United States Department of Labor
Employees' Compensation Appeals Board

H.M., Appellant	)	
	)	**Docket No. 09-1398**
and	)	**Issued: March 18, 2010**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Kearny, 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:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 6, 2009 appellant, through her attorney, filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated January 2, 2009, finding that she had five percent impairment to both arms. 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 five percent impairment of her upper extremities, for which she received schedule awards.

FACTUAL HISTORY

On November 8, 2002 appellant, then a 38-year-old mail handler, filed an occupational disease alleging that she developed carpal tunnel syndrome (CTS) due to factors of her federal employment. Dr. Mark A.P. Filippone, a physician Board-certified in physical medicine and rehabilitation, examined her on November 7, 2002 and described her right wrist and left shoulder

pain. He diagnosed bilateral CTS, bilateral ulnar neuritis and internal derangement of the left shoulder. The Office accepted appellant's claim for bilateral tenosynovitis of the upper extremities. Dr. Filippone performed nerve conduction studies (NCS) on December 12, 2002 and found prolonged median motor latencies. He diagnosed bilateral CTS based on these findings which he attributed to appellant's employment.

The Office authorized a magnetic resonance imaging scan of appellant's left shoulder on January 31, 2003. This test revealed distal infraspinatus tendinosis and subacromial subdeltoid bursitis. Appellant worked light duty eight hours a day.

Appellant filed a notice of recurrence of disability on March 14, 2003 alleging on March 8, 2003 she stopped work due to her January 16, 2002 employment injury. In a March 7, 2003 report, Dr. Filippone noted increased left shoulder pain. He recommended carpal tunnel releases on April 4, 2003. The Office accepted appellant's recurrence claim on June 26, 2003. It authorized surgical releases on July 14, 2003. The Office entered appellant on the periodic rolls on August 5, 2003. Dr. Teofilo A. Daunajre, a Board-certified orthopedic surgeon, performed a left carpal tunnel release on August 5, 2003. The Office expanded appellant's claim to include bilateral CTS on July 14, 2003. Appellant underwent electrodiagnostic testing on February 5, 2004, which demonstrated worsening of her right CTS and evidence of continued involvement of the sensory fibers on the left side. Dr. Daunajre performed a right carpal tunnel release on April 27, 2004. On September 10, 2004 he diagnosed mild impingement syndrome of the left shoulder.

Dr. Filippone obtained additional electromyelogram (EMG) and NCS on July 1, 2005 and found abnormal prolongation of the median motor latencies bilaterally and stated that the studies were consistent with bilateral CTS. He found that appellant had reached maximum medical improvement on October 21, 2005.

Dr. David Weiss, an osteopath, completed an evaluation on February 28, 2006 and found focal acromioclavicular (AC) point tenderness with anterior and posterior cuff tenderness. He provided left shoulder range of motion of forward elevation of 170 degrees, abduction of 170 degrees, adduction of 75 degrees and external rotation of 80 degrees. Dr. Weiss found that appellant's deltoid exhibited muscle testing of 4/5. In regard to appellant's left wrist, he found thenar atrophy and normal range of motion as well as positive Tinel's and Phalen's signs. On the right appellant also exhibited thenar atrophy and normal range of motion with positive Tinel's and Phalen's signs. Dr. Weiss also provided grip and pinch strength findings. He diagnosed bilateral CTS and chronic AC arthropathy with impingement in the left shoulder. Dr. Weiss applied the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) and concluded that appellant had motor strength deficit of the left deltoid of 9 percent, pinch strength deficit of 20 percent, Grade 2 sensory deficit of the median nerve of 31 percent for left upper extremity impairment of 50 percent. He found motor strength deficit of the right deltoid of 9 percent, right lateral pinch deficit of 20 percent and Grade 2 sensory deficit of the right median nerve of 31 percent for total right upper extremity impairment of 50 percent. Appellant requested a schedule award on August 7, 2006.

The district medical adviser reviewed Dr. Weiss' report on September 5, 2006 and found 40 percent impairment of the left upper extremity and 44 percent impairment of the right upper

extremity. He based this impairment rating on Grade 2 impairment of the median nerve bilaterally and pinch strength deficits. The district medical adviser excluded impairment for deltoid weakness as unrelated to bilateral CTS. The Office informed the district medical adviser on September 21, 2006 that the claim had been accepted for tenosynovitis of the shoulders and requested a more detailed report. On September 28, 2006 the district medical adviser found that appellant had motor strength deficit of the shoulders for 9 percent impairment each and total left upper extremity impairment of 45 percent and right upper extremity impairment of 49 percent.

The Office found that there was a conflict of medical opinion evidence between Dr. Weiss and the district medical adviser regarding the extent of appellant's permanent impairment and referred her to Dr. Thomas Nordstrom, a Board-certified orthopedic surgeon, for an impartial medical evaluation. In a report dated August 8, 2007, Dr. Nordstrom found that she had 10 percent impairment of the upper extremities bilaterally due to mild degree of impairment of the median nerve at the wrist. He also found that appellant had no shoulder crepitus, swelling or loss of motion and awarded 5 percent upper extremity impairment of the left shoulder for total upper extremity impairments of 25 percent. The district medical adviser reviewed this report on October 30, 2007 and stated that Dr. Nordstrom did not provide findings to support median nerve dysfunction and instead awarded appellant three percent impairment for pain in accordance with Chapter 18 of the A.M.A., *Guides*.

The Office requested a supplemental report from Dr. Nordstrom addressing the deficiencies in his August 8, 2007 report. Dr. Nordstrom stated that appellant's findings were based on her subjective complaints and noted that he had utilized the fourth edition of the A.M.A., *Guides* in reaching the impairment rating. He stated that he thought it was fair to award her five percent for shoulder impairment based on her subjective symptoms.

The Office referred appellant for a second impartial medical evaluation with Dr. Edward Krisiloff, a Board-certified orthopedic surgeon, on January 22, 2008. In a report dated February 15, 2008, Dr. Krisiloff noted appellant's history of injury and medical history. On examination he found a slightly positive left shoulder impingement sign. Dr. Krisiloff noted that appellant had excellent grip strength. He concluded that she had no left shoulder impairment. Dr. Krisiloff noted that appellant's only clinical finding in support of CTS was numbness in her hands. He stated that as she had normal clinical findings with abnormal nerve testing she should receive an impairment rating of five percent for each of her upper extremities.

The district medical adviser reviewed Dr. Krisiloff's report on February 29, 2008 and found he reported that appellant had no sensory deficit or muscle atrophy. He stated that the A.M.A., *Guides* at page 495 provided that she should receive five percent impairment of each upper extremity due to residual findings of CTS on electrodiagnostic testing.

The Office granted appellant a schedule award for five percent impairment of each upper extremity by decision dated May 20, 2008.

Appellant, through her attorney, requested an oral hearing on June 10, 2008. She testified at the oral hearing on October 28, 2008 and stated that she retired from the employing establishment in May 2005.

By decision dated January 2, 2009, the hearing representative affirmed the Office's May 20, 2008 decision.

On appeal, appellant's attorney contends that Dr. Krisiloff's report was not sufficient to establish appellant's permanent impairment for schedule award purposes as he did not consider appellant's preexisting shoulder condition. He further stated that the Office erred in not requesting clarification from Dr. Krisiloff.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulations[2] 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.[3] Effective February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[4]

The fifth edition of the A.M.A., *Guides* allows for impairment percentage to be increased by up to three percent for pain by using Chapter 18, which provides a qualitative method for evaluating impairment due to chronic pain. If an individual appears to have a pain-related impairment that has increased the burden on his or her condition slightly, the examiner may increase the percentage up to three percent. However, examiners should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.[5]

In evaluating CTS, the A.M.A., *Guides* provide that if after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias or difficulties in performing certain activities three possible scenarios can be present. The first situation is: "Positive clinical finding of median nerve dysfunction and electrical conduction delay(s); The impairment due to residual CTS rated according to the sensory and/or motor deficits as described earlier."[6] In this situation, the impairment due to residual CTS is evaluated

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999).

[3] *Id.*

[4] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a) (August 2002).

[5] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); A.M.A., *Guides*, 571, 18.3(b); *P.C.*, 58 ECAB 539 (2007); *Frantz Ghassan*, 57 ECAB 349 (2006).

[6] A.M.A., *Guides* 495.

by multiplying the grade of severity of the sensory or motor deficit by the respective maximum upper extremity impairment value resulting from sensory or motor deficits of each nerve structure involved. When both sensory and motor functions are involved the impairment values derived for each are combined.[7] In the second scenario: "Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS is still present and an impairment rating not to exceed five percent of the upper extremity may be justified." In the final situation: "Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and NCS: there is no objective basis for an impairment rating."[8]

ANALYSIS

Appellant requested a schedule award and submitted a report dated February 28, 2006 from Dr. Weiss, an osteopath, in support of her claim. Dr. Weiss examined appellant's left shoulder and focal AC point tenderness with anterior and posterior cuff tenderness with normal range of motion. He noted that appellant's left deltoid had motor strength of 4/5. In regard to appellant's left wrist, Dr. Weiss found thenar atrophy and normal range of motion as well as positive Tinel's and Phalen's signs. On the right appellant also exhibited thenar atrophy and normal range of motion with positive Tinel's and Phalen's signs. Dr. Weiss also provided grip and pinch strength findings. He diagnosed bilateral CTS and chronic AC arthropathy with impingement in the left shoulder. Dr. Weiss applied the A.M.A., *Guides* and concluded that appellant had motor strength deficit of the left deltoid of 9 percent, pinch strength deficit of 20 percent, Grade 2 sensory deficit of the median nerve of 31 percent for left upper extremity impairment of 50 percent. He found motor strength deficit of the right deltoid of 9 percent, right lateral pinch deficit of 20 percent and Grade 2 sensory deficit of the right median nerve of 31 percent for total right upper extremity impairment of 50 percent.

The Board notes that Dr. Weiss did not properly apply the A.M.A., *Guides* in reaching his impairment rating. The A.M.A., *Guides* do not provide for an impairment for decreased grip strength when addressing a compression neuropathy such as CTS.[9] Furthermore, Dr. Weiss did not provide any physical findings relating to appellant's right shoulder, but included an additional impairment rating for this condition. As Dr. Weiss' report is not consistent or comport with the A.M.A., *Guides,* it is not sufficient to establish appellant's permanent impairment.

The Board further finds that there was no existing conflict of medical opinion evidence in the record at the time the Office referred appellant's claim to Dr. Nordstrom, a Board-certified orthopedic surgeon. The district medical adviser had concurred with Dr. Weiss' findings and application of the A.M.A., *Guides* despite the errors and omissions detailed above. He merely combined the shoulder and wrist impairments rather than adding the impairments as Dr. Weiss had done. There was no disagreement between Dr. Weiss and the Office's physician. Therefore,

[7] *Id*. at 494, 481.

[8] *Id*. at 495.

[9] *Id*. at 494.

Drs. Nordstrom and Krisiloff should be considered Office second opinion physicians rather than impartial medical examiners.

Dr. Nordstrom's reports do not include sufficiently detailed findings and he failed to apply the appropriate version of the A.M.A., *Guides*. He offered no reason for the impairment ratings he reached. Therefore, Dr. Nordstrom's reports cannot constitute the weight of medical opinion on the extent of appellant's permanent impairment.

In his February 15, 2008 report, Dr. Krisiloff, a Board-certified orthopedic surgeon, noted appellant's history of injury and medical history. On examination he found a slightly positive left shoulder impingement sign. Dr. Krisiloff noted that she had excellent grip strength. He concluded that appellant had no left shoulder permanent impairment. Dr. Krisiloff noted that her only clinical finding in support of CTS was numbness in her hands. He stated that as appellant had normal clinical findings with abnormal nerve testing she should receive an impairment rating of five percent for each of her upper extremities. The district medical adviser reviewed this report and concluded that the correlation of the findings corresponded with the appropriate sections of the A.M.A., *Guides*, as noted above.

The district medical adviser and Dr. Krisiloff agreed that appellant demonstrated clinical findings of numbness as well as abnormal electrodiagnostic testing following her surgical releases and therefore in accordance with the A.M.A., *Guides*, had a maximum of five percent impairment of each of her upper extremities.[10] In his physical examination Dr. Krisiloff found that she had no impairments of her left shoulder and therefore was not entitled to a schedule award for this condition. The Board finds that detailed and well-reasoned medical evidence establishes that appellant has no more than five percent impairment of each of her upper extremities for which she has received schedule awards.

CONCLUSION

The Board finds that appellant has no more than five percent impairment of each of her upper extremities for which she has received schedule awards.

[10] *Id*. at 495, CTS.

ORDER

IT IS HEREBY ORDERED THAT the January 2, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 18, 2010
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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