United States Department of Labor
Employees' Compensation Appeals Board

M.T., Appellant	)	
and	)	**Docket No. 06-1522**
	)	**Issued: February 2, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Newark, 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:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 20, 2006 appellant filed a timely appeal from an Office of Workers' Compensation Programs' hearing representative's schedule award decision dated February 16, 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 a three percent permanent impairment of her right upper extremity for which she received a schedule award.

FACTUAL HISTORY

On December 10, 1992 appellant, then a 39-year-old senior mark-up clerk, filed an occupational disease claim alleging that she sustained carpal tunnel syndrome in the right hand due to her work. The Office accepted her claim for right carpal tunnel syndrome and right carpal

tunnel release surgery, which was performed on July 8, 1994.[1] She received appropriate compensation benefits.

On February 2, 1996 appellant filed a Form CA-7 requesting a schedule award.[2]

Appellant submitted a June 17, 1997 report from Dr. Ronald J. Potash, a Board-certified surgeon, who utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed. 1993). He noted that examination of the right elbow revealed no olecranon tenderness and no effusion and no medial epicondyle or lateral epicondyle tenderness, and positive Tinel's sign. Dr. Potash noted that appellant's pain with respect to activities of daily living was equivalent to 4 out of 10. Regarding elbow range of motion, he noted flexion-extension of 145/145 degrees, pronation of 80/80 degrees and supination of 80/80 degrees. Dr. Potash noted that wrist hyperextension was negative and wrist range of motion revealed dorsiflexion of 0 to 75/75 degrees; palmar flexion of 0 to 75/75 degrees; radial deviation of 0 to 20/20 degrees; and ulnar deviation of 0 to 35/35 degrees with a positive Tinel's sign, negative Phalen's sign and negative carpal compression. Regarding grip strength testing performed with the Jamar hand dynamometer, Dr. Potash noted that appellant had 13 kilograms of force strength involving the right hand. Regarding the upper arm circumference, Dr. Potash noted that appellant measured 24 centimeters on the right versus 26 centimeters on the left. He referred to Table 16 at page 57 of the fourth edition of A.M.A., *Guides,* and indicated that appellant was entitled to 30 percent for moderate right ulnar nerve entrapment and 20 percent for moderate right median nerve entrapment. Dr. Potash determined that, when combined, appellant had 44 percent impairment of the right arm. He opined that appellant reached maximum medical improvement on May 14, 1997.

On August 29, 1997 the Office referred appellant for a second opinion, along with a statement of accepted facts, a set of questions and the medical record to Dr. James Charles, a Board-certified neurologist. In a report dated September 23, 1997, Dr. Charles described appellant's history of injury and treatment, conducted a neurological examination and determined that appellant had a two percent impairment of her right arm due to the carpal tunnel syndrome.

On May 4, 2000 the Office referred appellant together with a statement of accepted facts, and the medical record to Dr. Howard Blank, a Board-certified orthopedic surgeon, for an

[1] The Office also accepted a recurrence of disability on July 8, 1994. Appellant subsequently returned to light duty.

[2] A second request for a schedule award was made on July 28, 1997.

impartial medical evaluation to resolve a conflict in medical opinion between Drs. Potash and Charles regarding the extent of appellant's permanent impairment.[3]

In a May 19, 2000 report, Dr. Blank noted appellant's history of injury and treatment and utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001) (A.M.A., *Guides*). He noted that appellant had an excellent result from her 1994 surgery and opined that she had two percent impairment of her right arm.

In a July 8, 2001 report, the Office medical adviser utilized Dr. Blank's report, and referred to page 495 of the A.M.A., *Guides.* He noted that the maximum allowed for carpal tunnel syndrome following surgery was five percent. The Office medical adviser agreed with Dr. Blank that appellant was entitled to no more than two percent impairment to the right upper extremity.

By decision dated July 10, 2001, the Office awarded appellant compensation for two percent permanent impairment of the right upper extremity. The award was for 6.24 weeks from May 16 to June 28, 2000.

By letter dated July 24, 2001, appellant requested a hearing.

In an October 22, 2001 decision, the Office hearing representative remanded the case for further development. He determined that the impartial medical examiner, Dr. Blank, did not explain how he arrived at the two percent award under the A.M.A., *Guides.* The Office medical adviser concluded that a supplemental report was in order to clarify the physician's opinion.

The record reflects that the Office attempted to obtain clarification from Dr. Blank; however, he did not provide an updated opinion.

On February 8, 2002 the Office referred appellant for a second opinion examination with Dr. David Rubinfeld, a Board-certified orthopedic surgeon.

In a report dated February 20, 2002, Dr. Rubinfeld opined that appellant had no objective basis for an impairment rating. In a February 28, 2002 report, the Office medical adviser agreed that appellant did not have any impairment.

By decision dated March 2, 2002, the Office determined that appellant was not entitled to a schedule award for her right upper extremity as there was no permanent impairment.

By letter dated March 8, 2002, appellant requested a hearing.

[3] The record reflects that, on July 1, 1998, the Office referred appellant along with a statement of accepted facts, and the medical record to Dr. Alan Clark, a Board-certified internist for an impartial medical evaluation to resolve the conflict in opinion between Drs. Potash and Charles regarding appellant's diagnosis. In a September 16, 1998 report, Dr. Clark determined that appellant had an abnormal electromyography (EMG) scan of the right upper extremity with evidence of carpal tunnel syndrome along the sensory nerve distribution of the median nerve below the wrist. On October 7, 1998 the Office medical adviser indicated that Dr. Clark needed to use the fourth edition of the A.M.A, *Guides.* The Office later requested an additional report from Dr. Clark and an opinion regarding whether appellant had an impairment utilizing the A.M.A., *Guides.* However, no response was received and a new referee examination was scheduled with Dr. Blank.

On April 7, 2003 the hearing representative remanded the case to the Office to schedule appellant for another impartial medical examination. The Office hearing representative determined that a medical conflict remained and that the Office erred when it scheduled appellant for a second opinion examination instead of a new impartial medical examination.

On July 15, 2003 the Office referred appellant, together with a statement of accepted facts, and the medical record to Dr. John E. Robinton, a Board-certified neurologist, for an impartial medical evaluation to resolve the conflict in opinion regarding the extent of appellant's right arm impairment.

In a report dated August 4, 2003, Dr. Robinton noted appellant's history of injury and treatment. He determined that appellant did not have any objective findings on examination. Appellant had complaints of pain and numbness associated with certain activities but her work activities were not restricted. Dr. Robinton utilized the A.M.A., *Guides* and noted that appellant was entitled to an impairment of two percent due to median nerve dysfunction, which was residual from the carpal tunnel. He opined that there was no basis for a diagnosis of ulnar neuropathy and that there was no objective evidence to support ongoing median nerve dysfunction beyond the two percent value. Dr. Robinton determined that appellant reached maximum medical improvement on the date of her surgery.

In an August 11, 2003 report, the Office medical adviser reviewed Dr. Robinton's report, and explained that Dr. Robinton did not refer to a specific page in the A.M.A., *Guides.* He also noted that Dr. Robinton's award was given for subjective complaints. The Office medical adviser explained that, because appellant had pain and numbness in the median nerve area which impacted on certain activities at work, she would be entitled to an impairment of three percent pursuant to Figure 18.1 at page 574 of the A.M.A., *Guides.*

By decision dated August 14, 2003, the Office granted appellant an additional one percent permanent impairment of her right upper extremity, for a total three percent permanent impairment of the right upper extremity.

On August 29, 2003 appellant's representative requested a hearing.

By decision dated July 7, 2004, the Office hearing representative remanded the case to the Office and instructed the Office to request clarification from Dr. Robinton regarding how he arrived at his impairment rating. The hearing representative explained that the Office medical adviser could not resolve the conflict in medical opinions.

In an August 17, 2004 letter, the Office requested that Dr. Robinton clarify his report.

In an August 30, 2004 supplemental report, Dr. Robinton explained that he estimated a disability of two percent utilizing page 495 from the A.M.A., *Guides.* He explained that he would classify appellant under scenario number two, and indicated that she had normal sensibility and opposition strength with abnormal electrophysiologic studies. Dr. Robinton noted that it was not uncommon following a surgery for values never to normalize and that he had taken these factors into consideration.

By decision dated November 10, 2004, the Office found that appellant had no more than three percent permanent impairment of her right arm.

On November 19, 2004 appellant requested a hearing, which was held on November 17, 2005.[4]

By letter dated December 14, 2005, appellant's representative contended that Dr. Robinton did not explain how he arrived at the two percent impairment rating.

By decision dated February 16, 2006, the Office hearing representative affirmed the November 10, 2004 decision.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[5] 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.[6] 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.[7] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[8]

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.[9] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.[10]

[4] At the hearing, appellant's attorney noted that, following her carpal tunnel surgery in July 1994, appellant had to have additional surgery because of an abscess. He noted that appellant continued to have carpal tunnel symptoms, and subsequently developed right elbow symptoms. Further, appellant's attorney advised that her physician recommended right ulnar nerve decompression and anterior ulnar nerve transposition. He alleged that appellant had significant neurological problems in the right arm that were not being considered in the impairment rating.

[5] 5 U.S.C. §§ 8101-8193.

[6] 5 U.S.C. § 8107.

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

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

[9] 5 U.S.C. § 8123(a).

[10] *Williams C. Bush*, 40 ECAB 1064, 1075 (1989).

ANALYSIS

The Office accepted appellant's claim for right carpal tunnel syndrome and right carpal tunnel release. In a decision dated July 10, 2001, the Office granted appellant a schedule award for two percent impairment of the right arm. However, on October 22, 2001, the Office hearing representative set aside the schedule award decision, as the impartial medical adviser's report was incomplete. After additional development, appellant was referred for a new impartial medical examination[11] with Dr. Robinton, a Board-certified neurologist, regarding the extent of appellant's impairment.

Office procedures[12] provide that upper extremity impairment secondary to carpal tunnel syndrome and other entrapment neuropathies should be calculated using section 16.5d and Tables 16-10, 16-11 and 16-15.[13] Regarding carpal tunnel syndrome, section 16.5d of the A.M.A., *Guides* provides:

> "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) [p]ositive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTS [computerized tomography scan] is rated according to the sensory and/or motor deficits as described earlier.
> >
> > (2) [n]ormal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG [electromyogram] 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.
> >
> > (3) [n]ormal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies: there is no objective basis for an impairment rating."[14]

Additionally, the Board has found that the fifth edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory impairments only.[15]

---

[11] As the previous impartial medical examiner did not clarify his opinion following, an Office request, the Office properly referred appellant to another impartial specialist. *See Nancy Keenan*, 56 ECAB ___ (Docket No. 05-949, issued August 18, 2005).

[12] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808 (August 2002).

[13] A.M.A., *Guides*, *supra* note 8; *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[14] A.M.A., *Guides* 495.

[15] *Robert V. Disalvatore*, 54 ECAB 351 (2003).

In an August 4, 2003 report, Dr. Robinton, conducted a physical examination and advised that appellant did not have any objective findings on examination. He utilized the A.M.A, *Guides*, and opined that appellant had two percent impairment due to her median nerve dysfunction, which was a residual from the carpal tunnel syndrome. In an August 30, 2004 supplemental report, Dr. Robinton explained how he arrived at his two percent estimate. He classified appellant under scenario number two of section 16.5d, noting that appellant had normal sensibility and opposition strength with abnormal electrophysiologic studies.[16] Dr. Robinton noted that it was not uncommon following a surgery for values never to normalize and that he had taken these factors into consideration. This portion of the A.M.A., *Guides* allows for an impairment rating of up to five percent. Dr. Robinton explained why he rated appellant's impairment at two percent. The Board finds that his report is based on a proper factual background and sufficiently well rationalized such that it is entitled to special weight. The report establishes that appellant has no more than two percent impairment of her right upper extremity.

Prior to receipt of Dr. Robinton's supplemental report, the Office's medical adviser referenced Dr. Robinton's initial report and opined that appellant's pain and numbness in the median nerve entitled her to an impairment of three percent pursuant to Figure 18.1 at page 574 of the A.M.A., *Guides.* However, according to section 18.3(b) of the A.M.A., *Guides*, "examiners should not use this chapter to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*."[17] Office procedures provide that Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain (Chapters 13, 16 and 17).[18]

The Board finds that the medical evidence establishes that appellant has two percent impairment of the right upper extremity. She has not established entitlement to a schedule award greater than the three percent awarded by the Office.

CONCLUSION

The Board finds that appellant does not have more than a three percent impairment of her right upper extremity.

[16] *Id*.

[17] A.M.A., *Guides* 571 (5th ed. 2001) section 18.3b.

[18] *See* FECA Bulletin No. 01-05 (issued January 31, 2001); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 16, 2006 is affirmed.

Issued: February 2, 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