United States Department of Labor
Employees' Compensation Appeals Board

W.H., Appellant	)	
and	)	**Docket No. 08-395**
	)	**Issued: July 1, 2008**
DEPARTMENT OF THE ARMY, INSTALLATION MANAGEMENT AGENCY, FORT LEWIS, WA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 19, 2007 appellant filed a timely appeal from the November 8, 2007 decision of the Office of Workers' Compensation Programs granting him a schedule award for both upper extremities. Pursuant to 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 established that he has greater than five percent impairment of each upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On January 24, 2005 appellant, then a 47-year-old fabric worker, filed an occupational disease claim. He alleged that he developed carpal tunnel syndrome over 10 years as a result of using sewing machines, scissors, cutting knives, electric drills and various other hand tools to repair upholstery, seat covers and tents. The Office accepted appellant's claim for carpal tunnel

syndrome, synovitis, tenosynovitis and enthesopathy of the elbow region. He underwent carpal tunnel release surgery for his left hand on July 12, 2005 and for his right hand on September 26, 2005.

On April 11, 2006 appellant requested a schedule award. He provided the March 24, 2006 report of Dr. Laura Kaufman, a Board-certified family practitioner, who stated that appellant continued to have wrist pain and weakness following the carpal tunnel releases. Using the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001), Dr. Kaufman found upper extremity range of motion impairments of 5 percent for appellant's right elbow, 12 percent for his right wrist, 7 percent for his left elbow and 6 percent for his left wrist. She found Grade 4 bilateral upper extremity sensory deficit, which resulted in seven percent impairment for each arm. Dr. Kaufman found that appellant had a combined right arm impairment of 22 percent and a combined left arm impairment of 19 percent. She stated that appellant appeared to be at maximum medical improvement.

The Office provided Dr. Kaufman's impairment rating to an Office medical adviser to determine appellant's entitlement to a schedule award. In a report dated April 26, 2006, Dr. Thomas Fleming, acting as an orthopedic consultant, stated that appellant had not yet reached maximum medical improvement. He noted that, under the A.M.A., *Guides*, maximum medical improvement cannot be determined until at least a year after carpal tunnel release surgery and that appellant had undergone these surgeries less than a year prior to the impairment rating. Dr. Fleming also stated that wrist and elbow range of motion ratings were not appropriate in cases of carpal tunnel syndrome.

On May 19, 2006 the Office notified appellant that it was unable to process his claim for a schedule award because he had not yet reached maximum medical improvement.

On July 12, 2006 the Office sent a letter to Dr. Kaufman asking her for a new opinion on appellant's permanent impairment. Dr. Kaufman responded with a report dated September 9, 2006. She stated that appellant's range of motion impairments had not changed from the previous examination, but that his sensory deficit in the median nerve was now Grade 3, 60 percent, for each arm. Dr. Kaufman indicated that, under the A.M.A., *Guides*, this resulted in 24 percent impairment in each upper extremity. She opined that appellant had combined impairment of 34 percent in his right arm and 36 percent in his left arm.

On November 30, 2006 the Office provided Dr. Kaufman's report to an Office medical adviser. On December 12, 2006 Dr. Kenneth Sawyer, a Board-certified surgeon, stated that he was unable to affirm Dr. Kaufman's impairment rating. He noted that the range of motion findings were unusual for appellant's accepted diagnoses and could be related instead to appellant's diagnosed bilateral wrist degenerative joint disease. Dr. Sawyer found several areas of inconsistencies or unexplained differences between Dr. Kaufman's two impairment ratings and the rest of the medical record. He recommended that appellant be referred for a second opinion examination.

On December 15, 2006 the Office referred appellant for an examination by Dr. Joan Sullivan, a Board-certified orthopedic surgeon. In a report dated January 10, 2007, Dr. Sullivan noted that appellant continued to experience pain in his wrists and hands after his

surgeries. Appellant reported having pain and stiffness in his hands in the mornings and intermittent paresthesias in his fingers throughout the day. Dr. Sullivan reviewed appellant's medical records and conducted a physical and partial neurological examination of his upper extremities. She found full extension, supination and pronation in both elbows and flexion to 125 degrees. In the wrists, Dr. Sullivan noted 50 degrees of extension bilaterally, 40 degrees of flexion on the right and 30 degrees on the left, full radial deviation bilaterally and ulnar deviation of 25 degrees on the right and 15 degrees on the left. She found tenderness bilaterally over the lateral epicondyle, radioulnar joint, snuffbox and carpometacarpal joints of the thumbs. Dr. Sullivan found positive Tinel's signs, Phalen's signs and median nerve compression tests in both wrists. She stated that appellant had positive Tinel's signs over both cubital tunnels and a positive Finkelstein test bilaterally. Dr. Sullivan found no sensory abnormalities using dermatome, two-point discrimination or sharp/dull testing. She diagnosed employment-related conditions of bilateral carpal tunnel syndrome with residuals, bilateral cubital tunnel syndrome with mild neuropathy on the right and moderate neuropathy on the left, bilateral de Quervain's tenosynovitis and bilateral mild lateral epicondylitis. Dr. Sullivan also diagnosed probable arthritis at both wrists.

Dr. Sullivan stated that appellant's medical history did not appear to be adequately reflected in his charts, especially regarding the cubital tunnel syndrome. She opined that, because his symptoms and examination were consistent with ongoing carpal tunnel syndrome, appellant had not yet reached a fixed and stable point. Dr. Sullivan stated that appellant needed further diagnostic studies to determine whether the carpal tunnel releases had been effective. She recommended surgical intervention for appellant's cubital tunnel syndrome and more aggressive treatment of his lateral epicondylitis and de Quervain's syndrome. Dr. Sullivan stated that, after successful intervention, appellant should be evaluated according to the carpal tunnel syndrome guidelines on page 495 of the A.M.A., *Guides*.

On February 23, 2007 the Office notified appellant that his request for a schedule award could not be considered at that time because the medical evidence established that he had not yet reached maximum medical improvement.

On March 12, 2007 appellant submitted a report from Dr. Bruce Wheeler, a Board-certified orthopedic surgeon specializing in the hands, who evaluated him at the request of Dr. Kaufman. Dr. Wheeler noted that appellant's condition had improved since his surgeries. He reported that an electromyogram (EMG) conducted on January 29, 2007 showed moderately severe bilateral median neuropathy across the wrists, right greater than left, mild ulnar nerve irritation or neuropathy across his elbows and subluxation of ulnar nerves in both elbows. Dr. Wheeler found no evidence of underlying peripheral neuropathy or plexus lesion. On physical examination, he noted full range of motion in both upper extremities. Bilaterally, appellant had negative median nerve compression tests and Tinel's signs in the wrists, but a positive cubital compression test and elbow flexion test. Dr. Wheeler found no clinical evidence of subluxation of the ulnar nerves, lateral epicondylitis or tendinitis in the fingers. He noted tenderness and a positive Finkelstein sign over the first dorsal compartment bilaterally. Dr. Wheeler diagnosed status post carpal tunnel releases with minimal symptoms and positive electrical studies, bilateral cubital tunnel syndrome, right worse than left and bilateral de Quervain's tenosynovitis. He opined that appellant's carpal tunnel syndrome was fixed and stable.

On March 29, 2007 appellant filed a claim for a schedule award. On May 1, 2007 the Office requested clarification of Dr. Sullivan's report on the issue of whether appellant's condition would be considered fixed and stable if he elected not to pursue surgery. It also requested an impairment rating.

On May 9, 2007 Dr. Sullivan reiterated her opinion that appellant was not fixed and stable in terms of his carpal or cubital tunnel syndromes and that he needed further conservative and surgical treatment. She noted that, because she could not compare the January 29, 2007 EMG and nerve conduction study results with earlier tests, she could not tell whether the positive test results showed a recurrent carpal tunnel syndrome or residuals from the original condition. Dr. Sullivan stated that, if appellant did not want to pursue surgery, his permanent impairment under the A.M.A., *Guides*, would be rated as at least five percent because of his "marked residuals."

On May 31, 2007 the Office provided the reports of Dr. Sullivan to Dr. Kaufman for comment. Dr. Kaufman stated that she concurred with Dr. Sullivan. On July 25, 2007 she indicated that appellant had declined further surgical intervention and was therefore at maximum medical improvement.

On September 21, 2007 appellant again requested a schedule award. He submitted the September 12, 2007 report of Dr. Kaufman, who provided an impairment rating based on results of a July 12, 2007 examination. Dr. Kaufman stated that, as a result of appellant's carpal tunnel syndrome, he had a 61 percent, Grade 2, sensory deficit of the median nerve, which had a maximum upper extremity impairment of 39 percent. This yielded 24 percent impairment in each upper extremity. Dr. Kaufman stated that the de Quervain's tenosynovitis, a form of tendinitis, was generally not rated without surgical intervention. She opined, however, that appellant's reduced range of motion due to tendinitis in his wrists and right thumb justified impairment ratings for decreased range of motion in his wrist and thumb. Dr. Kaufman stated that appellant had upper extremity range of motion impairments of 10 percent in his right wrist, 5 percent in his left wrist, 2 percent in his right thumb and 1 percent in his left thumb. She indicated that there was no impairment related to appellant's elbow enthesopathy. Combining the range of motion impairments, Dr. Kaufman found that appellant had 33 percent right upper extremity impairment and 29 percent left upper extremity impairment.

On October 3, 2007 the Office provided appellant's medical record to an Office medical adviser. On October 10, 2007 Dr. Morley Slutsky, a Board-certified occupational physician, informed the Office that he needed a copy of Dr. Kaufman's July 12, 2007 examination report before he could make a final determination on appellant's condition and schedule award entitlement.

On October 18, 2007 the Office provided Dr. Slutsky with the requested medical documentation and again requested an opinion on the date of maximum medical improvement and degree of impairment. In a report dated October 23, 2007, Dr. Slutsky opined that appellant had upper extremity impairments of five percent on each side. He stated that the date of appellant's maximum medical improvement was January 10, 2007, the date of Dr. Sullivan's examination. Dr. Slutsky stated that, because appellant did not want to pursue surgery, his condition might change overtime. He noted that, contrary to Dr. Kaufman, neither Dr. Sullivan

nor Dr. Wheeler found clinical evidence of carpal tunnel syndrome. Dr. Slutsky opined that Dr. Sullivan's and Dr. Wheeler's findings were the proper basis for an impairment rating because they were consistent and represented the best effort of the claimant. He stated that, under the A.M.A., *Guides*, appellant was eligible for a schedule award of five percent for each upper extremity because he had no median nerve deficits, but an abnormal EMG. Dr. Slutsky opined that appellant was not entitled to a schedule award for his tendinitis because there were no special circumstances, such as surgery, associated with this condition, as required by the A.M.A., *Guides*. He noted that appellant had no impairment related to the abnormalities in EMG testing because there was no clinical neurological evidence of ulnar nerve neuropathy.

By decision dated November 8, 2007, the Office granted appellant a schedule award for five percent of each upper extremity.

LEGAL PRECEDENT

The schedule award provisions of the Federal Employees' Compensation Act[1] and its implementing regulations[2] 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 should be determined. For consistent results and to ensure equal justice under the law for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standards applicable to all claimants.[3] Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[4]

If, after an optimal recovery time following surgical decompression, an individual continues to experience pain, paresthesias or difficulties performing certain activities and there are positive clinical findings of median nerve dysfunction and electrical conduction delays, the impairment due to residual carpal tunnel syndrome is rated according to sensory or motor deficits.[5] Table 16-10 of the A.M.A., *Guides* set forth a grading scheme and procedure for determining impairment of the upper extremity due to sensory deficit or pain resulting from peripheral nerve disorders.[6]

Section 8123(a) of the Act provides, in pertinent part: "If there is a 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."[7] In

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

[3] 20 C.F.R. § 10.404(a).

[4] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

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

[6] *Id*. at 482.

[7] 5 U.S.C. § 8123(a).

situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[8]

ANALYSIS

The Board finds that his case is not in posture for a decision because of an unresolved conflict in medical opinion as to the extent and degree of impairment of appellant's upper extremities.

On October 23, 2007 Dr. Slutsky, a Board-certified occupational physician acting as an Office medical adviser, stated that the medical reports of Dr. Sullivan and Dr. Wheeler, Board-certified orthopedic surgeons, formed the basis for his permanent impairment rating. He indicated that he used those reports because they were consistent and represented the best effort of the claimant. Using page 495 of the A.M.A., *Guides*, he opined that appellant had a permanent impairment of five percent for each upper extremity because he had positive EMG findings without clinical deficits of the median nerve. The Board finds, however, that Dr. Slutsky misstated Dr. Sullivan's findings when he indicated that she had found no clinical evidence of carpal tunnel syndrome. Although Dr. Sullivan did not find sensory abnormalities with dermatome, two-point discrimination or sharp/dull testing, she did find positive Phalen's and Tinel's signs and median nerve compression tests in both of appellant's wrists. Based on these findings, she diagnosed "carpal tunnel syndrome with an exam[ination] consistent with residuals." As this is in contradiction to what Dr. Slutsky stated, the Board finds that his rationale for a permanent impairment rating does not comport with the medical evidence of record and is therefore an insufficient basis for a schedule award.

The Board finds that, because Dr. Slutsky misinterpreted Dr. Sullivan's report, he did not note the conflict between her medical opinion and that of Dr. Wheeler, who diagnosed status post carpal tunnel release with minimal residuals. Contrary to Dr. Sullivan, Dr. Wheeler found negative median nerve compression tests and Tinel's signs bilaterally. He opined that appellant's carpal tunnel syndrome was fixed and stable. The Board finds that the reports of Dr. Sullivan and Dr. Wheeler, who are both orthopedic specialists, are of virtually equal weight. Therefore, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the medical conflict regarding the degree of appellant's impairment related to carpal tunnel syndrome.[9]

The Board also finds that the impairment rating prepared by Dr. Kaufman, a Board-certified family practitioner, is not a sufficient basis for a schedule award because it was not adequately rationalized on the issue of the impairment related to carpal tunnel syndrome. On May 31, 2007 Dr. Kaufman concurred with Dr. Sullivan's medical opinion that appellant was entitled to at least five percent impairment because of his "marked residuals." Her September 21, 2007 rating of 24 percent impairment of each upper extremity due to carpal tunnel

[8] *Roger Dingess*, 47 ECAB 123 (1995); *Nathan L. Harrell*, 41 ECAB 401, 407 (1990).

[9] *Richard R. LeMay*, 56 ECAB 341 (2005).

syndrome was based on a finding of Grade 2, 61 percent, sensory deficit in the median nerves. However, Dr. Kaufman did not explain which clinical or diagnostic factors she relied on in coming to this determination. The Board has held that a medical opinion not fortified by rationale is of diminished probative value.[10]

On remand, the Office should refer appellant for evaluation by an impartial medical examiner to resolve the conflict between the medical opinions of Dr. Sullivan and Dr. Wheeler on the degree of appellant's permanent impairment related carpal tunnel syndrome, along with his other accepted conditions and any preexisting impairment to the upper extremities.[11] Following this and any further development, the Office should issue a *de novo* opinion decision related to appellant's claimed schedule award.

CONCLUSION

The Board finds that this case is not in posture for a decision.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 8, 2007 is set aside and remanded for action consistent with this opinion.

Issued: July 1, 2008
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[10] *Cecelia M. Corley*, 56 ECAB 662 (2005).

[11] *Peter C. Belkind*, 56 ECAB 580 (2005) ("It is well established that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.")