



## FACTUAL HISTORY

The Office accepted that, on January 15, 1999, appellant, then a 38-year-old letter carrier, slipped and fell during the performance of her duties and sustained a cervical strain, a lumbar strain and a right knee strain with resultant arthroscopy, which she underwent on July 31, 2000.

Appellant also sustained injuries resulting from a motor vehicle accident on February 10, 1999 which the Office accepted for the conditions of cervical strain, permanent aggravation of cervical disc disease and anterior cervical discectomy with bone bank fusion (ACDF) surgery of C4-5 and C5-6, which appellant underwent on August 17, 1999. The Office assigned that case file number 110170759 and doubled it into the current claim.

On October 8, 2002 and refiled on November 12, 2002, appellant claimed a schedule award for her neck condition and impairment to her extremities due to her cervical spine condition.

In letters dated December 12, 2002 and January 31, 2003, the Office requested that appellant provide specific medical documentation necessary for a determination of whether her case was in posture for a schedule award. The Office advised that it was necessary to have a statement from her physician stating that maximum medical improvement had been reached.

In a January 14, 2003 report, Dr. Stephen G. Smith, a Board-certified anesthesiologist, advised that he had offered all that was possible in terms of appellant's pain management and opined that she reached maximum medical improvement during her examination on September 16, 2002. A copy of the September 16, 2002 report was provided.

On January 31, 2003 the Office requested that Dr. Raymond F. Cohen, a neurologist who began treating appellant, perform a medical impairment evaluation in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*) for an impairment to an extremity due to the cervical spine condition. No response was received.

By letters dated March 11 and 14, 2003, the Office referred appellant to Dr. John Gragnani, Board-certified in physical medicine and rehabilitation, for a second opinion evaluation along with a copy of the case record, a statement of accepted facts and a copy of a March 5, 2003 letter from the Office's medical adviser, which contained instructions on how the examining physician should do an impairment rating under the fifth edition of the A.M.A., *Guides*. In a March 27, 2003 medical report, Dr. Gragnani submitted his examination findings and provided the following impressions: "cervical spine injury, by history; cervical fusion, C4-5 and C5-6, by record; subjective complaints of pain, headaches, and dysfunction not substantiated by physical findings; and invalid testing on the Jamar dynamometer." Dr. Gragnani advised that his examination did not yield anything to rate as appellant's findings were too subjective to yield objective evidence of any sensory or motor changes involving the upper extremities and no radiculopathy, neuropathy or other neurologic dysfunction was in evidence. The physician concluded that he could not offer a specific rating and felt that appellant's subjective response further limited him from being able to consider Chapter 18 for pain complaints. Accordingly, Dr. Gragnani offered no impairment rating.

On April 5, 2003 the Office medical adviser reviewed Dr. Gragnani's report and opined that Dr. Gragnani's impairment rating of zero percent for the right and left upper extremities was acceptable. The Office medical adviser noted that Dr. Gragnani had dismissed radicular pain, sensory deficit and weakness in the upper extremities, and that appellant had incompletely cooperated in the assessment. Dr. Gragnani found no valid upper extremity weakness, no radicular sensory changes, and the pain complaint, as reported, was not radiating into either upper extremity.

By decision dated April 29, 2003, the Office denied appellant's claim for a schedule award on the grounds that the medical evidence presented by Dr. Gragnani and the Office medical adviser substantiated a zero impairment to the right and left upper extremity due to the accepted work-related condition of permanent aggravation of cervical disc disease and ACDF surgery at C4-5, C5-6.

In a May 23, 2003 letter, appellant requested reconsideration advising that she had complied with the Office's requests and had yet to see her physician, who she was scheduled to see on May 28, 2003. By decision dated June 9, 2003, the Office denied appellant's request for reconsideration, without a merit review, on the grounds that she neither raised substantive legal questions nor included new and relevant evidence.

In an August 29, 2003 letter, appellant requested reconsideration and submitted additional evidence. In a May 28, 2003 report, Dr. Cohen noted the history of injury and diagnosed "status postcervical discectomy for disc herniation at C4-5 and C5-6; cervical myofascial pain; and cervical radiculopathy on the right." Examination findings revealed a loss of flexion and extension of approximately 15-20 degrees; symmetric reflexes; intact sensory function; a 4+/5 weakness in the right biceps and brachial radialis muscle; and no definite grip strength weakness. Dr. Cohen recommended that appellant undergo an upper extremity electromyogram (EMG)/nerve conduction velocity (NCV) study to objectively assess the upper extremity function. Appellant underwent the above studies on July 15, 2003, which revealed no abnormal spontaneous activity, normal involuntary motor recruitment morphology, normal bilateral medial and ulnar motor nerves and contained an impression of compression of the right median nerves at the wrist affecting only sensory fibers.

In an August 12, 2003 report, Dr. Cohen noted that appellant had undergone objective testing and opined that under the fifth edition of the A.M.A., *Guides* appellant has a 6.4 percent impairment of her right upper extremity or a whole person impairment of 4 percent. He noted that, under Table 6-11, appellant had a Grade 4 weakness of her right biceps and brachioradialis muscle of 20 percent for loss of flexion. He indicated that the right C6 nerve root was involved and the maximum impairment for this spinal nerve was 35 percent.

In a September 29, 2003 report, the Office medical adviser noted that there were discrepancies between Dr. Cohen's reports of May 28 and August 12, 2003 with regards to weakness in appellant's right biceps and brachial radialis muscle and stated that Dr. Cohen did nothing to evaluate the credibility of this weakness through measuring girths of either upper extremity or report a sensory assessment using a two-point discrimination device or Watenberg wheel. He further noted that the physical examination section was short. He also noted that Dr. Gragnani had, in his March 27, 2003 report, pointed out that appellant was not credible, a

particularity germane observation in that he noted when appellant was distracted she had normal strength in the arm (from shoulder to elbow level) than when she thought she was being tested for strength in those muscles. The Office medical adviser opined that the Office should not use Dr. Cohen's rating recommendation as his credibility was impaired when the examination findings he reported were cursory, he did nothing to consider credibility and, in his August 12, 2003 note, claimed that the weakness was worse than he reported it to be in his May 28, 2003 examination report.

By decision dated October 1, 2003, the Office denied modification of its prior decision on the grounds that the weight of the medical evidence regarding permanent impairment remained with Dr. Gragnani. The Office found that, as Dr. Cohen did not provide a detailed medical explanation based on objective findings in support of his conclusions, his reports were of diminished probative value.

By letter dated November 12, 2003, appellant requested reconsideration. In an October 14, 2003 report, Dr. Cohen refuted the Office medical adviser's comments. He advised that, when he first examined appellant, she had a 4+ weakness in her right arm and that this was a common grading system used by neurologists. He stated that he had used Table 16-11, which did not have a place for a 4+ weakness, and had assigned a Grade 4 weakness. He stated that a normal EMG did not rule out a neurological problem, noting that appellant had neck surgery and her subjective complaints were consistent with the examination. He further stated that there were several ways to assess sensory function and that the two-point discrimination was only one part of sensory testing. Dr. Cohen indicated that there was no neurological test which could substantiate weakness and indicated that appellant did cooperate with the examination. He further noted that appellant obviously had a serious enough injury that she needed cervical surgery and her clinical systems fit the examination. Dr. Cohen also objected to the Office medical adviser's preference for using Dr. Gragnani's report to assess appellant's impairment.

By decision dated December 24, 2003, the Office denied appellant's request for reconsideration on the grounds that Dr. Cohen's report was cumulative in nature, similar to evidence previously reviewed and not sufficient to warrant a merit review of its previous decision.

In a January 2, 2004 letter, appellant again requested reconsideration. Additional evidence submitted consisted of a December 15, 2003 notice of recurrence; a December 16, 2003 medical report from Dr. Cohen which indicated that appellant had permanent restrictions and had reached maximum medical improvement on September 16, 2002; a December 19, 2003 report from Dr. Mark E. Belew, a Board-certified orthopedic surgeon, which diagnosed appellant with degenerative arthritis with reactive synovitis and a December 19, 2003 duty status report from Dr. Belew setting forth appellant's restrictions.

By decision dated January 13, 2004, the Office denied appellant's request for reconsideration on the grounds that her letter neither raised substantive legal questions nor included new and relevant evidence.<sup>1</sup>

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<sup>1</sup> The Board notes that, subsequent to the Office's January 13, 2004 decision, the Office received additional evidence. However, the Board may not consider new evidence on appeal. *See* 20 C.F.R. § 501.2(c).

## LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act<sup>2</sup> and its implementing federal regulation,<sup>3</sup> sets 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* as the uniform standard applicable to all claimants.<sup>4</sup> Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.<sup>5</sup>

## ANALYSIS -- ISSUE 1

In this case, the office accorded the weight of the medical evidence to Dr. Gragnani Board-certified in physical rehabilitation and rehabilitation and a second opinion examiner. Dr. Gragnani opined he could not offer an impairment rating as appellant's findings were too subjective to yield any objective evidence of any sensory or motor changes involving the upper extremities, there was no evidence of radiculopathy, neuropathy or other neurologic dysfunction, and her subjective responses limited him from considering her pain complaints. Dr. Cohen, a neurologist and appellant's treating physician, however, opined that an impairment rating could be calculated based on weakness in her right biceps and brachioradialis muscle. Specifically, Dr. Cohen advised that his May 28, 2003 examination, which revealed a 4+/5 weakness in her right biceps and brachial radialis muscle, equated to a Grade 4 weakness of 20 percent under Table 16-11, page 484 of the A.M.A., *Guides* and calculated a 6.4 percent right upper extremity impairment.

The Board finds that this case is not in posture for decision due to a conflict in the medical opinion evidence between Dr. Gragnani, who concluded that he could not offer an impairment rating, and Dr. Cohen, who opined that appellant had a 6.4 percent impairment to her right upper extremity.

The Board finds that Dr. Cohen's reports of May 28 and August 12, 2003 are of equal probative value to Dr. Gragnani's report. In his May 28, 2003 report, Dr. Cohen reported that appellant had a 4+/5 weakness in her right biceps and brachial radialis muscle, with no definite grip weakness noted. In his August 12, 2003 report, Dr. Cohen advised that appellant had a Grade 4 weakness in her right biceps and brachioradialis muscle in strength testing. Under Table 16-11, page 484 of the A.M.A., *Guides*, a Grade 4 weakness covers a wide range of weakness, from minimal detectable weakness to severe weakness in which the muscles are functional through a full range with only very slight resistance, and covers a range of 1 to 25 percent degree

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<sup>2</sup> 5 U.S.C. § 8107.

<sup>3</sup> 20 C.F.R. § 10.404.

<sup>4</sup> 20 C.F.R. § 10.404.

<sup>5</sup> See Federal (FECA) Procedure Manual, Part 3 -- Medical, Chapter 3.700, Exhibit 4 (November 2002); FECA Bulletin No. 01-5(1) (issued January 29, 2001).

of weakness. The A.M.A., *Guides* provides for the physician to exercise clinical judgment in estimating the appropriate percentage of motor deficits and loss of power within the range of values shown for each severity grade. Thus, Dr. Cohen exercised his clinical judgment in assigning a 20 percent motor deficit. Although the Office medical adviser questioned the validity of Dr. Cohen's examination findings and his credibility as compared to Dr. Gragnani, Dr. Cohen's reports were based upon a complete factual history and physical examination, were detailed and thorough, and included his opinion based upon his examination findings and objective tests.<sup>6</sup> Furthermore, as the Office medical adviser is a nonexamining physician, deference is provided to the examining physician's findings.<sup>7</sup> This is important, especially in a case like this, where the second opinion physician concludes he cannot offer an impairment rating and the treating physician finds that appellant's weakness of her right biceps and brachioradialis muscle is ratable.

Due to the equally probative examinations of and final impairment ratings between Dr. Gragnani, the second opinion physician, and Dr. Cohen, appellant's physician, there is an unresolved conflict of the medical opinion evidence regarding the extent of appellant's permanent impairment to her right upper extremity. Section 8123(a) of the Act 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."<sup>8</sup>

On remand the Office should prepare a statement of accepted facts and a list of specific questions and refer appellant to an appropriate Board-certified physician to determine the extent of her permanent impairment as a result of her accepted employment injuries. After this and any such other development as the Office deems necessary, the Office should issue an appropriate decision.<sup>9</sup>

### **CONCLUSION**

The Board finds that the case is not in posture for a decision, due to an unresolved conflict of medical opinion evidence regarding the extent of appellant's permanent impairment due to her accepted employment-related injuries.

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<sup>6</sup> See *Maurissa Mack*, 50 ECAB 498 (1999) (the factors that comprise the evaluation of medical evidence include the opportunity for and the thoroughness of, physical examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion).

<sup>7</sup> *John Keller*, 39 ECAB 543 (1988) (the Office medical adviser, as the nonexamining physician, cannot select a percentage without explanation or reference to the examining physician's findings); *Ronnie V. Jones*, Docket No. 90-1149 (issued February 11, 1991) (opinion of the examining physician takes precedence where the A.M.A., *Guides* requires subjective judgment on the percentage of impairment).

<sup>8</sup> 5 U.S.C §§ 8101-8193, 8123(a).

<sup>9</sup> In light of the Board's resolution of the first issue, the second nonmerit issue in this case is moot.

**ORDER**

**IT IS HEREBY ORDERED THAT** the January 13, 2004, December 24, October 1 and April 29, 2003 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further development consistent with this opinion of the Board.

Issued: September 30, 2004  
Washington, DC

Alec J. Koromilas  
Chairman

Colleen Duffy Kiko  
Member

Willie T.C. Thomas  
Alternate Member