# United States Department of Labor
# Employees' Compensation Appeals Board

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| **C.K., Appellant** | ) | |
| **and** | ) | **Docket No. 09-1782** |
| | ) | **Issued: May 4, 2010** |
| **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:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

### ***JURISDICTION***

On July 8, 2009 appellant, through his representative, filed a timely appeal from the August 14, 2008 and April 1, 2009 merit decisions of the Office of Workers' Compensation Programs, which found a seven percent impairment of each upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

### ***ISSUE***

The issue is whether appellant has more than a seven percent impairment to each upper extremity.

### ***FACTUAL HISTORY***

On October 16, 1998 appellant, then a 49-year-old clerk, filed a claim alleging that he had bilateral wrist pain in the performance of duty as a result of repetitive activities. The Office accepted his claim for bilateral wrist strains. It also accepted a torn cartilage in the left wrist and bilateral ulnar neuropathy.

On June 22, 1999 appellant underwent a right wrist arthroscopy with extensive synovectomy at the ulnar wrist joint and excision of the plical band at the mid carpal joint and debridement of the radio-scapho-lunate ligament. On February 29, 2000 he underwent a left wrist arthroscopy with synovectomy and debridement of a small flap defect in the triangular fibrocartilage complex. Appellant filed a claim for a schedule award.

A conflict arose between appellant's physician and the Office second-opinion physician on the extent of permanent impairment in the upper extremities. The Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. Scott R. Sharetts, a Board-certified neurologist, to resolve the conflict.

On December 6, 2006 Dr. Sharetts related appellant's history and symptoms. He reviewed appellant's medical record and described his findings on neurologic examination. On sensory testing appellant reported hypesthesia to "primary modalities" in the fourth and fifth fingers and medial palm region bilaterally. There was no forearm sensory involvement. Strength testing in the upper arms and forearms was intact. Upon sensory testing there was guarding and giving out due to reported discomfort in the ulnar aspect of the wrists bilaterally. Otherwise hand and finger strength appeared intact.

Dr. Sharetts explained that, when one is dealing with a potential ulnar neuropathy, it is important to try to differentiate whether the irritation or injury is at the wrist or more proximal in the elbow region or a combination of both. He noted that the clinical examination on November 19, 1998, as part of an electrodiagnostic study, was more consistent with ulnar irritation at the level of the wrist. However, other examiners reported sensory symptoms in a more traditional distribution in terms of ulnar irritation in the elbow region, which would result in numbness in the palmar aspect of the fourth and fifth fingers, medial palm and at times in varying degrees of the medial forearm. Dr. Sharetts stated that his clinical examination demonstrated numbness that one would see traditionally in a more proximal ulnar nerve irritation, although because of the overlapping sensation he could not clinically rule out an element of ulnar nerve irritation at the level of the wrist. Motor examination revealed some restricted effort (guarding and giving out) primarily because of focal pain in the ulnar aspect of the left wrist "although within these parameters strength on initial exertion appeared intact bilaterally in the hands." Dr. Sharetts found no clinical evidence of a superimposed median neuropathy at the wrist or cervical or lumbar radiculopathy or reflex sympathetic dystrophy type symptoms.

Dr. Sharetts concluded that appellant had a seven percent impairment of each upper extremity due to ulnar sensory deficit or pain. He added an additional three percent bilaterally for pain-related impairment.

In a supplemental report dated May 14, 2007, Dr. Sharetts clarified his rating:

> "With regard to the details of my sensory examination the following details are noted with respect to 'primary sensory modalities.' My sensory examination includes not only light touch discrimination as well as protective sensibility to direct tactile stimulation. There was also decreased sharp/dull differentiation. Based on [T]able 16-10 (page 482), this would translate to an 80 percent sensory

deficit of the 7 percent determined by the ulnar nerve distribution (5.6 percent for each right and left arm).

"In addition my report indicates that [appellant's] job situation was changed in that he has mild to moderate discomfort associated with his job and activities of daily living. Based on Table 18-3 (page 575) I would add 1.4 percent impairment for superimposed pain beyond that identified in Table 16-10.

"Accordingly, this would translate to a [seven] percent impairment rating for the right and left hand [sic]. Otherwise my diagnostic impressions and recommendation stand as previously outlined."

An Office medical adviser noted that Dr. Sharetts did not find significant strength loss related to ulnar nerve deficits. "This is consistent with other physician reports in the records provided."

On August 14, 2008 the Office granted schedule awards for a seven percent impairment of each upper extremity. In a decision dated April 1, 2009, an Office hearing representative affirmed, finding that Dr. Sharetts' opinion represented the weight of the medical opinion evidence.

On appeal, appellant's representative argues that although Dr. Sharetts provided a thorough sensory examination, he failed to provide any evidence of motor strength testing. The representative argues that grip strength testing is critical and that there is no evidence Dr. Sharetts used any grip strength instrumentation such as a dynamometer. He further argues that Dr. Sharetts' December 6, 2006 and May 14, 2007 ratings are contradictory.

## ***LEGAL PRECEDENT***

Section 8107 of the Federal Employees' Compensation Act[1] 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2]

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.[3] When 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

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404. Here A.M.A., *Guides* (5th ed., 2001).

[3] 5 U.S.C. § 8123(a).

the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[4]

## ***ANALYSIS***

Dr. Sharetts, the neurologist and impartial medical specialist, explained that his clinical examination demonstrated numbness that one would see traditionally in a more proximal ulnar nerve irritation. He identified the ulnar nerve above the midforearm as the structure innervating the area of involvement. Table 16-15, page 492 of the A.M.A., *Guides* states that the maximum upper extremity impairment due to sensory deficit or pain in the ulnar nerve above the midforearm is seven percent. With his supplemental report, Dr. Sharetts explained how he classified the severity of the peripheral nerve disorder as 80 percent or Grade 2 under Table 16-10, page 482. Following the procedure described in Table 16-10, he multiplied the severity of the sensory deficit, 80 percent, by the maximum impairment value of the affected nerve, 7 percent and concluded that appellant had a 5.6 percent impairment of each upper extremity due to bilateral ulnar sensory deficit or pain.

Dr. Sharetts added 1.4 percent bilaterally for pain-related impairment. The A.M.A. *Guides* discussed the difficulties associated with integrating pain-related impairment into an impairment rating system:

> "Finally, at a practical level, a chapter of the A.M.A., *Guides* devoted to pain-related impairment should not be redundant of or inconsistent with principles impairment rating described in other chapters. The A.M.A., *Guides'* impairment ratings currently include allowances for the pain that individuals typically experience when they suffer from various injuries or diseases, as articulated in Chapter 1 of the A.M.A., *Guides*: 'Physicians recognize the local and distant pain that commonly accompanies many disorders. Impairment ratings in the A.M.A., *Guides* already have accounted for pain. For example, when a cervical spine disorder produces radiating pain down the arm, the arm pain, which is commonly seen, has been accounted for in the cervical spine impairment rating.' Thus, if an examining physician determines that an individual has pain-related impairment, he or she will have the additional task of deciding whether or not that impairment has already been adequately incorporated into the rating the person has received on the basis of other chapters of the A.M.A., *Guides*."[5]

An impairment rating under Table 16-10 for sensory deficit or pain obviously accounts for pain. Dr. Sharetts' classification of the sensory deficit or pain, Grade 2, is defined by superficial cutaneous pain and decreased tactile sensibility with abnormal sensations or moderate pain "that may prevent some activities." This would appear to encompass what Dr. Sharetts observed in his supplemental report, that appellant's job situation was changed due to his mild to moderate discomfort associated with his job and activities of daily living. The Board finds,

[4] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

[5] A.M.A., *Guides* 570.

therefore, that he did not justify an additional pain-related impairment under Chapter 18.[6] Dr. Sharetts did not sufficiently explain how the classification or grade he selected to rate sensory deficit or pain under Table 16-10 inadequately reflected appellant's pain.

The Board finds that the opinion of the impartial medical specialist is based on a proper factual and medical history and is sufficiently well rationalized that it must be given special weight in resolving the extent of appellant's impairment. As his opinion establishes a six percent (rounded) impairment of each upper extremity, the Board will affirm the Office's August 14, 2008 and April 1, 2009 decisions on the grounds that appellant has no more than the seven percent awarded for each upper extremity.

Appellant's representative does not dispute Dr. Sharetts' rating for sensory deficit or pain, but, he argues that grip strength is critical and the impartial medical specialist failed to provide any evidence of motor strength testing.

Dr. Sharetts reported that appellant's strength appeared to be intact bilaterally in the hands. The Office medical adviser noted this was consistent with the clinical findings of other physicians. Therefore, it would appear that evaluating impairment due to peripheral nerve injury was clinically more appropriate than evaluating impairment due to muscle strength, particularly as the A.M.A. *Guides* cautions against the use of strength evaluations.[7] For this reason, the lack of dynamometer readings or other specific measurements of appellant's grip strength is not fatal to appellant's claim of permanent impairment.

Appellant's representative notes that Dr. Sharetts reported a 10 percent impairment of each upper extremity on December 6, 2006 and a seven percent impairment of each upper extremity on May 14, 2007. However, in his initial rating, Dr. Sharetts did not follow the procedure set out in Table 16-10, page 482. He did not classify or grade the severity of appellant's sensory deficit or pain. Instead, Dr. Sharetts simply looked at Table 16-15, page 492 and assigned the seven percent impairment he saw for ulnar sensory deficit or pain. To this he added an additional pain-related impairment of three percent. In the May 14, 2007 report, Dr. Sharetts followed proper procedures and multiplied the 7 percent he found in Table 16-15 by the severity of the sensory deficit or pain in Table 16-10, which he graded at 80 percent. That is how he arrived at a 5.6 percent impairment of each upper extremity due to ulnar sensory deficit or pain. To this he added an additional pain-related impairment of 1.4 percent, which he did not establish was justified.

## ***CONCLUSION***

The Board finds that appellant has no more than a seven percent impairment of each upper extremity.

[6] *See id.* ("When This Chapter Should Be Used to Evaluate Pain-Related Impairment").

[7] A.M.A., *Guides* 507-08. Because strength measurements are functional tests influenced by subjective factors that are difficult to control, and the A.M.A., *Guides* is for the most part based on anatomic impairment, the A.M.A., *Guides* does not assign a large role to such measurements.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the April 1, 2009 and August 14, 2008 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: May 4, 2010 1
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