United States Department of Labor
Employees' Compensation Appeals Board

M.W., Appellant	)	
	)	**Docket No. 09-228**
and	)	**Issued: August 7, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Pittsburg, PA, 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
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 30, 2008 appellant, through her attorney, filed a timely appeal of the Office of Workers' Compensation Programs' hearing representative's merit decision dated July 24, 2008 finding that she had no more than 10 percent bilateral upper extremity 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 10 percent impairment of each of her upper extremities for which she has received a schedule award.

FACTUAL HISTORY

Appellant, a 47-year-old mail handler, filed an occupational disease claim in March 1976 alleging that she developed carpal tunnel syndrome due to factors of her federal employment. The Office accepted her claim for bilateral carpal tunnel syndrome and she underwent surgical releases. Appellant also underwent surgery for excision of a nonemployment-related ganglion cyst on January 31, 1997.

In support of her claim for a schedule award, appellant submitted a report dated June 6, 2000 from Dr. Nicholas Diamond, an osteopath, who opined that she had 40 percent impairment due to entrapment of the median nerve at the wrists bilaterally based on findings of surgical scars, positive Phalen's sign, full range of motion, decreased grip strength, decreased motor strength and decreased sensation over the median nerve. Dr. Diamond found that appellant reached maximum medical improvement on October 4, 1999.

The Office referred appellant for an evaluation with Dr. Richard J. Mandel, a Board-certified orthopedic surgeon. In a report dated May 11, 2001, Dr. Mandel found that appellant reported that her symptoms of numbness and paresthesias had completely resolved postoperatively and that her symptoms involved weakness of grip and occasional pain. He noted that appellant had full range of motion with no thenar atrophy of wasting and no provocative signs of carpal tunnel syndrome. Dr. Mandel performed grip strength testing and noted that results were nonphysiologic and opined that grip and pinch efforts were submaximal bilaterally. He diagnosed resolved carpal tunnel syndrome with no evidence of ongoing median nerve entrapment or median nerve dysfunction. Dr. Mandel assigned 10 percent impairment secondary to decreased grip strength.

By decision dated January 22, 2002, the Office granted appellant a schedule award for 10 percent impairment of each of her upper extremities. Appellant, through her attorney, requested an oral hearing and by decision dated December 2, 2002, the hearing representative set aside the Office's January 22, 2002 decision due to an unresolved conflict of medical opinion evidence between Drs. Diamond and Mandel and remanded for additional development of the medical evidence and an appropriate decision.

The Office referred appellant, a statement of accepted facts and a list of questions to Dr. James N. Nutt, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict of medical opinion evidence. In a report dated February 20, 2003, Dr. Nutt noted appellant's history of injury and medical history and reported that appellant had full range of motion in her neck, shoulders, elbows and wrists. He found that neither Tinel's or Phalen's tests were abnormal and that sensibility to pin prick was intact in all fingers as was two-point discrimination. Dr. Nutt found no dysfunction of the median or ulnar nerve in either hand, but relative weakness in her hands on grasping of 81 percent or 25 percent impairment of the right upper extremity and 23 percent impairment of the left upper extremity. He noted that he was surprised to find weak hand grasps in view of the fairly normal manual testing of the elbows and shoulders.

The district medical director reviewed Dr. Nutt's report and noted the impairment rating for loss of grip strength and the appropriate sections of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. The Office requested a supplemental report based on the A.M.A., *Guides* from Dr. Nutt on March 25, 2003. Dr. Nutt submitted a supplemental report on April 8, 2003 and stated that appellant exhibited a loss of grip strength which he attributed to the muscles of the outside of the hand. He also recommended a repeat electromyelogram (EMG) and nerve conduction velocity and noted that her impairment did not seem to be related to her carpal tunnel syndrome. The Office authorized the additional testing on April 21, 2003. Dr. Laurence D. Smith, a neurologist, performed an EMG on May 12, 2003 and found a "borderline prolonged" right median distal sensory latency, but otherwise normal results

for the bilateral median and ulnar sensory and motor nerve conduction. He concluded that appellant's EMG was normal. In a report dated May 30, 2003, Dr. Nutt reviewed the EMG results and concluded that appellant had fully recovered from the carpal tunnel releases. He stated, "She demonstrates weakness of grip on manual muscle testing. This phenomenon is of unclear etiology also but is not related to a work-related injury or condition that I can conceive. My medical opinion is that she has fully recovered from the carpal tunnel condition and surgical releases."

By decision dated June 23, 2003, the Office denied appellant's claim for a schedule award finding that Dr. Nutt's report did not support an increase in appellant's schedule award. Appellant, through her attorney, requested an oral hearing on June 24, 2003. At the oral hearing, counsel argued that the Office improperly selected Dr. Nutt as the Office bypassed Dr. Bruce Horowitz, a Board-certified orthopedic surgeon, on the grounds that the commute was too far, when the distance to Dr. Nutt's office was equally great. By decision dated May 24, 2004, the hearing representative agreed with appellant's attorney finding that the Office erred in selecting Dr. Nutt by improperly bypassing Dr. Bruce Horowitz, a Board-certified orthopedic surgeon. The hearing representative remanded the case for the Office to refer appellant to Dr. Horowitz for an impartial medical evaluation.

In a report dated September 1, 2004, Dr. Horowitz reviewed the medical records and statement of accepted facts. He diagnosed, "status post release of bilateral carpal tunnel syndromes due to work-related injury with complete recovery." Dr. Horowitz noted that grip strength was tested in a "gross manner" and that there "appears to be suboptimal grip efforts bilaterally, although they appeared to be symmetric and without focal deficit." He recommended a functional capacity evaluation to determine if appellant was demonstrating suboptimal performance on grip strength testing. Dr. Horowitz concluded that appellant had 10 percent impairment secondary to decreased grip strength.

The Office issued a decision on October 5, 2004 denying appellant's claim for an additional schedule award based on Dr. Horowitz' report. Appellant, through her attorney, requested an oral hearing. By decision dated February 7, 2006, the hearing representative found that the case was not in posture for decision as Dr. Horowitz' report had not been reviewed by the district medical director and remanded for this review. On May 31, 2006 the district medical director disagreed with Dr. Horowitz' opinion as it was based on a subjective loss of strength. He recommended an evaluation by a second opinion physician.

The Office issued a letter decision dated June 5, 2006 noting that the district medical director did not agree with Dr. Horowitz and found that appellant had no ratable impairment. It concluded that appellant was not entitled to an additional schedule award. Appellant requested an oral hearing on June 9, 2006. By decision dated July 25, 2006, the hearing representative found that the medical evidence required additional development consisting of a request for a supplemental report from Dr. Horowitz complying with the requirements of the A.M.A., *Guides*. The hearing representative noted that, if Dr. Horowitz was unwilling or unable to provide the requested information, then referral to a new impartial medical examiner would be required.

The Office informed appellant's attorney that Dr. Horowitz had advised that he no longer performed "this type of examination." It referred appellant for an impartial medical evaluation

with Dr. Barry A. Silver, a Board-certified orthopedic surgeon, on September 8, 2006. Dr. Silver completed a report on November 3, 2006 which reviewed appellant's history of injury as well as the medical history. He performed a physical examination and found normal range of motion in the wrists. Dr. Silver found good grip strength and good pinch with equal thenar eminences and no evidence of major atrophy. He concluded that her motor power was normal and that appellant's sensory testing was 100 percent. Dr. Silver reviewed the EMG and nerve conduction findings and opined that appellant had reached maximum medical improvement with no evidence of any residual tendinitis or other permanent impairment under the A.M.A., *Guides* due to her accepted carpal tunnel syndrome. He specifically noted that the A.M.A., *Guides* did not favor evaluations of grip strength especially when the diagnosis was carpal tunnel syndrome. The district medical director reviewed Dr. Silver's report on November 18, 2006 and concurred with his findings that appellant had no objective basis for an impairment rating. By decision dated November 20, 2006, the Office denied appellant's claim for an additional schedule award based on Dr. Silver's report.

Appellant requested an oral hearing on November 27, 2006. The hearing representative affirmed the Office's November 20, 2006 decision on July 16, 2007. Appellant filed an appeal with the Board and the Board issued an order remanding case on May 12, 2008 finding that the record was not complete and requiring the Office to issue an appropriate decision.[1] After securing additional documents, by decision dated July 24, 2008, the hearing representative again affirmed the Office's November 20, 2006 decision denying appellant's claim for an additional schedule award.

On appeal, appellant's attorney argues that Dr. Nutt's supplemental report should be disregarded as the Office asked him leading questions and as there was improper contact by the claims examiner and the district medical director. Counsel further argued that the Office should have requested a supplemental report from Dr. Horowitz and that, because there was no such report in the record, Dr. Silver was not properly selected to serve as the impartial medical examiner. He alleged that Dr. Silver failed to mention Dr. Horowitz' report and therefore his report was not based on a proper history and that Dr. Silver failed to provide pinch or grip strength and merely agreed with the district medical director instead of independently resolving the conflict of medical opinion. Counsel asserted that Dr. Nutt's initial report should be accorded the weight of the medical opinion evidence.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[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,

[1] Docket No. 08-411 (issued May 12, 2008).

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

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 regulations 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]

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 CTS [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 CTS 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]

Grip strength is used to evaluate power weaknesses related to the structures in the hand wrist or forearm.[11] The A.M.A., *Guides* do not encourage the use of grip strength as an impairment rating because strength measurements are functional tests influenced by subjective factors that are difficult to control and the A.M.A., *Guides* for the most part is based on anatomic impairment. Thus the A.M.A., *Guides* does not assign a large role to such measurements. Only

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[4] *Id.*

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

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

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

[8] *Id.* at 495.

[9] *Id.* at 446.

[10] *Id.* at 445.

[11] *Id.* at 508, 16.8b.

in rare cases should grip strength be used, and only when it represents an impairing factor that has not been otherwise considered adequately.[12] The A.M.A., *Guides* state, "*Otherwise, the impairment ratings based on objective anatomic findings take precedence.*" (Emphasis in the original.)[13]

ANALYSIS

There was a conflict of medical opinion evidence between appellant's physician, Dr. Diamond, an osteopath, and the Office second opinion physician, Dr. Mandel, a Board-certified orthopedic surgeon, regarding the extent of appellant's impairment for schedule award purposes. Dr. Diamond found that appellant had 40 percent impairment of the median nerve bilaterally, while Dr. Mandel found that appellant had 10 percent impairment due to loss of grip strength. 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.[14] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician, or 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.[15]

The Board finds, however, that the Office improperly referred appellant for an impartial examination with Dr. Nutt, a Board-certified orthopedic surgeon, after it bypassed Dr. Horowitz, a Board-certified orthopedic surgeon, on the grounds that the commute was too extensive when the distance was comparable to both physicians as argued by appellant's attorney and found by the hearing representative. As Dr. Nutt was not properly selected under the Office's rotational selection to serve as an impartial medical specialist, his report is not entitled to special weight and cannot resolve the existing conflict of medical opinion evidence. The Board notes that, as Dr. Nutt cannot serve as the impartial medical specialist, the allegations of improper conduct or leading questions made by appellant's attorney are harmless error.

On remand from the Branch of Hearings and Review, the Office properly referred appellant to Dr. Horowitz, a Board-certified orthopedic surgeon, to resolve the conflict. In a report dated September 1, 2004, Dr. Horowitz reviewed the medical records and statement of accepted facts. He diagnosed, "status post release of bilateral carpal tunnel syndromes due to work-related injury with complete recovery." Dr. Horowitz noted that grip strength was tested in a "gross manner" and that there "appears to be suboptimal grip efforts bilaterally, although they appeared to be symmetric and without focal deficit." He recommended a functional capacity evaluation to determine if appellant was demonstrating suboptimal performance on grip strength

[12] *Id.* at 507, 16.8 Strength Evaluation; *Cerita J. Slusher*, 56 ECAB 532 (2005); *Mary L. Henninger*, 52 ECAB 408, 409 (2001).

[13] A.M.A., *Guides* 508.

[14] 5 U.S.C. §§ 8101-8193, 8123.

[15] 20 C.F.R. § 10.321.

testing. Dr. Horowitz concluded that appellant had 10 percent impairment secondary to decreased grip strength. On May 31, 2006 the district medical director disagreed with Dr. Horowitz' opinion as it was based on a subjective loss of strength. The Board finds that, as Dr. Horowitz recommended additional testing, the hearing representative properly determined that a supplemental report was necessary before this report was sufficiently well rationalized to constitute the weight of the medical opinion evidence. However, the record reflects that Dr. Horowitz was unwilling to provide a supplemental report. When the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[16]

The Board finds that the Office, therefore, properly determined that an additional impartial medical examination was necessary and appropriately referred appellant to Dr. Silver, a Board-certified orthopedic surgeon, to resolve the existing conflict of medical opinion evidence. Dr. Silver completed a report on November 3, 2006 which reviewed appellant's history of injury as well as the medical history. He performed a physical examination and found normal range of motion in the wrists, good grip strength and good pinch with equal thenar eminences and no evidence of major atrophy. Dr. Silver concluded that her motor power was normal and that appellant's sensory testing was 100 percent. He agreed that appellant had reached maximum medical improvement with no evidence of any residual tendinitis or other permanent impairment under the A.M.A., *Guides* due to her accepted carpal tunnel syndrome. The district medical director reviewed Dr. Silver's report on November 18, 2006 and concurred with his findings that appellant had no objective basis for an impairment rating.

Dr. Silver's report was based on a proper history of injury and medical history. The Board notes that it is not necessary for the impartial medical examiner to specifically state that he has reviewed every medical report in the record in order to provide an adequate history of the claim. Dr. Silver reviewed the appropriate sections of the A.M.A., *Guides* and noted that appellant had normal findings on nerve conduction, no findings on physical examination and that she therefore had no impairment for carpal tunnel syndrome under the A.M.A., *Guides*. He also noted that the A.M.A., *Guides* do not favor grip or pinch strength measurements and opined that these measurements were not appropriate based on his physical evaluation of appellant. Dr. Silver while agreeing with the application of the A.M.A., *Guides*, previously made by the district medical director, provided his independent findings and conclusions. The Board finds that Dr. Silver's report is entitled to the weight of the medical evidence and establishes that appellant has no more than 10 percent impairment of each of her upper extremities for which she has received a schedule award.

CONCLUSION

The Board finds that appellant has no more than 10 percent impairment of each of her upper extremities for which she has received a schedule award.

[16] *Raymond A. Fondots*, 53 ECAB 637, 641 (2002).

ORDER

IT IS HEREBY ORDERED THAT July 24, 2008 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 7, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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