United States Department of Labor
Employees' Compensation Appeals Board

PHILLIP H. CONTE, Appellant	)	
and	)	**Docket No. 04-1524**
	)	**Issued: December 22, 2004**
U.S. POSTAL SERVICE, POST OFFICE, Southwestern, PA, 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, Chairman
MICHAEL E. GROOM, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On May 24, 2004 appellant, through his attorney, filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated January 12, 2004 granting schedule awards for 34 percent impairment of the left upper extremity and 35 percent impairment of the right upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than 34 percent impairment of his left upper extremity and more than 35 percent impairment of his right upper extremity entitling him to additional schedule awards.

FACTUAL HISTORY

This case has previously been before the Board. Appellant previously received three separate schedule awards from the Office due to the accepted conditions of bilateral thoracic outlet syndrome, carpal tunnel syndrome and surgical arthroscopy. The awards totaled 35

percent impairment of the right upper extremity and 34 percent impairment of the left upper extremity. In a July 3, 2001 decision,[1] the Board found that the case was not in posture for decision regarding the extent of any further impairment of appellant's upper extremities due to an unresolved conflict of medical opinion between appellant's attending physician, Dr. David Weiss, an osteopath, and an Office medical adviser regarding the type of surgery appellant underwent as well as the severity of pain or sensory loss due to brachial plexus and median nerve compression. The Board remanded the case for the Office to refer appellant, a statement of accepted facts and a list of specific questions to an appropriate Board-certified physician for an impartial medical examination in accordance with section 8123(a) of the Federal Employees' Compensation Act.[2] The facts and the circumstances of the case as set out in the Board's prior decision are adopted herein by reference.

The Office referred appellant to Dr. Richard Mandel, a Board-certified orthopedic surgeon, for a second opinion examination on August 23, 2001. On September 19, 2001 the Office noted that appellant had been referred to Dr. Mandel for a second opinion examination in error. An Office medical adviser noted that Dr. Mandel failed to address the specific medical issues in conflict and reiterated that an impartial medical examination was necessary.

On December 17, 2001 the Office referred appellant to Dr. Michael J. Pushkarewicz, a Board-certified orthopedic surgeon, for an impartial examination. In a report dated January 25, 2002, Dr. Pushkarewicz reviewed the statement of accepted facts and the medical reports of record. He performed a physical examination and found a negative Tinel's sign bilaterally, but a positive Phalen's sign. Appellant had good range of motion of each shoulder with mild tenderness in the subacromial space on the right, negative impingement, no evidence of muscle atrophy and no instability. Dr. Pushkarewicz stated that he found the form for range of motion confusing regarding the difference between backward elevation and extension. He stated that the surgery in 1996 on the right shoulder was a normal diagnostic arthroscopy, and that the left shoulder had tearing of the labrum which was debrided. The surgery on March 6, 1998 documented a partial rotator cuff tear which was debrided as well as a labral tearing which was debrided and a acromioplasty to relieve an impingement syndrome.

Dr. Pushkarewicz opined that appellant had 10 percent impairment bilaterally due to carpal tunnel syndrome. He found two percent impairment bilaterally due to loss of range of motion and no significant pain. Dr. Pushkarewicz was not able to give a firm opinion on whether appellant had a thoracic outlet syndrome. He completed the Office's questionnaire and stated that appellant had permanent impairment due to variable pain. Dr. Pushkarewicz listed appellant's range of motion as: forward elevation, 170 degrees bilaterally; backward elevation, 40 degrees bilaterally; abduction, 170 degrees bilaterally; adduction, 40 degrees bilaterally; internal rotation, 80 degrees bilaterally; external rotation, 90 degrees bilaterally, with mild pain on the right; and extension, 40 degrees bilaterally. However he questioned whether backward elevation and extension were the same.

[1] Docket No. 00-2187 (issued July 3, 2001).

[2] 5 U.S.C. §§ 8101-8193, § 8123(a).

By decision dated February 12, 2002, the Office denied appellant's claim for additional schedule awards based on Dr. Pushkarewicz's report. Appellant, through his attorney, requested an oral hearing on February 19, 2002. By decision dated September 4, 2002, the hearing representative found that the case was not in posture for a hearing. She remanded the case for clarification of Dr. Pushkarewicz's opinion.

On November 21, 2002 the Office again referred appellant, a statement of accepted facts and a list of specific questions to Dr. Pushkarewicz. On January 20, 2003 he noted that appellant had undergone a functional capacity evaluation (FCE). He attributed appellant's bilateral carpal tunnel syndrome to repetitive work as a letter sorter machine clerk. Dr. Pushkarewicz noted that thoracic outlet syndrome was a controversial diagnosis and that appellant actually exhibited none of the classic criteria for this condition. However, he recognized that the Office had accepted this condition in accordance with the statement of accepted facts.

Dr. Pushkarewicz correlated his physical findings with the appropriate tables of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[3] He found that appellant had Grade 3 impairment due to loss of sensation of pain in the median nerve or 10 percent impairment bilaterally due to carpal tunnel syndrome. Regarding the thoracic outlet syndrome, Dr. Pushkarewicz found that appellant had no permanent nerve damage to any portion of the brachial plexus, arteries or veins. He found that appellant did have decreased function of his shoulder. Dr. Pushkarewicz stated that appellant had loss of range of motion in his shoulder on the right with 135 degrees of flexion or 3 percent impairment, 65 degrees of internal rotation or 2 percent impairment, and abduction of 138 degrees or 2 percent impairment. He added these figures to reach seven percent impairment due to loss of range of motion of the right upper extremity. Appellant's left shoulder demonstrated 142 degrees of flexion or 3 percent impairment, internal rotation of 75 degrees was 1 percent impairment and abduction of 132 was 2 percent impairment. Dr. Pushkarewicz found that appellant had six percent impairment of the left upper extremity due to loss of range of motion.

Dr. Pushkarewicz noted that the A.M.A., *Guides* discouraged strength testing but indicated that he believed that it was appropriate to evaluate appellant's loss of strength of the shoulders noting that the FCE revealed a significant loss of grip strength. He stated, "Specifically using Table 16-34, [appellant] had a 54 percent deficit of right upper extremity grip as measured in his FCE and this calculates to a 20 percent upper extremity impairment, using [T]able 16-34. Similarly, the 50 percent deficit on the left correlates with a 20 percent impairment of the left upper extremity." He noted that appellant's impairment rating for carpal tunnel syndrome eliminated the need for loss of strength due to pinch deficits.

Dr. Pushkarewicz combined appellant's impairment ratings due to thoracic outlet syndrome and shoulder surgeries for 26 percent impairment of the right upper extremity and 25 percent impairment of the left upper extremity. He then combined these impairments with the carpal tunnel syndrome rating of 10 percent for 33 percent impairment of the upper extremities bilaterally.

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

The Office medical adviser reviewed this report on February 27, 2003 and agreed with Dr. Pushkarewicz's calculations. By decision dated February 28, 2003, the Office noted that appellant had previously received schedule awards totaling 35 percent impairment for the right upper extremity and 34 percent impairment for the left upper extremity. The Office concluded that based on Dr. Pushkarewicz's evaluation appellant was not entitled to an additional schedule award for permanent impairment of either his right or left upper extremities.

Appellant, through his attorney, requested an oral hearing on March 3, 2003. Counsel appeared at the oral hearing on October 22, 2003 and requested additional time to submit evidence to the record.[4] By decision dated January 12, 2004, the hearing representative affirmed the February 28, 2003 decision, finding that Dr. Pushkarewicz's supplemental report was sufficiently detailed and rationalized to constitute the weight of the medical opinion evidence and established that appellant was not entitled to additional schedule awards.[5]

LEGAL PRECEDENT

When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report.[6] It is well established that, when a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on proper factual and medical background must be given special weight.[7]

The schedule award provision of the Federal Employees' Compensation Act[8] and its implementing regulation[9] sets 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 regulation as the appropriate standard for evaluating schedule losses.[10] Effective

[4] The record contains several medical reports from Dr. John William Boor, a Board-certified neurologist. However, as these reports did not address the extent of appellant's permanent impairment, they are not relevant to the issue on appeal and will not be addressed.

[5] Following the hearing representative's January 12, 2004 decision, appellant submitted additional new evidence. As the Office did not consider this evidence in reaching a final decision, the Board cannot review this evidence for the first time on appeal. 20 C.F.R. § 501.2(c).

[6] *Roger W. Griffith*, 51 ECAB 491, 505 (2000).

[7] *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id.*

February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[11]

Grip strength is used to evaluate power weaknesses related to the structures in the hand wrist or forearm.[12] The A.M.A., *Guides* do not encourage the use of grip strength as an impairment rating because strength measurements are functional tests influenced by subjective factors that are difficult to control and the A.M.A., *Guides* for the most part is based on anatomic impairment. Thus the A.M.A., *Guides* does not assign a large role to such measurements. Only in rare cases should grip strength be used, and only when it represents an impairing factor that has not been otherwise considered adequately.[13] The A.M.A., *Guides* state, "*Otherwise, the impairment ratings based on objective anatomic findings take precedence.*"[14] (Emphasis in the original.)

ANALYSIS

The Board previously found an unresolved conflict of medical opinion regarding the extent of appellant's upper extremity impairments. The Board remanded the case for an impartial medical evaluation to resolve this conflict. The Office properly referred appellant to Dr. Pushkarewicz to address the extent of his permanent impairment. The September 4, 2002 decision of the Office hearing representative found that Dr. Pushkarewicz's January 25, 2002 report was not sufficiently detailed and properly remanded the case for a supplemental report. Dr. Pushkarewicz referred appellant for an FCE and submitted a detailed supplemental report on January 20, 2003.

Dr. Pushkarewicz based his January 20, 2003 report on the statement of accepted facts. He provided detailed physical findings and correlated his findings with the appropriate sections of the A.M.A., *Guides*. The Board finds that Dr. Pushkarewicz's January 20, 2003 report is sufficiently detailed, is based on a proper factual background and contains sufficient correlation between his findings and conclusions to represent the special weight of the medical opinion evidence and resolve the existing conflict between appellant's physician Dr. Weiss, an osteopath, and the Office medical adviser.

Dr. Pushkarewicz properly found that appellant's loss of sensation or pain in the median nerve correlated with a Grade 3 impairment abnormal sensation or slight pain, at 26 to 60 percent impairment of the median nerve, which was a maximum of 39 percent impairment of the upper extremity due to sensory deficit or pain resulting in 10 percent impairment of the upper extremities bilaterally.[15]

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[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a) (August 2002).

[12] *Id.*

[13] *Mary L. Henninger*, 52 ECAB 408, 409 (2001).

[14] A.M.A., *Guides*, 508.

[15] *Id.* at 492, Table 16-15; 482, Table 16-10.

He further found that appellant had loss of range of motion of his shoulder due to thoracic outlet syndrome. On the right appellant had 135 degrees of flexion or 3 percent impairment,[16] 65 degrees of internal rotation or 2 percent impairment,[17] and abduction of 138 degrees or 2 percent impairment.[18] He added these figures to reach seven percent impairment due to loss of range of motion of the right upper extremity. Appellant's left shoulder demonstrated 142 degrees of flexion or 3 percent impairment,[19] internal rotation of 75 degrees or 1 percent impairment[20] and abduction of 132 or 2 percent impairment.[21] Dr. Pushkarewicz found that appellant had six percent impairment of the left upper extremity due to loss of range of motion.

Dr. Pushkarewicz indicated that it was appropriate to evaluate appellant's loss of grip strength, which he attributed to his shoulder condition, due to the significant losses demonstrated by the FCE. He noted that appellant's impairment rating for carpal tunnel syndrome eliminated the need for evaluation of loss of strength due to pinch deficits. Dr. Pushkarewicz found that appellant had a 54 percent loss of right upper extremity grip strength, for 20 percent right upper extremity impairment.[22] Appellant's 50 percent deficit on the left is 20 percent impairment of the left upper extremity.[23] Dr. Pushkarewicz properly combined appellant's upper extremity ratings to find a total 33 percent impairment of the upper extremities bilaterally. The evidence from the impartial medical specialist does not establish impairment of either upper extremity greater than that for which appellant has received schedule awards.

CONCLUSION

The Board finds that Dr. Pushkarewicz was properly designated as an impartial medical specialist and that his report constitutes the weight of the medical evidence and resolves the conflict of medical opinion. Dr. Pushkarewicz found that appellant has no more than 33 percent impairment of either of his upper extremities. As appellant has not established that he has more than 34 percent impairment of the left upper extremity and 35 percent impairment of his right upper extremity for which he has received schedule awards, he did not establish that he is entitled to an additional schedule award.

[16] *Id* at 476, Figure 16-40.

[17] *Id.* at 479, Figure 16-46.

[18] *Id.* at 477, Figure 16-43.

[19] *Id.* at 476, Figure 16-40.

[20] *Id.* at 479, Figure 16-46.

[21] *Id.* at 477, Figure 16-43.

[22] *Id.* at 509, Table 16-34.

[23] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the January 12, 2004 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 22, 2004
Washington, DC

Alec J. Koromilas
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member