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

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| **W.G., Appellant** | ) | |
| **and** | ) | **Docket No. 08-1980** |
| | ) | **Issued: April 17, 2009** |
| **DEPARTMENT OF JUSTICE, U.S. MARSHAL'S SERVICE, Harrisburg, 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:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

## *JURISDICTION*

On July 9, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs' decision of the Office hearing representative dated May 6, 2008, which affirmed the Office's October 4, 2007 schedule award decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

## *ISSUES*

The issues are: (1) whether appellant has established that he sustained more than 10 percent permanent impairment of his left arm and more than 11 percent impairment of his right arm for which he received a schedule award; and (2) whether appellant met his burden of proof to establish that he was entitled to receive a schedule award to any of his other extremities.

## *FACTUAL HISTORY*

On March 16, 1995 appellant, then a 39-year-old marshal, filed a traumatic injury claim alleging that on March 13, 1995, he was struck by a motor vehicle while in the performance of

duty. He stopped work on March 13, 1995 and returned on March 16, 1995.[1] The Office accepted appellant's claim for a cervical and lumbar strain, post-traumatic cervical discogenic disease at C5-6 and C6-7 and authorized an anterior cervical discectomy and fusion. Appellant received appropriate compensation benefits.

On April 10, 2006 appellant's representative requested a schedule award.[2] In support of his claim, he submitted a February 16, 2005 report from Dr. Nicholas Diamond, a Board-certified osteopath, specializing in osteomanipulative medicine. Dr. Diamond noted appellant's history of injury and treatment and utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001). He determined that appellant had 18 percent left arm impairment, 20 percent right arm impairment, 15 percent right leg impairment and 15 percent left leg impairment.

In a June 13, 2006 report, an Office medical adviser noted appellant's history of injury and determined that the lower extremities showed no evidence or any motor or sensory deficit. He explained that the left upper extremity did not have any sensory deficits that would justify a schedule award under the A.M.A., *Guides*. Regarding the right upper extremity, the Office medical adviser opined that appellant had 11 percent right upper extremity impairment.

By decision dated August 8, 2006, the Office granted appellant a schedule award for a total of 34.32 weeks of compensation for an 11 percent permanent impairment of the left upper extremity.[3] Appellant's representative requested a hearing on August 14, 2006.

The record reflects that appellant retired in December 2006.

By decision dated December 6, 2006, the Office hearing representative determined that the case was not in posture for a hearing. He set aside and remanded the Office's August 8, 2006 decision for further development of the medical evidence. The Office hearing representative determined that the Office had failed to discuss how the medical evidence was weighed in determining the upper extremity impairment rating. Additionally, he noted that it failed to address the claim for impairment for the bilateral lower extremities, as well as the upper left extremity. The Office also determined that a conflict had arisen between the Office medical adviser and Dr. Diamond regarding the extent of appellant's impairment.

On February 2, 2007 the Office referred appellant along with a statement of accepted facts and the medical record to Dr. Robert Allen Smith, a Board-certified orthopedic surgeon, for a second opinion examination.[4] In a February 20, 2007 report, Dr. Smith noted appellant's history of injury and treatment and utilized the A.M.A., *Guides*. He examined appellant and noted that the only extremity with identifiable deficits was the left arm. Dr. Smith indicated that

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[1] The record reflects that appellant has a previous history of back pain dating back to 1984, which slowly progressed over the years.

[2] The Office received the Form CA-7 dated May 12, 2006 on June 1, 2006.

[3] The Office made a typographical error and put in left instead of right upper extremity.

[4] An earlier appointment was rescheduled.

appellant had Grade 4 sensory and motor changes, referred to Tables 16-10 and 16-11[5] and determined that appellant had 25 percent impairment for sensory and motor function. He utilized Table 16-13[6] and advised that for the C6 root, for a sensory deficit there was 2 percent impairment (8 percent times 15 percent) and for the motor function there is 9 percent impairment (35 percent times 25 percent). Dr. Smith determined that appellant reached maximum medical improvement and had 11 percent impairment to the left upper extremity. He opined that appellant was not entitled to an impairment of the right upper extremity or the lower extremities.

By decision dated March 2, 2007, the Office found that appellant had no more than 11 percent impairment of the left arm previously awarded and also found that there was no permanent impairment of appellant's other extremities.

On March 14, 2007 appellant's representative requested a hearing. In a June 5, 2007 decision, the Office hearing representative found that a conflict remained regarding the extent of appellant's impairment. She found that the Office did not follow earlier remand instructions to refer appellant for an impartial medical examination. The hearing representative also noted that the award previously granted should be for the right arm. She also found that Dr. Smith's report was not based upon a proper medical or factual background.

By letter dated June 8, 2007, appellant's representative notified the Office that appellant wished to participate in the selection of an impartial medical examiner.

On June 26, 2007 the Office referred appellant along with a statement of accepted facts, and the medical record to Dr. David C. Baker, a Board-certified orthopedic surgeon for an impartial medical evaluation to resolve the conflict in opinion between Dr. Diamond and the Office medical adviser regarding the extent of appellant's permanent impairment.

By letter dated June 20, 2007, appellant's representative requested that the Office provide additional information to include the physician's name and appointment times. It provided appellant's representative with the requested information on July 10, 2007.

By letter dated July 25, 2007, appellant's representative confirmed that he was in receipt of the letter scheduling appellant for an impartial medical examination with Dr. Baker. He also requested a copy of the statement of facts and the correspondence to the physician. The Office provided appellant's representative with the requested information on August 2, 2007.

In an August 10, 2007 report, Dr. Baker noted appellant's history of injury and treatment and utilized the A.M.A., *Guides.* He indicated that appellant had neck pain with some pain in the left shoulder and left arm. On examination, Dr. Baker noted no deformity to the spine. Spurling's test reproduced pain in the left shoulder, pain along the medial border of the scapula and some paresthesias into the long finger. Motor examination revealed no visible abnormalities in the arm with the exception of some mild atrophy of the interosseous muscles of the left hand. Dr. Baker advised that there were no neurologic deficits in the lower extremities. He diagnosed

[5] A.M.A., *Guides* 482, 484.

[6] A.M.A., *Guides* 489.

post cervical fusion at 5 to 6 and nonunion at 6 to 7 with mild C7 radiculopathy, as manifested by paresthesias in the long finger and slight weakness in the interosseous muscles. In assessing left arm impairment, Dr. Baker referred to Table 16-13[7] and explained that the maximum amount that could be assigned for a sensory deficit or pain was five percent upper extremity impairment. He explained that he assigned 20 percent of this value because appellant's sensation was intact and advised that it would result in 1 percent upper extremity impairment. Dr. Baker noted that motor deficit for the C7 nerve root would correlate to a maximum 35 percent upper extremity. He advised that he had assigned a Grade 4 or 25 percent deficit despite the weakness being reflected in the interosseous muscles more than the triceps. Dr, Baker determined that this would translate to nine percent upper extremity impairment. He advised that combining 9 percent for the motor deficit in the left upper extremity with 1 percent for the sensory deficit in the upper extremity in the C7 distribution resulted in 10 percent upper extremity impairment. Dr. Baker explained that the impairment involving the C7 nerve was consistent with the fact that the fusion did not heal at the C6-7 level. He noted that appellant's initial symptoms were recorded to the C6 nerve root which was consistent with the original herniation. Dr. Baker explained that appellant's problem was now related to the failure of the C6-7 fusion which was a necessary component of the fusion of C5-6 because of appellant's preexisting degenerative changes at C6-7. He opined that appellant had 10 percent left upper extremity impairment based on the C7 nerve dysfunction.

By letter dated September 4, 2007, the Office requested that Dr. Baker provide an opinion as to whether appellant had impairment for the right upper extremity or any of the lower extremities.

In a September 17, 2007 report, Dr. Baker opined that appellant did not qualify for impairment of the right upper extremity or the right and left lower extremity, based on the absence of neuritic symptoms or neurologic findings. He explained that in order to qualify for impairment, there must be measurable neurologic complaints as manifested by pain in a dermatomal distribution or measurable neurologic deficits such as manifested by strength, reflexes or atrophy. Dr. Baker advised that there were no dermatomal neurologic complaints in the right upper extremity or either leg and there were no neurologic findings as manifested by weakness or atrophy. He repeated that appellant was entitled to an impairment of 10 percent to the left upper extremity.

In a September 25, 2007 report, an Office medical adviser noted appellant's history of injury and treatment and utilized the A.M.A, *Guides.* He concurred with the findings of Dr. Baker and opined that appellant was entitled to no more than a 10 percent impairment of the left upper extremity. For the left C7 sensory nerve root, the Office medical adviser referred to Table 15-15[8] and explained that a Grade 4 would correspond to 20 percent sensory deficit. He referred to Table 15-17[9] and noted that the maximum sensory deficit for a C7 nerve root was equal to five percent. The Office medical adviser explained that the total sensory C7 nerve

[7] *Id.*

[8] A.M.A., *Guides* 424.

[9] The Office medical adviser actually indicated Table 15-18; however, the correct Table is 15-17.

impairment would equate to 20 percent times 5 percent and result in 1 percent upper extremity impairment. He referred to the left C7 motor nerve root and explained that a grade C7 motor nerve deficit utilizing Table 15-15 would warrant a Grade 4 which would translate to a 25 percent sensory deficit. The Office medical adviser referred to Table 15-17 and determined that the maximum motor deficit for a C7 nerve root was equal to 35 percent. He multiplied these together and determined that appellant was entitled to nine percent impairment for his motor deficit to the C7 nerve root. The Office medical adviser referred to the Combined Values Chart and determined that appellant was entitled to an impairment of 10 percent to the left upper extremity. He opined that he did not believe that there was any other evidence of impairment to any other extremity.

On October 4, 2007 the Office awarded appellant compensation for 31.2 weeks from October 15, 2006 to May 21, 2007 based upon a 10 percent permanent impairment of the left upper extremity. It also amended its March 2, 2007 decision to correctly allocate the 11 percent impairment to the right upper extremity.

Appellant's representative requested a hearing, which was held on February 20, 2008.

By decision dated May 6, 2008, the Office hearing representative affirmed the Office's October 4, 2007 decision.

## ***LEGAL PRECEDENT -- ISSUE 1 & 2***

The schedule award provision of the Federal Employees' Compensation Act[10] and its implementing regulations[11] 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 regulations as the appropriate standard for evaluating schedule losses.[12]

No schedule award is payable for a member, function or organ of the body not specified in the Act or in the implementing regulations.[13] As neither the Act nor its regulations provide for the payment of a schedule award for the permanent loss of use, of the back or the body as a whole, no claimant is entitled to such a schedule award.[14] The Board notes that section 8109(19) specifically excludes the back from the definition of organ.[15] However, a claimant may

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] A.M.A., *Guides* (5th ed. 2001).

[13] *See Richard R. Lemay*, 56 ECAB 341 (2005); *see also Thomas J. Engelhart*, 50 ECAB 319 (1999).

[14] 5 U.S.C. § 8107; *see also Richard R. Lemay*, *supra* note 13.

[15] 5 U.S.C. § 8109(19).

be entitled to a schedule award for permanent impairment to an upper or lower extremity even though the cause of the impairment originated in the neck, shoulders or spine.[16]

## ***ANALYSIS -- ISSUE 1 & 2***

In this case, Dr. Diamond, a Board-certified osteopath, determined that appellant had an 18 percent left upper extremity impairment, a 20 percent right upper extremity impairment, a 15 percent right lower extremity impairment and a 15 percent left lower extremity impairment. An Office medical adviser reviewed Dr. Diamond's report and determined that appellant had 11 percent right upper extremity impairment. The Office hearing representative determined that a conflict had arisen between Dr. Diamond and the Office medical adviser regarding the extent of appellant's impairment.

Section 8123(a) of the Act provides, in pertinent part: "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."[17] Where 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 a proper factual and medical background, must be given special weight.[18]

The Board finds that the thorough and well-documented report of Dr. Baker, the impartial medical specialist selected to resolve the conflict in the medical opinion evidence is based upon correct application of the A.M.A., *Guides* and is entitled to special weight. Dr. Baker took measurements, referred to Tables 16-10 and 16-11[19] and explained his calculations. In an August 10, 2007 report, he noted appellant's history of injury and treatment and utilized the A.M.A., *Guides.* Dr. Baker examined appellant and noted that there were no neurologic deficits in the lower extremities. He indicated that appellant had mild C7 radiculopathy, as manifested by paresthesias in the long finger and slight weakness in the interosseous muscles. Dr. Baker determined that appellant was entitled to 10 percent upper extremity impairment. He explained that the impairment involving the C7 nerve was consistent with the fact that the fusion did not heal at the C6-7 level. Dr. Baker also explained that while appellant's initial symptoms were recorded to the C6 nerve root, which was consistent with the original herniation, appellant's problem was now related to the failure of the C6-7 fusion. He noted that it was a necessary component of the fusion of C5-6 because of appellant's preexisting degenerative changes at C6-7. Dr. Baker opined that appellant had 10 percent left arm impairment based on the C7 nerve dysfunction. He did not provide an opinion regarding whether appellant was entitled to an impairment rating for his other extremities. In a letter dated September 4, 2007, the Office requested that Dr. Baker provide a supplemental opinion as to whether appellant had impairment

[16] *See Richard R. Lemay* and *Thomas J. Engelhart*, *supra* note 13.

[17] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan*, 45 ECAB 207, 210 (1993).

[18] *See Roger Dingess*, 47 ECAB 123, 126 (1995); *Juanita H. Christoph*, 40 ECAB 354, 360 (1988); *Nathaniel Milton,* 37 ECAB 712, 723-24 (1986).

[19] A.M.A., *Guides* 424, 482 & 484.

for the right upper extremity or any of the lower extremities. Board precedent provides that, when it 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 his original report.[20]

In a September 17, 2007 report, Dr. Baker opined that appellant did not quality for impairment of the right upper extremity or the right and left lower extremity based on the absence of neuritic symptoms or neurologic findings. He explained that there were no dermatomal neurologic complaints in the right upper extremity or either leg and there were no neurologic findings as manifested by weakness or atrophy. Dr. Baker restated his conclusion that appellant had 10 percent impairment of the left upper extremity. The Board finds that his opinion is sufficiently well rationalized and based on a proper factual and medical background such that it must be given special weight.

In a September 25, 2007 report, an Office medical adviser reviewed Dr. Baker's finding and concurred in his impairment finding that, under the A.M.A., *Guides,* appellant had no more than 10 percent impairment to the left upper extremity. He referred to Table 15-15[21] and explained that for the left C7 sensory nerve root a Grade 4 would correspond to 20 percent sensory deficit. The Office medical adviser referred to Table 15-17[22] and noted that the maximum sensory deficit for a C7 nerve root was equal to five percent. He multiplied the 20 percent sensory deficit by the 5 percent sensory deficit for 1 percent upper extremity impairment. The Office medical adviser indicated that the motor deficit for left C7 motor nerve root would result in a Grade 4 or a 25 percent sensory deficit according to Table 15-15.[23] He referred to Table 15-17[24] which reveals that the maximum motor deficit for a C7 nerve root was equal to 35 percent. The Office medical adviser multiplied 35 percent times 25 percent which resulted in 9 percent impairment for his motor deficit to the C7 nerve root. He combined the values and determined that appellant was entitled to an impairment of 10 percent to the left upper extremity.[25] The Office medical adviser explained that there was no evidence of impairment to any other extremity.

The Board also notes that while the Office medical adviser referred to Tables 15-15 and 15-17 which pertains to the spine and Dr. Baker referred Tables 16-10 and 16-11,[26] which pertain to the upper extremities, they are functional equivalents of each other and result in identical findings. As noted, section 8109(19) specifically excludes the back from the definition

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[20] *April Ann Erickson*, 28 ECAB 336, 341-42 (1977).

[21] A.M.A., *Guides* 424.

[22] *Id.*

[23] *Id.*

[24] *Id.*

[25] *Id.* at 604.

[26] *Id.* at 424, 482 & 484.

of organ.[27] However, a claimant may be entitled to a schedule award for permanent impairment to an upper or lower extremity even though the cause of the impairment originated in the neck, shoulders or spine.[28]

Appellant has not submitted any other medical evidence conforming with the A.M.A., *Guides* establishing that he has a greater schedule award.[29]

On appeal, appellant's representative alleged that Dr. Baker was not properly selected from the Physician's Directory System (PDS). The Board notes initially that counsel did not raise a timely objection to the impartial medical examiner until his appeal. The record reflects that appellant's representative notified the Office on June 8, 2007, that appellant wished to participate in the selection of an impartial medical examiner. On June 20, 2007 appellant's representative requested additional information regarding the physician's name and appointment times. The Board notes that the Office provided appellant's representative with the requested information on July 10, 2007. Further, on July 25, 2007 appellant's representative confirmed that he was in receipt of the pertinent information pertaining to the examination with Dr. Baker and requested a copy of the statement of facts and the correspondence to the physician. The Board notes that the representative was provided the requested information on August 2, 2007. However, this objection was not made until the appeal on July 9, 2008, almost a year later. Appellant's representative did not provide a valid reason other than to make a general allegation that there was no indication in the file that the PDS was utilized and that Dr. Baker was selected at random. The Board finds that counsel did not raise a timely objection or provide a valid reason for this stated objection. Therefore, the evidence does not establish an error in the selection of Dr. Baker as an impartial medical examiner.[30]

Appellant's representative also alleged that Dr. Baker's report could not carry the weight of the evidence. However, as determined above, the Board finds that Dr. Baker's opinion is thorough and well rationalized and based on a complete and accurate factual and medical background. Accordingly, it is entitled to special weight.

## ***CONCLUSION***

The Board finds that appellant has not met his burden of proof to establish that he has greater than the 10 percent impairment of the left upper extremity or 11 percent impairment of the right upper extremity, for which he received a schedule award. The Board also finds that

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[27] *See supra* note 15.

[28] *See supra* note 20.

[29] The Board notes that appellant retains the right to file a claim for an increased schedule award based on new exposure or on medical evidence indicating that the progression of an employment-related condition, without new exposure to employment factors, has resulted in a greater permanent impairment than previously calculated. *Linda T. Brown*, 51 ECAB 115 (1999).

[30] *See Willie M. Miller,* 53 ECAB 697 (2002) (appellant did not raise an objection to selection of referee physician until after claim was denied and raised only general allegations the claim was improper).

appellant has not met his burden of proof to establish that he was entitled to receive a schedule award to any of his other extremities.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs' hearing representative dated May 6, 2008 is affirmed

Issued: April 17, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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