United States Department of Labor
Employees' Compensation Appeals Board

P.M., Appellant	)	
and	)	**Docket No. 08-533**
	)	**Issued: July 10, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Neptune, NY, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 12, 2007 appellant, through her attorney, filed a timely appeal of an Office of Workers' Compensation Programs' hearing representative's August 1, 2007 merit decision addressing her permanent impairment. 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 more than five percent impairment to each of her upper extremities for which she received a schedule award.

FACTUAL HISTORY

On January 17, 2002 appellant, then a 39-year-old letter carrier, filed a occupational disease claim alleging whiplash, a compression fracture of C6-7 and carpal tunnel syndrome due to a motor vehicle accident in the performance of duty. In a letter dated June 3, 2003, her attorney noted that the Office had accepted that appellant sustained cervical sprains due to a March 18, 1987 motor vehicle accident. Appellant's attorney stated that appellant's light-duty

work following her accident aggravated her neck condition and caused new conditions, including bilateral carpal tunnel syndrome. He alleged that appellant's right carpal tunnel syndrome was due to the 1987 employment injury and she underwent right carpal tunnel release in August 1987. A magnetic resonance imaging (MRI) scan report dated May 1, 2001 demonstrated disc space narrowing at C6-7. In reports dated May 1 and August 15, 2001, Dr. Scott M. Fried, an osteopath, examined appellant and diagnosed repetitive strain injury with cumulative trauma disorder, secondary to repetitive casing and letter carrying activities, cervical strain and disc space narrowing at C6-7 due to the 1987 motor vehicle accident, radio-ulnar neuropathy and brachial plexitis due to these conditions.

The Office noted that appellant's 1987 motor vehicle claim had been accepted for acute cervical strain with minor subluxation of C5 over C6. The Office referred appellant for a second opinion evaluation. On October 24, 2003 Dr. Lester Lieberman, a Board-certified orthopedic surgeon, diagnosed bilateral carpal tunnel syndrome and cervical disc with superimposed cervical sprain and subluxation of C5 on C6. He opined that appellant had no continuing work-related disability. The Office accepted appellant's 2002 occupational disease claim for bilateral carpal tunnel syndrome on April 15, 2004.

Appellant requested a schedule award on November 8, 2004. In a report dated August 23, 2004, Dr. David Weiss, a Board-certified osteopath, noted that she underwent right carpal tunnel release on September 19, 1987 and left carpal tunnel release on April 25, 1997. He described appellant's physical findings including positive Tinel's and Phalen's signs bilaterally. Appellant underwent an electromyogram (EMG) on June 18, 2001 which revealed normal parameters of the bilateral median nerves. Dr. Weiss diagnosed post-traumatic bilateral carpal tunnel syndrome as well as post-traumatic cervical strain and sprain, discogenic disease of the cervical spine at C5-6 and C6-7 and cervical radiculopathy. He rated appellant's impairment for the C5, C6 and C7 nerve roots, motor strength deficit in the right deltoid, right pinch strength deficit and pain-related impairment as 40 percent of the right upper extremity. Dr. Weiss made similar findings on the left to find 23 percent impairment. He concluded that appellant reached maximum medical improvement on August 23, 2004.

The Office medical adviser reviewed the medical records and concluded that appellant had five percent impairment to each upper extremity due to carpal tunnel syndrome following a surgical release. On August 4, 2006 the Office requested a supplemental report from Dr. Weiss limiting his impairment rating to the accepted condition of carpal tunnel syndrome. There was no response.

In a letter dated November 29, 2006, the Office informed appellant that there was a conflict of medical opinion between Dr. Weiss and the Office medical adviser regarding the extent of her permanent impairment. The Office referred appellant to Dr. Robert M. Moore, a Board-certified orthopedic surgeon, for an impartial medical examination. In a December 26, 2006 report, Dr. Moore reviewed appellant's history of injury and medical treatment and diagnosed mild residual bilateral median neuropathy as well as neck and bilateral upper extremity pain secondary to cervical degenerative disc disease, radiculopathy or brachial plexopathy. He found positive Tinel's and Phalen's signs in both upper extremities as well as hypesthesia in both long, ring and small fingers. Dr. Moore noted that appellant's EMG showed no clear evidence of residual median nerve abnormality, but that the positive Tinel's and

Phalen's signs did support the possibility of some residual median neuropathy at the wrists bilaterally. He opined that based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), appellant had five percent impairment to each upper extremity due to the accepted condition of carpal tunnel syndrome. The Office medical adviser reviewed this report on January 10, 2007 and opined that Dr. Moore had properly applied the A.M.A., *Guides.* He agreed that appellant had no more than five percent impairment of each upper extremity due to residuals of her accepted carpal tunnel syndrome.

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

Appellant, through her attorney, requested an oral hearing on February 13, 2007. She submitted a statement describing her symptoms. Appellant's attorney submitted argument at the oral hearing on June 12, 2007, contending that Dr. Moore did not provide adequate findings. He further alleged that appellant's cervical condition should be included in her impairment rating as it was either a preexisting condition or occurred during the March 17, 1987 employment injury.

By decision dated August 1, 2007, the hearing representative affirmed the February 8, 2007 decision, finding that Dr. Moore's report was entitled to the weight of the medical evidence and comported with the A.M.A., *Guides.* The hearing representative found that the only condition accepted as employment related was carpal tunnel syndrome, it was appropriate for Dr. Moore to limit his evaluation for schedule award purposes to this condition.[1]

LEGAL PRECEDENT

The schedule award provision 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* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[4] Effective February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[5]

[1] The Board notes that the Office has not issued a final decision addressing the issue of whether appellant's additional cervical conditions are causally related to the 1987 motor vehicle accident. Therefore, the Board will not address this aspect of appellant's schedule award claim on appeal. 20 C.F.R. § 501.2(c).

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] *Id.*

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a) (August 2002).

In evaluating carpal tunnel syndrome, the A.M.A., *Guides* provide that if after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias or difficulties in performing certain activities three possible scenarios can be present. The first situation is: "Positive clinical finding of median nerve dysfunction and electrical conduction delay(s): The impairment due to residual [carpal tunnel syndrome] is rated according to the sensory and/or motor deficits as described earlier."[6] In this situation, the impairment due to residual carpal tunnel syndrome is evaluated by multiplying the grade of severity of the sensory or motor deficit by the respective maximum upper extremity impairment value resulting from sensory or motor deficits of each nerve structure involved. When both sensory and motor functions are involved the impairment values derived for each are combined.[7] In the second scenario: "Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual [carpal tunnel syndrome] is still present and an impairment rating not to exceed five percent of the upper extremity may be justified." In the final situation: "Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies: there is no objective basis for an impairment rating."[8]

To accurately evaluate sensory impairment clinically and reduce the subjective nature of these findings,[9] the A.M.A., *Guides* recommend either the two-point test for fine discrimination, the monofilament touch-pressure threshold test or the pinprick test.[10]

ANALYSIS

The Office accepted appellant's claim for bilateral carpal tunnel syndrome. She submitted a report from Dr. Weiss, an osteopath and a Board-certified orthopedic surgeon, dated August 23, 2004 opining that she had 40 percent impairment of her right upper extremity and 23 percent impairment of the left upper extremity due to her conditions of carpal tunnel syndrome, cervical sprain and discogenic disease of the cervical spine. The Office medical adviser disagreed with this assessment and opined that appellant had five percent impairment bilaterally due to her carpal tunnel syndrome. The Office found a conflict of medical opinion evidence between Dr. Weiss and the Office medical adviser regarding the extent of appellant's employment-related permanent impairment and referred her to Dr. Moore, a Board-certified orthopedic surgeon, for an impartial medical evaluation. The Act provides that 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.[11] The implementing regulation states that if a conflict exists between the medical

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

[7] *Id*. at 494, 481.

[8] *Id.* at 495.

[9] *Id.* at 446.

[10] *Id.* at 445.

[11] 5 U.S.C. §§ 8101-8193, 8123.

opinion of the employee's physician and the medical opinion of either a second opinion physician of an Office medical adviser or consultant, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.[12]

Dr. Moore examined appellant and provided her history of injury and medical history. He relied on the statement of accepted facts in noting that appellant's only accepted condition was bilateral carpal tunnel syndrome and opined that based on the A.M.A., *Guides*, appellant was entitled to no more than five percent impairment of each upper extremity due to this condition based on her surgical releases and the negative EMG findings. The Office medical adviser reviewed Dr. Moore's report and agreed with his conclusions.

It is well established that, when 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 proper factual and medical background must be given special weight.[13] Dr. Moore's report was based on the statement of accepted facts and provided medical reasoning for his conclusions that under the A.M.A., *Guides* appellant had no more than five percent impairment of her upper extremities bilaterally. As noted above, the A.M.A., *Guides* provided that following surgical decompression optimal recovery time, if a residual carpal tunnel syndrome is still present without both positive clinical findings of median nerve dysfunction and electrical conduction delay then an impairment rating not to exceed five percent of the upper extremity may be justified. Dr. Moore noted that appellant had undergone carpal tunnel releases in 1987 and 1997 and that her postsurgical EMG was normal, but found positive Tinel's and Phalen's signs supporting a continued residual medial neuropathy at the wrists bilaterally. He concluded that appellant was entitled to a schedule award for five percent impairment of each upper extremity. The Office medical adviser agreed that based on the sole accepted diagnosis of carpal tunnel syndrome, this was the only impairment rating available for appellant. The Board finds that based on the conditions accepted by the Office and the medical evidence of record, appellant has not established that she is entitled to more than five percent impairment of each of her upper extremities.

CONCLUSION

The Board finds that appellant has no more than five percent impairment of her upper extremities bilaterally due to her accepted condition of bilateral carpal tunnel syndrome for which she has received a schedule award.

[12] 20 C.F.R. § 10.321.

[13] *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

ORDER

IT IS HEREBY ORDERED THAT the August 1, 2007 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 10, 2008
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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