

On October 12, 1998 appellant filed a Form CA-7 claim for a schedule award based on a partial loss of use of her right upper extremity.

In order to determine the degree of permanent impairment causally related to her accepted conditions, the Office referred appellant to Dr. Gregory S. Maslow, a Board-certified orthopedic surgeon, for a second opinion examination. In a report dated August 30, 2001, Dr. Maslow, applying the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), fifth edition found that appellant had a three percent permanent impairment of the right upper extremity due to an ulnar neurapraxia causally related to her accepted conditions.

In a report dated March 20, 2002, an Office medical adviser agreed that appellant had a three percent right upper extremity impairment based on Dr. Maslow's opinion.

On March 25, 2002 the Office granted appellant a schedule award for a 3 percent permanent impairment of the right upper extremity for the period August 20, 2001 to November 3, 2001, for a total of 9.36 weeks of compensation.

By letter dated April 2, 2002, appellant's attorney requested a hearing, which was held on October 28, 2003.

By decision dated December 16, 2003, the Office hearing representative set aside the March 25, 2002 decision, finding that there was a conflict in the medical evidence between the opinions of Drs. Maslow and Goldberg. The Office remanded the case for referral to an impartial medical specialist to resolve the conflict regarding the impairment to appellant's right upper extremity.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. Gerald Packman, a Board-certified orthopedic surgeon, for an impartial medical evaluation. In report dated March 29, 2004, Dr. Packman determined that appellant had a 17 percent whole person impairment. He calculated the impairment, as follows:

“There is restriction of cervical spine range of motion with flexion to 45 degrees and extension to 80 degrees. Lateral bending is 35 degrees symmetrically. Lateral rotation is 60 degrees symmetrically. Thus, there is reduction in flexion, lateral bending and lateral rotation. Lumbosacral flexion was 30 degrees beyond sacral hip flexion of 45 degrees, so that true lumbosacral flexion was diminished by 25 degrees. Lumbosacral extension was 20 degrees, which is 5 degrees diminished. Lateral bending was 25 degrees symmetrically.”

* * *

“Stiffness and pain in the neck, more right sided than left, with radiation to the shoulder blades bilaterally and the right arm and right thumb. Additionally, there is low back pain with radiation down the right lower extremity to the plantar aspect of the foot.”

* * *

“Ulnar neuropathy is not included as a diagnosis. EMG [electromyogram] finding of changes in the ulnar nerve at the elbow do not constitute a physical impairment. Thus [appellant] has no findings at this site suggestive of a cubital tunnel syndrome or an ulnar neuropathy. There has never been documented a clear cut ulnar nerve pattern of symptoms or findings outside of the EMG. The findings suggestive of nerve compression have either been out of the distribution of the ulnar nerve or much more wide spread than the distribution of the ulnar nerve. There [are] no symptoms or physical findings appropriate to an ulnar neuropathy.”

* * *

“With the information available to me, I believe that the portion of range of motion which would be diagnosis related as indicated in Table 15.7 of the A.M.A., *Guides* would be [2]-B, which would give a 4 percent whole person impairment.... The cervical spine range of motion portion of the range of motion method reveals slight impairment related to loss of [five] degrees of flexion from neutral. There is no loss of extension. There is 10 degrees loss of lateral bending to the left and also to the right. There is 20 degrees loss of rotation to the right and rotation to the left.

“Using Table 15-12 I rate the loss of flexion as worth ½ of one percent. The loss of lateral bending to the right as 0/7 percent, loss of lateral bending to the left as 0/7 percent, loss of rotation to the right as one and the loss or rotation to the left as a one whole person impairment.

“Adding impairment related to loss of cervical spine motion and rounding off gives a four percent loss for lack of full range of motion. The third part of the range has to do with neurologic loss and I believe there is none.

“Methodology requires combination of the impairment of diagnosis and the range of motion portions of the range of motion method. The [C]ombined [V]alues [C]hart (page 604) gives the combined whole person impairment for the neck related symptom complex as [eight] percent. The same chart permits combining of the lumbar whole person impairment with the cervical spine whole person impairment and this provides a value of 17 percent whole person impairment.”

Dr. Packman also noted some sensory change over the palmar aspect of the right index finger, insofar as there was diminished sensation in that distribution. He did not provide a rating for these symptoms.

In an memorandum dated April 20, 2004, the Office medical adviser noted that Dr. Packman found that there was no objective evidence of ulnar neuropathy on examination and no finding upon which an objective schedule award could be calculated based on right-sided cervical radiculopathy. However, the Office medical adviser calculated that appellant had a nine percent right upper extremity impairment based on symptoms of altered sensation in the right index finger, palmar surface, which were noted, but not rated, by Dr. Packman. The Office

medical adviser found that these findings of Dr. Packman were of cervical origin and applied Table 16-15 at page 492 of the A.M.A., *Guides*, which rates the “Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to *Combined* 100 percent Deficits of the Major Peripheral Nerves.” Utilizing Table 16-15, the Office medical adviser accorded appellant a five percent impairment for loss of sensation in the radial palmar digital of the right index finger (median nerve) and a four percent impairment for loss of sensation in ulnar palmar digital of the right index finger (median nerve), for a total nine percent impairment of his right upper extremity.

On April 22, 2004 the Office granted appellant a schedule award for a nine percent permanent impairment of the right upper extremity for the period November 4, 2001 to March 15, 2002, for a total of 46.08 weeks of compensation.

By letter dated April 29, 2004, appellant’s attorney requested an oral hearing, which was held on February 23, 2005. Appellant’s attorney argued that appellant was entitled to an award greater than a nine percent right upper extremity impairment. He argued that Dr. Packman’s report did not merit the special weight of an impartial specialist because although he stated that appellant had full range of motion and normal strength he failed to have appellant undergo range of motion, abduction and strength testing. Appellant’s attorney also argued that Dr. Packman failed to include a rating for ulnar neuropathy or neurological impairment and mischaracterized ulnar neuropathy as a nondiagnosed condition. Counsel contended that the Office medical adviser improperly relied on Dr. Packman’s flawed report to render an incorrect nine percent rating for right upper extremity impairment.

By decision dated May 20, 2005, an Office hearing representative affirmed the April 22, 2004 Office decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees’ Compensation Act¹ sets forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.² However, the Act does not specify the manner in which the percentage of loss of use of a member is to be determined. For consistent results and to insure equal justice under the law to all claimants, the Office has adopted the A.M.A., *Guides*, fifth edition as the standard to be used for evaluating schedule losses.³

¹ 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

² 5 U.S.C. § 8107(c)(19).

³ 20 C.F.R. § 10.404.

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.⁴

ANALYSIS

In this case, the Office found a conflict in the medical evidence between the impairment ratings of Dr. Goldberg, who found that appellant had a 14 percent right upper extremity impairment and Dr. Maslow, who accorded appellant a 3 percent right upper extremity impairment.

The case was referred to Dr. Packman, an impartial medical specialist, who found that appellant had a 17 percent whole person impairment. In his April 20, 2004 impairment evaluation, the Office medical adviser noted that Dr. Packman found no objective evidence of ulnar neuropathy on examination, despite the fact that this was an accepted condition and therefore could not calculate an impairment rating due to right-sided cervical radiculopathy. The Office medical adviser found, however, that Dr. Packman noted an altered sensation in the right index finger, palmar surface, on examination but had not derived an impairment rating based on these symptoms. The Office medical adviser determined that these symptoms originated from the cervical region, applied them to Table 16-15 at page 492 of the A.M.A., *Guides* and derived a nine percent right upper extremity rating. He derived this rating by according appellant a five percent impairment for loss of sensation in the radial palmar digital of the right index finger (median nerve) and a four percent impairment for loss of sensation in ulnar palmar digital of the right index finger (median nerve), the maximum amount allowed under Table 16-15. The Office relied on the Office medical adviser's opinion and accorded appellant a nine percent schedule award in its April 22, 2004 decision.

The Board finds that the Office medical adviser's April 20, 2004 report utilizing the physician findings reported by the impartial medical examiner constitutes the weight of medical opinion evidence. As noted, where there are opposing medical reports of virtually equal weight, the opinion of an impartial medical specialist is entitled to special weight if well rationalized and based upon a proper medical and factual background.⁵ In this case, the Office medical adviser did rely on findings rendered by Dr. Packman. The Office medical adviser used Dr. Packman's physical findings to determine an impairment rating, which was in conformance with the applicable tables and figures of the A.M.A., *Guides*. While Dr. Packman assessed appellant's whole man impairment the Act does not allow for "whole man" impairment schedule awards.⁶ The Board therefore finds that the Office properly relied on the Office medical adviser's nine percent right upper extremity impairment rating in its April 22, 2004 decision and accordingly found that his opinion constituted the weight of the medical evidence in granting appellant a schedule award for a nine percent right upper extremity impairment.

⁴ 5 U.S.C. § 8123(a).

⁵ See *Soloman Polen*, 51 ECAB 341 (2000); *Edward E. Wright*, 43 ECAB 702 (1992).

⁶ *Janae J. Triplette*, 54 ECAB 792 (2003).

Following this decision, appellant's attorney requested a hearing and argued that Dr. Packman's report did not merit the special weight of an impartial specialist because he failed to have appellant undergo range of motion, abduction and strength testing and failed to include a rating for ulnar neuropathy or neurological impairment, despite the fact that ulnar neuropathy was an accepted condition. The Board finds that the Office properly relied on the Office medical adviser's April 20, 2004 report, which relied on findings made by Dr. Packman, applied them to the applicable table of the A.M.A., *Guides*, Table 16-15 and derived the correct impairment rating which conformed with the standards for rating schedule awards under the A.M.A., *Guides*. Although Dr. Packman and the Office medical adviser did not render an impairment rating based on ulnar neuropathy, an accepted condition, it was not practicable for Dr. Packman to derive an impairment rating based on a condition which he was unable to diagnose upon examination. The Office medical adviser was able, however, to derive an impairment based on Dr. Packman's additional findings of sensory nerve loss in appellant's right finger, which constituted probative evidence in support of the Office medical adviser's finding of a nine percent right upper extremity impairment. The Board therefore affirms the May 20, 2005 decision of the Office hearing representative, which affirmed the April 22, 2004 Office decision awarding appellant a schedule award for a nine percent right upper extremity impairment.

CONCLUSION

The Board finds that appellant has no more than a nine percent impairment of the right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the May 20, 2005 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: May 8, 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