U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LEO W. PECARSKY and U.S. POSTAL SERVICE,
POST OFFICE, Trenton, NJ

Docket No. 99-122; Submitted on the Record;
Issued July 19, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether appellant has more than a four percent impairment of the right upper extremity for which he received a schedule award.

On January 7, 1990 appellant, then a 27-year-old mailhandler, was struck on the head by a parcel that fell out of a mail truck while in the performance of duty. The Office of Workers' Compensation Programs accepted the claim for cervical strain. He received continuation of pay and compensation for intermittent periods of wage loss. Appellant was off work from January 8 to February 26, 1990 and from March 17, 1990 until September 23, 1991, when he returned to limited-duty position. He began working 30 hours per week increasing his hours at work until he was up to 40 hours per week by August 13, 1993.

Appellant was initially treated by Dr. John J. DiBiase, a Board-certified orthopedic surgeon, on January 8, 1990 for a cervical strain, right arm pain and headaches. Dr. DiBiase prescribed a course of physical therapy, medication and a battery of objective tests to rule out a fracture.

A magnetic resonance imaging (MRI) scan performed on January 15, 1990 of the cervical spine revealed no evidence of disc herniation or nerve root impingement. An electromyogram (EMG) performed on February 20, 1990 showed "irritation at the nerve root level" and minimal evidence of nerve root irritation at the right C6-7 posterior paraspinal muscle site with no evidence of denervation in peripheral musculature."

In a report dated March 21, 1990, Dr. DiBiase noted that appellant complained of pain in his right arm after several hours of working and that physical therapy had not alleviated appellant's neck problems. He reported physical findings of limited range of motion either on a voluntary or involuntary basis. Dr. DiBiase noted that, since appellant's problem was related to nerve root irritation and not a bone injury, appellant should seek further treatment with a neurologist.

Appellant next came under the care of Dr. Harold J. Brown, an internist. In a series of (Form CA-20a) attending physicians reports dated from March 1990 to August 1991, Dr. Brown diagnosed cervical radiculopathy, which he causally related to appellant's January 7, 1990 work injury. He prescribed physical therapy and opined that appellant was unable to work.

Appellant was examined by Dr. Harvey E. Smires, a Board-certified orthopedic surgeon, at the request of the employing establishment on July 19, 1991. Dr. Smires noted appellant's history of injury and physical findings. He diagnosed cervical myofascitis, bilateral occipital headaches and right radiculopathy. Dr. Smires recommended that appellant undergo a myelogram computerized tomography (CT) scan to rule out a herniated disc since appellant's neck pain had not resolved after six months of conservative treatment. He opined that there was a direct causal relationship between appellant's work injury and his symptoms of headaches, neck and right arm pain.

Appellant subsequently filed a claim for a schedule award on March 18, 1993.

In support of his schedule award claim, appellant submitted a February 15, 1993 report by Dr. Ronald Goldberg, a Board-certified family practioner, who noted that appellant complained of constant pain in the right upper extremity and shoulder and that he demonstrated definite weakness in grip in the right hand. He stated:

> "Based on the A.M.A., *Guides* [American Medical Association, *Guides to the Evaluation of Permanent Impairment*] third edition (revised), page 42, Table 10 and 11, the patient showed a sensory loss of function due to involvement of C8, C6-7. You will note that these involve the sensory branches of the axillary nerve, the musculocutaneous nerves, the radial nerves and the ulnar nerves. Based on Table 10, minor causalgia, [appellant] has a minor causalgia which is 8 percent times 80, which is a 6.4 percent impairment of the right upper extremity of C6. C7 minor causalgia is 5 percent times 80 which is a 4 percent impairment of the right upper extremity. In evaluating motor loss of function ... utilizing the same tables [appellant] is a 35 times 50 which is a 17.5 [percent] impairment of the right upper extremity involving C6. C7 is 35 times 50 or 17.5 percent impairment of the right upper extremity."

Dr. Goldberg concluded that appellant had a 24 percent impairment of the right upper extremity at C6 and a 22 percent impairment of the right upper extremity based on C7. Using the combined charts, he concluded that appellant had 32 percent impairment of the right upper extremity and a 13 percent impairment of the whole person.

By letter dated September 24, 1993, the Office advised appellant that the objective medical evidence of record was insufficient to support a diagnosis of cervical radiculopathy causally related to the January 7, 1990 work injury, and that a conflict existed in the medical record even if radiculopathy was present as to the cause of that condition. Appellant was advised to submit additional medical evidence in thirty days as to the cause of his alleged radiculopathy.

On August 2, 1995 the Office scheduled appellant for an impartial evaluation with Dr. Robert N. Dunn, a Board-certified orthopedic surgeon, on August 30, 1995. The Office noted that Dr. Dunn's opinion was intended to resolve a conflict in the medical evidence between Drs. DiBiase and Goldberg.

In an August 30, 1995 report, Dr. Dunn reviewed appellant's history of injury symptoms of intermittent neck and right upper arm pain consistent with ulnar nerve distribution. On physical examination, he reported that appellant was able to flex his neck approximately 45 degrees forward and that extension lacked approximately 20 degrees. Dr. Dunn also noted that appellant was able to rotate to 45 degrees to the right and left with decreased tilt to either side of 30 to 40 degrees. He diagnosed chronic cervical sprain with "subjective" radiculitis down the right arm. Dr. Dunn concluded that appellant had reached maximum medical improvement.

By letter dated February 26, 1996, the Office requested that Dr. Dunn evaluate appellant's impairment in accordance with the fourth edition of the A.M.A., *Guides.*

In a report dated March 6, 1996, Dr. Dunn, stated:

> "I do not have, nor do we use the A.M.A., *Guides*, as disability ratings are usually conducted by state disability physicians in New Jersey. However, utilizing the 'Manual for Orthopedic Surgeons in Evaluating Permanent Physical Impairment,' the percent of whole body permanent physical impairment and loss of physical function in a patient with a healed sprain or contusion of the cervical spine and manifesting no involuntary muscle spasm, subjective symptoms of pain not substantiated by demonstrable structural pathology is zero percent.

The Office forwarded the case to the district medical adviser for review. The district medical adviser reviewed Dr. Dunn's report and diagnosed right ulnar radiculitis. Applying the fourth edition of the A.M.A., *Guides* the district medical adviser noted a seven percent impairment of the ulnar nerve above the mid-forearm at page 54, Table 15 and a Grade 3 peripheral nerve disorder rated at 60 percent at page 48, Table 11. He then noted that sensory deficit/pain (60 percent times 7 percent) equaled 4 percent impairment of the right upper extremity.

On February 25, 1997 the Office issued a schedule award for a four percent permanent impairment of the right upper extremity. The period of the award was from August 30 to November 25, 1995.

Appellant requested a hearing that was held on September 17, 1997.

In a decision dated February 18, 1998, an Office hearing representative determined that the Office erred in finding a conflict in the medical evidence and determined that Dr. Dunn was only a second opinion physician and not an impartial medical examiner. The Office hearing representative also determined, however, that Dr. Dunn's report was entitled to controlling weight since Dr. Goldberg's impairment rating appeared to be out of line with "appellant's minimal findings on physical examination and normal MRI scan of the cervical spine. The

Office hearing representative also noted that Dr. Goldberg incorrectly applied the third and not the fourth edition of the A.M.A., *Guides*. He therefore found that the Office properly referred Dr. Dunn's report to the Office medical adviser for an impairment rating and affirmed the Office's decision awarding a four percent schedule award.

The Board finds that the case is not in posture for a decision.

Section 8107 of the Federal Employees' Compensation Act provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[1] Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, the Board has authorized 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 Office as a standard for evaluating schedule losses and the Board has concurred in such adoption.[2]

In the instant case, the Office hearing representative correctly determined that there was no conflict in the record created by the reports of Drs. DiBiase and Goldberg since Dr. DiBiase was appellant's treating physician and Dr. Golberg's opinion was proffered by appellant in support of his schedule award. Thus, the Board also finds that Dr. Dunn's opinion is that of an Office referral physician and not an impartial medical specialist.

According to Dr. Goldberg, appellant has a 32 percent impairment to the right upper extremity caused by impairment to the peripheral nerve system including spinal nerves at C6-7 and minor causalgia. In contrast, Dr. Dunn, the Office referral physician, diagnosed only that appellant suffered from cervical radiculopathy caused by impairment to the ulnar nerve. He did not make any assessment of impairment related to appellant's diagnosed root irritation at C6-7. Dr. Dunn also suggested that appellant's condition was subjective and specifically stated that appellant had no impairment based on the "Manual for Orthopedic Surgeons in Evaluating Permanent Physical Impairment."

The Board finds that a conflict in the record exists between the opinions of Drs. Goldberg and Dunn as to the nature of appellant's impairment and extent of appellant's impairment of the

[1] 5 U.S.C. § 8107(a).

[2] *James Kennedy, Jr.*, 40 ECAB 620 (1989); *Quincy E. Malone*, 31 ECAB 846 (1980).

right upper extremity. Given the conflict in the record created by the different impairment ratings provided by Drs. Goldberg and Dunn,[3] and the fact that neither physician referenced the fourth edition of the A.M.A., *Guides* as required, the Board finds that the Office erred in seeking an impairment rating from the Office medical adviser based solely on Dr. Dunn's physical findings. The Office medical adviser must base his impairment rating on the findings of an examining physician, and prior to resolution of the conflict between Drs. Goldberg and Dunn, the Office erred in directing the Office medical adviser to apply Dr. Dunn's examination findings in his impairment evaluation.[4] The Board, therefore, finds that the Office is required to send appellant for an impartial medical evaluation.[5]

On remand, the Office should refer appellant, along with a copy of the case record and a statement of accepted facts, to an appropriate medical specialist for an impartial medical evaluation pursuant to section 8123(a). The impartial medical specialist should be directed to evaluate appellant with respect to the extent of permanent impairment in the right upper extremity. After such development of the case record as the Office deems necessary, a *de novo* decision shall be issued.

[3] In the present case, the fourth edition of the A.M.A., *Guides* provides the appropriate standards for evaluating appellant's right upper extremity impairment in that the Office's decision pertaining to appellant's right upper extremity was issued by the Office after November 1, 1993, the effective date of the fourth edition of the A.M.A., *Guides; see* FECA Bulletin No. 94-4 (issued November 1, 1993). Appellant's counsel notes on appeal that Dr. Goldberg correctly applied the third edition when he prepared his March 1993 report, but the case was delayed for three years before the Office finally issued a schedule award.

[4] Contrary to the Office's determination, Dr. Dunn's report is no more probative than Dr. Goldberg's report as neither physician properly applied the fourth edition of the A.M.A., *Guide*s. Furthermore, although the Office hearing representative noted that appellant's physical findings were minimal and more in keeping with Dr. Dunn's report, he suggested that appellant had no impairment whatsoever. The Board does not consider Dr. Dunn's opinion to be controlling as he fails to explain why appellant would have no impairment whatsoever despite EMG findings of irritation at the nerve root level at C6-7.

[5] Section 8123(a) of the Act provides that, "If there is a 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." 5 U.S.C. § 8123(a).

The decision of the Office of Workers' Compensation Programs dated February 18, 1998 is hereby set aside and the case is remanded for further consideration consistent with this opinion.

Dated, Washington, D.C.
July 19, 2000

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member