United States Department of Labor
Employees' Compensation Appeals Board

D.M., Appellant	)	
and	)	**Docket No. 07-1050**
	)	**Issued: September 24, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Swarthmore, 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:
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 11, 2007 appellant, through counsel, timely appealed the October 6, 2006 merit decision of the Office of Workers' Compensation Programs, which affirmed a schedule award for permanent impairment of the left upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the schedule award.

ISSUE

The issue is whether appellant has more than a 23 percent impairment of her left upper extremity.

FACTUAL HISTORY

On February 8, 1995 appellant, then a 42-year-old letter carrier, filed a traumatic injury claim alleging that she injured her left wrist and shoulder blade on that date when she slipped on ice and fell. The Office accepted the claim for left wrist sprain and authorized arthroscopic surgery, which was performed on July 11, 2005. Appellant's claim was accepted for left shoulder arthroscopy, left shoulder rotator cuff repair, right lateral epicondylitis and right trigger thumb. She returned to light-duty work for four hours per day on September 19, 1995. The

Office accepted appellant's February 6, 1996 recurrence claim and authorized surgery for a left wrist arthroscopy and ulnar shortening osteotomy, which was performed on February 6, 1996. She returned to light-duty work on May 20, 1996. On September 4, 1997 appellant filed a recurrence claim, which the Office accepted. She returned to light-duty work on January 23, 1998.[1] Appellant accepted a light-duty job offer on December 16, 1999 and returned to work that day.[2]

Appellant filed a claim for a schedule award. In a report dated September 27, 2002, Dr. David Weiss, an examining physician, provided findings on physical examination. He diagnosed chronic post-traumatic cervical sprain and strain; status post tear to left wrist tendon and status post tendon repair; left upper extremity radiculitis; left wrist ulnar attachment syndrome with synovitis; status post left wrist arthroscopic surgery, status post partial tear to the lunotriquetral ligament; status post ulnar shortening osteotomy with internal fixation bone grafting; status post removal of painful hardware; status post left shoulder rotator cuff tear; left shoulder post-traumatic acromioclavicular arthropathy with impingement; status post left shoulder arthroscopic surgery and partial synovectomy; positive electromyography and left ulnar nerve neuropathy to cubital tunnel; and right elbow overuse syndrome with a chronic epicondylitis and right trigger finger. Dr. Weiss noted that appellant had neck, left upper extremity and right elbow pain. He calculated a 43 percent impairment to appellant's left upper extremity and a 3 percent permanent impairment of the right upper extremity. The rating consisted of 4 percent impairment based on a 4/5 motor strength deficit of the left supraspinatous muscle and Table 16-11 at page 484 and Table 16-15 at page 492 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*;[3] 9 percent for a 4/5 motor strength deficit of the left deltoid muscle based on Tables 16-11 and 16-15; 10 percent for left ulnar wrist resection arthroplasty based on Table 16-27 at page 506; 10 percent for grip left strength deficit based on Tables 16-32 and 16-34 at page 509; 4 percent for left C5 sensory nerve root deficit based on Tables 16-11 at page 484 and 16-15 at page 492; 7 percent for left C6 sensory nerve root deficit based on Tables 16-11 at page 484 and 16-15 at page 492; 4 percent for left C7 sensory nerve root deficit based on Tables 16-11 at page 484 and 16-15 at page 492; and 3 percent for pain based on Figure 18-1 at page 575. As to the right upper extremity, Dr. Weiss concluded that appellant had three percent for pain based on Figure 18-1 at page 575.

In a January 28, 2003 report, an Office medical adviser noted the diagnoses of chronic post-traumatic cervical sprain and strain and left upper extremity radiculitis were not accepted by the Office as employment-related conditions. Thus, the impairment Dr. Weiss calculated for these nonaccepted conditions were not included in the schedule award determination. The Office medical adviser determined that appellant had 3 percent for pain, and 23 percent permanent

[1] By decision dated February 1, 1999, the Office denied appellant's claim for a consequential emotional condition, which was affirmed by an Office hearing representative on October 15, 1999.

[2] On July 17, 2000 the Office issued a loss of wage-earning capacity determination based on her actual earnings. It found the modified distribution position. On July 13, 2000 appellant accepted the employing establishment's job offer of modified city letter carrier and began the position on July 15, 2000.

[3] A.M.A., *Guides*, 5th ed.

impairment of the left upper extremity. In calculating the left upper extremity impairment, the Office medical adviser found a 10 percent impairment due to ulnar arthroplasty; a 4 percent impairment for supraspinatous motor deficit; a 9 percent impairment for deltoid motor deficit; and a 3 percent impairment for pain, which resulted in a combined 23 percent impairment of the left upper extremity.

By decision dated December 16, 2003, the Office issued a schedule award for 23 percent permanent impairment of the left arm and a 3 percent permanent impairment of the right arm. The period of the award was September 27, 2002 to April 16, 2004.

In a letter dated December 18, 2003, appellant's counsel requested an oral hearing before an Office hearing representative, which was held on July 27, 2004.

By decision dated November 8, 2004, the Office hearing representative found an unresolved conflict in the medical opinion evidence between Dr. Weiss and the Office medical adviser with respect to appellant's left upper extremity impairment. The Office hearing representative set aside the December 16, 2003 schedule award decision, as it pertained to the left upper extremity, and remanded the case to the Office to resolve the conflict in the medical opinion evidence. He noted that, as there was no dispute regarding the schedule award for the right upper extremity, it was not at issue and thus not part of the remand.

On February 2, 2005 the Office referred appellant to Dr. Stanley R. Askin, a Board-certified orthopedic surgeon, to resolve the conflict in the medical opinion evidence between Dr. Weiss and the Office medical adviser on the issue of appellant's left upper extremity impairment. In a report dated February 24, 2005, Dr. Askin concluded that appellant had a 15 percent impairment of her left upper extremity. Range of motion for the left shoulder revealed 80 degrees abduction and 100 degrees lateral extension. Dr. Askin opined that "this is not her true limitation" as "there is no true block to motion for the glenohumeral joint." He also noted external and internal rotation as essentially normal, negative Neer/Hawkins test, "no left shoulder crepitance on motion" and "no winging of the scapula." As to grip strength, Dr. Askin found that "the Jamar is 45/17 at I, 58-35 at II, and 45/22 at V." He found that appellant had a 10 percent impairment due to ulnar resection arthroplasty based on Table 16-27 at page 506. In calculating appellant's left shoulder impairment, Dr. Askin stated:

> "It is reasonable to accept some 'strength deficit' in lieu of a specific 'table' for her shoulder problem. The example posed in Example 16-72 on page 511 is a reasonable analogy to [appellant]. Even using Dr. Weiss' more generous 'deficits' per Table 16-35 on page 510 would garner two percent external rotation impairment (supraspinatous) and three percent abduction (deltoid) impairment of the upper extremity.
>
> "If I understand the [A.M.A.,] *Guides*' instructions correctly the 2 percent plus 3 percent upper extremity impairment for the shoulder add to 5 percent for the upper extremity and that is then 'combined' with the 10 percent upper extremity impairment for the 'ulnar' process using the Combined Values Chart."

He noted that, while both the Office medical adviser and Dr. Weiss included a calculation for pain, he related that he had "no way to objectively assay pain." Thus, Dr. Askin did not provide an impairment rating for pain.

By decision dated March 7, 2005, the Office found that appellant was not entitled to greater than 27 percent impairment of the left upper extremity.

In a letter dated March 10, 2005, appellant's counsel requested an oral hearing before an Office hearing representative, which was held on December 16, 2005.

By decision dated February 21, 2006, the Office hearing representative affirmed the March 7, 2005 decision. He found that the weight of the evidence rested with the opinion of the impartial medical examiner, Dr. Askin.

In a letter dated July 12, 2006, appellant requested reconsideration and submitted a January 18, 2006 report by Dr. Weiss in support of her request. Dr. Weiss noted his disagreement with Dr. Askin's impairment rating. He also opined that Dr. Askin did not properly use the A.M.A., *Guides* in calculating appellant's impairment. Specifically, Dr. Weiss noted that he was "unclear how he rated supraspinatous weakness at two percent, and deltoid weakness at three percent. He stated that a correct use of the A.M.A., *Guides* would show a four percent impairment based on supraspinatous weakness and a nine percent impairment for deltoid weakness. In addition, Dr. Weiss stated that Dr. Askin noted that appellant had a sensory deficit but provided no impairment rating for it. Lastly, he was "confused" by Dr. Askin's grip strength measures and the use of Table 16-34 at page 509. In concluding, Dr. Weiss alleged that Dr. Askin did not correctly apply the fifth edition of the A.M.A, *Guides* when calculating deltoid and supraspinatous motor strength deficit and he "failed to grade the sensory deficit which he found, as well as grip strength deficit."

On September 18, 2006 an Office medical adviser reviewed the medical evidence and concluded that the evidence was insufficient to show that appellant had a left upper extremity impairment greater than 23 percent. He noted that he calculated appellant's left upper extremity impairment as 17 percent. In reaching this calculation, the medical adviser found that appellant was entitled to a 10 percent impairment for left wrist resection arthroplasty, 3 percent impairment for pain; 2 percent impairment for supraspinatous external rotation; and 3 percent impairment for deltoid abduction. Based upon 16.8a Principles at page 508 of the A.M.A., *Guides*, he concluded that calculating loss of strength using grip strength was not the best method to use. Using Table 16-35, the medical adviser concurred with Dr. Askin that appellant had a two percent impairment for supraspinatous external rotation and a three percent impairment due to deltoid abduction, resulting in a total five percent impairment of the left upper extremity. He opined that this was the "appropriate rating for loss of left shoulder strength related to an accepted condition and is not affects by the ulnar head arthroplasty." (sic) The medical adviser stated that he disagreed with Dr. Weiss' left shoulder loss of strength rating because he incorrectly based it upon a peripheral nerve impairment. He noted that the Office did not accept "a peripheral nerve deficit leading to a reduced left shoulder strength and there is no medical evidence for a peripheral nerve deficit leading to the loss of left shoulder strength."

By decision dated October 6, 2006, the Office denied modification.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing federal regulation,[5] 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 for all claimants, the Office has adopted the A.M.A., *Guides* (5th ed. 2001) as the uniform standard applicable to all claimants.[6] Effective February 1, 2001, the fifth edition of the A.M.A., *Guide*s is used to calculate schedule awards.[7]

Section 8123(a) of the Act provides that, 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.[8] When the case is referred to an impartial medical specialist for the purpose of resolving a conflict in medical evidence, the opinion of such specialist will be given special weight when based on a proper factual and medical background and sufficiently well rationalized on the issue presented.[9] In a situation where the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original report.[10]

ANALYSIS

The Office erroneously found a conflict in medical opinion between Dr. Weiss and the Office medical adviser. The Board notes that a conflict was not created as to the impairment estimates of Dr. Weiss and the medical adviser as their impairment ratings do not fully conform to the A.M.A. *Guides*.

Dr. Weiss rated total impairment to the left upper extremity of 43 percent. For motor loss, he identified motor deficit to the left supraspinatous and left deltoid muscles indicating a peripheral nerve loss. In a footnote, Dr. Weiss indicated that he had applied Tables 16-15 and

---

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] 20 C.F.R. § 10.404(a).

[7] *Id.*; *see Thomas P. Lavin*, 57 ECAB ___ (Docket No. 05-1229, issued February 3, 2006); *Jesse Mendoza*, 54 ECAB 802 (2003).

[8] 5 U.S.C. § 8123(a).

[9] *J.M.*, 58 ECAB ___ (Docket No. 06-661, issued April 25, 2007).

[10] *See Harold Travis*, 30 ECAB 1071 (1979).

Table 16-11 in rating motor loss, to the supraspinatous (4 percent loss) and to the deltoid (9 percent loss). However, no maximum values or grading classification for motor deficit was provided. The Board notes that Table 16-15 provides that maximum motor deficit for the axillary nerve, which innervates the deltoid muscle, is 35 percent. The suprascapular nerve, which innervates the supraspinatous muscle, has a maximum motor deficit of five percent. Neither the nerves nor the specific maximum impairment values were specifically identified by Dr. Weiss. As to Table 16-11, which grades the motor deficit, Dr. Weiss did not identify the grading classification he utilized in rating motor impairment to the left upper extremity. Moreover, he allowed additional impairment for strength loss by rating grip strength. At Chapter 16.8, the A.M.A. *Guides* provide that loss of grip strength may be rated separately only if the loss of strength represents an impairing factor that has not been considered adequately by the other methods of the A.M.A., *Guides*. As the criteria for rating such weakness relies on subjective factors which are difficult to control, the A.M.A., *Guides* do not assign a large role to such measurements. The A.M.A., *Guides* clearly state that impairment ratings based on objective anatomic findings take precedence. Dr. Weiss disregarded this instruction, thereby providing a rating for loss of strength without adequate explanation.

In rating pain, Dr. Weiss indicated by footnote that he applied Tables 15-15 and 15-17 at Chapter 15. Table 15-17 provides maximum loss for sensory deficit of unilateral cervical nerve roots, allowing a maximum of five percent for sensory deficit at C5 and C7 and eight percent at C6. Again, Dr. Weiss did not specify the grade classification he allowed for sensory deficit under Table 15-15. It is not readily apparent to the reviewer why Dr. Weiss relied on the rating system of Chapter 15 instead of rating sensory deficit under Tables 16-15 and Table 16-10 which directly pertain to the upper extremity. Moreover, he erroneously added to the pain impairment by allowing an additional three percent under Chapter 18, Figure 18-1. The A.M.A. *Guides* clearly provide that examiners "should not use this chapter to rate pain-related impairment for any condition that can be adequately rated on the basis of the body and organ impairment rating systems given in other chapters of the [A.M.A.,] *Guides*." By so doing, Dr. Weiss disregarded the clear directions of the A.M.A., *Guides* and artificially inflated the impairment rating for pain.

As to the resection arthroplasty of the left wrist ulnar head, Table 16-27 provides for 10 percent impairment of the left upper extremity. In this rating, all the medical examiners agree.

The Office medical adviser adopted several of the impairment ratings provided by Dr. Weiss. He did not accept the 10 percent impairment for loss of grip strength, but allowed the motor loss of 9 percent motor loss of the left deltoid and 4 percent of the left supraspinatous muscle. He also allowed the 10 percent impairment of the wrist for arthroplasty. The medical adviser disallowed the pain impairment derived under Chapter 15, noting that appellant's claim was never accepted for a cervical strain and sprain or for upper extremity radiculitis. However, he allowed the three percent rating for pain under Chapter 18 which, as noted, does not conform to the directions of the A.M.A., *Guides*. As there are deficiencies in the impairment ratings by both Dr. Weiss and the Office medical adviser, they are of reduced probative value and insufficient to create a conflict in medical opinion. For this reason, the opinion of Dr. Askin is not that of an impartial medical specialist. However, it may be reviewed for its own probative value on the issue of impairment to appellant's left upper extremity.

Dr. Askin reviewed appellant's medical history, noting her status was post surgery for her left wrist sprain and left rotator cuff disease of the left shoulder. He noted clinical signs of bilateral carpal tunnel syndrome which was not an accepted condition and common among individuals in appellant's age group. Dr. Askin stated that there were inconsistencies in appellant's limitations to her left shoulder and left forearm in supination and that examination did not reveal any atrophy, ankylosis, or muscular wasting that would give objective corroboration to her stated complaints. Applying the A.M.A. *Guides*, Dr. Askin concurred that appellant had 10 percent impairment for the resection arthroplasty of the left ulnar head. He did not find any true loss of left shoulder motion but noted that there was some strength deficit, best represented by Example 16-72 on page 511 of the A.M.A., *Guides*. Dr. Askin applied Table 16-35 to rate impairment of the left shoulder, specifying two percent external rotation impairment and three percent abduction impairment. He added the strength deficits to find a total 5 percent impairment which was combined with the 10 percent rating for the resection arthroplasty to yield a total 15 percent impairment to the left upper extremity. As to pain, Dr. Askin noted the ratings provided by other physicians but stated that he had no objective way to assess such impairment.

Dr. Weiss subsequently critiqued the report of Dr. Askin and reiterated his earlier impairment rating. An Office medical adviser adopted the findings of Dr. Askin, adding three percent for pain as was noted by Dr. Weiss. He did not agree with the rating Dr. Weiss provided for loss of left shoulder strength as there was no evidence of any peripheral nerve deficit leading to reduced shoulder strength. The medical adviser noted that loss of grip strength was not a suitable rating method as the resection arthroplasty would prevent effective application of maximal force in the region being evaluation.

The Board finds that the case is not in posture for decision. Although Dr. Askin rated impairment using Table 16-35, he did not specify the degrees of loss in range of motion of the left shoulder. Chapter 16.8c Manual Muscle Testing provides that such testing is subject to the individual's conscious or unconscious control but that the results should be reproducible on different occasions. Dr. Askin did not clearly state how he applied Table 16-35 to classify the severity of strength loss to the left shoulder. The text accompanying Table 16-35 makes reference to the classification system found at Table 16-11 for grading motor deficit, noting that most weaknesses fall in Grade 4 with few injuries resulting in more profound weakness, such as a Grade 3. The report of Dr. Askin is not clear in this impairment rating: Grade 4 at Table 16-11 allows for motor deficit from 1 to 25 percent for complete active range of motion against gravity with some resistance. The two percent for external rotation loss and three percent for abduction impairment appear to fall within this range. Moreover, Dr. Askin discounted appellant's complaints of pain as too subjective to rate. The Board has long noted, however, that the element of pain may serve as the basis for determining impairment for schedule award purposes.[11] The A.M.A. *Guides*, at Chapter 16 provide tables for rating sensory loss to the upper extremity.

[11] *See Cynthia M. Judd*, 42 ECAB 246 (1990).

CONCLUSION

The Board finds that this case is not in posture for decision to determine whether appellant is entitled to more than a 23 percent impairment of the left upper extremity, which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 6, 2006 is set aside and the case remanded for further proceedings consistent with this decision.

Issued: September 24, 2007
Washington, DC

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

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