United States Department of Labor
Employees' Compensation Appeals Board

J.L., Appellant	)	
and	)	**Docket No. 09-884**
	)	**Issued: January 6, 2010**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Syracuse, NY, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 18, 2009 appellant filed a timely appeal from September 4, 2008 and January 15, 2009 decisions of the Office of Workers' Compensation Programs regarding a schedule award for right upper extremity impairment. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has established that she sustained more than a 10 percent impairment of the right upper extremity, for which she received a schedule award.

On appeal, appellant contends that Dr. Raymond C. Traver, Jr., an impartial medical specialist, did not have access to a September 17, 2008 electrodiagnostic study as it came in "after the fact." Therefore, Dr. Traver's opinion was not based on a complete understanding of her medical history. Appellant also asserts that the Office in stating that an attending physician found a 15 percent impairment of the right arm he found a 25 percent impairment.

FACTUAL HISTORY

The Office accepted that on March 25, 2005 appellant, then a 45-year-old nurse, sustained a closed dislocation of the metacarpophalangeal and interphalangeal joints of the left fifth finger while changing a bed. On April 26, 2005 Dr. Walter Short an attending Board-certified orthopedic surgeon, performed metacarpophalangeal joint exploration and repair of radial collateral ligament of left little finger. The Office issued a schedule award for an 18 percent impairment of the left upper extremity. Appellant remained off work through August 1, 2005 and returned to work on August 2, 2005.

The Office later accepted that on August 2, 2005, appellant sustained specific bursitis and flexor tenosynovitis of the right wrist due to overcompensating for left hand weakness.[1] Appellant again stopped work on August 2, 2005 and returned to full duty in mid-October 2005. On November 16, 2006 she claimed an additional schedule award for right upper extremity impairment and included medical evidence.

Dr. Short submitted reports from August 2, 2005 through October 16, 2006 diagnosing flexor tenosynovitis of the right wrist. In a March 21, 2007 report, he indicated that appellant reached maximum medical improvement. Dr. Short performed a schedule award evaluation. Referring to the fifth edition of the American Medical Associations, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*), he found that according to Figure 16-37, page 474,[2] appellant had a two percent impairment of the right upper extremity due to wrist pronation limited to 50 degrees and a one percent impairment due to wrist supination limited to 50 degrees. Utilizing Figure 16-31[3] Dr. Short found that she had a five percent impairment of the right upper extremity due to ulnar deviation at zero degrees and two percent impairment due to radial deviation limited to 10 degrees. He found a three percent impairment due to wrist flexion limited to 40 degrees and a five percent impairment due to wrist extension limited to 30 degrees, based on Figure 16-28.[4] Dr. Short stated that according to Figure 16-34,[5] page 472, appellant had a three percent impairment of the right upper extremity due to elbow extension limited to 110 degrees and a four percent impairment due to elbow flexion limited to 30 degrees. He totaled these losses to equal a 25 percent impairment of the right upper extremity.

[1] The Office initially denied appellant's claim for a recurrence of disability by a March 9, 2006 decision. By decision dated June 12, 2006, the Office reversed its March 9, 2006 decision and accepted the claimed recurrence of disability.

[2] Figure 16-37, page 474 of the fifth edition of the A.M.A., *Guides* is entitled "Pie Chart of Upper Extremity Motion Impairments Due to Lack of Pronation and Supination" of the elbow.

[3] Figure 16-31, page 469 of the fifth edition of the A.M.A., *Guides* is entitled "Pie Chart of Upper Extremity Motion Impairments Due to Abnormal Radial and Ulnar Deviation of Wrist Joint."

[4] Figure 16-28, page 467 of the fifth edition of the A.M.A., *Guides* is entitled "Pie Chart of Upper Extremity Motion Impairments Due to Lack of Flexion and Extension of Wrist Joint."

[5] Figure 16-34, page 472 of the fifth edition of the A.M.A., *Guides* is entitled "Pie Chart of Upper Extremity Motion Impairments Due to Lack of Flexion and Extension of the Elbow Joint."

In an April 20, 2007 report, an Office medical adviser explained that the A.M.A., *Guides* did not allow impairments for wrist tendinitis or pain in the absence of other factors. Therefore, there was no ratable impairment related to the accepted conditions.

On June 26, 2007 the Office found a conflict of opinion between Dr. Short, for appellant and the Office medical adviser, for the government, regarding the presence of a ratable permanent impairment of the right upper extremity. To resolve the conflict it selected Dr. Traver, a Board-certified orthopedic surgeon, as impartial medical examiner. On July 9, 2007 the Office referred appellant, the medical record and a statement of accepted facts to Dr. Traver. In an August 16, 2007 letter, it authorized Dr. Daniel Reich, a Board-certified neurologist, to perform any electrodiagnostic testing ordered by Dr. Traver.

In an August 8, 2007 report, Dr. Traver reviewed the history of injury and medical treatment. On examination, he reported full ranges of motion for all joints of both upper extremities. Regarding the right upper extremity, Dr. Traver noted swelling over the dorsum of the hand, diminished grip strength and positive Tinel's signs at the forearm and cubital tunnel. He diagnosed repetitive stress syndrome of the right upper extremity, consequential to the left hand injury. In a September 7, 2007 addendum, Dr. Traver reviewed August 20, 2007 electromyography (EMG) and nerve conduction velocity (NCV) studies of Dr. Robert E. Todd, an attending Board-certified neurologist, and August 29, 2007 EMG and NCV studies by Dr. Reich. He stated that although Dr. Todd reported abnormal findings in the median, radial and ulnar nerves on the right, Dr. Reich found no abnormalities. Dr. Traver opined that appellant had "underlying neurological abnormalities most consistent with overuse syndrome of the right upper extremity. He noted that 15 percent of patients with carpal tunnel syndrome had negative electrodiagnostic results. Dr. Traver found that appellant had an entrapment or compression neuropathy according to page 492 of the A.M.A., *Guides*.[6] He assessed a five percent impairment rating for postoperative carpal tunnel syndrome and a five percent impairment for cubital tunnel syndrome, for a "combined 10 percent right upper extremity impairment."[7]

A September 20, 2007 magnetic resonance imaging scan of the right wrist performed for Dr. Short revealed a volar ganglion at the level of the radial styloid extending proximally from the radiocarpal joint and a potential partial separation of the triangular fibrocartilage from the radial origin.

In October 9 and December 6, 2007 reports, an Office medical adviser reviewed the medical record and Dr. Traver's report. He opined that Dr. Traver's report was speculative, confusing and poorly rationalized. The medical adviser found that based on the medical record appellant did not have a ratable impairment of the right upper extremity.

[6] Page 492 of the fifth edition of the A.M.A., *Guides* contained Table 16-15, entitled "Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to *Combined* 100 percent Deficits of the Major Peripheral Nerves" and a discussion of entrapment and compression neuropathies.

[7] In a September 7, 2007 letter, appellant asserted that Dr. Traver was not thorough in his findings and would not listen to her in regards to her injury." Appellant noted that she was a registered nurse.

By decision dated December 28, 2007, the Office denied appellant's claim for a right upper extremity impairment, based on the Office medical adviser's opinion of Dr. Traver's report.

In a January 7, 2008 letter, appellant requested an oral hearing. She submitted Dr. Todd's September 19, 2007 EMG and NCV studies showing mild abnormalities of the median, ulnar and radial nerves suggesting a chronic overuse syndrome of the right hand and arm.

By decision dated March 27, 2008, an Office hearing representative set aside the December 28, 2007 decision and remanded the case to obtain a supplemental report from Dr. Traver.

In a June 11, 2008 report, Dr. Traver found that according to Table 16-15, page 492,[8] of the A.M.A., *Guides*, the maximum upper extremity impairment for motor defects of the median nerve below the forearm was 10 percent. Under Table 16-11, page 484[9] he rated appellant's strength deficit as Grade 3 or up to 50 percent. Dr. Traver found that appellant had a five percent impairment due to carpal tunnel syndrome. He noted that this was consistent with paragraph 2 on page 495 of the A.M.A., *Guides*, "where the impairment for carpal tunnel syndrome following surgery is not to exceed five percent."[10] Dr. Traver applied Table 16-15 to note that the maximum deficit for ulnar motor deficit below the elbow due to cubital tunnel syndrome was 35 percent. Using Table 16-11, he found a Grade 3 deficit of the ulnar nerve. He then made his "best guess" and utilized Grade 4 instead, allowing a motor deficit of 15 percent, to rate impairment as 5 percent. Dr. Traver then used the Combined Values Chart on page 604 of the A.M.A., *Guides* to find a total 10 percent impairment for the right upper extremity. He explained that 15 percent of compressive neuropathy patients had normal electrodiagnostic results.

On July 7, 2008 the Office requested a second Office medical adviser to review Dr. Traver's June 11, 2008 supplemental report. In a July 9, 2008 report, an Office medical adviser concurred with Dr. Traver's impairment rating. He found that appellant had reached maximum medical improvement.

By decision dated September 4, 2008, the Office granted appellant a schedule award for a 10 percent permanent impairment of the right upper extremity. The period of the award ran from "August 8, 2007 to March 13, 2007, 31.2 weeks of compensation [sic]."

[8] Table 16-15, page 492 of the fifth edition of the A.M.A., *Guides* is entitled "Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to *Combined* 100 percent Deficits of the Major Peripheral Nerves."

[9] Table 16-11, page 484 of the fifth edition of the A.M.A., *Guides* is entitled "Determining Impairment of the Upper Extremity Due to Motor and Loss-of-Power Deficits Resulting from Peripheral Nerve Disorders Based on Individual Muscle Rating."

[10] Page 495 of the fifth edition of the A.M.A., *Guides* discusses the evaluation of carpal tunnel syndrome. Paragraph 2 states that "Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG 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."

In a September 13, 2008 letter, appellant requested a review of the written record. She contended that Dr. Traver's opinion did not have Dr. Todd's studies available for review.

By decision dated and finalized January 15, 2009, an Office hearing representative affirmed the September 4, 2008 schedule award determination. The hearing representative found that Dr. Traver's opinion, was sufficiently well rationalized to represent the weight of the medical evidence.

LEGAL PRECEDENT

The schedule award provisions of the Federal Employees' Compensation Act[11] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[12] As of February 1, 2001, schedule awards are calculated according to the fifth edition of the A.M.A., *Guides*, published in 2000.[13]

The standards for evaluation of the permanent impairment of an extremity under the A.M.A., *Guides* are based on loss of range of motion, together with all factors that prevent a limb from functioning normally, such as pain, sensory deficit and loss of strength. All of the factors should be considered together in evaluating the degree of permanent impairment.[14] Chapter 16 of the fifth edition of the A.M.A., *Guides* provides a detailed grading scheme and procedures for determining impairments of the upper extremities due to pain, discomfort, loss of sensation, or loss of strength.[15]

Section 8123 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 shall appoint a third physician, who shall make an examination.[16] In situations where 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.[17] However, in a situation where the Office secures an opinion from an

[11] 5 U.S.C. §§ 8101-8193.

[12] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

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

[14] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[15] A.M.A. *Guides*, Chapter 16, "The Upper Extremities," pp. 433-521 (5th ed. 2001).

[16] 5 U.S.C. § 8123; *see Charles S. Hamilton*, 52 ECAB 110 (2000).

[17] *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[18]

ANALYSIS

The Office accepted that appellant sustained specific bursitis and flexor tenosynovitis of the right wrist. It granted appellant a schedule award for a 10 percent impairment of the right upper extremity based on the opinion of Dr. Traver, a Board-certified orthopedic surgeon and impartial medical examiner. Dr. Traver was selected to resolve a conflict of medical opinion between Dr. Short, an attending Board-certified orthopedic surgeon and an Office medical adviser. On March 21, 2007 Dr. Short found that appellant had 25 percent impairment of her right arm due to loss of range of motion of the right wrist and elbow. An Office medical adviser disagreed, finding that appellant had no ratable impairment.

Dr. Traver submitted an August 8, 2007 report in which advised that appellant had a full range of motion of all joints in both upper extremities. He diagnosed carpal tunnel syndrome and cubital tunnel syndrome based on his clinical assessment and conflicting electrodiagnostic results. Dr. Traver reviewed the studies of Dr. Reich and compared them with the studies reported by Dr. Todd. He assessed a five percent impairment of the right upper extremity due to cubital tunnel syndrome and a five percent impairment due to carpal tunnel syndrome.

Dr. Traver provided a June 11, 2008 supplemental report. He reiterated that appellant had intact sensation throughout both upper extremities, a positive Tinel's sign at the right forearm and right cubital tunnel and that two diagnostic studies were obtained. The first revealed some slight nerve condition abnormalities, which were not substantiated by the second. Dr. Traver's based his impairment rating to the right arm on motor deficit involving the ulnar and median nerves below the forearm. Under Table 16-15, he noted that 35 percent was the maximum motor deficit allowed for the ulnar nerve. From Table 16-11, he found that appellant's motor deficit was Grade 4, for which he allowed 15 percent. Multiplying the 35 percent maximum value by 15 percent deficit was 5.25 percent, rounded down to 5 percent impairment of the right arm. For the median motor deficit, Dr. Traver noted that Table 16-15 provides a maximum of 10 percent impairment. Utilizing Table 16-11, he found that appellant's motor deficit was Grade 3 for which he allowed 50 percent. Dr. Traver multiplied the 10 percent maximum value by 50 percent to find 5 percent impairment due to median nerve deficit to the right arm. He properly applied the motor deficit findings to the Combined Values Chart to find a total 10 percent right arm impairment.

The Board finds that the impairment rating of the impartial medical specialist constitutes the weight of medical opinion. Dr. Traver advised that he found no loss in range of motion and intact sensation throughout both upper extremities. Based on appellant's loss of strength due to weakness involving the ulnar and median nerves, he found 10 percent impairment. Contrary to appellant's assertions, Dr. Traver's reviewed the results of diagnostic studies obtained by

[18] *Margaret M. Gilmore*, 47 ECAB 718 (1996).

Dr. Reich and Dr. Todd and explained that he utilized the test results in making his impairment rating. As the impartial medical specialist, the Board finds that Dr. Traver's opinion is entitled to special weight.

CONCLUSION

The Board finds that appellant has 10 percent impairment of her right arm for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated January 15, 2009 and September 4, 2008 are affirmed.

Issued: January 6, 2010
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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