

**United States Department of Labor
Employees' Compensation Appeals Board**

MICHELLE G. McALPINE, Appellant)

and)

U.S. POSTAL SERVICE, POST OFFICE,)
South Eastern, PA, Employer)

**Docket No. 05-1633
Issued: January 11, 2006**

Appearances:
Thomas 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
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 2, 2005 appellant filed a timely appeal from the Office of Workers' Compensation Programs schedule award decision dated April 12, 2005. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue is whether appellant met her burden of proof to establish that she sustained permanent impairment of her right upper extremity.

FACTUAL HISTORY

On May 9, 1991 appellant, then a 37-year-old flat sorter clerk, filed a traumatic injury claim alleging that on May 5, 1991 she lifted a tub of mail and felt a pull in her neck, pain in her upper back and tingling down both arms and hands. Appellant stopped work on May 7, 1991. The Office accepted her claim for cervical and dorsal strain and brachial plexitis. On April 3, 1993 appellant returned to a limited-duty position. Appellant received appropriate compensation benefits. She received treatment from Dr. William Dickerman, an osteopath Board-certified in

family practice, and Dr. Scott Fried, a Board-certified hand surgeon, who diagnosed severe brachial plexopathy.

Appellant filed a claim for a schedule award.

By letter dated May 2, 1994, the Office referred appellant, together with a statement of accepted facts and copies of medical records, to Dr. Noubar Didizian, a Board-certified orthopedic surgeon, for a second opinion examination. In a report dated June 1, 1994, Dr. Didizian noted appellant's history of injury and treatment and determined that she "did not have evidence of brachial plexus pathology or thoracic outlet syndrome." He noted that appellant had minimal subjective complaints and no evidence of objective findings. He determined that appellant had been "over-treated for a simple sprain/strain" and was "over-diagnosed into brachial plexus pathology and thoracic outlet syndrome." Dr. Didizian determined that appellant had reached maximum medical improvement and was not totally or partially disabled.

By decision dated June 23, 1995, the Office denied appellant's claim for a schedule award. Appellant's representative requested a hearing on July 14, 1995, which was held on March 19, 1996. In an April 24, 1996 report, Dr. Fried advised that appellant had an impairment of 75 percent to the upper extremity.

By decision dated October 18, 1996, the Office hearing representative affirmed the June 23, 1995 decision.

In a September 29, 1999 report, Dr. David Weiss, an osteopath, opined that appellant had a 44 percent impairment of the right upper extremity and 11 percent of the left based upon the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001). He noted that regarding activities of daily living, appellant was unable to perform her previous gainful employment and noted difficulties with household duties, which included duties. He also noted that appellant had difficulty with personal hygiene matters and could only sit comfortably for 20 minutes in an hour. He also indicated that appellant had a pain level of a 4 out of 10 in both the cervical spine and right upper extremity as determined by the visual analogue scale. Dr. Weiss indicated that appellant had a positive supraclavicular tinel sign, Wright's test and Roos sign and also advised that appellant had a well-healed surgical scar on the right wrist and determined that appellant had a positive carpal compression test. Dr. Weiss noted that, for both the right and left wrists, 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. Dr. Weiss also indicated that appellant had thenar atrophy on the left. He subsequently determined that appellant was entitled to a 4 percent impairment for each of the sensory deficits on the C5-7 and T1 nerve roots, 12 percent for the motor strength deficit of the right biceps and 1 percent for the right triceps, 20 percent for the right grip strength deficit. Dr. Weiss advised that this was equivalent to 44 percent for the right upper extremity and also determined that appellant was entitled to an additional 10 percent for her entrapment of the median nerve on the left wrist.

By letters dated January 6 and December 4, 2000, appellant's representative requested a schedule award.

On November 15, 2001 the Office medical adviser determined that appellant had reached maximum medical improvement on September 29, 1999 and that she was entitled to 24 percent impairment of the right upper extremity.¹ However, in a December 5, 2002 report, another Office medical adviser determined that appellant should be referred for a second opinion.

The Office referred appellant to Dr. Gerald D. Schuster, a Board-certified orthopedic surgeon. In an April 22, 2003 report, he determined that appellant had no more than a two percent permanent impairment of the right upper extremity. He explained his impairment rating by reference to Table 16-10 of the A.M.A., *Guides*² and determined that this would entitle appellant to a Grade 3 or (40 percent) which when multiplied by the maximum impairment of 5 percent allowed for the median nerve involvement in Table 16-15³ would total 2 percent of the right upper extremity based on sensory deficit.

In an April 28, 2003 report, the Office medical adviser determined that appellant had no permanent impairment of the right upper extremity. In a second report dated May 5, 2003, the Office medical adviser reviewed Dr. Schuster's April 22, 2003 report and determined that appellant had a two percent impairment of the right upper extremity. The Office medical adviser concurred with Dr. Schuster's calculations utilizing Tables 16-10 and 16-15 of the A.M.A., *Guides*,⁴ for a sensory deficit.

By decision dated May 8, 2003, the Office granted appellant a schedule award for a two percent impairment of the right upper extremity. The award covered a period of 6.24 weeks from April 3 to May 16, 2003.

By letter dated May 14, 2003, appellant requested a hearing.

In decision dated November 20, 2003, the Office hearing representative found that the case was not in posture for a decision as a conflict in the medical evidence existed between Drs. Weiss and Schuster regarding the extent of appellant's impairment to her right arm and regarding whether appellant's present condition was due to her right brachial plexopathy or due to degenerative disc disease in the cervical spine. The Office hearing representative set aside the May 8, 2003 schedule award decision and remanded the case for additional development.

By letter dated December 18, 2003, the Office referred appellant to Dr. Marshall A. White, a Board-certified neurologist, for an impartial medical examination.

In a January 7, 2004 report, Dr. White noted appellant's history of injury and treatment. He reviewed electrodiagnostic studies, which included an electromyography (EMG) scan, which

¹ He also noted that appellant had a previous award for 10 percent to the right arm under file No. A3-162857. This claim is not presently before the Board.

² A.M.A., *Guides* 482.

³ A.M.A., *Guides* 492.

⁴ A.M.A., *Guides* 482 and 492.

revealed no relevant pathology relating to a 1991 injury.⁵ He noted that the EMG scan and nerve conduction studies were performed in both upper extremities and that the results demonstrated that neurologically and electrophysiologically, “there is absolutely no evidence of a neurologic injury present in [appellant]. Her nerve conduction studies are completely within normal limits. Electromyography fails to reveal any relevant pathology as it might relate to her 1991 accident.” Dr. White also advised that during his examination, appellant’s reflexes in the upper extremities and her motor power and sensation throughout the upper extremities were completely normal. He explained that he conducted maneuvers to elicit the presence of vascular thoracic outlet syndrome; however, “[n]o supraclavicular bruits were appreciated.” He explained that appellant’s vascular distal radial pulses were noted to be completely intact with abduction of both arms and therefore no compression of the vascular structures could be accomplished by way of physical maneuvers. Dr. White determined that appellant “has no evidence of neurologic disease involving the peripheral nervous system in the upper extremities.” He further determined that there was no evidence of neurological disease involving the peripheral nervous system in the upper extremities and that on clinical examination appellant had normal cranial nerves and her neuromuscular evaluation was otherwise intact with normal reflexes throughout and good motor power throughout with normal balance and a normal gait. He opined that appellant did not have thoracic outlet syndrome as no neurologic diagnosis could be established. Dr. White determined that appellant was not entitled to a disability rating due to the absence of neurologic disease.

By decision dated March 12, 2004, the Office denied the claim for a schedule award finding that the medical evidence did not support that the appellant sustained a permanent partial impairment to her right upper extremity.

By letter dated March 16, 2004, appellant requested a hearing, which was held on November 30, 2004. On April 12, 2005 the Office hearing representative affirmed the March 12, 2004 decision.

LEGAL PRECEDENT

Section 8107 of the Federal Employees’ Compensation Act⁶ 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.⁷ 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.⁸ The Act’s implementing regulation has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule award losses.⁹

⁵ The record reflects that the diagnostic studies were performed by Dr. John H. Lucas, a Board-certified neurologist on behalf of Dr. White on January 6, 2004.

⁶ 5 U.S.C. §§ 8101-8193.

⁷ 5 U.S.C. § 8107.

⁸ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

⁹ 20 C.F.R. § 10.404.

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*.¹⁰ However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.¹¹

ANALYSIS

The Office determined that a conflict in medical opinion was created between Dr. Weiss, who found that appellant was entitled to an impairment of 44 percent to the right upper extremity and Dr. Schuster, the second opinion physician, who determined that appellant was entitled to 2 percent of the right upper extremity. The Office referred appellant to Dr. White, a Board-certified neurologist and impartial medical examiner, to resolve the conflict.

Section 8123(a) of the Act¹² provides, 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.¹³ 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.¹⁴

Dr. White examined appellant, discussed the history of injury and reviewed the evidence of record. He reviewed electrodiagnostic studies, which included an EMG scan and noted that there was no relevant pathology relating to a 1991 injury and determined that there was no evidence of a neurological injury. He explained that appellant's nerve conduction studies were normal and also explained that the electromyography did not reveal any relevant pathology related to appellant's employment injury. Dr. White advised that appellant's reflexes in the upper extremities, as well as her motor and sensation throughout the upper extremities were completely normal. He also indicated that he conducted maneuvers designed to elicit the presence of vascular thoracic outlet syndrome; however, none were found. Dr. White also determined that appellant's vascular distal radial pulses were completely intact with abduction of both arms and that no compression of the vascular structures could be accomplished by way of physical maneuvers. He explained that appellant had "no evidence of neurologic disease involving the peripheral nervous system in the upper extremities" and that there was no evidence

¹⁰ See *William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

¹¹ *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000); see also *Paul A. Toms*, 28 ECAB 403 (1987).

¹² 5 U.S.C. §§ 8101-8193.

¹³ 5 U.S.C. § 8123(a).

¹⁴ *Barbara J. Warren*, 51 ECAB 413 (2000).

of neurological disease involving the peripheral nervous system in the upper extremities. He also indicated that appellant had good motor power with a normal balance and a normal gait. Dr. White opined that appellant did not have thoracic outlet syndrome as “[n]o neurologic diagnosis can be established.” Dr. White found no basis on which to attribute an impairment rating due to the absence of neurologic disease.

The Board finds that Dr. White provided a detailed and well-rationalized report based on a proper factual background and thus his opinion is entitled to the special weight accorded an impartial medical examiner. His report therefore constitutes the weight of the medical opinion evidence and establishes that appellant does not have any impairment due to May 5, 1991 work-related injury.

On appeal, appellant’s representative asserts that the impartial medical examiner did not provide an impairment rating. However, as noted above, Dr. White examined appellant and found no basis on which to rate any permanent impairment of the right arm. In the absence of objective findings warranting a rating under the A.M.A., *Guides*, the weight of the medical evidence does not support a schedule award.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she has permanent impairment of her right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers’ Compensation Programs dated April 12, 2005 is affirmed.

Issued: January 11, 2006
Washington, DC

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

David S. Gerson, Judge
Employees’ Compensation Appeals Board

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