United States Department of Labor
Employees' Compensation Appeals Board

T.S., Appellant	)	
	)	**Docket No. 08-1605**
and	)	**Issued: April 8, 2009**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Newark, NJ, 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
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 19, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated February 12, 2008 which affirmed a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than a three percent permanent impairment of the left upper extremity.

FACTUAL HISTORY

This is the second appeal in this matter. In a February 2, 2005 decision, the Board affirmed an Office decision which denied appellant's recurrence of disability claim on September 24, 2001. The Board determined that the medical evidence was insufficient to

establish a change in the nature and extent of his work injury.[1] The facts and the circumstances of the case are set forth in the Board's prior decision and incorporated herein by reference.[2]

Appellant submitted reports dated July 12, 2005 to March 30, 2006 from Dr. Mark A.P. Filippone, a Board-certified physiatrist, who treated appellant for persistent pain, guarding and spasm in the left and right cervical paraspinals, left shoulder and left elbow. Dr. Filippone opined that appellant was totally disabled. In a December 28, 2005 report, Dr. David Weiss, an osteopath, found that appellant reached maximum medical improvement on December 28, 2005. He noted left shoulder range of motion findings for flexion of 165 degrees, abduction of 160 degrees, adduction of 65 degrees and internal rotation of 65 degrees, negative crepitance and negative impingement sign. Left elbow examination showed tenderness over the medial epicondyle and a Tinel's sign was positive over the cubital tunnel producing pins and needles sensation into the fourth and fifth digits. Left hand examination showed normal range of motion, Tinel's and Phalen's signs were negative, thumb abduction was 4/5 on the left, pinch key testing revealed 13 kilogram (kg) on the right and 8 kg on the left, sensory examination revealed a perceived sensory deficit over the C5, C6 and C7 dermatomes of the left upper extremity. Dr. Weiss diagnosed chronic, post-traumatic cervical strain and sprain, right cervical radiculopathy, left cervical radiculopathy with double crush syndrome, left ulnar nerve neuropathy at the cubital tunnel, left carpal tunnel syndrome, chronic post-traumatic acromioclavicular arthropathy to the left shoulder and a subsequent 2003 pedestrian-related motor vehicle accident with further aggravation of cervical pathology. Under the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[3] he estimated that appellant had 48 percent impairment of the left arm. Dr. Weiss found left shoulder flexion of 165 degrees for one percent impairment, abduction of 160 degrees for one percent impairment and internal rotation of 65 degrees for two percent impairment. He further found a Grade 4 motor strength deficit for left thumb abduction for 9 percent impairment, left lateral pinch deficit for 20 percent impairment, a Grade 3 sensory deficit of the left ulnar nerve for 4 percent impairment and Grade 3 sensory deficit of the left median nerve for 23 percent impairment.

On April 13, 2006 appellant filed a claim for a schedule award.

In a report dated May 11, 2006, an Office medical adviser determined that appellant had three percent impairment of the left arm. He noted that appellant had three percent impairment for pin and vibratory sensation along the ulnar nerve distribution of the left elbow.[4] The medical adviser noted that there was no grading system for this impairment but the maximum permitted was seven percent impairment and he opined that in appellant's case three percent impairment for this sensory deficit was appropriate.

[1] The Office accepted appellant's claim for contusion of the left elbow and later expanded to include left elbow neuritis.

[2] Docket No. 04-1743 (issued February 2, 2005).

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

[4] *Id.* at 492, Table 16-15.

In reports dated June 6 to September 13, 2006, Dr. Filippone noted appellant's central and peripheral neurologic examinations were unchanged with spasms persistent in the left cervical paraspinals, left upper trapezius, left shoulder and left elbow. He opined that appellant remained totally disabled.

On October 25, 2006 the Office found that a conflict of medical opinion existed between Dr. Weiss, appellant's treating physician, and the Office medical adviser, regarding the degree of permanent partial impairment of the upper extremities due to appellant's work-related injury. On November 21, 2006 the Office referred appellant to Dr. Ronald E. Gennace, a Board-certified orthopedic surgeon. In a December 6, 2006 report, Dr. Gennace reviewed the records and medical history and examined appellant. He noted that appellant's history was significant for a childhood injury in which he fell and cut his wrist damaging the ulnar nerve which resulted in ulnar nerve palsy, residual weakness of his left hand, palsy affecting his fingers, contractures of the finger joints and hyperextension deformities of the joints of both the fourth and fifth fingers of the left hand. Dr. Gennace noted that this preexisting injury made the evaluation of appellant's left arm more difficult and affected the overall use of his left hand. He advised that range of motion of both shoulders was symmetrical, there was a deficit of 20 degrees of abduction and flexion bilaterally. Range of motion of the left elbow revealed full extension and flexion, no laxity in valgus, positive Tinel's sign at the ulnar groove which represented irritation of the ulnar nerve at the elbow. Dr. Gennace noted decreased sensation over the ulnar aspect of the fourth and fifth fingers and decreased sensation which extends into the forearm, grip strength was diminished on the left side by 50 percent with clawing of the ulnar two fingers, the fifth finger and left ring finger. He noted a large scar over the palmar aspect of the left hand that extended up the forearm two inches and represented a well-healed traumatic wound that was repaired when appellant was a child. Dr. Gennace diagnosed a contusion of the left shoulder, sprain of the left elbow and ulnar nerve injury subsequent to appellant's injury on July 30, 1999. He noted that appellant was right-hand dominant. Dr. Gennace opined that, under the A.M.A, *Guides,* appellant had three percent impairment of the left arm based on an increased ulnar deficit due to the aggravation of his left ulnar nerve due to the accepted work-related injury.[5]

On June 28, 2007 the Office referred Dr. Gennace's report and the case record to an Office medical adviser. In a report dated July 6, 2007, the medical adviser concurred with Dr. Gennace's determination that appellant had three percent impairment of the left upper extremity. Dr. Gennace noted that appellant had a decreased sensory finding secondary to the ulnar nerve with no loss of range of motion or motor function. The medical adviser noted that the physical examination revealed a claw hand and 50 percent loss of grip strength which were attributed to a childhood injury and not secondary to appellant's work injury. He noted the work injury was a contusion and did not result in appellant's ulnar nerve dysfunction. The medical adviser opined that any deficit secondary to his work injury was an aggravation of the ulnar nerve causing mild sensory changes for three percent impairment.[6]

[5] *Id.* at 492, Figure 16-15.

[6] *Id.* at 492, Figure 16-15.

In a decision dated July 17, 2007, the Office granted appellant a schedule award for three percent permanent impairment of the left upper extremity. The period of the schedule award was from December 6, 2006 to February 9, 2007.

On July 20, 2007 appellant requested an oral hearing which was held on November 28, 2007. He submitted reports from Dr. Filippone dated June 28 to November 27, 2007.

In a decision dated February 12, 2008, the hearing representative affirmed the July 17, 2007 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] and its implementing regulations[8] 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.

It is well established that in determining the amount of a schedule award for a given member of the body that sustained an employment-related permanent impairment, preexisting impairments of that scheduled member of the body are to be included.[9]

ANALYSIS

On appeal, appellant contends that he has more than a three percent permanent impairment to the left upper extremity. The Office accepted appellant's claim for contusion of the left elbow and later expanded to include left elbow neuritis. It properly found that a conflict in the medical evidence existed between appellant's attending physician, Dr. Weiss, who disagreed with the first Office medical adviser, concerning the extent of appellant's impairment to the upper extremities. Consequently, the Office referred appellant to Dr. Gennace to resolve the conflict.

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999).

[9] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b (June 1993). This portion of Office procedure provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[10]

The Board notes that Dr. Gennace incorrectly excluded appellant's preexisting ulnar nerve condition from the schedule award calculation. It is well established that, in determining the degree of impairment for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body member are to be included in the evaluation of the permanent impairment.[11] In this case, Dr. Gennace opined that, in accordance with the A.M.A, *Guides,* appellant sustained three percent impairment to the left upper extremity based solely on an increased ulnar deficit due to the aggravation of his left ulnar nerve following the accepted work-related injury.[12] Appellant had a childhood injury in which he damaged the ulnar nerve which resulted in ulnar nerve palsy, residual weakness of his left hand, diminished grip strength on the left side by 50 percent, clawing of the ulnar two fingers, the fifth finger and left ring finger, palsy affecting his fingers and contractures of the finger joints of the left hand. Dr. Gennace noted that the preexisting ulnar nerve injury and residuals made the evaluation of appellant's left arm injury more difficult and affected the overall use of his left hand. He did not include the preexisting impairment as it was not due to the work injury. The Office medical adviser concurred in Dr. Gennace's determination, agreeing that appellant's claw hand and 50 percent loss of grip strength were attributed to a childhood injury and were not secondary to appellant's work injury and did not result in appellant's ulnar nerve dysfunction. However, preexisting impairment to the member under consideration is to be included in calculating the percentage of loss. Dr. Gennace should have considered any additional preexisting impairment in the evaluation of permanent impairment. The statement of accepted facts and questions to be addressed did not inform the impartial medical specialist to rate preexisting impairment.

Because Dr. Gennace did not assess appellant's permanent impairment of the left upper extremity in accordance with the standards adopted by the Office and approved by the Board, his opinion does not resolve the conflict in medical opinion. When the Office 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.[13]

The Board will set aside the Office's July 17, 2007 and February 12, 2008 decisions and remand the case for such further development as may be required, followed by an appropriate final decision on appellant's entitlement to a schedule award for the left upper extremity.

[10] *Aubrey Belnavis,* 37 ECAB 206 (1985). *See* 5 U.S.C. § 8123(a).

[11] *See D.F.*, 59 ECAB ___ (Docket No. 07-1607, issued December 21, 2007); *Carol A. Smart,* 57 ECAB 340 (2006); *Kenneth E. Leone,* 46 ECAB 133 (1994).

[12] A.M.A., *Guides* 492, Figure 16-15.

[13] *L.R. (E.R.),* 58 ECAB ___ (Docket No. 06-1942, issued February 20, 2007).

CONCLUSION

The Board finds that this case is not in posture for decision regarding the extent of appellant's left upper extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the February 12, 2008 and July 17, 2007 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further action consistent with this opinion.

Issued: April 8, 2009
Washington, DC

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

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

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