U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of STANLEY M. GOBER and DEPARTMENT OF DEFENSE, U.S. AIR FORCE, MINOT AIR FORCE BASE, Great Falls, MT

Docket No. 03-129; Submitted on the Record;
Issued February 13, 2003

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS, A. PETER KANJORSKI

The issue is whether appellant has any additional ratable impairment than that previously awarded by the Office of Workers' Compensation Programs of his right and left upper extremities.

On October 30, 1996 the Office accepted that appellant, then a 45-year-old quality assurance specialist, developed bilateral carpal tunnel syndrome in the performance of duty. Appellant underwent a right carpal tunnel release surgery on November 11, 1996.

On May 29, 1997 appellant filed a claim for a schedule award. On July 24, 1997 the Office issued a schedule award for 11 percent impairment of the right arm and 10 percent impairment of the left arm for the period from June 2, 1997 through September 3, 1998. The Office medical adviser recommended to the Office the percentage of impairment for the schedule award, based on the medical opinion of Dr. Kirk Kindsfater, in his report dated January 14, 1997.

In a letter dated April 7, 1998, the Office informed appellant that payment of the schedule award had been terminated. The Office indicated that the payment of the schedule award of 10 percent of the left upper extremity was premature given Dr. Kindsfater's prognosis of appellant's left hand condition, particularly since although stable, it had the potential to progress with no operative intervention. The Office indicated that the 11 percent permanent impairment of the right upper extremity was paid in full for the period June 2, 1996 to January 30, 1998 and advised that schedule award payments subsequent to that date were considered an overpayment. The Office noted that impairment resulting from the left carpal tunnel was being evaluated and that surgery may result; therefore, the overpayment issue would be set aside until resolution of those issues.

The record reflects that appellant underwent left carpal tunnel release on June 1, 1998. In reports dated July 21 and December 17, 1998, Dr. Oliva Alfonso, a Board-certified plastic and reconstructive surgeon, advised that following left release surgery appellant's tingling, numbness and paresthesias had largely resolved and markedly improved. Dr. Alfonso found that because

appellant still experienced constant achy feelings and occasional piercing pain in the palm and forearm, that appellant should undergo occupational therapy.

Appellant underwent physical therapy until September 1998 and his condition was considered stable in March 1999. Appellant thereafter requested that his interrupted schedule award for the left hand be reinstated.

In a report dated July 27, 1999, Dr. J.B. Watkins, a Board-certified orthopedist, indicated that appellant presented for a permanent impairment rating. Dr. Watkins noted that because of invalid muscle testing and confusing sensory patterns, appellant was sent for nerve conduction studies, which indicated that the left and right median distal motor latencies were normal and the distal sensory and palm to wrist latencies were prolonged. On examination he found slight tenderness over the volar surgical scars on the wrists, more so on the left, with no actual swelling or deformity noted. Dr. Watkins reported that appellant had full range of motion in both wrists and all of the fingers and thumb. He found that appellant had five and equal muscle strength throughout the upper extremities except for considerable give way on wrist flexion and extension on the left, which appellant stated was due to pain. Dr. Watkins noted that appellant had weakness of grip strength and some mild hypesthesia on the dorsum of the right hand and stocking hypesthesia on the left. He diagnosed history of bilateral carpal tunnel syndrome with releases on both sides, which he stated was work related and olecranon bursitis of the left elbow with the cause unknown. The physician concluded that, based on the electrical studies and primarily the sensory deficit, using the Fourth Edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), appellant had a 5 percent impairment of the right upper extremity and a 10 percent impairment of the left upper extremity.

Dr. Richard McCollum, the district medical adviser, reviewed Dr. Watkins' findings in his report on October 8, 1999 and opined that Dr. Watkins' findings were inaccurate. Dr. McCollum stated that he could not determine how Dr. Watkins had reached his impairment rating unless he was using motor testing, although Dr. Watkins indicated that the motor testing was invalid. Dr. McCollum recommended that Dr. Watkins' examination be redone with particular attention to the details of strength evaluation on page 3/64 and 3/65 in the fourth edition of the A.M.A., *Guides*. He opined that the sensory deficit did not justify any impairment based on Dr. Watkins' report and that the motor examination was so equivocal and checkered with nonfunctional pain behavior that further evaluation should be done. Dr. McCollum stated that there was a likelihood that no impairment rating would be provided to appellant but that it could not be determined until a more detailed motor examination was performed with reexamination of appellant's sensory patterns.

On November 15, 1999 the Office found that a conflict was created and referred appellant to a referee examination by Dr. Warren Adams, a Board-certified orthopedic surgeon. In a report dated December 1, 1999, Dr. Adams reviewed that release surgeries had markedly improved appellant's wrist conditions, but that there were continued complaints of pillar pain and tingling. The physician found that on examination appellant exhibited tenderness over the scars of both wrists and that he demonstrated some discomfort at the extension, flexion and subsequent testing of his left wrist. Dr. Adams indicated that appellant's condition was fixed and stable and found that appellant had no ratable residual impairment of his left or right wrist.

In a March 29, 2000 letter to Dr. Adams, the Office indicated that according to Table 16 on page 57 of the A.M.A., *Guides*, impairment is awarded for mild sensory and motor deficit of the upper extremities and advised that the Office recognized residual pain as a sensory deficit. The Office requested that Dr. Adams consider the above factors and determine whether his opinion regarding impairment of either or both of appellant's arms might change.

In a letter dated November 1, 2000, Dr. Adams responded that examination of appellant noted normal two-point discrimination of the digits of the right and left hands at four millimeter (mm), which was normal; therefore, his sensory examination was normal. The physician further stated that appellant's motor strength was normal in reference to the muscles innervated by the right and left median nerve and grip strength as noted on the Jamar dynamometer was not ratable according to the Fourth Edition of the A.M.A., *Guides*. Dr. Adams noted that there is trouble with using Table 16 for evaluating mild sensory and motor deficits of the upper extremities in that the A.M.A., *Guides* does not define what mild sensory and mild motor deficits are based on objective findings. He indicated that for those reasons, use of Table 16 in this regard has not been recommended. Dr. Adams, therefore, stated that strictly interpreting the A.M.A., *Guides*, appellant had no impairment as stated in his December 1, 1999 report. He noted, however, that considering appellant's subjective complaints and the fact that he did have right and left carpal tunnel releases, he would not be adverse to a 5 percent upper extremity impairment in both upper extremities due to his right and left wrist surgeries.

In a November 18, 2000 report, an Office medical adviser agreed that the rating performed by Dr. Adams supported no impairment pursuant to the A.M.A., *Guides*. The Office medical adviser stated that even if 5 percent impairment were allowed for each upper extremity, because he had already been awarded 11 percent of the right arm and 10 percent of the left, there would be no increase in the award.

By decision dated March 7, 2001, the Office denied appellant's claim for additional schedule award. The Office relied on the reports of the independent medical examiner as the weight of the medical evidence and his conclusion that there was zero percent ratable impairment per strict interpretation of the A.M.A., *Guides*. The Office found, however, that since the Office does take into account the factors of mild sensory and motor deficits of the upper extremities, the recommended 5 percent permanent impairment of the right and left arms found by the independent medical examiner would be utilized.[1] The Office noted that appellant had been previously awarded the schedule award for 11 percent of the right arm. Therefore, the Office would deduct the combined left and right arm impairment of 10 percent from the amount and pursue the previously issued schedule award compensation in excess of 10 percent as an overpayment as previously discussed.

[1] Subsequently, in a memorandum to the Office dated January 11, 2002, an Office hearing representative noted that appellant's record was reviewed for purposes of determining the percentage of impairment of both upper extremities under the fifth edition of the A.M.A., *Guides* adopted by the Office effective February 1, 2001. The Office hearing representative stated that, according to the reports by Dr. Adams, appellant had no sensory deficits of either upper extremity. The motor strength in the muscles innervated by the right and left median nerves was also noted to be normal. However, the nerve conduction study dated August 16, 1999 was suggestive of mild bilateral carpal tunnel syndrome. The Office hearing representative determined that, according to the A.M.A., *Guides* 5th ed., page 495, appellant would warrant 5 percent impairment to the right and left upper extremity.

On March 17, 2001 appellant through counsel requested an oral hearing. Appellant's counsel submitted a brief in support of his request, in which he argued that the Office improperly relied on the reports of Dr. Adams, which he argued gave no consideration to Table 16 of the A.M.A., *Guides*, which appropriately provides for 10 percent impairment for median entrapped nerve under the "mild" degree of severity. Appellant's counsel argued that use of Table 16 for impairment due to carpal tunnel syndrome is one of two methods available under the A.M.A., *Guides* and that because he ignored Table 16, his report was not well rationalized and should not be given any weight.

The hearing was held on February 28, 2002. By decision dated July 16, 2002, an Office hearing representative affirmed the Office determination that appellant sustained no more than 5 percent impairment to the right and left upper extremities.

The Board finds that appellant has no additional ratable impairment than that previously awarded by the Office of his right and left upper extremities.

The schedule award provisions of the Federal Employees' Compensation Act[2] and its implementing regulation[3] 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 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*[4] has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

The Office accepted appellant's claim for bilateral carpal tunnel syndrome and authorized bilateral release surgeries. The Office initially awarded a schedule award for 11 percent impairment of the right arm and 10 percent impairment of the left arm from June 2, 1997 to September 3, 1998.[5] The Office found that the 10 percent schedule award for the left arm was premature and terminated payments for the schedule award as of April 26, 1998. Appellant requested reinstatement of the initial award once his condition was fixed and stable and in support of the claim for schedule award new evidence was submitted. The Office reviewed the medical evidence and determined that a conflict existed in the medical evidence between the Office medical adviser, who disagreed with Dr. Watkins concerning whether an impairment rating could be properly determined by Dr. Watkins' examination. The Office medical adviser specifically noted that based on a confusing sensory pattern provided by appellant and invalid muscle testing, that a more detailed evaluation should be performed. Consequently, the Office referred appellant to Dr. Adams, to resolve the conflict.

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] A.M.A., *Guides*, 5th edition (2001).

[5] The record reflects that the schedule award began on June 2, 1997 although the award letter indicated that it began June 2, 1996.

Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[6]

The Board finds that the opinion of Dr. Adams is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight.

Dr. Adams reviewed appellant's history, reported findings and noted an essentially normal physical examination. Particularly, he indicated that upon examination that appellant had zero percent impairment to either extremities since his sensory examination was normal and testing did not demonstrate any weakness of the muscles innervated by the right and left median nerve. The Office questioned Dr. Adams concerning his disregard of Table 16 on page 57 of the A.M.A., *Guides* in determining impairment for mild sensory and motor deficit of the upper extremities and advised that the Office recognized residual pain as a sensory deficit. Dr. Adams responded that there is generally trouble with using Table 16 for evaluating mild sensory and motor deficits of the upper extremities in that the A.M.A., *Guides* does not define what mild sensory and mild motor deficits are based on objective findings. He indicated that for these reasons use of Table 16 in this regard has not been recommended.

The Board notes that according to the A.M.A., *Guides*, evaluating impairment of the upper extremity based on sensory and motor deficits can be accomplished by performing two-point discrimination tests and muscle testing or alternatively by determining the grade of severity as outlined in Table 16 of the A.M.A., *Guides*.[7] Dr. Adams found that examination of appellant noted normal two-point discrimination of the digits of the right and left hands at four mm, which was normal, therefore, his sensory examination was normal.[8] He further stated that appellant's motor strength was normal in reference to the muscles innervated by the right and left median nerve and grip strength as noted on the Jamar dynamometer was not ratable. Dr. Adams sufficiently explained why he did not utilize Table 16 for determining upper extremity impairment in this case.

The Office found that, since the Office does take into account the factors of mild sensory and motor deficits of the upper extremities, the recommended five percent permanent impairment of the right and left arms found by the independent medical examiner would be utilized. Dr. Adams noted that considering appellant's subjective complaints of pain and the fact that he did have right and left carpal tunnel releases, he would not be adverse to a five percent upper extremity impairment in both upper extremities due to his right and left wrist surgeries.

[6] *Aubrey Belnavis*, 37 ECAB 206 (1985).

[7] *See* Chapter 3, *The Musculoskeletal System*, 4th edition; *see* Chapter 16, *The Upper Extremities*, 5th edition.

[8] *See* Table 16-5, page 447, (5th ed.).

The medical adviser properly applied the A.M.A., *Guides* to the information provided in Dr. Adams' report to conclude that there was no additional impairment.[9] This evaluation conforms to the A.M.A., *Guides* and establishes that appellant has no additional ratable impairment of the upper extremities than that previously awarded by the Office of his right and left upper extremities.

The July 16, 2002 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC
February 13, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

[9] The Board notes that Dr. Adams' reliance of the 4th edition of the A.M.A., *Guides* was proper inasmuch as his reports were dated December 1, 1999 and November 1, 2000. The 5th edition of the A.M.A., *Guides* was required on all evaluations performed on or after February 1, 2001. The Office recalculated appellant's impairment based on the new edition of the A.M.A., *Guides* on January 11, 2002.