United States Department of Labor
Employees' Compensation Appeals Board

GARY W. THOMAS, Appellant	)	
	)	**Docket No. 05-1238**
and	)	**Issued: January 10, 2006**
U.S. POSTAL SERVICE, CARROLLTON STATION, New Orleans, LA, Employer	)	

Appearances:
Gary W. Thomas, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On May 16, 2005 appellant filed a timely appeal from an April 21, 2005 merit decision of the Office of Workers' Compensation Programs, which granted a schedule award for a five 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 schedule award case.

ISSUE

The issue is whether appellant established that he has more than a five percent permanent impairment of the right upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On August 16, 2002 appellant, then a 47-year-old letter carrier, filed an occupational disease claim in which he attributed the numbness and pain in his right arm and hand to his limited-duty work. He noted that he was on limited duty and had been casing mail, which caused pain in his right arm, hand and shoulder. The employing establishment stated that appellant had worked under physical restrictions that had not changed, due to a prior

work-related injury. By letter dated December 10, 2002, the Office accepted appellant's claim for bilateral cubital syndrome.

On June 12, 2003 appellant filed a claim for a schedule award. He submitted a June 7, 2003 medical report of Dr. Sofjan Lamid, a Board-certified physiatrist, which noted his physical limitations. In a letter dated July 24, 2003, the Office requested that appellant submit a medical report from a treating physician which addressed maximum medical improvement and the extent of impairment based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).

Dr. Lamid submitted a July 14, 2003 report in which he provided a history that appellant was injured due to repetitive movements of the right and left arms while casing mail. He diagnosed bilateral cubital tunnel syndrome, right radiculopathy at C-6 and left radiculopathy at C-8. He stated that appellant reached maximum medical improvement on June 30, 2003. Based on the A.M.A., *Guides*, Dr. Lamid found that appellant had retained active motion. Regarding the left elbow, he reported flexion of 90 degrees and extension of 30 degrees, which he related as a 17 percent impairment of the left upper extremity or a 10 percent impairment of the whole person based on the A.M.A., *Guides* 471, 439, Figure 16-32 and Table 16-3. Dr. Lamid reported right elbow flexion of 90 degrees and extension of 30 degrees, which also constituted a 17 percent impairment of the right upper extremity or a 10 percent impairment of the whole person. Right and left ulnar sensory loss above the mid-forearms constituted a 20 percent impairment of the upper extremities according to the A.M.A., *Guides* 492, 439, Tables 16-15 and 16-3. Right radiculopathy at C-6 constituted an eight percent impairment of the right upper extremity or a five percent impairment of the whole person based on the A.M.A., *Guides* 424, 439, Tables 15-17 and 16-3. Left radiculopathy at C-8 constituted a five percent impairment of the left upper extremity or a three percent impairment of the whole person based on the A.M.A., *Guides* 424, 439, Tables 15-17 and 16-3. Utilizing the Combined Values Chart, A.M.A., *Guides* 604, Dr. Lamid determined that appellant had a 43 percent impairment of the whole person.

An August 20, 2002 nerve conduction study report of Dr. Mary Mathai, a Board-certified physiatrist, accompanied Dr. Lamid's July 14, 2003 report. Regarding both of appellant's upper extremities, Dr. Mathai found normal distal latencies in the median and ulnar nerves bilaterally but amplitude was decreased in the ulnar nerves bilaterally. Motor conduction studies showed normal distal latencies, amplitudes and distal conduction velocities in the median and ulnar nerves but conduction velocity across the elbow in the ulnar nerves was decreased. F-wave studies were normal. Dr. Mathai's August 20, 2002 electromyogram (EMG) of both upper extremities and cervical paraspinals revealed increased insertional activity in the right first dorsal interroseeous (FDI). Complex repetitive discharges were seen in the left C-8 paraspinal. On minimal contraction, increased polyphasics were noted in right deltoid and FDI. On maximal contraction, the interference pattern was minimally decreased in the right abductor digiti quinti. Dr. Mathai diagnosed bilateral mild to moderate entrapment neuropathy of the ulnar nerves at the elbow as in cubital tunnel syndrome, possible right C-6 radiculopathy and chronic left C-8 radiculopathy.

On August 15, 2003 the Office requested that an Office medical adviser review the case record and provide the date of maximum medical improvement and a percentage of impairment to the injured members based on the A.M.A., *Guides*. On August 25, 2003 an Office medical

adviser responded that the information supplied by Dr. Lamid was inadequate to determine a schedule award for appellant's upper extremities. He recommended a detailed impairment evaluation by a Board-certified physician familiar with the fifth edition of the A.M.A., *Guides*.

By letter dated September 10, 2003, the Office referred appellant, together with a statement of accepted facts, the case record and a list of questions, to Dr. Stephen Kishner, a Board-certified physiatrist, for a second opinion medical examination. Dr. Kishner submitted a November 7, 2003 report, which provided the history of appellant's bilateral arm condition, his symptoms and medical treatment. On physical examination, he reported a full bilateral range of motion of the fingers, hands, wrists and elbows but not the shoulders. He reported 95 degrees of right shoulder abduction and 80 degrees of left shoulder abduction. Appellant had full right and left shoulder adduction. External rotation was 45 degrees on the right and 40 degrees on the left. Internal rotation was full bilaterally and flexion was 115 degrees on the right and 95 degrees on the left. Dr. Kishner stated that appellant had good muscular development in his arms and there was no sensory loss. There was no specific tenderness, swelling or rolling nerves in the ulnar grooves. Appellant had normal deep tendon reflexes and normal strength and sensation to light touch in both upper extremities. He had tenderness over bilateral lateral epicondyles of the elbow and both supraspinatus insertions at the shoulders. Dr. Kishner found no evidence of cubital tunnel syndrome. He stated that the nerve conduction study was of no relevance clinically. Dr. Kishner opined that appellant had rotator cuff problems in his shoulders, as well as, bilateral frozen shoulders or adhesive capsulitis. Appellant also appeared to have bilateral elbow lateral epicondylitis or tennis elbow. Utilizing the A.M.A., *Guides*, 477, 476, 470, Figures 16-43, 16-40 and 16-46, Dr. Kishner determined that on the right, appellant had a 4 percent impairment related to abduction, a 1 percent impairment due to external rotation and a 5 percent impairment related to flexion. On examination of the left side, he determined that appellant had a four percent impairment related to abduction, a one percent impairment due to external rotation and a six percent impairment related to flexion. Dr. Kishner found that appellant had a 10 percent impairment of the right upper extremity and an 11 percent impairment of the left upper extremity related to loss of range of motion of his shoulders.

On December 22, 2003 a second Office medical adviser reviewed Dr. Kishner's report and noted that the only abnormal findings described by Dr. Kishner were the decreased range of motion of each shoulder, which constituted an 11 percent impairment of the left upper extremity and a 10 percent impairment of the right upper extremity. The Office medical adviser stated that no injury of either shoulder had been accepted and, thus, Dr. Kishner's impairment estimates were not probative for adjudication by the Office. The Office medical adviser concluded that there was no medical evidence of impairment to either upper extremity resulting from appellant's 1999 work-related injuries.

By decision dated January 28, 2004, the Office denied appellant's claim for a schedule award.

In a February 20, 2004 letter, appellant requested a review of the written record by an Office hearing representative. He submitted an August 15, 2002 report, by Dr. Lamid who listed a history of repetitive movement of the right arm at work for seven and one-half years, with motor and sensory neuropathy of the right arm and hand. Dr. Lamid concluded that there was a

causal relationship between the repetitive movements of the right arm at work and motor and sensory neuropathy of the right arm and hand.

By decision dated June 16, 2004, an Office hearing representative found a conflict in the medical opinion evidence between Dr. Lamid and Dr. Kishner as to the employment-related medical conditions sustained by appellant, the extent of any permanent impairment and the members affected. The hearing representative directed the Office to refer appellant to an impartial medical examiner.

The Office referred appellant by letter dated July 6, 2004, together with the case record, a statement of accepted facts and list of questions, to Dr. Francis A. Johnston, a Board-certified orthopedic surgeon, for an impartial medical examination. However, Dr. Johnston's reports of July 21, 2004 and January 5, 2005 did not respond to the Office's inquires and the claim was further developed by referral to a new impartial specialist.

By letter dated January 18, 2005, the Office referred appellant to Dr. George F. Chimento, a Board-certified orthopedic surgeon, for an impartial medical examination.

Dr. Chimento submitted a March 2, 2005 report in which he provided a history of appellant's employment injury, medical treatment and family and social background. On physical examination, he reported full range of motion of all joints in appellant's right upper extremity and no atrophy. Appellant had very mild intrinsic weakness of the right upper extremity, decreased light touch to the small finger of the right hand and a palpable radial pulse. Dr. Chimento noted that x-rays of appellant's elbow did not reveal any pathology. He further noted Dr. Mathai's August 20, 2002 EMG/nerve conduction studies, which showed mild to moderate entrapment of the ulnar nerve at the elbow and possible right C-6 radiculopathy. Dr. Chimento diagnosed cubital tunnel syndrome (ulnar nerve entrapment) of the right elbow and upper extremity. He estimated that appellant reached maximum medical improvement for this condition in June 2003, barring any surgical intervention. Dr. Chimento stated that he had no restriction of motion in the right upper extremity but he had very mild intrinsic muscle weakness and decreased sensation to light touch in the small digit of the right hand. His main subjective complaint was pain which radiated from his elbow to his mid-hand, weakness, numbness and tingling. Utilizing the A.M.A., *Guides*, 482, 484, Tables 16-10 and 16-11, Dr. Chimento found that, as both the sensory and motor deficits were very mild, appellant had a one percent deficit for each. Dr. Chimento stated that, given that the deficit was a combined motor and sensory deficit, appellant had a 5 percent impairment of the right upper extremity based on the A.M.A., *Guides* 492, Table 16-15. In calculating the impairment rating, he took his estimate for the percentage for motor deficit and multiplied it by the appropriate factor in Table 16-15. Dr. Chimento stated that the five percent impairment rating was based on the deficit to the radial palmar digital branch and the ulnar palmar digital branch of the little finger multiplied by the combined motor and sensory deficit. He concluded that appellant's impairment was work related.

On April 3, 2005 a second Office medical adviser reviewed the case record. Utilizing, the A.M.A., *Guides* 482, 484, 492, Tables 16-10, 16-11 and 16-15, the Office medical adviser found that appellant had a 3 percent impairment for sensory deficit and a 2 percent impairment for motor deficit totaling a five percent permanent impairment of the right upper extremity. The

Office medical adviser stated that, although Dr. Chimento did not provide any details as to how he arrived at the above values, it was clear that his estimates were derived from correct reference to the A.M.A., *Guides* and his impairment rating should be approved.

By decision dated April 21, 2005, the Office granted appellant a schedule award for a five percent permanent loss of use of his right upper extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulation[2] sets forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[3] 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 for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[4]

Before the A.M.A., *Guides* can be utilized, a description of appellant's impairment must be obtained from appellant's physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[5]

Section 8123(a) of the Act provides: "[i]f there is 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."[6]

When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the

[1] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[2] 20 C.F.R. § 10.404.

[3] 5 U.S.C. § 8107(c)(19).

[4] 20 C.F.R. § 10.404.

[5] *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

[6] *Richard L. Rhodes*, 50 ECAB 259 (1999); *Noah Ooten*, 50 ECAB 283 (1999); *Rosita Mahana* (*Wayne Mahana*), 50 ECAB 331(1999); *Richard Coonradt*, 50 ECAB 360 (1999); *Gwendolyn Merriweather*, 50 ECAB 411 (1999); *Marsha R. Tison*, 50 ECAB 535(1999).

defect in his original report.[7] However, when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[8]

ANALYSIS

On appeal appellant contends that he is entitled to greater than a five percent impairment of the right upper extremity based on the opinion of Dr. Lamid, an attending physician.

In a July 14, 2003 report, Dr. Lamid diagnosed bilateral cubital tunnel syndrome, right radiculopathy at C-6 and left radiculopathy at C-8. He reported his range of motion findings regarding appellant's right and left upper extremities and determined that he had a 43 percent impairment of the whole person based on the A.M.A., *Guides*. The Office referred appellant to Dr. Kishner, for a second opinion medical examination. In a November 7, 2003 report, Dr. Kishner found no evidence of cubital tunnel syndrome but stated that appellant suffered from rotator cuff problems in his shoulders and bilateral frozen shoulders or adhesive capsulitis. He reported his range of motion findings and found that appellant had an 11 percent impairment of the left upper extremity and a 10 percent impairment of the right upper extremity based on the A.M.A., *Guides*. The Board finds that the Office properly determined that a conflict in the medical opinion evidence was created between Dr. Lamid and Dr. Kishner as to appellant's employment-related medical conditions, the extent of any resulting permanent impairment and the members affected.

The Office properly referred appellant to Dr. Johnston, selected as the impartial medical specialist to resolve the conflict in the medical opinion evidence. Dr. Johnston found that appellant had right ulnar nerve entrapment at Guyon's canal in the wrist and recommended an ulnar nerve wrist release and ulnar nerve decompression at the elbow and/or transposition be performed if appellant's symptoms persisted. The Office requested that Dr. Johnston clarify his opinion and answer specific questions relating to appellant's claim. He responded by reiterating his diagnosis and surgery recommendation. The Board notes that, as Dr. Johnston failed to adequately respond to the Office, it properly referred appellant for an impartial medical evaluation with Dr. Chimento on January 18, 2005.

In a March 2, 2005 report, Dr. Chimento provided an accurate factual and medical background. He conducted a thorough medical examination, which revealed no restriction of motion in the right upper extremity but described very mild intrinsic muscle weakness and decreased sensation to light touch in the small digit of the right hand. He diagnosed cubital tunnel syndrome (ulnar nerve entrapment) of the right elbow and upper extremity. Dr. Chimento estimated that appellant reached maximum medical improvement in June 2003. He noted appellant's subjective complaint of pain which radiated from his elbow to his mid-hand, weakness, numbness and tingling. Utilizing the A.M.A., *Guides* 482, 484, 492 Tables 16-10,

[7] *Nancy Lackner* (*Jack D. Lackner*), 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

[8] *Roger W. Griffith*, 51 ECAB 491 (2000); *Talmadge Miller*, 47 ECAB 673 (1996).

16-11 and 16-15, Dr. Chimento found that as both the sensory and motor deficits were very mild, appellant had a one percent deficit for each. As the deficit was a combined motor and sensory deficit, he determined that appellant had a 5 percent permanent impairment of the right upper extremity based on the A.M.A., *Guides* 492, Table 16-15. Dr. Chimento stated that the impairment rating was based on the deficit to the radial palmar digital branch and the ulnar palmar digital branch of the little finger multiplied by the combined motor and sensory deficit. He concluded that appellant's impairment was work related.

Dr. Chimento has provided a thorough evaluation in conformance with the proper edition of the A.M.A., *Guides*. His finding was also approved by the Office medical adviser. The Board finds that Dr. Chimento's opinion is entitled to the special weight accorded an impartial medical specialist.

CONCLUSION

The Board finds that appellant has failed to establish that he has more than a five percent permanent impairment of the right upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the April 21, 2005 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 10, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board