He indicated that Table 16-10 includes impairment for sensory deficit and pain and Dr. Diamond did not explain why an additional three percent impairment for pain based on Chapter 18 was warranted.

[6] The record for sub file number xxxxxx215 shows that the Office selected Dr. Stark through the Physicians Directory Service (PDS), on a strict rotational basis, to act as an impartial medical specialist evaluating appellant's schedule award claim under the two combined case files.

and nerve conduction velocity tests were positive for left carpal tunnel syndrome. Dr. Stark noted that appellant had left wrist and left elbow pain described as an 8 in severity on a scale of 0 to 10. The pain woke him up at night. Appellant experienced difficulty performing tasks such as cutting the grass. He had numbness over the volar aspect of the left wrist. Appellant had local tenderness over the lateral epicondyle of his left elbow and the extensor tendon in the proximal forearm. There was no swelling or erythema. Flexion in the left elbow was measured at 150 degrees with 0 degrees of extension. Pronation and supination measured 80 degrees.[7] No instabilities were noted. There was no increased pain in the elbow with resisted extension of the wrist. Tinel's test was negative for entrapment of the ulnar or radial nerves of the left elbow. Examination of the left wrist revealed no swelling. There was local tenderness on palpation over the volar aspect of the wrist and over the ulnar and radial margins. Range of motion measurement of the left wrist revealed 60 degrees of dorsiflexion, 70 degrees palmar flexion, 20 degrees radial deviation and 30 degrees ulnar deviation.[8] There was no atrophy of the thenar muscles. Tinel's and Phalen's tests were negative for entrapment of the median or ulnar nerve at the wrist. There was no weakness in grip strength or motor strength of the left wrist or elbow. Dr. Stark found no clinical evidence of tenosynovitis of the left elbow or wrist and no left elbow impairment. He calculated five percent left upper extremity impairment based on the second scenario for carpal tunnel syndrome described at page 495 of the A.M.A., *Guides*.

On November 17, 2007 Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and an Office medical adviser, noted that Dr. Stark found no evidence of atrophy, sensory loss or reduced muscle power. Tinel's and Phalen's tests were negative. There was full range of motion of both wrists. EMG testing and a nerve conduction study were positive for left carpal tunnel syndrome. Dr. Berman stated that appellant had five percent left upper extremity impairment based on the second scenario described at page 495 in the fifth edition of the A.M.A., *Guides*, normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles. The A.M.A., *Guides* provides that no more than five percent impairment is justified for the residual carpal tunnel syndrome described in the second scenario.

By decision dated November 27, 2007, the Office denied appellant's claim for more than 11 percent left upper extremity impairment. Appellant requested reconsideration. He stated that Dr. Stark examined his arm with different instruments and had him move his arm and elbow in different positions. Appellant stated that Dr. Stark examined him for only 10 minutes. On July 30, 2008 an Office hearing representative affirmed the November 27, 2007 decision.[9]

[7] Left elbow range of motion measurements were normal based on Figure 16-34 at page 472 of the fifth edition of the A.M.A., *Guides* and Figure 16-37 at page 474.

[8] Left wrist range of motion measurements were normal based on Figure 16-28 at page 467 and Figure 16-31 at page 469.

[9] Subsequent to the July 30, 2008 Office decision, additional evidence was associated with the file. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

LEGAL PRECEDENT

Section 8107 of the Act[10] 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*.[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.

The 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

The Board finds that this case is not in posture for a decision. The case must be remanded for further development of the medical evidence.

Due to the conflict in the medical opinion evidence between Dr. Diamond and Dr. Magliato as to appellant's left upper extremity impairment, the Office properly referred him to Dr. Stark for an impartial medical evaluation.

Dr. Stark reviewed the medical history and provided findings on physical examination. The medical history revealed that an EMG and nerve conduction velocity tests were positive for left carpal tunnel syndrome. Dr. Stark noted that appellant had left wrist and left elbow pain described as 8 on a scale of 0 to 10. The pain woke appellant up at night. He experienced difficulty with tasks such as cutting the grass. Appellant had local tenderness over the lateral epicondyle of his left elbow and the extensor tendon in the proximal forearm. There was no swelling or erythema. No instabilities were noted. Tinels' test was negative for entrapment of

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

[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).

the ulnar or radial nerves at the left elbow. Examination of the left wrist revealed no swelling. There was local tenderness on palpation over the volar aspect of the wrist and over the ulnar and radial margins. There was no atrophy of the thenar muscles. Tinel's and Phalen's tests were negative for entrapment of the median or ulnar nerves at the wrist. There was no weakness in grip strength or motor strength of the left wrist or elbow. Dr. Stark found no clinical evidence of tenosynovitis of the left elbow or wrist and no left elbow impairment. He calculated five percent left upper extremity impairment based on the second scenario for carpal tunnel syndrome described at page 495 of the A.M.A., *Guides*. The Board finds that Dr. Stark's report requires clarification regarding appellant's left elbow impairment. Dr. Stark did not explain why he ruled out impairment for left elbow pain based on appellant's description that the pain was an 8 in severity on a scale of 0 to 10. Appellant described the left elbow pain as severe enough to wake him at night. The pain also interfered with some activities such as cutting grass. Dr. Stark stated that the Tinel's test was negative for entrapment of the ulnar or radial nerves in appellant's left elbow. However, he did not address the inconsistency between appellant's description of significant left elbow pain and the negative Tinel's test. Dr. Stark stated that there was no weakness in grip strength or motor strength of the left elbow. However, he did not indicate how he determined that there was no weakness in grip strength. There were no grip strength measurements based on Jamar Dynamometer testing or other objective testing results in Dr. Stark report. Although appellant stated that Dr. Stark examined his arm with different instruments and had him move his arm and elbow in different positions, the medical report did not include the specific tests performed, the types of instruments used and the test results. The Board finds that additional information is required from Dr. Stark explaining his determination that appellant had no left elbow impairment. 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, it must secure a supplemental report from the specialist to correct the deficiency in his original report. On remand, it should obtain a supplemental report from Dr. Stark in which he explains how he determined that appellant had no left elbow impairment.

On appeal, appellant argues that the Office medical adviser's reports dated October 19, November 28 and December 21, 2005 were conflicting and confusing. In its July 11, 2006 decision, the Office found that these reports were insufficient to establish appellant's left upper extremity impairment and gave them no weight. Therefore, this argument is without merit. Appellant argues that Dr. Stark's medical opinion should not be given special weight because he acted as a second opinion physician. The record reflects that the Office inadvertently sent a July 30, 2007 letter to him advising that he was scheduled to be evaluated by an unnamed physician. The letter did not indicate that the examination was an independent examination for the purpose of resolving a conflict in the medical opinion evidence. The Office advised that appellant should refer to an attached letter for the time, date and location of the appointment. There was no letter with the appointment information attached to the July 30, 2007 letter. Also of record is a July 30, 2007 form entitled "Second Opinion Referral to Medical Consultants Network." However, the record reflects that the Office sent appellant a September 13, 2007 letter advising him of a scheduled appointment with Dr. Stark. It advised him that Dr. Stark was selected to resolve the conflict in the medical opinion evidence between Dr. Diamond and the Office medical adviser regarding his left upper extremity impairment. The Office sent Dr. Stark a September 13, 2007 letter advising him that he was selected to perform an independent

examination to resolve the conflict in the medical opinion evidence.[14] For these reasons, the argument that Dr. Stark was not selected or did not act, in the capacity of an impartial medical specialist is without merit.

Appellant argues that the Office medical adviser did not review Dr. Stark's report. However, in his November 17, 2007 report, the Office medical adviser did reference Dr. Stark's report. Therefore, this argument has no merit. Appellant argues that Dr. Stark's opinion cannot carry the weight of the medical evidence because it is not well reasoned and not based on an evaluation consistent with the impairment evaluation procedures in the A.M.A., *Guides*. The Board has instructed the Office to obtain a supplemental report from Dr. Stark regarding appellant's left elbow impairment. Regarding his left wrist condition, appellant asserts that Dr. Stark failed to provide medical rationale supporting his calculation of five percent impairment for carpal tunnel syndrome. Dr. Stark provided findings on physical examination regarding the left wrist, including negative Tinel's and Phalen's tests, no left wrist atrophy and no loss of range of motion. He quoted the description of the second carpal tunnel scenario at page 495 of the A.M.A., *Guides,* which provides for no more than five percent impairment of the upper extremity and he explained that appellant's left wrist condition fit that description. Therefore, this argument is without merit. Appellant asserts that Dr. Stark failed to provide grip or pinch strength measurements regarding his left wrist. However, the A.M.A., *Guides* provides that, in compression neuropathies such as carpal tunnel syndrome, additional impairment values are not given for decreased grip strength.[15] 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.[16] Therefore, this argument regarding left wrist grip strength is without merit.

CONCLUSION

The Board finds that this is not in posture for a decision. The case is remanded for the Office to obtain a supplemental report from Dr. Stark explaining how he determined that appellant had no left elbow impairment. After such further development as the Office deems necessary, it should issue an appropriate decision.

[14] Appellant asserts on appeal that a referee medical examination referral form did not indicate that Dr. Stark was selected from the PDS database on a strict rotational basis. However, as noted, the file number xxxxxx215 in this combined case shows that Dr. Stark was selected from the PDS on a strict rotational basis.

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

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

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated July 30, 2008 and November 27, 2007 are set aside and the case is remanded for further action consistent with this decision.

Issued: September 29, 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