United States Department of Labor
Employees' Compensation Appeals Board

D.R., Appellant	)	
	)	**Docket No. 08-1209**
and	)	**Issued: December 18, 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:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 18, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs' October 1, 2007 decision regarding his schedule award claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than four percent permanent impairment of the left upper extremity for which he received a schedule award.

FACTUAL HISTORY

On September 18, 2002 appellant, then a 41-year-old clerk filed an occupational disease claim for a cervical disc herniation and radiculopathy. The Office accepted his claim for cervical strain and expanded his claim to include cervical radiculopathy, cervical root lesion, radiculitis and myofascial syndrome. Appellant stopped work on September 9, 2002 and returned to a light-duty position on January 13, 2003.

Appellant submitted reports from Dr. Barry Schnall, a Board-certified orthopedist, who noted a history of injury and diagnosed cervical disc herniation, cervical radiculopathy, cervical sprain with myofascial syndrome. In an August 11, 2003 report, Dr. Schnall diagnosed chronic pain, cervical strain and sprain and a stable cervical disc herniation and protrusion. He opined that appellant reached maximum medical improvement.

On March 8, 2005 appellant submitted a claim for a schedule award. He submitted a June 17, 2004 report from Dr. Nicholas Diamond, an osteopath, who noted that appellant reached maximum medical improvement on June 17, 2004. Dr. Diamond stated that the right shoulder examination revealed forward elevation of 180 degrees, abduction of 100 degrees, adduction of 60 degrees, external rotation of 90 degrees and abnormal internal rotation. Motor strength testing of the upper extremities revealed supraspinatus and deltoids at Grades "4+/5" on the left versus "5/5" on the right, grip strength testing revealed 40 kilograms (kg) of force strength for the left and 30 kg of force strength on the right. Sensory examination failed to reveal any perceived dermatomal abnormalities in either upper extremity. Dr. Diamond diagnosed C5-6, C6-7 disc protrusion and herniated nucleus pulposus by magnetic resonance imaging (MRI) scan, left C6-7 radiculopathy by MRI scan and chronic myofascial pain syndrome with trigger points. He noted that, based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[1] appellant had 16 percent impairment of the left arm. Dr. Diamond noted 4/5 motor strength deficit of the left supraspinatus equated to four percent impairment;[2] 4/5 motor strength deficit of the left deltoid yielded nine percent impairment;[3] and three percent for pain.[4]

The Office referred Dr. Diamond's report to an Office medical adviser who found that appellant had three percent impairment of the left arm. The Office medical adviser disagreed with Dr. Diamond's finding of motor weakness in the arm. He noted that, for schedule award purposes, generally nerve root compression is the basis of impairment rather than muscle weakness because muscle weakness was subjective. The medical adviser advised that the A.M.A, *Guides* 508, Table 16.8a, provides that only in rare instances should muscle weakness be considered in impairment ratings because objective anatomic findings take precedence. He calculated that appellant had a 1.25 percent impairment of the left arm for sensory deficit or pain in the C7 nerve root distribution, under Table 16-13 of the A.M.A., *Guides*.[5] The medical adviser advised that appellant would be classified as Grade 4, for a 25 percent sensory deficit or pain, in the distribution of the C7 nerve root under Table 16-10.[6] Impairment of 1.25 percent for sensory loss would be calculated by multiplying the 25 percent grade with the 5 percent

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

[2] *Id*. at 484, 492, Table 16-11, 16-15.

[3] *Id*.

[4] *Id.* at 574, Figure 18-1.

[5] *Id.* at 489, Figure 16-13.

[6] *Id.* at 482, Figure 16-10.

maximum allowed for the C7 nerve. The medical adviser further opined that appellant was entitled to two percent for pain.[7]

In a decision dated October 3, 2005, the Office granted appellant a three percent permanent impairment of the left upper extremity. The period of the award was from June 17 to August 21, 2004.

On October 7, 2005 appellant requested an oral hearing which was held on March 1, 2006. He asserted that there was a conflict in opinion between his treating physician, Dr. Diamond and the Office medical adviser. Appellant continued to submit reports from Dr. Schnall dated September 8, 2005 to April 30, 2006 who treated appellant for intermittent pain in the left shoulder.

In a decision dated June 8, 2006, the hearing representative set aside the Office decision dated October 3, 2005 and remanded the matter for further medical development. The hearing representative determined that there was a conflict in medical opinion between Dr. Diamond, appellant's treating physician, and the Office medical adviser, regarding the degree of permanent partial impairment of the upper extremities due to his work-related injury.

On July 10, 2006 the Office referred appellant to Dr. David R. Steinberg, a Board-certified orthopedic surgeon, to resolve the conflict. In an August 3, 2006 report, Dr. Steinberg noted appellant's history and examined appellant. He listed findings of full range of motion of the shoulders and elbows, tenderness over the right medial and lateral epicondyles, full range of motion of the wrists and digits. Provocative testing for peripheral nerve compression on the left was negative except for percussion of the cubital tunnel. There was full intrinsic strength, no atrophy, no motor findings of nerve dysfunction and symmetric reflexes. Dr. Steinberg diagnosed sprain/strain of the neck, cervical radiculopathy, myofascial pain syndrome and cervical degenerative disc disease and opined that these diagnoses were medically connected to the work injury of July 5, 2002. He noted appellant's subjective complaints of neck pain with radiation in the left arm which affected his ability to workout, interact with his children, sleep, perform work activities and activities of daily living. Dr. Steinberg noted electrodiagnostic evidence of cervical radiculopathy and MRI scan findings consistent with mild disc protrusion and foraminal narrowing at C6-7. He opined that appellant had seven percent whole person impairment due to his work injury. Dr. Steinberg noted that, under Table 15-5 of the A.M.A., *Guides*, appellant would be classified as cervical category II, with mild MRI scan findings and electromyogram (EMG) findings of C7 radiculopathy. He assigned seven percent whole person impairment based on an 11 to 12 percent upper extremity impairment[8] based on objective findings and appellant's inability to perform certain activities at work and of daily living. Dr. Steinberg indicated that appellant could work full time subject to restrictions.

Dr. Steinberg's report was referred to an Office medical adviser. In a report dated September 25, 2006, the Office medical adviser determined that appellant had one percent permanent impairment of the left arm. He calculated that appellant had one percent impairment

[7] *Id.* at 574, Figure 18-1.

[8] *Id.* at 439, Table 16.2.

of the left upper extremity for sensory deficit or pain in the distribution of the C7 nerve root under Table 16-13 of the A.M.A., *Guides*.[9] The Office medical adviser advised that appellant would be classified as Grade 4, for a 25 percent sensory deficit or pain, in the distribution of the C7 nerve root under Table 16-10.[10] Impairment due to sensory loss was calculated as 1 percent impairment for the upper extremities by multiplying the 25 percent grade with the 5 percent maximum allowed for the C7 nerve. The Office medical adviser disagreed with the rating provided by Dr. Steinberg and noted that spinal impairment ratings were not accepted by the Office; rather, spinal conditions were rated pursuant to residual deficits to the upper extremity.

In a decision dated October 2, 2006, the Office denied appellant's claim for an additional schedule award. On October 5, 2006 appellant requested an oral hearing.

In a December 6, 2004 decision, a hearing representative set aside the Office's October 2, 2006 decision. The hearing representative noted that Dr. Steinberg provided an impairment rating derived from cervical spine impairment rather than the functional deficit of the affected limb and therefore did not adhere to the Office's standards for impairment ratings. The hearing representative further noted that the Office erred in substituting the medical adviser's rating of one percent for that of the referee physician. The hearing representative instructed the Office to seek an addendum report from Dr. Steinberg advising him that the Office was unable to utilize ratings based on spinal or whole person impairments and request him to provide a rating for the left upper extremity in accordance with the A.M.A., *Guides*.

On January 19, 2007 the Office requested Dr. Steinberg provide an impairment of the left upper extremity in accordance with the A.M.A., *Guides*. It further requested that Dr. Steinberg review the report of the medical adviser's dated September 25, 2006 and provide an opinion as to whether the impairment rating based on C7 sensory deficit accurately reflected appellant's functional impairment.

In a March 8, 2007 report, Dr. Steinberg noted reviewing his prior findings and the September 25, 2006 report of the medical adviser. He disagreed with the Office medical adviser and opined that appellant had a C7 deficit which would be classified as a Grade 2 which is characterized as preventing some or most activities. Dr. Steinberg calculated that appellant had a four percent impairment of the left arm for sensory deficit or pain in the distribution of the C7 nerve root under Table 16-10 of the A.M.A., *Guides.*[11] He calculated that appellant had a maximum sensory loss of 5 percent for the C7 nerve of the left upper extremity under Table 16-13,[12] a Grade 2 pain in the distribution of the C7 nerve root under Table 16-10.[13] Dr. Steinberg

[9] *Id.* at 489, Figure 16-13.

[10] *Id.* at 482, Figure 16-10.

[11] *Id*. at 482, Table 16-10.

[12] *Id.* at 489, Figure 16-13

[13] *Id.* at 482, Figure 16-10.

noted that appellant's constellation of symptom frequency and intensity, which was characterized as preventing some or most activities, would merit a Grade 2 or 80 percent deficit.[14] Impairment due to sensory loss was calculated as 4 percent impairment for the left upper extremity by multiplying the 80 percent grade with the 5 percent maximum allowed for the C7 nerve.

In a decision dated March 28, 2007, the Office granted appellant a schedule award for four percent permanent impairment of the left arm. The period of the award was from August 22 to September 12, 2004. The Office noted that appellant was previously granted an award for three percent permanent impairment of the left upper extremity and was only entitled to an additional one percent impairment rating.

Appellant requested an oral hearing which was held on July 18, 2007. He submitted a functional capacity evaluation dated October 13, 2006 which noted his work restrictions. A July 19, 2007 EMG revealed eased flare-up of cervical radiculopathy affecting the right arm and stable cervical sprain, strain, myofascial syndrome and left upper extremity radiculopathy. On July 31, 2007 Dr. Schnall opined that appellant sustained 15 percent whole person impairment. He noted that based on the A.M.A., *Guides* appellant would be rated according to the diagnosis related estimate (DRE) designation for spine impairment, a category III which allows for a 15 to 18 percent rating of the whole person.[15] In a decision dated October 1, 2007, the hearing representative affirmed the Office decision dated March 28, 2007.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[16] and its implementing regulation[17] 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 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.[18]

ANALYSIS

On appeal, appellant contends that he has more than four percent permanent impairment of the left upper extremity. The Office accepted his claim for cervical strain, cervical radiculopathy, cervical root lesion, radiculitis and myofascial syndrome. It properly found that a

[14] *Id.*

[15] *Id.* at 392, Table 15-5.

[16] 5 U.S.C. § 8107.

[17] 20 C.F.R. § 10.404.

[18] *Donald E. Stockstad,* 53 ECAB 301 (2002), *petition for recon. granted* (*modifying prior decision*), Docket No. 01-1570 (issued August 13, 2002).

conflict in the medical evidence existed between Dr. Diamond, appellant's attending physician, and an Office medical adviser regarding the extent of appellant's impairment of the left upper extremity. Consequently, the Office referred appellant to Dr. Steinberg to resolve the conflict.

Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[19]

The Board finds that, under the circumstances of this case, the opinion of Dr. Steinberg is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight and establishes that appellant sustained no more than four percent impairment of the left upper extremity.

Dr. Steinberg reviewed appellant's history and reported findings. In a report dated August 3, 2006, he noted provocative testing for peripheral nerve compression on the left was positive for percussion of the cubital tunnel, there was full intrinsic strength, no atrophy, no motor findings of nerve dysfunction and reflexes were symmetric. Dr. Steinberg diagnosed sprain/strain of the neck, cervical radiculopathy, myofascial pain syndrome and cervical degenerative disc disease and opined that these diagnoses were medically connected to the work injury of July 5, 2002. He noted appellant's subjective complaints of neck pain with radiation affected appellant's activities of daily living. Dr. Steinberg applied Chapter 15 of the A.M.A., *Guides*, pertaining to the spine, and found 7 percent whole person impairment or 12 percent upper extremity impairment.

As Dr. Steinberg, in his August 3, 2006 report, derived his impairment finding based on the chapter of the A.M.A., *Guides* pertaining to the spine,[20] the Office, on January 19, 2007, properly requested that Dr. Steinberg determine appellant's impairment under provisions in the A.M.A., *Guides* pertaining to the upper extremities.[21] In a March 8, 2007 supplemental report, he calculated that appellant had four percent impairment of the left arm for sensory deficit or pain in the distribution of the C7 nerve root under Table 16-10 of the A.M.A. *Guides*.[22] Dr. Steinberg calculated that appellant had a maximum sensory loss of five percent for the C7 nerve of the left upper extremity under Table 16-13,[23] a Grade 2 pain in the distribution of the C7 nerve root under Table 16-10.[24] He noted that appellant's constellation of symptom frequency and intensity which was characterized as preventing some or most activities would merit a Grade

[19] *Aubrey Belnavis*, 37 ECAB 206 (1985). *See* 5 U.S.C. § 8123(a).

[20] No schedule awards are payable for the spine. *See George E. Williams*, 44 ECAB 530 (1993).

[21] *See Guiseppe Aversa*, 55 ECAB 164 (2003) (where 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 such specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original opinion).

[22] A.M.A., *Guides* 482, Table 16-10.

[23] *Id.* at 489, Figure 16-13.

[24] *Id.* at 482, Figure 16-10.

2 or 80 percent deficit.[25] Impairment due to sensory loss was calculated as 4 percent impairment for the left upper extremity by multiplying the 80 percent grade with the 5 percent maximum allowed for the C7 nerve. Dr. Steinberg found no other basis on which to attribute impairment of the left arm.

The Board finds that the opinion of Dr. Steinberg is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight and establishes that there is no basis under the A.M.A., *Guides* for more than four percent impairment. The Office properly noted that appellant was previously granted a schedule award for three percent permanent impairment of the left upper extremity therefore he was entitled to an additional schedule award for one percent for the left upper extremity.

Appellant submitted an impairment rating from Dr. Schnall dated July 31, 2007, who opined that appellant sustained 15 percent whole person impairment according to the DRE designation for spine impairment. Dr. Schnall referenced Table 15-5 of the A.M.A., *Guides* which pertains to impairment for a cervical spine injury.[26] However, neither the Act nor its regulations provide for the payment of a schedule award for whole body impairment or for impairment of the cervical spine, rather an appellant may be entitled to a schedule award for permanent impairment to an upper or lower extremity due to an injury of the neck, shoulders or spine.[27] Therefore, the Board finds that Dr. Schnall did not properly follow the A.M.A., *Guides*. An attending physician's report is of little probative value where the A.M.A., *Guides*, are not properly followed.[28]

CONCLUSION

The Board finds that the Office properly determined that appellant had no more than four percent permanent impairment of the left arm for which he received a schedule award.

[25] *Id.*

[26] *Id.* at 392, Table 15-5.

[27] *See Thomas J. Engelhart*, 50 ECAB 319, 320-21 (1999). *See supra* note 20.

[28] *See Paul R. Evans, Jr.*, 44 ECAB 646 (1993); *John Constantin*, 39 ECAB 1090 (1988) (medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

ORDER

IT IS HEREBY ORDERED THAT the October 1 and March 28, 2007 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: December 18, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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