United States Department of Labor
Employees' Compensation Appeals Board

A.C., Appellant	)	
and	)	**Docket No. 06-2105**
	)	**Issued: April 6, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Jersey City, 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:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 12, 2006 appellant filed a timely appeal from Office of Workers' Compensation Programs' October 27, 2005 and April 3, 2006 schedule award decisions. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this appeal.

ISSUE

The issue is whether appellant has more than a 3 percent permanent impairment of his right upper extremity; a 2 percent permanent impairment of his right lower extremity; and a 10 percent permanent impairment of his left lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On January 23, 2001 appellant injured both knees and his right hand when he tripped on plastic strapping in the performance of his duties. His claim was accepted for cervical strain, right knee and right hand sprain, chondromalicia of the left knee patella and right internal knee

derangement. Appellant underwent authorized surgeries on the left and right knees on July 31, 2001 and December 10, 2002 respectively.

On November 16, 2004 appellant requested a schedule award. In a July 22, 2004 report, Dr. Nicholas P. Diamond, a treating physician, stated that examination of the cervical spine revealed restricted range of motion involving backward extension, left and right rotation and left and right flexion. Examination of the dorsal spine showed paravertebral muscle spasm and tenderness, as well as latissimus dorsi tenderness on the right side. Dorsal rotation was restricted on the right and bilateral rotation was carried through with pain at the extremes. In determining appellant's gross motor strength, adductor pollicis testing was graded at 4+/5 in the right upper extremity. Examination of the right hand revealed palmar aspect tenderness over the thenal eminence; tenderness over the metacarpophalangeal joint of the thumb. Grip strength testing performed via Jamar hand dynamometer at Level 3 revealed 17.5 kilograms (kg) of force strength in the right hand, versus 24 kg of force strength for the left hand. (Appellant is left hand dominant). Examination of the right knee revealed effusion over the medial joint line; peripatellar tenderness; crepitus; tenderness over the medial femoral condyle; and restricted range of motion (0 to 90 degrees) with pain. Dr. Diamond noted that patellofemoral compression produced pain and crepitus at 20 degrees. Examination of the left knee revealed peripatellar tenderness; crepitus; and restricted range of motion (0 to 90 degrees) with pain. Patellofemoral compression produced pain and crepitus at 20 degrees. Testing of the gastrocnemius musculature was graded at 4+/5 on the right and 4/5 on the left. Quadricep strength was graded at 4+/5 on both sides.

Dr. Diamond diagnosed post-traumatic left knee medial meniscal tear, with post-traumatic osteoarthritis; status post arthroscopic left knee partial medial meniscectomy, abrasion arthroplasty and chondroplasty; post-traumatic right knee medial and lateral menisci tears; status post arthroscopic right knee partial medial and lateral meniscectomies and abrasion arthroplasty; cervical disc syndrome; bilateral knee tenosynovitis; chronic cervical and thoracic spine sprain and strain; and right thumb metacarpophalangeal capsulitis. Dr. Diamond referred to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*) (5th ed. 2001) in determining the degree of appellant's permanent impairment. He determined that appellant had a right grip strength deficit of 30 percent (Tables 16-32 and 16-34, page 509) and a right upper extremity pain-related impairment of 3 percent (Table 18-2, page 574), for a total right upper extremity impairment of 33 percent. Dr. Diamond found that appellant had a left grip strength deficit of 20 percent (Tables 16-32 and 16-34, page 509) and a left upper extremity pain-related impairment of 3 percent (Table 18-2, page 574), for a total left upper extremity impairment of 23 percent. For each of appellant's knees, he found a 10 percent range of motion deficit for flexion (Table 17-10, page 537) and a 3 percent pain-related deficit (Table 18-1, page 574), for a total impairment rating of 13 percent for each knee. Dr. Diamond determined that July 22, 2004 was the date of maximum medical improvement. In an October 26, 2004 letter, Dr. Cornelius I. Nicoll, a treating physician, agreed with Dr. Diamond's July 22, 2004 report.

In a December 16, 2004 report, an Office medical adviser found that the date of maximum medical improvement was July 22, 2004, the date of Dr. Diamond's report. Referring to the A.M.A., *Guides*, he determined that appellant had a 13 percent impairment of each lower extremity, due to a 10 percent range of motion deficit (page 537) and a 3 percent impairment due

to pain (Table 17-10, page 574). The medical adviser found that appellant had a 13 percent right upper extremity impairment, due to a 10 percent grip strength deficit (Table 16-34, page 509) and a 3 percent impairment due to pain (Table 17-10, page 574).

On December 28, 2004 the Office asked the medical adviser to clarify his impairment rating for appellant's right upper extremity, in light of Dr. Diamond's 33 percent rating. On January 5, 2005 the medical adviser indicated that, while Dr. Diamond had used the average grip strength by age to determine the deficit, he had used the 24 kg value for the universal left hand, which was normal for appellant, who is left-hand dominant. Converting the 24 kg to a right-hand "normal," results in a 10 percent impairment, based on the loss of strength index:

$$\frac{\text{Left (24)} - \text{Right (17.5)}}{24} = \frac{6.50}{24} = 27 \text{ (strength loss index)} = 10 \text{ percent impairment}$$

Adding 3 percent for pain resulted in a 13 percent total right upper extremity impairment. On February 3, 2005 Dr. Diamond opined that, because the two hands were being compared to one another, the hand opposite the impaired hand should be used to obtain a "normal" grip strength. He stated that the A.M.A., *Guides* was unclear as to the method to be used for selecting a "normal" strength. Moreover, the A.M.A., *Guides* discouraged impairment ratings based on grip strength deficit.

The Office referred appellant to Dr. Alan R. Miller, a Board-certified orthopedic surgeon, for a second opinion examination. In a report dated April 5, 2005, Dr. Miller provided diagnoses of right and left knee internal derangement, status post arthroscopy; cervical disc syndrome; and right thumb metacarpal-phalangeal (MP) joint sprain and osteoarthritis. In the right hand, MP joint motion was from 15 to 90 degrees; interphalangeal (IP) joint motion was from 0 to 90 degrees. There was some pain with grip strength. Pursuant to Tables 16-32 and 16-34 at page 509, he concluded that appellant had a total right upper extremity impairment of 23 percent. Dr. Miller found minimal soft tissue swelling in both knees. Both knees were tender to palpation over the patellofemoral joint and medial joint line. Active range of motion was from 0 to 95 degrees. Lachman and anterior drawer signs were negative. Pursuant to Tables 17-10, page 537 and 18-1, page 574 of the A.M.A., *Guides*, he concluded that appellant had a 13 percent permanent impairment of each lower extremity.

The Office forwarded Dr. Miller's report to the district medical adviser for review. On May 23, 2005 the medical adviser stated that Dr. Miller's right upper extremity impairment rating was "way off," as there was no objective impairment present. Referring to Tables 16-12 and 16-15 at page 456-57 of the A.M.A., *Guides*, he found a one percent right thumb impairment, based on a 15 to 90 degree MP joint range of motion and a 0 percent right thumb impairment, based on a 0 to 90 degree IP joint range of motion, resulting in a 0 percent hand impairment. The medical adviser determined that appellant had a three percent impairment of the right upper extremity due to pain on grip strength testing, for a total right upper extremity impairment of three percent. He found a 10 percent impairment of each knee, due to active range of motion from 0 to 90 degrees (Table 17-10, page 537) and a 2 percent impairment for

arthroscopy and partial medial meniscectomy (Table 17-35, page 546), for a total impairment rating of 12 percent for each lower extremity.

The Office found a conflict between the medical opinions of Dr. Miller and Dr. Diamond as to the extent of appellant's permanent impairment. In order to resolve the conflict, the Office referred appellant, together with a statement of accepted facts and the entire medical record, to Dr. Thomas Helbig, a Board-certified orthopedic surgeon. The Office provided Dr. Helbig with a statement of issues, which asked him to determine the extent of permanent impairment to the right upper extremity and the date of maximum medical improvement.

In a report dated September 20, 2005, Dr. Helbig opined that appellant had a three percent impairment of his right upper extremity due to pain, pursuant to Figure 18-1, page 574 of the 5th edition of the A.M.A., *Guides*. He diagnosed chronic cervical sprain and osteoarthritis of the cervical spine; chronic sprain of the MP joint of the right thumb with capsulitis; and status post arthroscopic surgery of both knees. Dr. Helbig found no instability, atrophy or restriction in range of motion of the right thumb or fingers of the right hand. There was no evidence of entrapment neuropathy or peripheral nerve injury of the right hand. He recommended against a rating for diminished grip strength. A neurologic examination of the upper extremities revealed no motor or sensory deficit. Left knee examination revealed 0 to 135 degrees of flexion with complaints of pain. There was positive tenderness over the medial and lateral joint line; no ligamentous instability; and no angular deformity. Examination of the right knee revealed 0 to 85 degrees of flexion with complaints of pain; no effusion; positive tenderness over the medial and lateral joint line; positive tenderness over the patellofemoral joint; no ligamentous instability; and no angular deformity. A neurologic examination of the lower extremities showed no sensory or motor deficit. Reflexes were present and symmetrical. Straight leg raising was negative bilaterally in seated and supine positions.

Appellant was also referred to Dr. David Rubinfield for a second opinion examination. In a September 27, 2005 report, Dr. Rubinfield opined that appellant had a 10 percent impairment of his right lower extremity, pursuant to Table 17-10. Stating that appellant's subjective complaints were not supported by objective findings on examination, he found no impairment of the neck, right hand or left knee. An October 17, 2005 memorandum to the file indicated that Dr. Rubinfield's report was not to be used for the purpose of determining a schedule award impairment rating.

On October 17, 2005 the Office forwarded Dr. Helbig's report, together with a statement of accepted facts, to the district medical adviser for review. In a report dated October 20, 2005, the medical adviser modified his assessment of the degree of appellant's permanent impairment based on Dr. Helbig's referee report. He noted that appellant had no instability, atrophy, or restriction in range of motion of the right thumb or fingers of the right hand; no evidence of entrapment neuropathy or peripheral nerve injury; and full range of motion in his wrist. The medical adviser concluded that appellant had a three percent impairment of his hand due to pain (A.M.A., *Guides*, Figure 18-1, page 574), resulting in a three percent total impairment of his right upper extremity. In the left knee, he found that appellant had no loss of range of motion, no neurological damage and no atrophy. Pursuant to Table 17-33 at page 546 of the A.M.A., *Guides*, the medical adviser concluded that appellant had a two percent impairment of the right lower extremity due to a torn medial meniscus. The medical adviser found that appellant had no

atrophy or instability of the left knee. Noting that left knee flexion was 0 to 85 degrees, he concluded that appellant had a 10 percent impairment of the left lower extremity (Table 17-10, page 537).

By decision dated October 27, 2005, the Office granted appellant a schedule award for a 3 percent impairment of the right upper extremity (hand); a 2 percent impairment of the left lower extremity (knee); and a 10 percent impairment of the right lower extremity (knee). The period of the awards ran from September 20, 2005 to July 24, 2006. The Office found that the date of maximum medical improvement was September 20, 2005.

Appellant requested an oral hearing, which was held on February 8, 2006. At the hearing, appellant's representative argued that Dr. Helbig's report did not provide adequate findings on which to base his conclusions regarding appellant's impairment.

In a decision dated April 3, 2006, the Office hearing representative affirmed the October 27, 2005 schedule award decision. The hearing representative found that Dr. Helbig's report represented the weight of the medical evidence and that the district medical adviser had properly calculated the degree of impairment based upon Dr. Helbig's findings.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[1] and its implementing federal regulation,[2] set 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 for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[3]

The fifth edition of the A.M.A., *Guides* allows for an impairment percentage to be increased by up to three percent for pain by using Chapter 18, which provides a qualitative method for evaluating impairment due to chronic pain. If an individual appears to have a pain-related impairment that has increased the burden on his or her condition slightly, the examiner may increase the percentage up to three percent.

When there exist 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 upon a proper factual background, must be given special weight.[4]

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[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

[3] *Id*. at § 10.404(a).

[4] *Barry Neutuch*, 54 ECAB 313 (2003); *David W. Pickett*, 54 ECAB 272 (2002).

ANALYSIS

The Board finds that a conflict in medical opinion was created between the report of Dr. Helbig and the reports of Dr. Miller and Dr. Diamond, as to the degree of impairment of appellant's left and right lower extremities. Accordingly, the case must be remanded for resolution of the conflict.

The Office accepted appellant's claim for cervical strain, right knee and right hand sprain. The claim was later expanded to include left chondromalicia of patella and right internal knee derangement and appellant underwent authorized surgeries on both knees. The Office properly determined that a conflict in medical opinion existed between appellant's attending physician, Dr. Diamond and the second opinion physician, Dr. Miller, on the degree of permanent impairment of the right upper extremity. The Office referred appellant to Dr. Helbig for resolution of the conflict. Based on Dr. Helbig's report, the Office granted a schedule award for a 3 percent impairment of the right upper extremity (hand); a 2 percent impairment of the left lower extremity (knee); and a 10 percent impairment of the right lower extremity (knee). Appellant claimed that he was entitled to additional schedule award compensation. Giving special weight to Dr. Helbig's opinion, the Office found that he was not entitled to such additional compensation. The Board notes, however, that a conflict in medical opinion was not created between Dr. Diamond and Dr. Miller, with regard to the extent and degree of permanent impairment to the right and left lower extremities. On July 22, 2004 Dr. Diamond diagnosed post-traumatic left knee medial meniscal tear, with post-traumatic osteoarthritis; status post arthroscopic left knee partial medial meniscectomy, abrasion arthroplasty and chondroplasty; post-traumatic right knee medial and lateral menisci tears; status post arthroscopic right knee partial medial and lateral meniscectomies and abrasion arthroplasty; cervical disc syndrome; bilateral knee tenosynovitis. For each of appellant's knees, Dr. Diamond found a 10 percent range of motion deficit for flexion (Table 17-10, page 537)[5] and a 3 percent pain-related deficit (Table 18-1, page 574),[6] for a total impairment rating of 13 percent for each knee. On April 5, 2005 Dr. Miller provided diagnoses of right and left knee internal derangement, status post arthroscopy and cervical disc syndrome. He found minimal soft tissue swelling in both knees. Both knees were tender to palpation over the patellofemoral joint and medial joint line. Active range of motion was from 0 to 95 degrees. Lachman and anterior drawer signs were negative. Pursuant to Tables 17-10, page 537 and 18-1, page 574, he also concluded that appellant had a 13 percent permanent impairment of each lower extremity.[7] In that both physicians opined that appellant had a 13 percent impairment of each lower extremity, there was no conflict created. Therefore, Dr. Helbig's opinion on the degree of impairment as to those extremities was not entitled to special weight. The Board notes that the Office instructed Dr. Helbig to determine only the extent of permanent impairment to the right upper extremity.

[5] A.M.A., *Guides* 537, Table 17-10.

[6] *Id*. at 574, Table 18-1.

[7] *See supra* note 5. *Id.*

Although not entitled to the special weight afforded to the opinion of an impartial medical specialist resolving a conflict of medical opinion, Dr. Helbig's opinion can still be considered for its own intrinsic value.[8] Dr. Helbig reviewed the entire case record and statement of accepted facts. He diagnosed chronic cervical sprain and osteoarthritis of the cervical spine and status post arthroscopic surgery of both knees. Left knee examination revealed 0 to 135 degrees of flexion with complaints of pain. There was positive tenderness over the medial and lateral joint line; no ligamentous instability; and no angular deformity. Examination of the right knee revealed 0 to 85 degrees of flexion with complaints of pain; no effusion; positive tenderness over the medial and lateral joint line; positive tenderness over the patellofemoral joint; no ligamentous instability; and no angular deformity. A neurologic examination of the lower extremities showed no sensory or motor deficit. Reflexes were present and symmetrical. Straight leg raising was negative bilaterally in seated and supine positions. Based upon Dr. Helbig's findings, the district medical adviser concluded that appellant had no loss of range of motion, no neurological damage and no atrophy in the right knee. Pursuant to Table 17-33 at page 546 of the A.M.A., *Guides*, he concluded that appellant had a two percent impairment of the right lower extremity due to a torn medial meniscus.[9] He also found that appellant had no atrophy or instability of the left knee. Noting that, left knee flexion was 0 to 85 degrees, he concluded that appellant had a 10 percent impairment of the left lower extremity. Table 17-10, page 537.[10] The Board finds that there exists a conflict in medical opinion as to the degree of impairment of appellant's lower extremities.

Regarding the right upper extremity, the Office properly referred the case to an impartial medical specialist to resolve the conflict in medical opinion between Drs. Miller and Diamond. Dr. Helbig diagnosed chronic sprain of the metacarpal phalangeal joint of the right thumb with capsulitis. He found no instability, atrophy or restriction in range of motion of the right thumb or fingers of the right hand. There was no evidence of entrapment neuropathy or peripheral nerve injury of the right hand. Dr. Helbig recommended against a rating for diminished grip strength. A neurologic exam of the upper extremities revealed no motor or sensory deficit. Referring to Figure 18-1, page 574 of the A.M.A., *Guides*, he opined that appellant had a three percent impairment due to pain.[11] An Office medical adviser reviewed Dr. Helbig's September 20, 2005 report and applied the A.M.A., *Guides* to his findings. Properly, applying Figure 18-1 on page 574, he concluded that appellant had a three percent impairment of his right upper extremity. Dr. Helbig's report was well rationalized and provided a complete factual background. The Board finds that Dr. Helbig's report represents the weight of the medical evidence and is sufficient to resolve the conflict in medical opinion. The Board further finds that the weight of the medical evidence establishes that appellant has no more than a three percent impairment of his right upper extremity for which he received a schedule award.

[8] *Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996).

[9] A.M.A., *Guides* 546, Table 17-33.

[10] *See supra* note 5.

[11] A.M.A., *Guides* 574, Figure 18-1.

CONCLUSION

The Board finds that appellant has no more than a three percent permanent impairment of his right upper extremity. The Board further finds that a conflict in medical opinion was created between the report of Dr. Helbig and the reports of Drs. Miller and Diamond, as to the degree of impairment of appellant's left and right lower extremities. Accordingly, the case must be remanded for resolution of the conflict. On remand, the Office shall refer appellant, along with the entire case record and statement of accepted facts, to an impartial medical specialist for an examination and an opinion as to the degree of permanent impairment to appellant's left and right lower extremities and the date of maximum medical improvement.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated April 3, 2006 and October 27, 2005 are affirmed in part and remanded in part, in accordance with the provisions of this order.

Issued: April 6, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board