United States Department of Labor
Employees' Compensation Appeals Board

MARIE NIWORE, Appellant	)	
and	)	**Docket No. 04-2003**
	)	**Issued: May 3, 2005**
U.S. POSTAL SERVICE, POST OFFICE, Trenton, 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:
ALEC J. KOROMILAS, Chairman
COLLEEN DUFFY KIKO, Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On August 11, 2004 appellant filed a timely appeal from a merit decision of the Office of Workers' Compensation Programs dated April 14, 2004 in which an Office hearing representative determined that appellant had no more than a 10 percent impairment of the right upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award.

ISSUE

The issue is whether appellant has more than a 10 percent impairment of the right upper extremity for which she received a schedule award. On appeal counsel argues that the report of the impartial specialist, Dr. Aaron A. Sporn, establishes that she has greater than a 10 percent impairment of the right upper extremity.

FACTUAL HISTORY

This case has been before the Board previously. On April 25, 1991 the Office accepted that appellant, then a 34-year-old letter sorting machine clerk, sustained a sprain of her right

hand and fingers and right carpal tunnel syndrome, and in decisions dated July 14, 1998 and June 10, 1999, granted schedule awards totaling a four percent right upper extremity impairment.[1] By decision dated October 11, 2000, the Board set aside the Office's July 10, 1999 decision and remanded the case to the Office. The Board found that the opinion of the impartial medical specialist dated July 15, 1997 and annotated on July 21, 1997 was improperly obtained and should be excluded from the case record. The Office was to refer appellant to an appropriate impartial medical examiner not previously associated with this case for resolution of the conflict regarding the degree of appellant's right upper extremity impairment.[2] The law and the facts as set forth in the previous Board decision and order are incorporated herein by reference.

Subsequent to the Board's October 11, 2000 decision, the Office initially referred appellant to Dr. Howard Zeidman, Board-certified in orthopedic surgery, to resolve the conflict regarding the degree of appellant's right upper extremity impairment. Based on Dr. Zeidman's January 16, 2001 report that appellant had no right upper extremity impairment, in a decision dated January 24, 2001, the Office found that appellant was not entitled to an additional schedule award. Appellant, through her representative, requested a hearing that was held on June 12, 2001. In an August 17, 2001 decision, an Office hearing representative remanded the case to the Office to obtain a supplementary report from Dr. Zeidman.

By report dated September 7, 2001, Dr. Zeidman reiterated his conclusion that appellant had no permanent impairment and, therefore, did not provide a rating under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[3] In a decision dated October 18, 2001, the Office again found that appellant was not entitled to an additional schedule award. On October 23, 2001 appellant, through counsel, requested a hearing. By decision dated February 14, 2002, an Office hearing representative remanded the case to the Office. The hearing representative specifically found that Dr. Zeidman's report was insufficient to establish that appellant was not entitled to an increased schedule award as he provided no range of motion or grip strength measurements. The hearing representative ordered that the case was to be referred to a second impartial specialist for an appropriate rating under the fifth edition of the A.M.A., *Guides*.

In a letter dated April 1, 2002, the Office referred appellant to Dr. Aaron A. Sporn, a Board-certified orthopedic surgeon, for an impartial medical evaluation regarding the degree of appellant's right upper extremity impairment. The Board provided Dr. Sporn with a list of questions to be resolved and asked him to determine if appellant had reached maximum medical improvement and, if so, to evaluate her in accordance with the fifth edition of the A.M.A., *Guides*. The Office specified that the physician was required to detail the measurements taken, including grip strength and range of motion findings for radial deviation, ulnar deviation, dorsiflexion and palmar flexion.

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[1] The Office also authorized carpal tunnel release on November 23, 1992. Appellant returned to work on December 14, 1992.

[2] Docket No. 99-2280. The Board notes that the October 11, 2000 decision contains an error in that it indicates a May 3, 1999 Office decision was set aside. The record, however, does not contain a May 3, 1999 decision. Nonetheless, this is deemed a harmless, typographical error.

[3] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

In a report dated April 16, 2002, Dr. Sporn noted his review of the medical record and statement of accepted facts and appellant's subjective complaints. Physical findings of the right hand included no localized tenderness, hypersensitivity, swelling or atypical laxity in any of the joints of the fingers. Range of motion of the fingers was full in all directions, including extension and flexion of the various joints of the second through fifth digits and extension, flexion, opposition, abduction and adduction of the thumb. Right wrist examination demonstrated negative Tinel's and Phalen's tests. Finkelstein's test was moderately positive. Right forearm and humerus showed no tenderness, swelling or other pathology that would explain appellant's symptoms. Right elbow demonstrated full range of motion in all directions with no atypical tenderness or laxity. Tinel's sign was negative. The right shoulder showed full range of motion in all directions with no tenderness or other pathology that would explain her symptoms. Sensory testing revealed an altered sensation in a patchy, nonspecific, nondermatomal and relatively nonneurotomal distribution involving the median and ulnar nerve distribution from the distal one-third portion of the forearm going distally, with some areas of normal sensation. There was no alteration in the thumb or proximal two-thirds of the forearm. Motor testing revealed 4/5 strength to all groups in the hand and wrist, including finger extension, finger flexion, pinch grip, wrist dorsiflexion, wrist volar flexion and others. Wrist range of motion, right compared to left, revealed dorsiflexion of 80/80, volar flexion of 60/60, radial deviation of 20/20 and ulnar deviation of 30/30. Dr. Sporn advised that he performed grip strength testing as defined in section 16.8d of the A.M.A., *Guides* using the Jamar dynamometer and repeated three times with each hand. Right hand measurements were 39, 34 and 46 pounds with an average of 39.67 pounds; left hand measurements were 64, 60 and 66 pounds with an average of 63.33 pounds. Dr. Sporn advised that the A.M.A., *Guides* provided that, if there was more than a 20 percent variation, as he found on the right, "one may assume the individual is not exerting full effort."

In answer to specific Office questions, Dr. Sporn stated that there were no objective findings of any residual effects of carpal tunnel syndrome, noting that electrical tests performed on December 29, 1995 revealed no electrophysiologic evidence of carpal tunnel syndrome. He stated that, if appellant had another condition causing a right upper extremity impairment, it was not employment related, and that maximum medical improvement had been reached within 6 to 12 months following appellant's November 23, 1992 surgery. Dr. Sporn opined appellant "may not even qualify for a permanent impairment rating according to the A.M.A., *Guides.*" He nonetheless found that, under Table 16-10, she had a sensory deficit of Grade 4 or 20 percent and that, under Table 16-15, the maximum upper extremity impairment resulting from a sensory deficit of the median nerve was 39 percent. He then multiplied the 2, as provided by the A.M.A., *Guides*, and found that appellant had a sensory deficit of 7.8 percent or, rounded up, 8 percent. He then stated that appellant's impairment due to motor and loss of power equaled Grade 4 or 15 percent based on his clinical judgment, and under Table 16-15, the maximum upper extremity impairment due to a motor deficit of the median nerve is 10 percent which, when multiplied together, an impairment of 1.5 percent rounded up to 2 percent, was reached. He then utilized the Combined Values Chart and found that 8 percent combined with 2 percent equaled a 10 percent right upper extremity impairment.

On May 15, 2002 the Office medical adviser reviewed Dr. Sporn's report and advised that appellant's wrist and finger range of motion were normal which would equal no impairment,

that, as there was greater than a 20 percent variation in appellant's Jamar dynamometer readings on the right, the results must be discounted under the A.M.A., *Guides*. He further noted that appellant had no electromyographic evidence of carpal tunnel syndrome, and agreed with Dr. Sporn's analysis of appellant's right upper extremity sensory deficits under Tables 16-10 and 16-15 but disagreed that appellant had any motor deficit, noting that Dr. Sporn found appellant's Jamar readings to be unreliable. The Office medical adviser concluded that appellant had an eight percent impairment of the right upper extremity, noting that this was "a generous award" based upon Dr. Sporn's comments of no objective disability and prior awards of three to four percent.

By decision dated May 17, 2002, the Office granted appellant an additional four percent impairment for a total schedule award of eight percent for the right upper extremity. Appellant then requested a hearing that was held on December 9, 2002. She thereafter submitted a January 23, 2003 report in which Dr. David Weiss, an osteopath,[4] advised that he was submitting an addendum to his October 19, 1993 report and providing an impairment rating based on the fifth edition of the A.M.A., *Guides*. He advised that, under Table 16-34 of the fifth edition, appellant's grip strength equaled a 20 percent deficit, that, under Tables 16-10 and 16-15, her Grade 3 right median nerve deficit equaled 23 percent, and when the 2 deficits were combined, a 38 percent right upper extremity impairment was reached. Pursuant to Figure 18-1, he found an additional 3 percent impairment for pain and concluded that appellant had a 41 percent right upper extremity impairment.

On March 6, 2003 the hearing representative set aside the Office's May 17, 2002 decision and remanded the case to the Office to obtain a supplementary report from Dr. Sporn who was to provide specific range of motion findings for each of appellant's fingers. On May 14, 2003 Dr. Sporn reexamined the fingers and thumb of appellant's right hand. He stated:

> "Right hand shows that the fingers are warm and they manifest good color and good capillary refill. No localized tenderness is present to palpation. The skin is not hypersensitive to light touch. No atypical swelling is present. Ligamentous examination reveals a normal stability pattern. Grind test is negative. When I examined for Tinel['s] sign over the carpal canal, she is a little bit uncomfortable but she does not have symptoms of paresthesias, numbness or tingling.
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> "I specifically examined the five fingers of the right hand for active range of motion. The thumb interphalangeal joint manifested flexion of 80 degrees and hyperextension of 30 degrees. The thumb metacarpal phalangeal joint manifested flexion of 60 degrees and hyperextension of 40 degrees beyond the functional position of 20 degrees of flexion. This is as indicated in the top column on page 456 and in Figure 16-13 on page 456 of the [A.M.A., *Guides*]. Thumb opposition

[4] Dr. Weiss characterizes himself as a diplomate of the American Board of Orthopedic Medicine. However, a search of the American Osteopathic Association Directory does not yield a listing for Board certification. A David Weiss, D.O. is listed in the American Medical Association Directory as Board-certified in family practice. However, a search of the American Board of Medical Specialties Directory does not contain this information.

was full and normal. Thumb radial abduction was 50 degrees while thumb adduction revealed a lack of 1 centimeter."

Dr. Sporn stated that the only difference found on the left was that thumb radial adduction revealed a 0 centimeter (cm) lack of motion. He further found that the distal interphalangeal joints of the second, third, fourth and fifth digits all revealed active motion of 0 degrees of extension to 70 degrees of flexion bilaterally, that the proximal interphalangeal joints of the second, third, fourth and fifth digits all revealed active motion of 0 degrees of extension to 100 degrees of flexion bilaterally, and the metacarpal phalangeal joints of the second, third, fourth and fifth digits all revealed active motion from +20 degrees of hyperextension to 90 degrees of flexion bilaterally. He observed that appellant made a clenched fist in the normal manner bilaterally. Pinch strength was recorded as 4, 3 and 4 pounds on the right and 12, 9 and 10 pounds on the left with a right average of 3.67 pounds and a left average of 10.33 pounds. Dr. Sporn noted that, under Table 16-8b, appellant's lack of right thumb adduction of 1 cm yielded no impairment and reiterated his previous conclusions that appellant had an 8 percent sensory deficit and a 2 percent motor deficit of the right upper extremity, for a total 10 percent right upper extremity impairment. He discounted the pinch strength findings, noting that appellant had greater than a 20 percent variation bilaterally. He stated that, if appellant were exerting full effort, under Table 16-34, the strength loss would yield a 30 percent upper extremity impairment, and further noted that section 16.8 of the A.M.A., *Guides* provides that loss of strength should not be applied in addition to impairment values found under section 16.5. He again concluded that appellant's right upper extremity impairment equaled 10 percent.

In a decision dated July 1, 2003, the Office determined that appellant's impairment was no greater than 10 percent for the right upper extremity. On July 8, 2003 the Office amended its May 17, 2002 award and granted appellant an additional 2 percent right upper extremity impairment, for a total of 10 percent schedule award. Appellant again requested an oral hearing, which was held on February 18, 2004.[5] By decision dated April 14, 2004, an Office hearing representative affirmed the Office's July 1 and 8, 2003 decisions.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[6] and section 10.404 of the implementing federal regulations,[7] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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*[8] has been adopted by the Office, and the Board has concurred in such adoption,

[5] Appellant was not present at the hearing but was represented by counsel.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] A.M.A., *Guides, supra* note 3.

as an appropriate standard for evaluating schedule losses.[9] Chapter 16 provides the framework for assessing upper extremity impairments.[10]

Regarding carpal tunnel syndrome, the A.M.A., *Guides* provide:

> "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:
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> (1) Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTSE is rated according to the sensory and/or motor deficits as described earlier.
>
> (2) Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTSS is still present, and an impairment rating not to exceed 5 percent of the upper extremity may be justified.
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> (3) 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."[11]

In 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.[12]

ANALYSIS

The Board finds that it was proper for the Office to refer appellant to Dr. Sporn for an additional impartial evaluation. When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in the original report.[13] However, when an impartial medical specialist's statement of clarification or elaboration is not forthcoming to the Office, or if the physician is unable to clarify or elaborate on the original report, or if the physician's report is vague, speculative or lacks rationale, the Office must refer the employee to another impartial

[9] *See Joseph Lawrence, Jr., supra* note 3; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[10] A.M.A., *Guides, supra* note 3 at 433-521.

[11] *Id.* at 495.

[12] *Manuel Gill*, 52 ECAB 282 (2001).

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

specialist for a rationalized medical opinion on the point at issue.[14] In this case, the Office initially referred appellant to Dr. Zeidman for an impartial medical evaluation but, as found by an Office hearing representative, Dr. Zeidman's reports were not sufficient in that he did not provide range of motion or grip strength measurements. The Office therefore properly referred appellant to Dr. Sporn to resolve the conflict regarding the degree of impairment of appellant's right upper extremity.[15]

The Board further finds that appellant did not establish that she was entitled to greater than a 10 percent right upper extremity impairment. Section 16.5b of the A.M.A., *Guides* describes the methods for evaluation of upper extremity impairments due to peripheral nerve disorders and provides that the severity of the sensory or pain deficit and motor deficit should be classified according to Tables 16-10a and 16-11a respectively. The values for maximum impairment are then to be discerned, utilizing the appropriate table for the nerve structure involved. The grade of severity for each deficit is then to be multiplied by the maximum upper extremity impairment value for the nerve involved to reach the proper upper extremity impairment for each function. Mixed motor and sensory or pain deficits for each nerve structure are then to be combined.[16]

Dr. Sporn, the referee physician, provided a comprehensive report in which he described his examination findings, applied the fifth edition of the A.M.A., *Guides* and, in reports dated April 1, 2002 and May 14, 2003, advised that appellant had a 10 percent right upper extremity impairment. Dr. Sporn provided thumb range of motion measurements for interphalangeal joint flexion of 80 degrees and extension of 30 degrees which, under Figure 16-12 of the A.M.A., *Guides*, indicates zero percent impairment.[17] He then advised that thumb metacarpal joint flexion of 60 degrees and extension of 40 degrees equated to 0 percent impairment under Figure 16-15.[18] Dr. Sporn found thumb opposition full and normal and radial abduction of 50 degrees which, under Figure 16-16, provides 0 percent impairment.[19] He found that thumb adduction revealed a lack of one cm which, under Figure 16-18 and Table 16-8b, indicates a zero percent impairment.[20] The record thus establishes that appellant has no impairment due to thumb lack of range of motion.

Dr. Sporn also provided range-of-motion measurements for appellant's fingers bilaterally, indicating that the distal interphalangeal joints of each finger revealed 0 degrees of extension to 70 degrees of flexion which, under Figure 16-21 of the A.M.A., *Guides*, provides a

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[14] *Id.*

[15] *Id.*

[16] A.M.A., *Guides, supra* note 3 at 481.

[17] *Id.* at 456.

[18] *Id.* at 457.

[19] *Id.* at 458.

[20] *Id.* at 459.

0 percent impairment.[21] He further noted that the proximal interphalangeal joints of all fingers revealed 0 degrees of extension to 100 degrees of flexion which, under Figure 16-23, equates to a 0 percent impairment.[22] He next noted metacarpal phalangeal joints of all fingers revealed active motion from +20 degrees of extension to 90 degrees of flexion bilaterally which, under Figure 16-25, also indicates a 0 percent impairment.[23] The record therefore also establishes that appellant has no impairment due to finger lack of range of motion.

Dr. Sporn, however, found that appellant had a sensory deficit resulting from carpal tunnel syndrome. The Board finds that, based on his physical findings, he properly rated appellant's sensory deficit as Grade 4 and found that, pursuant to Table 16-10 of the A.M.A., *Guides*, a severity rating of 20 percent should apply.[24] He also properly found that, under Table 16-15, the maximum upper extremity impairment resulting from a median nerve sensory deficit was 39 percent and, multiplying the 39 percent by the 20 percent, properly concluded that appellant had an 8 percent right upper extremity sensory impairment.[25] Dr. Sporn also found that appellant had a right upper extremity median nerve motor loss. The Board again finds that he properly graded appellant's motor deficit at Grade 4 which, under Table 16-11, equaled a severity rating of 15 percent[26] and, under Table 16-15, the a maximum impairment rating was 10 percent.[27] Dr. Sporn then properly multiplied the 10 percent by the 15 percent to find a median nerve motor impairment of 1.5 percent which, rounded up, was equal to 2 percent. He utilized the Combined Values Chart and determined that the right upper extremity impairment due to a sensory deficit of 2 percent combined with an 8 percent impairment due to a motor deficit was equal to a 10 percent upper extremity impairment.[28]

Dr. Sporn also provided grip strength findings. In his April 16, 2002 report, he advised that he performed grip strength testing as defined in section 16.8d of the A.M.A., *Guides* using the Jamar dynamometer which was repeated three times with each hand. Right hand measurements were 39, 34 and 46 pounds with an average of 39.67 pounds; left hand measurements were 64, 60 and 66 pounds with an average of 63.33 pounds. Dr. Sporn, however, noted that there was more than a 20 percent variation of the readings on the right and advised that the A.M.A., *Guides* provided that, if there was more than a 20 percent variation, as he found on the right, "one may assume the individual is not exerting full effort." In his May 14, 2003 report, Dr. Sporn reported pinch strength of 4, 3 and 4 pounds on the right and 12, 9 and 10 pounds on the left with a right average of 3.67 pounds and a left average of 10.33 pounds. He,

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[21] *Id.* at 461.

[22] *Id.* at 463.

[23] *Id.* at 465.

[24] *Id.* at 482.

[25] *Id.* at 492.

[26] *Id.* at 484.

[27] *Id.* at 492.

[28] *Id.* at 604-05.

however, discounted the pinch strength findings, noting that again appellant had greater than a 20 percent variation bilaterally. Dr. Sporn further noted that section 16.8 of the A.M.A., *Guides* provides that loss of strength should not be applied in addition to impairment values found under section 16.5, advising that, if appellant were exerting full effort, under Table 16-34, the strength loss would yield a 30 percent upper extremity impairment, but again concluded that appellant's right upper extremity impairment equaled 10 percent.

Appellant submitted a January 23, 2003 report in which Dr. Weiss stated that he was furnishing an addendum to his October 19, 1993 report and providing findings pursuant to the fifth edition of the A.M.A., *Guides*. The Board, however, finds Dr. Weiss' report to be of diminished probative value. He advised that, under Table 16-34, appellant's grip strength equaled a 20 percent deficit, that, under Tables 16-10 and 16-15, her Grade 3 right median nerve deficit equaled 23 percent and, when the two deficits were combined, a 38 percent right upper extremity impairment was reached. He found that, pursuant to Figure 18-1, appellant had an additional 3 percent impairment for pain, and concluded that she had a 41 percent right upper extremity impairment.

While Dr. Weiss found a Grade 3 median nerve deficit and Dr. Sporn advised that appellant's median nerve deficit was classified at Grade 4, Dr. Weiss provided no physical findings on which to base his conclusion that appellant's deficit equaled Grade 3. In fact, he did not indicate that he had reexamined appellant, and the conflict of medical opinion had been created between Dr. Weiss' October 13, 1993 report[29] and that of the second opinion examiner for the Office, Dr. Irwin A. Moskowitz, Board-certified in orthopedic surgery. Dr. Sporn noted that he had examined appellant April 16, 2002 and May 14, 2003. Furthermore, 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 in rare cases should grip strength be used, and only when it represents an impairing factor that has not been otherwise considered adequately.[30] Section 16.5d of the fifth edition of the A.M.A., *Guides,* provides that, in compression neuropathies, additional impairment values are not given for decreased grip strength.[31] Here Dr. Weiss did not provide an explanation as to why appellant's impairment could not be adequately rated based on the objective anatomic findings such that a grip strength rating should be used.

Dr. Weiss also indicated that, pursuant to Figure 18-1 of the A.M.A., *Guides*, appellant was entitled to an additional three percent impairment for pain. Section 18.3b of the fifth edition of the A.M.A., *Guides* provides that pain-related impairment should not be used if the condition can be adequately rated under another section of the A.M.A., *Guides*. Office procedures provide that, if the conventional impairment adequately encompasses the burden produced by pain, the

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[29] Dr. Weiss also submitted a supplementary report dated December 30, 1994.

[30] *Mary L. Henninger*, 52 ECAB 408 (2001).

[31] A.M.A., *Guides, supra* note 3 at 494; *see Silvester DeLuca*, 53 ECAB 500 (2002).

formal impairment rating is determined by the appropriate section of the A.M.A., *Guides*,[32] and the use of Figure 18-1 is generally precluded by Office procedures if other methods to measure impairment due to sensory pain are used.[33] Table 16-10 and its associated tables are designed to calculate ratings for pain associated with peripheral nerve disorders, and in the case at hand, Dr. Sporn properly rated appellant's right upper extremity impairment in accordance with section 16.5 of the A.M.A., *Guides*.

The Board therefore finds that, as Dr. Weiss' January 23, 2003 report is based on his prior reports without further examination or explanation and is not in conformance with the A.M.A., *Guides*, it is insufficient to overcome the opinion of the impartial specialist, Dr. Sporn, or to create a new medical conflict, especially as Dr. Weiss' prior reports, on which the January 23, 2003 report is based, created the conflict that the impartial medical specialist resolved.[34] Dr. Sporn provided a basis for his impairment rating and referenced the specific figures and tables in the A.M.A., *Guides* on which he relied. His report thus establishes that appellant is not entitled a schedule award for her right upper extremity of greater than 10 percent.[35]

CONCLUSION

The Board finds that appellant has failed to establish that she is entitled to more than a 10 percent schedule award for the right upper extremity.

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[32] *See Philip A. Norulak*, 55 ECAB ____ (Docket No. 04-817, issued September 3, 2004).

[33] FECA Bulletin Number 01-05 (issued January 29, 2001); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, exhibit 4 (June 2003).

[34] *See William Morris*, 52 ECAB 400 (2001).

[35] *See Mary L. Henninger, supra* note 30.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 14, 2004 is affirmed.

Issued: May 3, 2005
Washington, DC

Alec J. Koromilas
Chairman

Colleen Duffy Kiko
Member

A. Peter Kanjorski
Alternate Member