

overuse syndrome and tenosynovitis of the right wrist (xxxxxxx130).¹ On December 18, 2001 she underwent a right shoulder arthroscopy with labral debridement and acromioplasty.² Appellant retired effective October 31, 2003.

On February 23, 2004 appellant filed a claim for a schedule award (Form CA-7). In a report dated November 12, 2003, Dr. David Weiss, a Board-certified orthopedist, diagnosed chronic post-traumatic extensor and flexor tendinitis of the right wrist, right carpal tunnel syndrome, right brachial plexopathy, chronic post-traumatic cervical strain and sprain, cervical discogenic disease at C5-6 and C6-7, right upper extremity radiculitis, right shoulder glenoid labral tear, acromioclavicular arthropathy with right shoulder impingement, status post right shoulder arthroscopic surgery with labral debridement and acromioplasty and complex regional pain syndrome of the right upper extremity. He attributed appellant's condition to both the August 2000 and November 2001 employment injuries. Dr. Weiss found a total right upper extremity impairment of 53 percent. He assigned 10 percent impairment for appellant's right shoulder acromioplasty, 1 percent impairment for loss of shoulder flexion, 18 percent impairment for Grade 3/5 motor strength deficit for right thumb abduction (radial nerve) and 3 percent impairment for loss of grip strength. Dr. Weiss also assigned an additional three percent impairment for pain.³

Dr. James W. Dyer, a Board-certified orthopedic surgeon and district medical adviser (DMA), reviewed the claim on May 11, 2004. He found one percent impairment for loss of motion (forward elevation/flexion) in the right shoulder.

The Office declared a conflict in medical opinion. Dr. Timothy R. Wagner, a Board-certified orthopedic surgeon and impartial medical examiner (IME), reviewed the relevant medical records and examined appellant on February 5, 2008. Appellant's chief complaint was pain that started in the palmar area and extended proximally to the elbow and then to the shoulder into the intrascapular area. She also complained that her RSD had spread to her right hip. Dr. Wagner indicated that, despite complaints of right arm pain, appellant had a normal neurologic examination of the cervical spine and both upper extremities. He found no evidence of RSD involving her right hand, forearm, elbow or her right shoulder. Dr. Wagner also indicated that appellant's complaints of right greater trochanteric pain were in contrast to what he considered a normal neurological examination of the lower back and both lower extremities. He noted that appellant had a myriad of complaints which were not substantiated by well-defined clinical findings. Dr. Wagner further noted that appellant admitted she had not taken any pain medicine in over three years. He found that appellant did not have any permanent impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment*

¹ Appellant has also been diagnosed with cervical radiculopathy, cervical degenerative disc disease, reflex sympathetic dystrophy (RSD) and right carpal tunnel syndrome, none of which have been accepted as employment related. The records for the August 8, 2000 and November 13, 2001 employment injuries were combined under master file number xxxxxx727.

² The Office did not authorize appellant's December 18, 2001 surgery.

³ Although Dr. Weiss found a total right upper extremity impairment of 53 percent, the individual components he identified did not add up to 53 percent.

(5th ed. 2001). Dr. Wagner reiterated that she did not have RSD or any vasomotor, sudomotor or trophic changes of her right upper extremity.

In a decision dated June 18, 2008, the Office denied appellant's claim for a schedule award. It based its decision on Dr. Wagner's February 5, 2008 impartial medical evaluation.

Appellant's counsel requested a hearing, which was held on November 19, 2008. Post hearing counsel submitted an addendum to Dr. Weiss' November 12, 2003 impairment rating. Dr. Weiss apparently incorrectly reported appellant's right grip strength impairment as 3 percent rather than 30 percent.

By decision dated February 17, 2009, the hearing representative affirmed the Office's June 18, 2008 decision.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.⁴ The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.⁵ Effective February 1, 2001, schedule awards are determined in accordance with the A.M.A., *Guides* (5th ed. 2001).⁶

ANALYSIS

The Office properly found there was a conflict of medical opinion between appellant's physician, Dr. Weiss, and the DMA, Dr. Dyer. Because of this conflict, the Office referred appellant to an IME to resolve the issue of whether she had any permanent impairment attributable to her August 8, 2000 and November 13, 2001 employment injuries.⁷ Dr. Wagner, the IME, found that appellant did not have RSD and that her myriad of complaints were not substantiated by well-defined clinical findings. He further noted that there were no vasomotor, sudomotor or trophic changes with respect to appellant's right upper extremity. Notwithstanding appellant's complaints of right arm pain, Dr. Wagner indicated that appellant had a normal neurologic examination of the cervical spine and both upper extremities and he found no evidence of RSD involving her right hand, forearm, elbow or her right shoulder. Consequently,

⁴ For a total loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1) (2006).

⁵ 20 C.F.R. § 10.404 (2009).

⁶ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

⁷ The Act provides that, if there is disagreement between the physician making the examination for the Office and the employee's physician, the Office shall appoint a third physician who shall make an examination. 5 U.S.C. § 8123(a); *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

he determined that appellant did not have a permanent impairment under the A.M.A., *Guides* (5th ed. 2001).

Contrary to counsel's contention, the Office properly accorded determinative weight to Dr. Wagner's findings, as he was the IME.⁸ Dr. Wagner's February 5, 2008 opinion is sufficiently well reasoned and based upon a proper factual background. He conducted a thorough physical examination and undertook an extensive review of the relevant medical records. Accordingly, the Board finds that the Office properly denied appellant's claim for a schedule award.

CONCLUSION

Appellant has not established entitlement to a schedule award for permanent impairment of the right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the February 17, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 19, 2010
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

⁸ Where the Office has referred appellant to an IME to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight. *Gary R. Sieber*, 46 ECAB 215, 225 (1994).