United States Department of Labor
Employees' Compensation Appeals Board

J.Z., Appellant	)	
and	)	
DEPARTMENT OF TRANSPORATION, TRANSPORTATION SECURITY ADMINISTRATION, JFK AIRPORT, Jamaica, NY, Employer	)	**Docket No. 07-309** **Issued: June 1, 2007**

Appearances:
Thomas Harkins, 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 November 2, 2006 appellant filed a timely appeal from an Office of Workers' Compensation Programs' schedule award decision dated September 21, 2006. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than an eight percent permanent impairment of his right upper extremity for which he received a schedule award.

FACTUAL HISTORY

On March 20, 2003 appellant, then a 42-year-old lead transportation security screener, sustained injury while lifting luggage.[1] He did not initially stop work. On June 18, 2003 the Office accepted appellant's claim for right carpal tunnel syndrome (CTS). The Office authorized

[1] Appellant has nonwork-related conditions, including a prior history of epilepsy and hernia repair surgery.

an electromyogram (EMG) scan and a right wrist carpal tunnel release.[2] Appellant received appropriate compensation benefits.

On May 4, 2005 appellant requested a schedule award. In an April 12, 2005 report, Dr. Steven L. Goodman, a Board-certified orthopedic surgeon and treating physician, addressed appellant's hand and wrist condition causally related to his work-related injury of March 20, 2003. He opined that he reached maximum medical improvement on January 9, 2004. Dr. Goodman advised that appellant did not subjectively complain of any pain with regard to his arm. He determined that there was no atrophy or deformities, although appellant had diminished sensation in the tips of the index, long and ring finger. Dr. Goodman utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) and referred to Table 16-10.[3] He also noted that he would rate distorted tactile sensibility at 25 percent sensory deficit. Dr. Goodman indicated that appellant had a diffuse disc bulge at C5-6, which was causing central spinal stenosis and right sixth nerve impingement and a diffuse disc bulge at C6-7 which was causing stenosis and bilateral nerve impingement. He also determined that appellant did not have any symptoms or clinical findings that would demonstrate ongoing radicular symptomatology.

By letter dated August 15, 2005, appellant's representative requested that the Office proceed with a schedule award determination and requested that the Office expand appellant's claim.

By letter dated October 6, 2005, the Office requested that appellant's physician provide an assessment of permanent impairment based upon the A.M.A., *Guides*. The Office provided Dr. Goodman with a copy of an earlier letter sent to appellant which requested that he provide an assessment of permanent impairment supported by a recent examination.

In an October 19, 2005 report, Dr. Goodman noted that he last saw appellant on January 9, 2004. He explained that appellant did not subjectively complain of any pain regarding his upper extremities. Dr. Goodman conducted an examination and noted that he found no evidence of atrophy in the muscles of the arm and no deformities. He noted diminished sensation in tips of the index, long and ring fingers and referred to Table 16-10.[4] Dr. Goodman advised that he would rate the distorted tactile sensibility at a 25 percent sensory deficit. He further reiterated that appellant had a diffuse disc bulge at C5-6, which was causing central spinal stenosis and right sixth nerve impingement and a diffuse disc bulge at C6-7 which was causing stenosis and bilateral nerve impingement. Additionally, Dr. Goodman opined that appellant had reached maximum medical improvement and that he did not have any symptoms or clinical findings to support ongoing radicular symptomatology.

In a November 9, 2005 report, an Office medical adviser noted appellant's history of injury and treatment, including that maximum medical improvement was reached on October 19,

[2] The record reflects that appellant underwent the EMG on March 24, 2003 and a right carpal tunnel release on July 8, 2003.

[3] A.M.A., *Guides* 482.

[4] *Id.*

2004 the date of Dr. Goodman's final report. He noted that appellant had sensory loss of 25 percent for the loss of sensation in the medium distribution of the finger. The Office medical adviser multiplied the maximum percentage for upper extremity impairment of 39 percent for sensory deficit or pain by 25 percent for sensory loss and noted that this equated to an impairment of 9.7 percent or rounded up to 10 percent for the right upper extremity.

On March 6, 2006 the Office determined that a conflict existed between the reports of appellant's treating physician, Dr. Goodman and the Office medical adviser regarding the degree of impairment. On April 21, 2006 it referred appellant for an impartial medical examination with Dr. James Sarno, a Board-certified orthopedic surgeon.

In a May 4, 2006 report, Dr. Sarno noted appellant's history of injury and treatment which included carpal tunnel surgery on the right wrist on March 24, 2003. He conducted a neurological examination which included findings that appellant was alert, with no dysphasia, and his integrative functions were intact. For the right hand, Dr. Sarno found diminished pin over the first, second and third digits over the palmar aspect. He also found diminished light touch in the same distribution and a weakness of 4/5 of the right hand compared to the left. Dr. Sarno advised that the Phalen's and Tinel's were negative bilaterally and there was a well-healed transverse carpal ligament incision over the right transverse carpal ligament. He referred to Table 16-10[5] and noted that, based on light touch and pinprick loss, appellant had a Grade 4 loss which was a sensory deficit of 1 to 25 percent and explained that, because this was appellant's nondominant hand, he was applying a 20 percent loss. Dr. Sarno referred to Table 16-15[6] and noted that the combination of motor and sensory loss for the median nerve was 45 percent. He multiplied the 45 percent by 25 percent and arrived at an 11 percent upper extremity impairment. Dr. Sarno referred to Table 16-3[7] and explained that this would equal a seven percent whole person impairment.

In an August 17, 2006 report, the Office medical adviser utilized the findings in Dr. Sarno's report. He noted that appellant would be entitled to a 20 percent sensory deficit or a Grade 4 pursuant to Table 16-10.[8] Dr. Sarno advised that 20 percent to the hand translated to 18 percent to the upper extremity pursuant to Table 16-2.[9] He multiplied the 45 percent value for combined motor and sensory deficit from Table 16-15[10] by 18 percent and arrived at 8.1 percent to the right upper extremity. The Office medical adviser noted that Dr. Sarno did not use

[5] *Id.*

[6] *Id*. at 492.

[7] *Id.* at 439.

[8] *See supra* note 3.

[9]. *See supra* note 7.

[10] *See supra* note 6.

Table 16-2[11] to convert the hand to the upper extremity. He indicated that appellant reached maximum medical improvement on May 4, 2006.

On September 21, 2006 the Office granted appellant a schedule award for eight percent impairment of the right upper extremity. The award covered a period of 24.96 weeks from May 4 to October 25, 2006.[12]

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[13] sets forth the number of weeks of compensation to be paid for the permanent loss of use, of specified members, functions and organs of the body.[14] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[15] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[16]

The fifth edition of the A.M.A., *Guides*, regarding CTS, provides that, 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 CTS is rated according to the sensory and/or motor deficits; (2) 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; and (3) normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies, in which case there is no objective basis for an impairment rating.[17]

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the

[11] *See supra* note 7.

[12] The Office corrected a previous schedule award decision dated March 29, 2006.

[13] 5 U.S.C. §§ 8101-8193.

[14] 5 U.S.C. § 8107.

[15] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

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

[17] *Silvester DeLuca*, 53 ECAB 500 (2002).

tables in the A.M.A., *Guides.*[18] However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.

Section 8123(a) of the Act provides, in pertinent part: "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."[19] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[20]

ANALYSIS

The Office accepted that appellant sustained right CTS in the performance of duty and authorized a right wrist carpal tunnel release. On March 6, 2006 the Office determined that a conflict existed between the reports of appellant's treating physician, Dr. Goodman, and an Office medical adviser regarding the degree of impairment. It referred appellant for an impartial medical examination with Dr. James Sarno, a Board-certified orthopedic surgeon.

However, the Board notes that the Office incorrectly determined that a conflict existed as Dr. Goodman's reports were insufficiently reasoned. Dr. Goodman provided some findings, but failed to provide a rating that comports with the A.M.A., *Guides*. In both his April 12 and October 19, 2005 reports, Dr. Goodman referred to Table 16-10[21] and noted that he would rate distorted tactile sensibility at 25 percent sensory deficit. However, Dr. Goodman did not complete the process which would include referring to Table 16-15 to ascertain appellant's sensory deficit or his combined motor and sensory deficits. For example, the calculation for impairment of the right arm for the diagnosed CTS is based on an application of Tables 16-15 and 16-10 of the A.M.A., *Guides*. Under Table 16-15, the maximum impairment for sensory deficit or pain to the median nerve is 39 percent.[22] The impairment is then graded in accord with Table 16-10.[23] It appears that the Office incorrectly interpreted Dr. Goodman's findings that appellant had a 25 percent sensory deficit as an opinion that he had an impairment of 25 percent to the right upper extremity. When in fact, he only calculated the sensory deficit and did not provide an opinion with regard to the extent if any, of appellant's impairment due to unilateral

[18] *See William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

[19] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan*, 45 ECAB 207, 210 (1993).

[20] *See Roger Dingess*, 47 ECAB 123, 126 (1995); *Juanita H. Christoph*, 40 ECAB 354, 360 (1988); *Nathaniel Milton*, 37 ECAB 712, 723-24 (1986).

[21] *See supra* note 3.

[22] *See supra* note 6.

[23] *See supra* note 3.

sensory or motor deficits in accordance with Table 16-15.[24] Thus, his report was incomplete and did not comport with the A.M.A., *Guides* and it was insufficient to create a conflict pursuant to section 8123, with that of the Office medical adviser.[25]

Therefore, Dr. Sarno is a second opinion referral physician rather than an impartial medical specialist.

In a May 4, 2006 report, Dr. Sarno noted appellant's history and conducted a physical examination which included findings for the right hand of diminished pin over the first, second and third digits over the palmar aspect. He noted that appellant had diminished light touch in the same distribution and a weakness of 4/5 of the right hand compared to the left and referred to Table 16-10.[26] Dr. Sarno determined that appellant had a Grade 4 loss which was a sensory deficit of 1 to 25 percent and explained that, because this was appellant's nondominant hand, he was applying a 20 percent loss. However, the Board has held that the Act "makes no distinction between the right or left hand as to the amount of compensation payable. The same is true with respect to [the] arms."[27] Additionally, the Board notes that section 16.1b of the A.M.A., *Guides* provides that impairment ratings in the chapter for upper extremities "have not been adjusted for hand dominance.…"[28] In his August 17, 2006 report, the Office medical adviser relied upon the findings contained in Dr. Sarno's report. However, as the report of Dr. Sarno needs further clarification, the values upon which the Office medical adviser relied are unclear and of diminished probative value.

As the Office referred appellant to Dr. Sarno, it has the responsibility to obtain an evaluation which will resolve the issue involved in the case.[29] Accordingly, the case will be remanded for the Office to request clarification from Dr. Sarno regarding the extent of appellant's impairment. After such further development as it deems necessary, the Office shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision and requires further development.[30]

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[24] *See supra* note 6.

[25] *See John H. Taylor*, 40 ECAB 1228 (1989).

[26] *Id.*

[27] *See Andrew B. Poe*, 27 ECAB 510 (1976); *see also Robed R. Kueh*, 13 ECAB 77-78 (1961); and *Isidoro Riviera*, 12 ECAB 348 (1961).

[28] A.M.A., *Guides* 435.

[29] *Mae Z. Hackett*, 34 ECAB 1421 (1983).

[30] The Board also notes that the Office has not rendered a final decision regarding expanding appellant's claim. Therefore, the Board does not have jurisdiction over the matter. *See* 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 21, 2006 is set aside. The case is remanded for further development consistent with this decision.

Issued: June 1, 2007
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