United States Department of Labor
Employees' Compensation Appeals Board

M.H., Appellant	)	
and	)	**Docket No. 08-4**
	)	**Issued: April 14, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, 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, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On September 27, 2007 appellant, through counsel, filed a timely appeal of the April 20, 2007 merit decision of an Office of Workers' Compensation Programs' hearing representative, which denied an increase in her schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction of the merits of this appeal.

ISSUE

The issue is whether appellant has more than impairment of the left upper extremity.

FACTUAL HISTORY

This case has previously been before the Board. In a June 9, 2005 decision, the Board found a conflict in the medical opinion evidence between Dr. Richard H. Bennett, an Office referral physician, and Dr. David Weiss, an attending osteopath, as to whether appellant had more than a 10 percent impairment of her left upper extremity.[1] The Board remanded the case

[1] Docket No. 04-1490 (issued June 9, 2005).

for the Office to refer her for an impartial medical examination. The facts and the circumstances of the case as set forth in the Board's prior decision are incorporated herein by reference.[2]

On February 28, 2006 the Office referred appellant to Dr. Menachem M. Meller, a Board-certified orthopedic surgeon, selected as the impartial medical specialist. In a March 27, 2006 medical report, Dr. Meller reviewed a history of her October 25, 1985 employment injury, medical treatment and social, family and vocational background. He provided a detailed review of her medical records.

On physical examination, Dr. Meller removed a Futura wrist splint she was wearing on the left wrist and a Neoprene splint on the right wrist. He reported essentially normal findings regarding the upper extremities. Dr. Meller stated that range of motion testing of the cervical spine was slow and deliberate with cogwheeling maneuvering which indicated symptom embellishment that could not be explained based on appellant's complaints or findings. She had normal flexion to within two fingerbreadths, 40 degrees of extension and 60 degrees of left and right lateral rotation. Dr. Meller stated that the midline of the cervical spine, the trapeze, paravertebral muscles, splenius capitis, sternocleidomastoid, anterior and posterior triangle of the neck and periscapular muscles were palpated.

Range of motion measurements for both shoulders included 90 degrees of flexion on the right and 70 degrees of flexion on the left with a soft endpoint, cogwheeling maneuvering which indicated positional restriction, 80 degrees of abduction on the right and 70 degrees of abduction on the left. Dr. Meller stated that appellant was able to reach the back of her head and internally rotate to T12. He reported a forearm circumference of 22.5 centimeters on the right and 22.2 centimeters on the left consistent with right hand dominance. Dr. Meller found no sensory loss of both forearms. He noted appellant's complaint of burning numbness in both wrists to the fingertips which was a classic glove distribution which was nonphysiologic for any neurologic dysfunction. An Alan's test demonstrated distal symptoms which indicated a vascular basis for her symptoms resulting from age and presumably a smoking addiction. Tinel's testing at the cubital, carpal and radial tunnels and Watson's and Schuck's testing were unremarkable. A Finklestein's test was negative. Dynamometer testing using a GMR dynamometer at positions 1, 3, 5 on the right were 2, 5, 10, 5 and 6 and on the left were 2, 0, 1, 1 and 1.

Repeat sensory testing resulted in statements of the left forearm, *i.e.*, a cylindrical manner from the elbow to the wrist, but not above, beyond or different which could not be further qualified. Regarding the elbow appellant had a carrying angle of approximately 10 degrees, no warmth, swelling or synovitis. She was able to fully extend the elbows without hyperextension or flex to 145 degrees which was normal. Range of measurements for the forearm of 80 degrees of supination and 90 degrees of pronation were within normal limits. Range of motion measurements for the wrist included 70 degrees of extension, 75 degrees of flexion, 35 degrees of ulnar deviation and 25 degrees of radial deviation.

[2] On October 24, 1985 appellant, then a 38-year-old window clerk, sustained injury when she was struck on the head with a mail door and injured her neck. The Office accepted the claim for cervical sprain and left brachial plexopathy On February 18, 2000 she filed a claim for a schedule award. By decision dated July 31, 2000, the Office granted appellant a schedule award for a 10 percent impairment of the left upper extremity.

Dr. Meller asked appellant to define where her symptoms were located and she was unable to demonstrate the anatomic location. He was unable to substantiate that, in fact any impairment was present as there was no response to his question. Dr. Meller opined that if appellant had no demonstrable impairment, it did not exceed the 10 percent impairment previously awarded. In determining her impairment based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001), Dr. Meller stated that appellant undoubtedly had cervical spine degeneration that would limit her rotation. He applied the diagnosis-based estimates method to his cervical spine findings to determine that she fell into Category 1 which constituted a zero percent impairment of the whole person (A.M.A., *Guides* 292). Regarding the upper extremity, Dr. Meller stated that appellant had less than full maximal shoulder motion but, there was evidence of lack of valid effort. Based on page 19 of the A.M.A., *Guides*, he could modify an impairment rating when there was insufficient evidence to verify an impairment of a certain magnitude. In addition, he stated that there was no evidence to suggest that appellant had an accepted shoulder condition. Therefore, she demonstrated less than full maximal shoulder motion had no specific relevance in this context. Dr. Meller determined that she had normal elbow motion which constituted a zero percent impairment to this region (A.M.A., *Guides* 472, Figure 16-34). He determined that 80 degrees of supination and 80 degrees of pronation of the forearm was normal and constituted a zero percent impairment (A.M.A., *Guides* 473, Figure 16-36 and A.M.A., *Guides* 474, Figure 16-37). Dr. Meller further determined that appellant had normal range of motion of the wrist which constituted a zero percent impairment. (A.M.A., *Guides* 467, 469, Figures 16-28, 16-31). He stated that appellant could make a full fist bringing the fingertips down to the palm with good grip strength pinch and apposition resulting in a zero percent impairment (A.M.A., *Guides* 464, Figure 16-24). Appellant had normal thumb movements resulting in a zero percent impairment (A.M.A., *Guides* 449, Figure 16-8). Dr. Meller stated that appellant did not have carpal tunnel syndrome based on a normal September 21, 1999 electromyogram (EMG) as no abnormalities were demonstrated. He noted that the somatosensory evoked potential (SSEP) of the ulnar and median nerves performed by Dr. Apollo M. Arenas, a Board-certified neurologist, was also normal. Dr. Meller indicated that Dr. Arenas' September 14, 2000 and October 2, 2001 EMGs revealed mild left median nerve entrapment and mild ulnar nerve entrapment at the wrist. A November 21, 2001 follow-up evaluation still revealed mild left median nerve entrapment neuropathy of the wrist and no presence of Guyon's canal neuropathy. Dr. Meller explained that EMGs in a 50-year-old individual could have conduction delays as a result of numerous conditions. He stated that decades of a smoking addiction undoubtedly damaged the nerves, *i.e.*, caused basal spasm in the nerve root by causing spasm on the basilar nerve, as well as, direct damage to the nerves by the toxins contained in the cigarette smoke.

Dr. Meller opined that there were no objective findings of carpal tunnel syndrome and therefore no additional work-related impairment was warranted. He stated that appellant may have some subtle findings regarding her nerve dysfunction but, clearly there were no obvious findings such as a positive Tinel's sign, atrophy or reproducible weakness on a credible basis. Dr. Meller stated that appellant's light-duty positions beginning in 1985, *i.e.*, typing, caused her carpal tunnel syndrome. He noted that there was a body of knowledge which was strongly against the opinion that carpal tunnel syndrome was work related, particularly in the absence of compelling evidence to the contrary. Dr. Meller stated that there was an obvious contradiction regarding the prior 10 percent schedule award as one could not have a 10 percent impairment of the left upper extremity on September 4, 2000 as a result of an October 24, 1985 employment

injury and have a 53 percent impairment on December 28, 2001 at the same American Independent Injury site.

On August 2, 2006 Dr. Morley Slutsky, an Office medical adviser, reviewed the medical records. He agreed with Dr. Meller's opinion that appellant had no more than a 10 percent impairment of the left upper extremity. Dr. Slutsky stated that Dr. Meller clearly addressed all possible impairment and found no ratable impairments. Dr. Slutsky also stated that Dr. Meller reported no objective findings of carpal tunnel syndrome based on EMG testing.

By decision dated September 22, 2006, the Office denied appellant's claim for an additional schedule award. It found that Dr. Meller's March 27, 2006 impartial medical opinion that appellant did not have more than 10 percent impairment of the left upper extremity, was entitled to special weight.

In a September 26, 2006 letter, appellant, through counsel, requested an oral hearing before an Office hearing representative.

In an April 20, 2007 decision, an Office hearing representative affirmed the September 22, 2006 decision. The hearing representative accorded special weight to Dr. Meller's March 27, 2006 impartial medical report.

LEGAL PRECEDENT

A claim for an increased schedule award may be based on new exposure.[3] Absent any new exposure to employment factors, a claim for an increased schedule award may also be based on medical evidence indicating that the progression of an employment-related condition has resulted in a greater permanent impairment than previously calculated.[4]

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulations[6] set 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.[7] 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.[8]

[3] *Linda T. Brown*, 51 ECAB 115 (1999).

[4] *Id.*

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

[6] 20 C.F.R. § 10.404.

[7] 5 U.S.C. § 8107(c)(19).

[8] *See supra* note 6.

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]

ANALYSIS

In a March 27, 2006 report, Dr. Meller, the impartial medical specialist, provided range of motion findings regarding appellant's cervical spine, shoulder and left elbow, forearm, wrist and hand. He stated that appellant had cervical spine degeneration that could limit her range of motion. Utilizing diagnosis-based estimates, Dr. Meller determined that appellant fell into Category 1 which constituted a zero percent impairment of the cervical spine (A.M.A., *Guides* 292). He stated that there was no evidence that appellant sustained a shoulder condition. Therefore, appellant demonstrated less than full maximal shoulder motion was not relevant. Dr. Meller determined that she had normal elbow motion which constituted a zero percent impairment to this region (A.M.A., *Guides* 472, Figure 16-34). He further determined that 80 degrees of supination and 80 degrees of pronation of the forearm was normal and constituted a zero percent impairment (A.M.A., *Guides* 473, Figure 16-36 and A.M.A., *Guides* 474, Figure 16-37). Regarding the wrist, Dr. Meller found that 70 degrees of extension, 75 degrees of flexion, 35 degrees of ulnar deviation and 25 degrees of radial deviation constituted a 0 percent impairment (A.M.A., *Guides* 467, 469, Figures 16-28, 16-31). He found that appellant's hand had normal range of motion which constituted a zero percent (A.M.A., *Guides* 464, Figure 16-24). Dr. Meller stated that her thumb was also normal which represented a zero percent impairment (A.M.A., *Guides* 449, Figure 16-8).

Dr. Meller stated that EMG testing revealed no evidence of carpal tunnel syndrome and mild left median nerve entrapment and mild ulnar nerve entrapment at the wrist. He noted that SSEP testing of the ulnar and median nerves were within normal limits. Dr. Meller opined that there was no objective evidence of carpal tunnel syndrome and therefore appellant had no additional work-related impairment. He stated that she had some subtle findings regarding her nerve dysfunction but, clearly there were no obvious findings such as a positive Tinel's sign, atrophy or reproducible weakness on a credible basis. Dr. Meller stated that appellant's light-duty positions beginning in 1985 which involved typing caused her carpal tunnel syndrome. He noted a widely held opinion that carpal tunnel syndrome was not work related in the absence of compelling evidence to the contrary. Dr. Meller concluded that there was an obvious contradiction regarding the prior schedule award and the objective findings on his evaluation, noting that he was unable to substantiate any impairment.

Dr. Slutsky, an Office medical adviser, agreed with Dr. Meller's findings. He opined that appellant had no more than a 10 percent impairment of the left upper extremity. Dr. Slutsky stated that Dr. Meller clearly addressed all possible impairments and found no ratable impairments and he found no objective findings of carpal tunnel syndrome based on EMG testing.

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

The Board finds that Dr. Meller properly applied the A.M.A., *Guides* and provided a detailed and well-rationalized report for finding that appellant has no additional work-related permanent impairment of the left upper extremity. The Board notes that it appears Dr. Meller inadvertently stated that appellant's zero percent impairment of the cervical spine was based on page 292 of the A.M.A., *Guides* rather than Table 15.5 on page 392 of the A.M.A., *Guides* as his findings correlate to a zero percent impairment under Category 1 of Table 15.5. The Board finds that Dr. Meller's opinion, is entitled to special weight as the impartial medical specialist. The medical evidence does not establish more than a 10 percent impairment of the left upper extremity.

On appeal, appellant's attorney contends that Dr. Meller's grip strength findings cannot be understood and that Dr. Meller ignored EMG findings of carpal tunnel syndrome. Office procedures clearly provide that grip and/or pinch strength should not be used to calculate upper extremity impairment caused by a compression neuropathy such as carpal tunnel syndrome.[10] Additionally, the carpal tunnel syndrome was not found to be employment related.

Counsel further contends that Dr. Meller did not conduct a thorough medical examination which included motor strength testing of the tricep or bicep muscles. The Board, however, finds that a review of Dr. Meller's March 27, 2006 report refutes counsel's assertion. Dr. Meller provided an accurate history of appellant's work-related injury and medical treatment. After a thorough examination, he opined that appellant did not have more than a 10 percent impairment of the left upper extremity. Dr. Meller provided a proper analysis of the factual and medical history, his findings on examination and reached conclusions regarding the extent of appellant's left upper extremity impairment in accordance with the A.M.A., *Guides*.[11]

CONCLUSION

The Board finds that since the evidence of record does not establish more than the 10 percent left upper extremity impairment previously awarded, the Office properly denied appellant's request for an increased schedule award.

[10] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 Exhibit 4 (June 2003).

[11] *Pamela K. Guesford*, 53 ECAB 726 (2002).

ORDER

IT IS HEREBY ORDERED THAT the April 20, 2007 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 14, 2008
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