United States Department of Labor
Employees' Compensation Appeals Board

S.J., Appellant	)	
and	)	**Docket No. 10-705**
	)	**Issued: October 21, 2010**
U.S. POSTAL SERVICE, PALATINE P & DC, Palatine, IL, Employer	)	

Appearances:
Appellant, pro se
No appearance, for the Director

Oral Argument May 15, 2010

DECISION AND ORDER

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

JURISDICTION

On January 12, 2010 appellant filed a timely appeal from a December 9, 2009 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 this case.

ISSUE

The issue is whether appellant met her burden of proof to establish that she is entitled to a schedule award greater than one percent for each upper extremity previously awarded.

FACTUAL HISTORY

On October 1, 1986 appellant, then a 41-year-old distribution clerk, filed an occupational disease claim for an upper extremity condition. The Office accepted that appellant sustained employment-related bilateral/lateral epicondylitis and later expanded the claim to include myofascial pain syndrome of both upper extremities. On March 11, 2003 appellant filed a

schedule award claim,[1] and by decision dated April 26, 2004, was granted a schedule award for one percent permanent impairment of the right upper extremity and a one percent permanent impairment on the left. She timely requested a hearing, held on March 15, 2005 and submitted a May 31, 2004 report in which Dr. S.A. Ansari advised that she had impairments of 13 percent on the right and 6 percent on the left.[2] By decision dated June 16, 2005, an Office hearing representative found the case not in posture for decision and remanded the case for the Office to refer Dr. Ansari's report to an Office medical adviser for review and assessment in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[3] to be followed by an appropriate decision.

In an August 2, 2005 report, Dr. Ravi K. Ponnappan, a Board-certified orthopedic surgeon and Office medical adviser reviewed the medical record including Dr. Ansari's report. He noted that Dr. Ansari had based his impairment rating on subjective pain complaints and advised that there were no valid objective criteria to support Dr. Ansari's conclusion. Dr. Ponnappan found that appellant had a one percent impairment of each upper extremity. In a September 7, 2005 decision, the Office found that appellant was not entitled to an additional schedule award. On September 16, 2005 appellant requested a hearing and submitted reports dated January 25 and 27, 2006 from Dr. Jacob Salomon, Board-certified in general surgery, who advised that appellant had a 21 percent right upper extremity impairment and a 19 percent left upper extremity impairment.

On January 31, 2006 appellant filed an occupational disease claim, alleging that she had pain in both arms.[4] She submitted medical evidence including an October 15, 2005 electromyography (EMG) and nerve conduction study (NCS) that was interpreted as consistent with bilateral median mononeuropathies at the wrist consistent with moderate bilateral carpal tunnel syndrome. Appellant retired effective February 6, 2006.

By decision dated May 8, 2006, an Office hearing representative found that a conflict in medical evidence had been created between the opinions of Dr. Ponnappan, the Office medical adviser, and Dr. Salomon regarding the degree of upper extremity impairment and remanded the case to the Office for an impartial medical evaluation.

On June 26, 2006 the Office referred appellant to Dr. Kevin F. Walsh, a Board-certified orthopedic surgeon, for an impartial evaluation regarding the degree of impairment of the bilateral upper extremities. By report dated August 8, 2006, Dr. Walsh noted his review of the medical records and a statement of accepted facts that listed the accepted conditions of bilateral epicondylitis and myofascial pain syndrome. He reported appellant's complaint of bilateral shoulder and provided findings on physical examination of the upper extremities including

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[1] Appellant initially filed a schedule award claim in 1992. By decision dated April 10, 1995, the Office denied the claim on the grounds that the medical evidence did not establish a permanent impairment. On February 13, 1996 an Office hearing representative affirmed the April 10, 1995 decision.

[2] Dr. Ansari's credentials could not be ascertained.

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

[4] The claims were initially adjudicated separately.

shoulders, elbows, wrists and hands. Dr. Walsh noted that, although appellant had EMG evidence of carpal tunnel syndrome, the records did not indicate that this was causally related to her employment injury. He concluded that, as she had an objectively normal physical examination with no findings to support a permanent impairment rating, her impairment rating under the A.M.A., *Guides* would be zero percent.

In a September 5, 2006 decision, the Office found that appellant was not entitled to an additional schedule award. Following appellant's timely request, a hearing was held on February 28, 2007 regarding her original injury and claim for an increased schedule award. By decision dated April 30, 2007, an Office hearing representative affirmed the September 5, 2006 decision.

In the interim, on June 15, 2006, the Office denied appellant's claim for carpal tunnel syndrome. By decision dated January 25, 2007, an Office hearing representative reversed the June 15, 2006 decision denying appellant's carpal tunnel claim, and the Office accepted that she sustained employment-related bilateral carpal tunnel syndrome. She filed a schedule award claim on March 2, 2007, and submitted reports dated April 23 and 24, 2007 in which Dr. Mitchell L. Goldflies, an attending Board-certified orthopedic surgeon, advised that appellant had a right upper extremity whole person impairment of 28 percent and a left upper extremity whole person impairment of 7 percent, which combined for a 33 percent whole person impairment. On July 9, 2007 the Office referred the medical records of both claims to Dr. Robert W. Wysocki, an Office medical adviser, for review regarding appellant's degree of upper extremity impairment. In a July 20, 2007 report, Dr. Wysocki stated that, based on the large discrepancy between the examinations of Dr. Walsh and Dr. Goldflies, an impartial examination was warranted.

On August 15, 2007 the Office referred appellant to Dr. Martin L. Saltzman, a Board-certified orthopedic surgeon, for an impartial evaluation regarding the degree of upper extremity impairment. In a September 5, 2007 report, Dr. Saltzman noted her complaints of bilateral upper extremity pain and that her hands would swell. He reviewed the medical record, noting the positive EMG study done on October 15, 2005. Examination findings included some edema in both hands and no evidence of swelling in the carpal or cubital tunnel areas in either arm, and no evidence of significant thenar or hypothenar atrophy. Tinel's and Phalen's tests were negative bilaterally. Sensory and motor examination of both upper extremities revealed some slight generalized weakness in both upper extremities with no weakness directly related to carpal tunnel syndrome. Dr. Saltzman opined that appellant had no evidence of carpal tunnel syndrome on physical examination, stating that although an EMG was positive for moderate carpal tunnel syndrome, as documented in the literature, there is no direct relationship between the severity of the patient's subjective complaints, objective findings, and the severity of the EMG study. The physician quoted page 493 of the A.M.A., *Guides*, stating "the diagnosis is made not only on believable symptoms, but more importantly on a presence of positive clinical findings and loss of function." He concluded that in the absence of objective findings relating to carpal tunnel syndrome, appellant had no permanent impairment.

On December 18, 2007 the Office referred the medical records for both accepted claims to Dr. Wysocki, the Office medical adviser, for review. In a December 26, 2007 report, Dr. Wysocki noted his review of the records. He advised that maximum medical improvement was achieved on January 10, 1995 and that, in accordance with the fifth edition of the A.M.A., *Guides*, under Tables 16-10 and 16-15 appellant was entitled to a five percent impairment rating for Grade 4 pain in the right median nerve distribution in each upper extremity. On March 6, 2008 the two claims were administratively combined and by decision dated October 6, 2008 appellant was granted a schedule award for an additional four percent impairment of each upper extremity.

Appellant timely requested a hearing, and in a December 18, 2008 decision, an Office hearing representative set aside the October 6, 2008 decision, noting that in granting the additional schedule award, the Office relied on the opinion of an Office medical adviser rather than the opinion of Dr. Saltzman who had been selected to resolve a conflict in medical evidence. On remand the Office was to refer the case to an Office medical adviser to fully explain his reasons for awarding a total five percent impairment of each upper extremity and, if Dr. Saltzman's report was found to be deficient, to secure a supplementary report from him.

The Office referred the record to a different Office medical adviser, Dr. Amon Ferry. In a March 31, 2009 report, Dr. Ferry reviewed the medical record, including Dr. Saltzman's report, and concluded that appellant was not entitled to a schedule award greater than one percent for each upper extremity because Dr. Saltzman found no objective findings to suggest carpal tunnel syndrome. By decision dated May 27, 2009, the Office found that appellant was not entitled to a schedule award greater than one percent for each upper extremity. In a December 9, 2009 decision, an Office hearing representative affirmed the May 27, 2009 decision. On May 28, 2009 appellant again requested a hearing that was held on September 17, 2009. He testified that neither Dr. Walsh nor Dr. Saltzman examined her but only looked at files. By decision dated December 9, 2009, an Office hearing representative affirmed the May 27, 2009 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[5] and its implementing federal regulations,[6] 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 for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

to calculate schedule awards.[8] For decisions issued after May 1, 2009, the sixth edition will be used.[9]

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[10] Office procedures provide that to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred ("date of maximum medical improvement"), describes the impairment in sufficient detail to include, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment, and the percentage of impairment should be computed in accordance with the fifth edition of the A.M.A., *Guides*. The procedures further provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for opinion concerning the nature and percentage of impairment, and the Office medical adviser should provide rationale for the percentage of impairment specified.[11]

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.[12] Regarding carpal tunnel syndrome, the A.M.A., *Guides* provide:

> "If, after an *optimal recovery time* following surgical decompression, an individual continues to complain of pain, paresthesias, and/or difficulties in performing certain activities, three possible scenarios can be present:
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> > 1. Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTSE is rated according to the sensory and/or motor deficits as described earlier.[13]
> >
> > 2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a

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

[9] FECA Bulletin No. 09-03 (issued March 15, 2009).

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

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(d) (August 2002).

[12] A.M.A., *Guides*, *supra* note 3 at 433-521.

[13] Section 16.5b of the A.M.A., *Guides* describes the methods for evaluating upper extremity impairments due to peripheral nerve disorders and provides that the severity of the sensory or pain deficit and motor deficit should be classified according to Tables 16-10a and 16-11a respectively. The impairment is evaluated by multiplying the grade of severity of the sensory or motor deficit by the respective maximum upper extremity 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. *Id*. at 481; *Kimberly M. Held*, 56 ECAB 670 (2005).

residual CTSS is still present, and an impairment rating not to exceed five percent of the upper extremity may be justified.

3. Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength, and nerve conduction studies: there is no objective basis for an impairment rating."[14]

Section 16.5d of the A.M.A., *Guides* provide that, in compression neuropathies, additional impairment values are not given for decreased grip strength. Carpal tunnel syndrome is an entrapment/compression neuropathy of the median nerve, and the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory deficits only and that in the absence of a complex regional pain syndrome, additional impairment values are not given for decreased motion.[15]

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 shall appoint a third physician who shall make an examination.[16] When 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 on a proper factual background, must be given special weight.[17]

When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, it has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report. When the impartial medical specialist's statement of clarification or elaboration is not forthcoming, or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative or lacks rationale, the Office must submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question.[18] Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Act will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[19]

ANALYSIS

The Board finds that this case is not in posture for decision. As noted above, the fifth edition of the A.M.A., *Guides*, which was in effect at the time of Dr. Saltzman's September 5,

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[14] A.M.A., *Guides*, *supra* note 3 at 495.

[15] *Id*. at 494; *Kimberly M. Held, supra* note 13.

[16] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[17] *Manuel Gill*, 52 ECAB 282 (2001).

[18] *I.H*., 60 ECAB ____ (Docket No. 08-1352, issued December 24, 2008).

[19] *Id*.

2007 report, provides three scenarios for determining impairment due to carpal tunnel syndrome.[20] The second scenario advises that in cases with normal sensibility and opposition strength and abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles, residual carpal tunnel syndrome is still present, and an impairment rating not to exceed five percent of the upper extremity may be justified. In this case, appellant had an October 15, 2005 EMG/NCS that was interpreted as consistent with bilateral median mononeuropathies at the wrist consistent with moderate bilateral carpal tunnel syndrome. While Dr. Saltzman noted the positive EMG findings in his report, he did not adequately explain his conclusion that appellant had no impairment in accordance with the relevant standard mentioned above of the A.M.A., *Guides*, merely stating that in the absence of objective findings, appellant had no impairment.[21]

Because Dr. Saltzman did not adequately explain how his impairment rating conforms to the A.M.A., *Guides*, his opinion is not sufficiently rationalized and does not resolve the conflict in medical opinion and is not entitled to the special weight accorded a referee opinion. In a March 31, 2009 report, Dr. Ferry, an Office medical adviser, reviewed the medical record including Dr. Saltzman's report and concluded that appellant was not entitled to a schedule award greater than one percent for each upper extremity because Dr. Saltzman found no objective findings to suggest carpal tunnel syndrome. The Board also notes that the record does not contain a copy of the statement of accepted facts forwarded to Dr. Saltzman. The Board will set aside the Office's December 9, 2009 decision and remand the case, along with an updated statement of accepted facts listing all accepted conditions, to Dr. Saltzman for clarification regarding appellant's bilateral upper extremity impairments, utilizing the proper edition of the A.M.A., *Guides*. If he is unable to clarify his opinion, the Office shall refer appellant to another impartial medical specialist to resolve the issue of the extent of permanent impairment.[22]

CONCLUSION

The Board finds that the conflict in the medical evidence was not properly resolved and the case requires further development.

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[20] *Supra* note 15.

[21] *See V.G.,* 59 ECAB ____ (Docket No. 07-2179, issued July 14, 2008).

[22] To properly resolve a medical conflict, it is the impartial medical specialist who should provide a reasoned opinion as to the extent of permanent impairment in accordance with the A.M.A., *Guides.* An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist. *Richard R. LeMay*, 56 ECAB 341 (2005).

ORDER

IT IS HEREBY ORDERED THAT the December 9, 2009 decision of the Office of Workers' Compensation Programs be set aside and the case remanded to the Office for proceedings consistent with this decision of the Board.

Issued: October 21, 2010
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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