U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PATRICK J. LANI and DEPARTMENT OF THE NAVY, PHILADELPHIA NAVAL SHIPYARD, Philadelphia, PA

Docket No. 00-1566; Submitted on the Record;
Issued September 20, 2001

DECISION and ORDER

Before WILLIE T.C. THOMAS, BRADLEY T. KNOTT, A. PETER KANJORSKI

The issue is whether appellant has established that he sustained greater than a 20 percent impairment of each upper extremity, for which he received a schedule award.

On October 28, 1994 appellant, then a 47-year-old molder, filed an occupational disease claim for bilateral carpal tunnel syndrome. He did not stop work, but was placed on light duty with restrictions against heavy lifting.[1] Appellant submitted periodic medical reports through 1995 diagnosing bilateral carpal tunnel syndrome and restricting him to light-duty work.[2] On June 7, 1995 the Office accepted bilateral carpal tunnel syndrome. Appellant claimed a schedule award on December 17, 1996.

In an October 8, 1996 report, Dr. Ronald J. Potash, an attending Board-certified orthopedic surgeon, noted that appellant had operated pneumatic grinding tools for 19 years at work. He related appellant's symptoms of right hand numbness and tingling in all fingers, left hand pain, swelling and paresthesias, and difficulties with lifting and activities of daily living. Dr. Potash found no atrophy of the wrists, forearms or upper arms, bilaterally positive Phalen's

[1] On July 14, 1994 appellant filed a traumatic injury claim for right forearm flexor tendinitis sustained while "removing cast from mold with hammer." The record indicates that the Office of Workers' Compensation Programs proceeded to develop the claim as part of appellant's occupational disease claim.

[2] Dr. Robert A. Provencher, an attending osteopath, submitted periodic reports through 1994 regarding appellant's bilateral carpal tunnel syndrome and right elbow tendinitis. October 27, 1994 electromyography (EMG) and nerve conduction velocity (NCV) studies performed by Dr. David Levy, a physiatrist, showed bilateral carpal tunnel syndrome, right greater than left, without cervical radiculopathy. Dr. Frederick L. Ballet, an attending Board-certified orthopedic surgeon, placed appellant on restricted duty in October and November 1994, with no use of vibrating or grinding equipment. Dr. Ballet submitted periodic reports through 1995. In a May 15, 1995 report, Dr. Ballet noted that splinting and work restrictions were ineffective at improving appellant's condition. In an August 17, 1995 report, Dr. Ballet noted that two-point discrimination was at four to five millimeters on both hands and that appellant's condition had worsened to the point that both Tinel's and Phalen's signs were positive bilaterally, and that he was "beginning to develop right abductor pollicis brevis weakness."

and Tinel's signs, decreased sensation to pinprick in the second, third and fourth fingers of the left hand, bilaterally restricted wrist motion and grip strength of 11 kilograms on the right and 17 kilograms on the left. Dr. Potash diagnosed "[s]evere median nerve entrapment at the "right and left wrists (C6 and C7)," caused by the use of vibrating and grinding tools in the course of his federal employment. Referring to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (4th ed. 1993), Dr. Potash used Figure 45, page 50 to identify the lateral aspect of the left upper extremity, enervated by the median nerve as shown on Table 12, page 47. Dr. Potash then referred to Table 15, page 54 to ascertain that "maximum loss of function due to sensory deficit is 38 percent," and that Table 11a, page 48 provided that the allowable grade of "sensory deficit and pain" was 61 to 80 percent. Dr. Potash then multiplied the 38 percent sensory deficit by the 80 percent grade due to pain or sensory deficit, to arrive at a 30 percent impairment of the left upper extremity.

In a November 26, 1996 report, Dr. Potash stated that according to Tables 32 and 34, page 65 of the A.M.A., *Guides*, "for the grip strength loss," appellant had a 30 percent impairment of the right upper extremity.

In a February 4, 1997 report, an Office medical adviser opined that Dr. Potash's October 8 and November 26, 1996 reports were "not internally consistent. [Dr. Potash] reports severe median nerve entrapment but did not use Table 16, page 57 for severe entrapment. He only used pain for the left hand and grip strength deficit for the right hand. However, according to page 64, grip strength is used in rare cases to represent an impairing factor not adequately considered." The Office medical adviser noted that as appellant did not want to undergo carpal tunnel release surgery, the schedule award should be calculated. The adviser noted that appellant could no longer work as a "molder or pneumatic tool operator" due to "bilateral severe carpal tunnel syndrome."

On July 24, 1997 the Office referred appellant to Dr. Todd Marc Kelman, a Board-certified orthopedic surgeon, for a second opinion evaluation. In an August 20, 1997 report, Dr. Kelman noted appellant's symptoms of persistent numbness and discomfort in both hands, elbow pain and neck stiffness. On examination, he found minimal tenderness over the left rhomboid, left wrist and forearm, thenar atrophy greater on the left than on the right, wrist extensor reflexes 4+/5 bilaterally, "[d]eep tendon reflexes (biceps, triceps and brachioradialis) were 2/4 and symmetrical bilaterally, bilateral weakness of the thumb abductor, and mild weakness of intrinsic strength bilaterally. Grip strength was evaluated at 20 kilograms in both hands, the right hand being dominant. Dr. Kelman also found "decreased sensation to pinprick in all fingers," markedly positive Phalen's, reverse Phalen's and Tinel's signs bilaterally, "producing numbness in all fingers, with two-point discrimination at six millimeter for all fingers. He diagnosed advancing bilateral carpal tunnel syndrome, left worse than right, with thenar atrophy. Dr. Kelman stated that appellant had not reached maximum medical improvement and required further diagnostic studies.[3] He did not provide a description of impairment according to the A.M.A., *Guides*.

[3] In an accompanying work capacity evaluation (Form OWCP-5), Dr. Kelman prohibited lifting more than 10 pounds, "no exposure to vibration, no repetitive use of either hand."

On October 1, 1997 the Office requested that an Office medical adviser review Dr. Kelman's report and determine the percentage of impairment using the A.M.A., *Guides*. In an October 10, 1997 note, an Office medical adviser noted that Dr. Kelman's findings of bilateral thenar atrophy indicated the "moderate severity category of 20 percent for each arm, according to Table 16, page 57," of the A.M.A., *Guides*. The Office medical adviser determined that the date of maximum medical improvement was August 20, 1997, the date of Dr. Kelman's report.

By decision dated February 20, 1998, the Office awarded appellant a schedule award for a 20 percent impairment of the right and left upper extremities.[4] Appellant disagreed with this decision and in a March 9, 1998 letter requested a hearing before a representative of the Office's Branch of Hearings and Review.

By decision dated August 5, 1998 and finalized August 8, 1998, an Office hearing representative found that the case was not in posture for a hearing, as Dr. Kelman opined that appellant had not reached maximum medical improvement. The hearing representative stopped payment of the schedule award and remanded the case so that appellant could be referred for further diagnostic studies.

In an October 13, 1998 report, Dr. Cynthia Farrell, a physiatrist to whom appellant was referred by the Office, noted appellant's symptoms of "persistent numbness and paresthesias in both hands and bilateral shoulder pain," beginning on August 8, 1994. Dr. Farrell performed an NCV study showing "prolongation of the bilateral median nerve distal sensory and motor latencies," and an EMG study showing "abundant polyphasics and recruitment reduction … in the left C5-6 and right C5 myotomes." Dr. Farrell stated an impression of moderate bilateral carpal tunnel syndrome without "median nerve denervation," "left C5-6 and right C5 radiculopathies," "chronic, not acute," without an "acute cervical radicular process."

In a December 22, 1998 report, Dr. Kelman reviewed Dr. Farrell's report, and opined that the "chronic changes … [were] probably related to an underlying degenerative process in the cervical spine region." He recommended that appellant undergo surgical carpal tunnel release as his condition was progressive.

By decision dated January 20, 1999, the Office awarded appellant a schedule award for a 20 percent permanent impairment of each upper extremity.[5] Appellant disagreed with this decision and in a February 17, 1999 letter requested an oral hearing before a representative of the Office's Branch of Hearings and Review. At the hearing held on July 29, 1999, appellant alleged that the schedule award was improper as there was a conflict of medical opinion between

[4] The award was equivalent to 124.80 weeks of compensation and ran from August 20, 1997 to January 10, 2000, with weekly compensation of $489.00.

[5] In a January 11, 1999 letter, the Office advised appellant that as Dr. Kelman's opinion was unchanged the schedule award was being reinstated. The award was equivalent to 124.80 weeks of compensation at $489.00 per week, for the period August 20, 1997 to January 10, 2000.

Dr. Potash and Dr. Kelman, which required appointment of an impartial medical adviser to resolve.[6]

By decision dated and finalized January 4, 2000, the Office hearing representative affirmed the January 20, 1999 schedule award. The hearing representative found that the Office's procedures allowed an Office medical adviser to resolve a conflict of medical opinion in a schedule award case where the impairment rating is based on an attending physician's report not supported by reference to the A.M.A., *Guides*. The hearing representative found that the Office medical adviser's opinion that Dr. Potash's reports were "not internally consistent" was sufficient to resolve the apparent conflict in Dr. Kelman's favor.

The Board finds that appellant has not established that he sustained greater than a 20 percent impairment of each upper extremity, for which he received a schedule award.

The schedule award provisions of the Federal Employees' Compensation Act and its implementing regulation[7] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule.[8] However, the Act does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such a determination is a matter, which rests in the sound discretion of the Office.[9] The Board has held, however, that for consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitate the use of a single set of tables so that there may be uniform standards applicable to all claimants. The Office has adopted the A.M.A., *Guides*, (fourth edition 1993), as an appropriate standard for evaluating schedule losses and to ensure equal justice for all claimants.[10] The Board has concurred with the adoption of these A.M.A., *Guides*.

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

[6] Appellant also reiterated his symptoms of tingling, numbness, weakness, paresthesias, difficulty lifting and in performing activities of daily living. He stated that he did not want to undergo surgical carpal tunnel release due to the risk of a poor result.

[7] 20 C.F.R. § 10.404.

[8] 5 U.S.C. §§ 8107-8109.

[9] *Danniel C. Goings*, 37 ECAB 781 (1986); *Richard Beggs*, 28 ECAB 387 (1977).

[10] FECA Bulletin No. 89-30 (issued September 28, 1990).

itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*.[11] All factors that prevent a limb from functioning normally should be considered, such as pain and weakness, together with loss of motion, in evaluating the degree of permanent impairment.

In this case, appellant submitted reports from Dr. Ronald J. Potash, an attending Board-certified orthopedic surgeon, indicating that appellant had a 30 percent impairment of each upper extremity according to the A.M.A., *Guides*. Dr. Potash evaluated appellant's left upper extremity in an October 8, 1996 report, calculating a 30 percent impairment due to pain and sensory deficit.[12] However, in evaluating appellant's right upper extremity, Dr. Potash only used loss of strength, and not pain or sensory deficit, as criteria in determining a 30 percent impairment of the right arm.[13] Dr. Potash did not offer any explanation as to why he used such different methods of evaluation to assess impairment of each arm. The Board finds that these inconsistencies are so significant that Dr. Potash's opinion cannot represent the weight of the medical evidence in this case.

In a February 4, 1997 report, an Office medical adviser noted Dr. Potash's use of different criteria for each arm, and therefore recommended a second opinion referral. Based on this report, the Office referred appellant to Dr. Kelman, a Board-certified orthopedic surgeon, for a second opinion evaluation. In his August 20, 1997 report, Dr. Kelman found decreased reflexes in both upper extremities, bilateral weakness of the thumb abductor and intrinsic strength, grip strength of 20 kilograms in both hands, "decreased sensation to pinprick in all fingers," markedly positive Phalen's, reverse Phalen's and Tinel's signs bilaterally, and thenar atrophy.[14] An Office medical adviser submitted an October 10, 1997 note opining that bilateral thenar atrophy indicated the "moderate severity category of 20 percent for each arm, according to Table 16, page 57," of the A.M.A., *Guides*. Based on this note, the Office issued the January 20, 1999 schedule award for a 20 percent impairment of each upper extremity.

On appeal, appellant, through his attorney representative, asserts that according to the Office's procedures, an Office medical adviser may create, but not resolve, a conflict of medical opinion. However, the Board finds that there is not a conflict of medical opinion between

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

[12] Dr. Potash used Table 12, page 47 and Figure 45, page 50 to identify the lateral aspect of the left upper extremity, enervated by the median nerve. Dr. Potash then referred to Table 15, page 54 to ascertain that "maximum loss of function due to sensory deficit is 38 percent" and that Table 11a, page 48 provided that the allowable grade of "sensory deficit and pain" was 61 to 80 percent. Dr. Potash then multiplied the 38 percent sensory deficit by the 80 percent grade due to pain or sensory deficit, to arrive at a 30 percent impairment of the left upper extremity.

[13] In a November 26, 1996 report, Dr. Potash stated that according to Tables 32 and 34, page 65 of the A.M.A., *Guides*, "for the grip strength loss," appellant had a 30 percent impairment of the right upper extremity.

[14] Dr. Kelman submitted a December 22, 1998 report, opining that the chronic C5-6 radiculopathies found by Dr. Farrell on October 13, 1998 electrodiagnostic testing were "probably related to an underlying degenerative process in the cervical spine region" as opposed to carpal tunnel syndrome. However, Dr. Kelman did not provide a calculation of permanent impairment according to the A.M.A., *Guides*.

Dr. Potash, for appellant, and Dr. Kelman, for the government. In order for a conflict to exist, the opinions involved must be of virtually equal weight. In this case, Dr. Potash's opinion is flawed by his use of differing criteria in calculating the schedule award for each arm. Dr. Potash did not provide any medical rationale explaining why such a departure from usual evaluation methods was necessary, such as radically different findings in each extremity, or different mechanisms of injury. Therefore, Dr. Kelman's opinion, which clearly, consistently and correctly used the A.M.A., *Guides*, outweighs that of Dr. Potash. Thus, there is no conflict.

Consequently, appellant has not established that he sustained greater than a 20 percent impairment of each upper extremity as he provided insufficient medical evidence substantiating a greater degree of impairment.

The decision of the Office of Workers' Compensation Programs dated and finalized January 4, 2000 is hereby affirmed.

Dated, Washington, DC
September 20, 2001

Willie T.C. Thomas
Member

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member