United States Department of Labor
Employees' Compensation Appeals Board

JOHN THOMAS MORSE, Appellant	)	
and	)	**Docket No. 04-797**
	)	**Issued: July 13, 2004**
U.S. POSTAL SERVICE, POST OFFICE, Sewell, 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, Chairman
COLLEEN DUFFY KIKO, Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On February 5, 2004 appellant filed a timely appeal from decisions of the Office of Workers' Compensation Programs dated April 11 and May 13, 2003, which granted a schedule award for an additional one percent impairment of the left arm. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision in this case.

ISSUE

The issue is whether appellant has more than a five percent impairment of the left upper extremity for which he received schedule awards. On appeal counsel contends that a conflict in medical evidence exists because the impartial medical specialist did not consider preexisting cervical radiculopathy, did not measure shoulder range of motion and did not explain why appellant was not entitled to an impairment rating for pain and a motor deficit.

FACTUAL HISTORY

On March 2, 1999 appellant, then a 46-year-old window/distribution clerk, suffered an upper left biceps injury in the performance of his federal duties,[1] for which he underwent surgical repair by Dr. Robert M. Dalsey, his treating Board-certified orthopedic surgeon, on March 19, 1999. He received appropriate compensation, returned to modified duty on May 15, 1999 and resumed regular duty on August 4, 2000. The Office subsequently accepted that appellant also had employment-related tendinitis of the left arm, left shoulder and left elbow strains.[2]

On January 12, 2001 appellant filed a claim for a schedule award.[3] In support thereof, he submitted a November 17, 2000 report, in which Dr. Dalsey reported that heterotopic ossification had complicated appellant's postoperative course. He indicated that appellant had some residual achiness and fatigability and provided range of motion measurements for his left shoulder, advising that he had 165 degrees of forward elevation, 60 degrees of external rotation and internal rotation to T8. Left elbow range of motion demonstrated 85 degrees of supination and 50 degrees of pronation. Dr. Dalsey advised that appellant had normal sensibility in the median, ulnar and radial nerve distributions.

By report dated February 12, 2001, an Office medical adviser reviewed Dr. Dalsey's November 17, 2000 report and advised that under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* [4] appellant had a three percent impairment of the left arm. He concluded that under Figure 16-40, 165 degrees of shoulder

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[1] The claim was accepted for upper left biceps strain. Magnetic resonance imaging (MRI) scan demonstrated complete disruption of the distal biceps tendon.

[2] The record indicates that an occupational disease claim, accepted for right elbow tendinitis and bursitis, was adjudicated by the Office under File No. 022018035. Under File No. 022000419 the Office accepted that appellant sustained tendinitis of the left arm on May 3, 2000. Under File No. 022000303 the Office accepted that on July 21, 2000 appellant suffered left shoulder and left elbow strains. The instant case was adjudicated by the Office under File No. 020754769.

[3] Dr. Dalsey submitted a number of reports including a July 7, 1999 treatment note in which he noted appellant's complaints of numbness radiating down to the thumb, index finger and ulnar aspect of the hand with pain beginning in the upper neck. His physical examination demonstrated paresthesias in the thumb and index finger and he recommended an MRI scan and electromyography (EMG) studies. An MRI scan of the cervical spine dated July 19, 1999, read by Dr. Jeffrey J. Larkin, Board-certified in radiology, demonstrated mild degenerative disc disease and a small C5-6 herniation with minor bulging at C4-5. An EMG dated July 28, 1999 conducted by Dr. Robert A. Sammartino, an osteopath, revealed very mild electrophysiologic evidence of C6-7 radiculopathy. In an August 16, 1999 treatment note, Dr. Lawrence S. Deutsch, Board-certified in orthopedics, noted the MRI scan and EMG findings. Physical examination revealed fairly good range of motion of the neck with a positive Spurling sign when flexing to the right, absent deep tendon reflexes on the left with motor 5/5 and sensation intact. Dr. Deutsch opined that appellant had a disc herniation causing mild radiculopathy. In a September 22, 1999 treatment note, Dr. Dalsey advised that appellant could resume his regular activities and had reached maximum medical improvement. On October 4, 1999 Dr. Deutsch reported that appellant had "just slight numbness" in his arm, such that he was "barely aware of it." In a follow-up report dated June 2, 2000, Dr. Dalsey advised that appellant had elbow tendinitis and remained under the care of Dr. Deutsch for his cervical problem.

[4] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB ___ (Docket No. 01-1361, issued February 4, 2002).

flexion equaled a 1 percent impairment[5] and under Figure 16-46, 60 degrees of external equaled 0 percent impairment.[6] Under Figure 16-37, 50 degrees of elbow pronation provided a 2 percent impairment and 80 degrees of supination provided a 0 percent impairment.[7] The Office medical adviser stated that maximum medical improvement had been reached on March 17, 2000 one year after appellant's surgery and totaled the left arm impairment at three percent. In a decision dated April 2, 2001, appellant was granted a schedule award for a three percent impairment of the left arm, for a total of 9.36 weeks of compensation, to run from November 17, 2000 to January 21, 2001.

Appellant, through his attorney, requested a hearing that was held on October 25, 2001. He also submitted a report dated July 24, 2001 in which Dr. David Weiss, an osteopath, advised that neurological examination failed to reveal any perceived sensory deficits involving the left upper extremity and noted subjective complaints of left elbow pain and weakness. Dr. Weiss utilized the fifth edition of the A.M.A., *Guides* and found that forward shoulder elevation of 165 degrees provided a 1 percent impairment under Figure 16-40,[8] that under Figure 16-37, left elbow pronation of 35 degrees equaled a 7 percent impairment and left elbow supination of 35 degrees equaled a 2 percent impairment.[9] He further advised that motor strength of 4+/5 provided a 10 percent impairment under Tables 16-11 and 16-15[10] and that appellant had an additional 3 percent impairment due to pain, as provided in Figure 18-1,[11] for a total impairment of 22 percent.

By decision dated January 24, 2002, an Office hearing representative remanded the case to the Office to obtain a second-opinion examination. In a letter dated February 28, 2002, the Office referred appellant to Dr. Howard Zeidman, Board-certified in orthopedics, for a second-opinion evaluation.

In a report dated March 7, 2002, Dr. Zeidman provided findings under the fifth edition of the A.M.A., *Guides* and advised that appellant had a two percent left upper extremity impairment, noting that range of motion of the left elbow was about five degrees less than on the right with good comparable strength of both arms at the elbow, wrists and hands and no sensory or motor loss identified. He concluded that under Figure 16-37 appellant's five degree loss of

[5] *Id.* at 476.

[6] A.M.A., *Guides*, *supra* note 4 at 479.

[7] The Board notes that while Dr. Dalsey advised that appellant had 85 degrees of supination, both figures provide 0 percent impairment. *See* A.M.A., *Guides*, *supra* note 4, Figure 16-37 at 474.

[8] A.M.A., *Guides*, *supra* note 4 at 476.

[9] *Id.* at 474.

[10] A.M.A., *Guides*, *supra* note 4 at 492.

[11] *Id.* at 574.

motion in both pronation and supination of the elbow provided a one percent impairment each, totaling two percent for the left upper extremity.[12]

Finding that a conflict existed between the opinions of Drs. Weiss and Zeidman regarding the degree of appellant's left upper extremity impairment, on April 23, 2002 the Office referred appellant to Dr. Bruce W. Wulfsberg, also Board-certified in orthopedic surgery, for an impartial medical evaluation.[13]

In a report dated May 6, 2002, Dr. Wulfsberg noted that physical examination demonstrated gross sensation over all fingers with good capillary refill and good radial and ulnar pulses and negative Tinel's at the wrist with no major pain or injury. Wrist range of motion was equal bilaterally. Elbow range of motion was from 7 to 135 degrees for flexion and extension with 55 degrees of supination and 50 degrees of pronation. Shoulder range of motion and strength were near equal with the exception of 165 degrees of flexion on the left. Forearm circumference was 32 centimeter on the right and 31.5 centimeter on the left with no gross atrophy. Voluntary muscle testing of the biceps, triceps, wrist extensor and grip was good with trace biceps and triceps reflexes. Distal radial and ulnar pulses were intact. Dr. Wulfsberg further evaluated appellant's left upper extremity under the fifth edition of the A.M.A., *Guides* and found that under Figure 16-40 shoulder flexion of 165 degrees provided a 1 percent impairment[14] and that under Figure 16-37 elbow supination of 55 degrees and pronation of 50 degrees provided impairments of 1 percent and 2 percent respectively.[15] He further found that under Figure 16-34 appellant's lack of elbow extension to seven degrees equaled a one percent impairment, for a total left upper extremity impairment of five percent.[16] Dr. Wulfsberg stated that he found no evidence of any peripheral nerve disorder and, therefore, Table 16-11[17] would not apply and that, while appellant had slight atrophy, under Box 15-1 any difference in circumference of the arm should be greater than 1 centimeter to be ratable and in this case it was only 0.5 centimeter.[18] He concluded that maximum medical improvement had been long reached and any pain and atrophy had been taken into account in the range of motion deficits as found above.

In a June 2, 2002 report, an Office medical adviser agreed with Dr. Wulfsberg's findings with the exception that he disagreed regarding loss of extension and concluded that appellant had a total four percent impairment. On June 4, 2002 the Office granted appellant a schedule award for an additional one percent impairment of the left upper extremity for a four percent total. The

[12] A.M.A., *Guides*, *supra* note 4 at 474.

[13] Drs. Zeidman and Wulfsberg were furnished with a statement of accepted facts, a set of questions and the medical record.

[14] A.M.A., *Guides*, *supra* note 4 at 476.

[15] *Id.* at 474.

[16] A.M.A., *Guides*, *supra* note 4 at 472.

[17] *Id.* at 484.

[18] A.M.A., *Guides*, *supra* note 4 at 382.

award was for a period of 3.12 weeks, to run from January 22 to February 12, 2001. On June 7, 2002 appellant, through counsel, requested a hearing that was held on January 23, 2003.[19] At the hearing his counsel argued that the Office medical adviser could not substitute his opinion for that of the impartial examiner and further contended that appellant had preexisting radiculopathy which should be considered in granting a schedule award.

In a decision dated April 11, 2003, an Office hearing representative modified the prior decision to indicate that appellant was entitled to a total left upper extremity impairment of five percent and remanded the case to the Office for an additional award of one percent. On May 13, 2003 the Office granted appellant a schedule award for an additional one percent impairment of the left upper extremity for a period of 3.12 weeks, to run from February 13 to March 6, 2001.[20]

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[21] and section 10.404 of the implementing federal regulation,[22] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not 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 A.M.A., *Guides*[23] has been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[24] Chapter 16 provides the framework for assessing upper extremity impairments.[25]

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

[19] The record also contains a Form CA-2a recurrence claim submitted by appellant on March 4, 2003 in which he stated that he sustained a recurrence of disability on January 29, 2003 and stopped work on February 7, 2003. The record before the Board does not indicate that the Office issued a final decision regarding this claim and the Board's jurisdiction is limited to consider and decide appeals from final decisions of the Office issued within one year prior to the filing of the appeal. 20 C.F.R. §§ 501.2(c), 501.3(d)(2); *William N. Downer*, 52 ECAB 217 (2001). The record also contains a June 11, 2003 decision in which the Office approved an attorney fee application. This decision has not been appealed to the Board.

[20] Appellant, through counsel requested a hearing on May 15, 2003. He, however, withdrew the request on January 28, 2004.

[21] 5 U.S.C. § 8107.

[22] 20 C.F.R. § 10.404.

[23] A.M.A., *Guides*, *supra* note 4.

[24] *See Joseph Lawrence, Jr., supra* note 4; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[25] A.M.A., *Guides*, *supra* note 4 at 433-521.

the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[26]

ANALYSIS

The Office accepted that appellant sustained an employment-related upper left bicep strain, left shoulder and left elbow strains and left arm tendinitis[27] and paid schedule awards for the left upper extremity totaling five percent. The Board finds that the opinion of the impartial medical examiner, Dr. Wulfsberg, is entitled to special weight as he provided a thorough, well-rationalized report in which he noted his review of the medical record, the statement of accepted facts and questions provided as well as findings from his physical examination of appellant. Dr. Wulfsberg provided findings on physical examination and further evaluated appellant's left upper extremity under the fifth edition of the A.M.A., *Guides* and found that under Figure 16-40 shoulder flexion of 165 degrees provided a 1 percent impairment[28] and that under Figure 16-37 elbow supination of 55 degrees and pronation of 50 degrees provided impairments of 1 percent and 2 percent respectively.[29] He further found that under Figure 16-34 appellant's lack of extension to seven degrees equaled a one percent impairment, for a total left upper extremity impairment of five percent.[30] Dr. Wulfsberg stated that he found no evidence of any peripheral nerve disorder and, therefore, Table 16-11[31] would not apply and that, while appellant had slight atrophy, under Box 15-1 any difference in circumference of the arm should be greater than 1 centimeter to be ratable and in this case it was only 0.5 centimeter.[32] He concluded that maximum medical improvement had been long reached and any pain and atrophy had been taken into account in the range of motion deficits as found above.

Regarding appellant's contention that he is entitled to an increased award because of cervical radiculopathy, the Board notes that, although the A.M.A., *Guides* include guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under the Act for injury to the spine.[33] In 1960, amendments to the Act modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of the Act include the

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

[27] *Supra* note 2.

[28] A.M.A., *Guides*, *supra* note 4 at 476.

[29] *Id.* at 474.

[30] A.M.A., *Guides*, *supra* note 4 at 472.

[31] *Id.* at 484.

[32] A.M.A., *Guides*, *supra* note 4 at 382.

[33] *Pamela J. Darling*, 49 ECAB 286 (1998).

extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[34]

Section 15.12 of the fifth edition of the A.M.A., *Guides* describes the method to be used for evaluation of impairment due to sensory and motor loss of the extremities as follows. The nerves involved are to be first identified. Then, under Tables 15-15 and 15-16, the extent of any sensory and/or motor loss due to nerve impairment is to be determined, to be followed by determination of maximum impairment due to nerve dysfunction in Table 15-17 for the upper extremity and Table 15-18 for the lower extremity.[35] The severity of the sensory or motor deficit is to be multiplied by the maximum value of the relevant nerve.[36]

It is appellant's burden to submit sufficient evidence to establish entitlement to a schedule award.[37] In the instant case, such evidence was not submitted with regard to an impairment due to sensory and motor loss of the extremities. While there is evidence of record that a July 1999 EMG demonstrated very mild electrophysiologic evidence to suggest left C6-7 radiculopathy, in a report dated October 4, 1999, Dr. Deutsch advised that appellant had "just slight numbness" in his arm, such that he was "barely aware of it." In a November 17, 2000 report, Dr. Dalsey advised that appellant had normal sensibility in median, ulnar and radial nerve distributions and in his July 24, 2001 report, Dr. Weiss advised that neurological examination failed to reveal any perceived sensory deficits involving the left upper extremity. Lastly, Dr. Wulfsberg noted no evidence of any peripheral nerve disorder. Appellant, therefore, has not established that he is entitled to an increased schedule award due to cervical neuropathy at this time.[38]

Appellant also argued that Dr. Wulfsberg did not measure shoulder range of motion. This contention, however, is contradicted by Dr. Wulfsberg's report, as the physician specifically stated that shoulder range of motion and strength were near equal except for flexion and awarded appellant a 1 percent impairment for 165 degrees of flexion.

Regarding pain, the Board notes that the fifth edition of the A.M.A., *Guides* provides that "the impairment ratings in the body system organ chapters make allowance for any accompanying pain."[39] While additional impairments may be granted for chronic pain, Dr. Weiss did not characterize appellant's pain as chronic but merely stated "pain related impairment" equaled three percent.

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[34] *Thomas J. Engelhart*, 50 ECAB 319 (1999)]

[35] A.M.A., *Guides*, *supra* note 4 at 434.

[36] *Id.* at 423.

[37] *See Annette M. Dent*, 44 ECAB 403 (1993).

[38] The Board notes that appellant retains the right to request an increased schedule award based on medical evidence indicating a progression in his employment-related condition. *Linda T. Brown*, 51 ECAB 115 (1999).

[39] A.M.A., *Guides*, *supra* note 4, Chapter 2.5e, page 20.

Lastly, appellant argued that Dr. Wulfsberg provided no explanation regarding why he found no motor deficit present. The Board finds this argument without merit. Dr. Wulfsberg examined appellant and advised that voluntary muscle testing of biceps, triceps, wrist extensor and grip were good and as appellant had no evidence of a peripheral nerve disorder, loss of strength analysis did not apply.

The Board finds the opinion of Dr. Wulfsberg is entitled to special weight and appellant has no more than an five percent impairment of his left upper extremity for which he received a schedule awards.

CONCLUSION

The Board finds that appellant has no more than a five percent impairment of the left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated May 13 and April 11, 2003 be affirmed.

Issued: July 13, 2004
Washington, DC

Alec J. Koromilas
Chairman

Colleen Duffy Kiko
Member

Michael E. Groom
Alternate Member