United States Department of Labor
Employees' Compensation Appeals Board

M.L., Appellant	)	
and	)	**Docket No. 10-932**
	)	**Issued: January 11, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Bellmawr, 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
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 19, 2010 appellant, through her attorney, filed a timely appeal from a November 18, 2009 merit 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 has greater than 10 percent permanent impairment for her right upper extremity. On appeal, her attorney asserts that a conflict in medical evidence had been created between her attending physician and that of the Office medical adviser.[1]

[1] The Board notes that, by the November 18, 2009 decision, the Office also affirmed a schedule award for a 10 percent impairment of the left upper extremity. Appellant is not appealing the finding with regards to the left upper extremity.

FACTUAL HISTORY

On October 27, 2003 the Office accepted that appellant, then a 48-year-old mail handler, sustained employment-related bilateral carpal tunnel syndrome. A July 12, 2007 electromyography (EMG) and nerve conduction study (NCS) report demonstrated bilateral median neuropathies. Appellant continued to work until August 8, 2008, when Dr. Jeffrey P. Kovacs, an osteopath, performed decompression surgery on the left. Dr. Kovacs performed decompression surgery on the right on October 3, 2008 and she returned to full duty on November 16, 2008.

In a January 29, 2009 report, Dr. Nicholas Diamond, an osteopath, diagnosed bilateral carpal tunnel syndrome, status postbilateral releases and provided an impairment rating. Regarding, the right upper extremity, he advised that examination demonstrated mild thenar atrophy and tenderness over the palmar and dorsal aspects of the wrist joint with restricted range of motion involving dorsiflexion, palmar flexion and ulnar deviation. Grip strength testing, performed with the Jamar dynamometer at Level III, revealed 18 kilograms on the right versus 22.23 kilograms on the left and pinch testing revealed 4.75 kilograms on the right versus 5.50 kilograms on the left. Dr. Diamond advised that under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[2] appellant had a right lateral pinch deficit of 20 percent under Tables 16-33 and 16-34, and a Grade 4 sensory deficit of the right median nerve of 10 percent under Table 16-10 and Table 16-15, for a total combined right upper extremity impairment of 28 percent.

In a March 31, 2009 report, Dr. Morley Slutsky, an Office medical adviser who is Board-certified in occupational medicine, reviewed the medical record including Dr. Diamond's report, and advised that maximum medical improvement was reached on January 29, 2009. He noted that under the fifth edition of the A.M.A., *Guides*, carpal tunnel syndrome may not be rated using pinch strength and stated that Dr. Diamond should be asked if he tested the claimant's extremity strength in the muscles innervated by the median nerve, as required by Table 16-11 of the A.M.A., *Guides* and, if so, he should document his findings and rate any median nerve motor dysfunction in the carpal tunnel section of the A.M.A., *Guides*. Dr. Slutsky also noted that Dr. Diamond appeared to evaluate the right hand twice but not the left and asked that he clarify this.

On April 2, 2009 the Office asked that Dr. Diamond clarify his report, in accordance with the Office medical adviser's questions. In response, Dr. Diamond submitted an amended January 29, 2009 report noting that he had evaluated both the right and left upper extremities and resubmitted the *Quick*Dash evaluations. In an April 16, 2009 report, Dr. Slutsky, advised that maximum medical improvement was reached on January 29, 2009 and that appellant had a 10 percent impairment of the right upper extremity. He agreed with Dr. Diamond's assessment that she had a Grade 4 sensory loss but disagreed with his finding of pinch strength impairment, noting that the carpal tunnel section of the A.M.A., *Guides* did not allow pinch strength to be used as a basis for rating median nerve motor strength and that Dr. Diamond did not respond as to whether he tested the muscles innervated by the median nerve

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

By decision dated April 24, 2009, appellant was granted schedule awards for 10 percent impairments of each upper extremity, for a total of 62.4 weeks, to run from January 29, 2009 to April 10, 2010. The Office noted that Dr. Diamond did not respond when asked concerning strength finding on the right and found the weight of the medical evidence rested with the opinion of the Office medical adviser, Dr. Slutsky, who properly utilized the A.M.A., *Guides*. On May 1, 2009 counsel, requested a hearing that was held by videoconference on August 20, 2009. He indicated that they were not challenging the schedule award for the left upper extremity, only that of the right and argued that Dr. Diamond's lateral pinch strength deficit should be included in the impairment evaluation or, at the least, a conflict in medical evidence had been created.

On November 18, 2009 the Office hearing representative found that appellant did not establish an impairment of the right upper extremity greater than the 10 percent awarded and affirmed the April 24, 2009 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing federal regulations,[4] 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.[5] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[6] For decisions issued after May 1, 2009, the sixth edition will be used.[7]

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.[8] 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

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.* at 10.404(a).

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

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

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

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.[9]

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.[10] 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:
>
> 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.[11]
>
> 2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a 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." [12] (Emphasis in the original.)

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.[13]

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

[10] A.M.A., *Guides*, *supra* note 2 at 433-521.

[11] 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 Table 16-10a and Table 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).

[12] A.M.A., *Guides*, *id.* at 495.

[13] *Id*. at 494; *Kimberly M. Held*, *supra* note 11.

Section 16.8a provides that in a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods, the loss of strength may be rated separately. An example of such situation would be loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated.[14] Section 16.4 provides that in evaluating abnormal motion both active and passive motion measurements are necessary to evaluate the joint motion under the appropriate charts, and these should be added to obtain the total motion impairment.[15] Section 16.8b states that pinch strength measurements are done with a pinch gauge and should be repeated three times. These are averaged and compared with the opposite extremity, if normal but if both extremities are involved, the strength measurements are compared to the average normal strengths listed in Table 16-31 through Table 16-33.[16]

ANALYSIS

The Board finds that appellant did not establish that she has more than a 10 percent impairment of the right upper extremity for which she received a schedule award. The Office accepted that she sustained bilateral carpal tunnel syndrome.

On appeal, appellant's attorney asserts that a conflict in medical evidence has been created between the opinions of Dr. Diamond, an attending osteopath, who found a 28 percent impairment based on median nerve sensory loss and pinch strength impairment, and Dr. Slutsky, an Office medical adviser, who found a 10 percent impairment, who agreed that appellant had a median nerve sensory loss.

As noted above and as explained by Dr. Slutsky, section 16.8 of the A.M.A., *Guides* does not assign a large role to grip or pinch strength measurements as they are too influenced by subjective factors.[17] While Dr. Diamond advised that appellant had some difficulty performing nonspecialized hand activities of grasping bilaterally, he did not provide an explanation as to why her loss of strength had not already been adequately considered with reference to the other methods of the A.M.A., *Guides*. Rather, he merely listed measurements obtained on grip and pinch strength testing. Dr. Diamond did not address any of the factors listed under section 16.8 or seem to acknowledge that decreased strength cannot be rated in the presence of painful conditions that prevent effective application of maximal force. Moreover, the Office specifically

[14] A.M.A., *Guides*, *supra* note 2 at 508; *see Cerita J. Slusher*, 56 ECAB 532 (2005).

[15] *Id.* at 451-52.

[16] *Id*. at 508.

[17] *Supra* note 14.

asked him to address this deficiency and he did not do so. Thus, Dr. Diamond's report is not of sufficient weight and rationale to establish a conflict in medical evidence.[18] Dr. Slutsky, the Office medical adviser, who agreed with Dr. Diamond that appellant was entitled to a 10 percent impairment rating for Grade 4 sensory loss of the median nerve under Table 16-10,[19] properly applied the A.M.A., *Guides* and explained why Dr. Diamond's impairment rating for loss of pinch strength was disallowed.

While the report of an examining physician may be found to constitute the weight of medical opinion, such physician should clearly address the principles of the A.M.A., *Guides* in explaining how an impairment rating is reached. Absent such explanation, the Office may rely on the opinion of its medical adviser.[20] In this case, Dr. Slutsky explained why Dr. Diamond's pinch strength assessment was improper under the A.M.A., *Guides* and why he concurred with his impairment finding of a Grade 4 sensory deficit of the median nerve. There is no well-rationalized medical evidence establishing greater than a 10 percent right upper extremity impairment, based on a proper application of the A.M.A., *Guides*.

CONCLUSION

The Board finds that appellant did not establish that she has more than a 10 percent permanent impairment of the right upper extremity.

[18] In situations where there are 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 on a proper factual background, must be given special weight. *Manuel Gill*, 52 ECAB 282 (2001).

[19] A.M.A., *Guides*, *supra* note 2 at 482.

[20] *See Tommy R. Martin*, 56 ECAB 273 (2005).

ORDER

IT IS HEREBY ORDERED THAT the November 18, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 11, 2011
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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