United States Department of Labor
Employees' Compensation Appeals Board

D.G., Appellant	)	
and	)	**Docket No. 13-899**
	)	**Issued: July 28, 2014**
DEPARTMENT OF LABOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, Kansas City, MO, 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 March 5, 2013 appellant filed a timely appeal from an October 19, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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 7 percent impairment of the left arm or 10 percent impairment of the right arm, for which she received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] In a December 14, 2010 decision, the Board reviewed an OWCP decision denying any additional impairment beyond 5 percent of the left arm and 10 percent of the right arm.[3] The Board found that neither the impartial medical examiner, Dr. Joseph Huston, a Board-certified orthopedic surgeon, or an OWCP medical adviser, properly applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (2009). There was no indication that either physician made reference to Appendix 15-B of the A.M.A., *Guides* or applied Table 15-23 to the evaluation of the medical evidence. Further, neither physician provided any evaluation of the grade modifiers applicable to appellant's case.[4] The facts as set forth in the Board's prior decisions are hereby incorporated by reference.

On remand, OWCP asked Dr. Huston to clarify his rating. In a report dated April 1, 2011, he stated that his original report was the first time that he used the A.M.A., *Guides*. Dr. Huston did not recall whether Appendix 15-B or Table 15-23 was used or whether the grade modifiers in relation to functional history and physical examination were applied and that the information sought by OWCP was not available. OWCP subsequently determined that he was not able to resolve the conflict in medical opinion.

On August 4, 2011 OWCP referred appellant to Dr. Garth S. Russell, a Board-certified orthopedic surgeon, for an impartial medical examination. In an October 3, 2011 report, Dr. Russell reviewed the medical record and statement of accepted facts. On physical examination, he noted that appellant had no muscle spasm of the neck or shoulders and a full range of motion of the shoulders and elbows. Dr. Russell noted a loss of 10 degrees of flexion and 5 degrees of extension in the right wrist compared to the left. Appellant had 60 degrees of flexion in her left wrist with 25 degrees of extension. Dr. Russell further noted a 10 degree loss of supination with normal pronation and a loss of 10 degrees of flexion and 10 degrees of extension in her left wrist. Further, examination with a dynamometer on the right side revealed a grip of 24, 24, 20, 22 and 22 and in appellant's left wrist she had 16, 16, 16, 14 and 14. Dr. Russell found that her range of motion in her fingers was normal, although there was some decrease in sensory two-point touch over the median nerve distribution of the thumb, index and long fingers on both hands with some loss of sensation on a subjective basis in the left hand. Based on the sixth edition of the A.M.A., *Guides,* appellant had a 5 percent impairment of the right arm and 10 percent impairment of the left arm. The 10 percent impairment of the left upper extremity was due to the fact that she exhibited consistent motor weakness as well as a sensory

[2] Docket No. 07-2097 (issued January 29, 2008). The Board found that the case was not in posture for decision due to a conflict in the medical evidence on whether appellant had more than a 10 percent impairment of the right arm, for which she received a schedule award. In Docket Nos. 08-2134 and 08-2201 (issued August 5, 2009) the Board remanded the case for OWCP to further develop the medical evidence regarding the extent of impairment to both upper extremities.

[3] On June 4, 1993 appellant, then a 33-year-old senior claims examiner, filed an occupational disease claim alleging bilateral carpal tunnel syndrome and tendinitis due to repetitive typing, keying and grasping movements in her federal employment. OWCP accepted her claim for bilateral carpal tunnel syndrome.

[4] Docket No. 10-731 (issued December 1, 2010).

abnormality and night pain syndrome within the left forearm and wrist. In addition, there was impairment of motion in the left forearm, wrist and hand when compared to the right.

In a June 16, 2012 report, Dr. Lawrence A. Manning, an OWCP medical adviser, reviewed Dr. Russell's findings on examination and applied the sixth edition of the A.M.A., *Guides*. He stated that Table 15-23 at page 449 of the A.M.A, *Guides*, provided impairment for entrapment/compression neuropathy and Table 15-21 at pages 438 to 448, provided for peripheral nerve impairment. Dr. Manning noted that Dr. Russell rated five percent impairment of the right arm. He noted that the loss of range of motion measurements by Dr. Russell included 25 degrees extension and 50 degrees flexion, which represented 10 percent permanent impairment of the right arm; which did not supersede the 10 percent rating previously made and would not be in addition to what was previously awarded. As to the left wrist range of motion, 25 degrees extension represented seven percent impairment and 60 degrees flexion represented zero (no) impairment. Dr. Manning noted that Dr. Russell also mentioned decreased supination by 10 degrees with normal pronation, but the affected side (left or right) was not listed and the amount of pronation or supination was not given in degrees. He disagreed with Dr. Russell as to the 10 percent impairment rating of the left upper extremity as Dr. Russell did not provide adequate findings to support the rating. Dr. Manning found that the range of motion findings supported a seven percent left upper extremity impairment, which was two percent additional impairment than previously awarded.

By decision dated October 19, 2012, OWCP granted a schedule award for an additional two percent impairment of the left upper extremity. It denied appellant's claim for an additional impairment to the right arm as the medical evidence did not support greater impairment.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing 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, FECA 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.[7] The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.[8]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404. Effective May 1, 2009, OWCP began using the A.M.A., *Guides* (6th ed. 2009).

[7] *Id.*

[8] *Veronica Williams*, 56 ECAB 367, 370 (2005).

and Health (ICF).[9] Under the sixth edition for upper extremity impairments, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

For evaluating impairment related to dysfunction of the median nerves, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) contains Appendix 15-B (Electrodiagnostic Evaluation of Entrapment Syndromes). It provides that the criteria for carpal tunnel syndrome include distal motor latency longer than 4.5 milliseconds for an 8-centimeter (cm) study; distal peak sensory latency longer than 4 cm for a 14-cm distance; and distal peak compound nerve latency of longer than 2.4 milliseconds for a transcarpal or midpalmar study of 8 cm. If different distances were used in testing, correction to the above-state distances could be accomplished by assuming each 1 cm of distance required 0.2 milliseconds.[12]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[13] In Table 15-23, grade modifier levels (ranging from zero to four) are described for the categories of test findings, history and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier levels and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[14]

When an impartial medical specialist is selected to resolve a conflict in medical evidence, OWCP has the responsibility to assure that the medical opinion of the referee is well rationalized and based on a proper factual and medical background. When OWCP obtains a medical opinion that requires clarification or elaboration, it should secure a supplemental report to correct the defects of the original report.[15] Further, it is well established that in the circumstance of a conflict in medical opinion, an OWCP medical adviser may review the report of the impartial specialist but not substitute his or her opinion for that of the medical referee. The resolution of a conflict in medical evidence is the responsibility of the impartial medical specialist.[16]

[9] A.M.A., *Guides* 403, section 1.3, *The ICF; A Contemporary Model of Disablement.*

[10] *Id.* at 385-419.

[11] *Id.* at 411.

[12] *Id*. at 487, Appendix 15-B.

[13] *Id.* at 449.

[14] *Id.* at 448-50.

[15] *See V.G.*, 59 ECAB 635 (2008).

[16] *See G.J.*, Docket No. 14-137 (issued June 24, 2014); *Richard R. LeMay*, 56 ECAB 341 (2005).

ANALYSIS

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome. On November 29, 1994 it granted appellant a schedule award for 10 percent impairment of her right arm. On June 12, 2008 OWCP granted appellant a schedule award for five percent left arm impairment. Appellant contends that she has greater impairment.

In a prior appeal, the Board found a conflict in medical opinion between appellant's attending physician and an OWCP medical adviser. On remand, the case was initially referred to Dr. Huston for an impartial medical examination and impairment rating; however, he advised that he had not previously rated impairment of the A.M.A., *Guides* and was unable to respond to the request for clarification as to appellant's permanent impairment. Thereafter, OWCP properly referred appellant to Dr. Russell for an impartial medical evaluation as to the extent of her permanent impairment.

The Board finds that the report of Dr. Russell is not sufficient to resolve the conflict in medical opinion. The October 3, 2011 report provided by the physician addressed permanent impairment to appellant's arms with general reference to the A.M.A., *Guides* and "modifiers." Dr. Russell failed to address any specific tables relevant to the assessment of impairment due to carpal tunnel syndrome or explain how any specific grade modifier was determined in the final ratings provided in this case. The Board notes that the A.M.A., *Guides* provide that the impairment class is first determined by using the corresponding diagnosis-based regional grid. In turn, once the grade is determined that the adjustment grids are utilized under the Net Adjustment Formula to calculate the net adjustment. Impairment due to carpal tunnel syndrome is evaluated under Table 15-23 (Entrapment/Compression Neuropathy Impairment) and the accompanying relevant text. Under Table 15-23 grade modifiers (ranging from 0 to 4) are described for the categories of test findings, history and physical findings.[17] Dr. Russell failed to specify how he applied the A.M.A., *Guides*. His impairment ratings are deficient as they do not conform to the tables and protocols set forth in the sixth edition. As noted, with respect to evaluating impairment related to dysfunction of the median nerves, Appendix 15-B (Electrodiagnostic Evaluation of Entrapment Syndromes) contains criteria for evaluating whether carpal tunnel syndrome is present. If carpal tunnel is found under the standard of Appendix 15-B, impairment is evaluated under the schedule found in Table 15-23. If carpal tunnel syndrome is not found under the standards of Appendix 15-B, impairment due to median nerve dysfunction is evaluated under the scheme found in Table 15-21. There is no evidence that Dr. Russell took these factors into consideration in rating impairment.

In turn, Dr. Manning stated that he applied Table 15-23 at page 449 of the A.M.A., *Guides* as well as Table 15-21 at pages 438 to 448 of the A.M.A., *Guides.* Based on the report of Dr. Russell, he determined that appellant had an additional two percent impairment of the left arm. His report is also deficient in that he did not adequately explain how he applied the applicable tables. Further, Dr. Manning's report was utilized by OWCP to determine the extent of permanent impairment, which was error. It is well established that a conflict in medical opinion is to be resolved by the opinion of the selected impartial medical referee. An OWCP

[17] *See R.B.*, Docket No. 13-2040 (issued February 5, 2014).

medical adviser may review the report of an impartial specialist to determine whether the A.M.A., *Guides* were properly applied, but may not substitute his or her judgment for that of the selected referee physician.[18]

For these reasons, the Board finds that the medical evidence of record needs further development. On remand, OWCP should ask Dr. Russell for clarification as to the extent of impairment to appellant's upper extremities with specific reference to the sixth edition of the A.M.A., *Guides*. After such development as it deems necessary, OWCP shall issue a *de novo* decision on her claim for additional schedule awards.

CONCLUSION

The Board finds that this case is not in posture for decision on the extent of impairment to appellant's arms.

ORDER

IT IS HEREBY ORDERED THAT the October 19, 2012 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: July 28, 2014
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

[18] *See supra* note 16.