

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CARLOS FRANCESCHI and U.S. POSTAL SERVICE,
MAIL TRANSPORT EQUIPMENT CENTER, Edgewater, NJ

*Docket No. 01-159; Submitted on the Record;
Issued November 14, 2001*

DECISION and ORDER

Before DAVID S. GERSON, A. PETER KANJORSKI,
PRISCILLA ANNE SCHWAB

The issue is whether appellant has more than an eight percent impairment of the right upper extremity, for which he received schedule awards.

The Board has duly reviewed the case record and appellant's contentions on appeal and concludes that appellant has no more than an eight percent impairment of the right upper extremity.

Under section 8107 of the Federal Employees' Compensation Act¹ and section 10.404 of the implementing federal regulations,² schedule awards are payable for permanent impairment of specified body members, functions or organs. However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment*³ (hereinafter A.M.A., *Guides*) has been adopted by the Office of Workers' Compensation Programs pursuant to section 10.404,⁴ as an appropriate standard for evaluating schedule losses.

On September 23, 1985 appellant, then a 42-year-old mailhandler, filed a traumatic injury claim, alleging that he injured his back that day while lifting sacks of mail. He did not stop work. The Office accepted that he sustained a muscle strain and radiculitis at C5-6.⁵ By letter

¹ 5 U.S.C. § 8107.

² 20 C.F.R. § 10.404 (1999).

³ A.M.A., *Guides* (4th ed. 1993).

⁴ 20 C.F.R. § 10.404.

⁵ This claim was adjudicated by the Office under file number A2-549478.

dated April 3, 1992, appellant's representative requested a schedule award and, in a decision dated April 13, 1993, appellant was granted a schedule award for a five percent impairment of the right upper extremity. His representative requested a hearing that was held on December 28, 1993. By decision dated June 10, 1994, an Office hearing representative remanded the case to the Office for further development.

Upon remand, the Office referred appellant to Dr. Michael L. Sananman, who is Board-certified in psychiatry and neurology. By report dated August 9, 1994, Dr. Sananman advised that appellant had no impairment of the right upper extremity. In an October 20, 1994 decision, the Office found that appellant was not entitled to a greater schedule award.⁶

On March 23, 1996 appellant filed an occupational disease claim, alleging that factors of employment caused bilateral carpal tunnel syndrome, cervical radiculopathy with degenerative disc disease and lateral epicondylitis of the right elbow. He did not stop work at that time.⁷ In support of his claim, appellant submitted a report from Dr. David Weiss, an osteopathic physician, who advised that appellant had a 38 percent impairment of the right upper extremity and a 10 percent impairment of the left upper extremity. By decision dated September 13, 1997, the Office granted appellant a schedule award for a 10 percent permanent impairment of the left arm.

On September 23, 1997 appellant, through counsel, requested a hearing that was held on March 25, 1998. At the hearing, appellant testified regarding his symptoms and complaints. In a May 4, 1998 decision, an Office hearing representative noted that the Office had not evaluated appellant's right upper extremity and remanded the case to the Office. Upon remand the Office was to double case files A2-549478 and A2-713157 and refer appellant to a Board-certified orthopedic surgeon to determine if appellant had greater than a five percent impairment of the right upper extremity.

By letter dated June 11, 1998, the Office referred appellant, along with the medical record, a statement of accepted facts and a set of questions, to Dr. Harold Leeds, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a June 26, 1998 report, Dr. Leeds evaluated appellant based on the A.M.A., *Guides* and advised that he had a 2.5 percent impairment of the right upper extremity due to a right shoulder impairment and a 1.25 percent right upper extremity impairment due to right C5 nerve root deficit. He further advised that appellant had a 10 percent impairment of the left upper extremity due to mild carpal tunnel syndrome. By decision dated September 16, 1998, the Office granted appellant a schedule award for an additional three percent impairment of the right upper extremity.

⁶ In a March 1, 1995 letter, the Office informed appellant that it had made a preliminary determination that he had received a \$5,496.19 overpayment of compensation because he was not entitled to the schedule award that he had previously received. Appellant's counsel requested a hearing and, in an August 31, 1995 decision, an Office hearing representative found that, while appellant was not entitled to an increased schedule award, the overpayment declaration was inappropriate.

⁷ This claim was adjudicated by the Office under file number A2-713157. By letter dated July 30, 1996, the Office accepted that appellant sustained an employment-related right carpal tunnel syndrome. He underwent authorized carpal tunnel release on February 7, 1995, for which he received appropriate compensation. When he returned to work, he became a forklift operator.

On September 24, 1998 appellant, through counsel, requested a hearing. By decision dated July 9, 1999 and finalized July 15, 1999, an Office hearing representative remanded the case to the Office. The hearing representative found that a conflict in medical evidence existed between the opinions of Drs. Weiss and Leeds and remanded the case to the Office for an independent medical evaluation. By letter dated October 12, 1999, the Office referred appellant, along with a statement of accepted facts, a set of questions and the medical record, to Dr. Kent S. Lerner, a Board-certified orthopedic surgeon, for an independent medical evaluation.

In reports dated November 1 and 5, 1999, Dr. Lerner advised that examination of the right hand revealed no thenar atrophy and full sensation in the median nerve distribution. Regarding the cervical spine, he stated:

“The patient has full rotation of his head to the right and to the left. Upon rotating his head to the left, the patient complains of some pain on the right side of his neck at the end range of rotation. Forward flexion and extension are both full. Axial compression on the head does not elicit any radicular symptoms. The patient has full abduction of his right shoulder as well as internal and external rotation. Impingement sign is negative. Cross chest impingement sign is negative. Upper extremity deep tendon reflexes biceps, triceps and brachial radialis are 2+ and equal. Sensation in the radial, ulnar and median nerve distributions is intact. There is no evidence of arm or forearm atrophy. Grip strength is intact bilaterally.”

Dr. Lerner’s impression was status post sprain of the right shoulder superimposed upon preexisting post-traumatic injury to the right shoulder sustained in 1985 and status post decompression of right carpal tunnel syndrome. Dr. Lerner advised that appellant had reached maximum medical improvement and had no residuals regarding his carpal tunnel syndrome other than a small scar. He noted that appellant had full range of motion of the right shoulder and concluded that he had a five percent impairment of the right hand secondary to carpal tunnel syndrome.

In a brief note dated November 1, 1999, an Office medical adviser advised that he concurred with Dr. Lerner’s opinion. Dr. Lerner provided a supplementary report dated November 5, 1999, in which he advised that appellant had reached maximum medical improvement approximately four to six weeks after his carpal tunnel surgery in February 1995. Dr. Lerner noted that appellant had complaints of residual discomfort in his shoulder and neck areas when he tried to throw a ball or participate in athletic activities but had no restricted motion in the neck, right shoulder, right elbow, right wrist or right hand. He found no objective findings of decreased strength, atrophy, ankylosis or sensory changes and again concluded that, based on Table 16 of the A.M.A., *Guides*, appellant had a five percent impairment of the right upper extremity due to carpal tunnel syndrome and no impairment regarding the neck or shoulder.

By decision dated November 22, 1999, the Office found that appellant was not entitled to a greater schedule award based on by Dr. Lerner's report.⁸ On November 24, 1999 appellant, through counsel, requested a hearing that was held on April 12, 2000.

At the hearing, appellant's counsel argued that Dr. Lerner did not provide measurements regarding range of motion and atrophy, that his report was inconsistent with Table 57 and that he failed to consider appellant's right cervical radiculopathy. In a decision dated June 19, 2000, an Office hearing representative affirmed the prior decision.

On appeal, appellant's counsel has repeated the contentions he made before the Office hearing representative.

In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.⁹

In this case, contrary to appellant's arguments, Dr. Lerner provided two reports, in which he discussed appellant's physical findings, noting that he had full rotation, forward flexion and extension of the neck and that axial compression of the head did not elicit radicular symptoms. He further noted that appellant had full abduction, internal and external rotation of the shoulder with negative impingement and cross chest signs as well as equal deep tendon reflexes. Dr. Lerner further found sensation in the radial, ulnar and median nerve distributions to be intact with no evidence of arm or forearm atrophy and intact grip strength.

Table 16¹⁰ of the A.M.A., *Guides* provides a method for evaluating the upper extremity due to entrapment neuropathy. Dr. Lerner clearly stated that appellant had no objective findings regarding the right upper extremity yet generously concluded that appellant had a five percent impairment of the right hand due to carpal tunnel syndrome.

The Board, therefore, finds that the weight of the medical evidence is represented by the thorough, well-rationalized opinion of Dr. Lerner, who performed an independent medical evaluation and provided a comprehensive explanation supporting his reasoning in applying the values found in Table 16 of the A.M.A., *Guides*. Appellant, therefore, failed to establish that he is entitled to more than the eight percent impairment of the right upper extremity.

⁸ The Board initially referred appellant to Dr. Philip K. Keats, a Board-certified orthopedic surgeon, but in the letter of referral, he was identified as a second opinion evaluator. In a report dated September 21, 1999, Dr. Keats advised that appellant had a three percent impairment of the right upper extremity. In its November 22, 1999 decision, the Office recognized that the appointment with Dr. Keats was scheduled in error and, therefore, he could not resolve the conflict in medical opinion. The Office noted that Dr. Keats' opinion was consistent with the prior second opinion examiner.

⁹ See *Kathryn Haggerty*, 45 ECAB 383 (1994); *Edward E. Wright*, 43 ECAB 702 (1992).

¹⁰ A.M.A., *Guides*, *supra* note 3 at 57.

The June 19, 2000 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC
November 14, 2001

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member

Priscilla Anne Schwab
Alternate Member