United States Department of Labor
Employees' Compensation Appeals Board

S.S., Appellant	)	
and	)	**Docket No. 07-1654**
	)	**Issued: January 18, 2008**
U.S. POSTAL SERVICE, WEST MARKET STATION, Philadelphia, PA, Employer	)	

Appearances:
Appellant, pro se
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 June 6, 2007 appellant filed a timely appeal from schedule award decisions of the Office of Workers' Compensation Programs dated June 8 and 21, 2006. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determinations in this case.

ISSUE

The issue is whether appellant has more than 25 percent impairment of the right upper extremity and 15 percent impairment of the left upper extremity, for which she received schedule awards.

FACTUAL HISTORY

On March 15, 2002 the Office accepted that appellant, then a 38-year-old distribution clerk, sustained employment-related bilateral brachial plexus. She stopped work on August 25, 2001 and returned to full-time duty with permanent restrictions on May 16, 2002. On January 23, 2003 the Office accepted bilateral shoulder impingement and tendinitis. Appellant

missed intermittent periods from work for which she received disability compensation. By decision dated May 6, 2003, the Office denied her claim for wage-loss compensation for the period February 13 through 20, 2003. Appellant requested reconsideration on December 16, 2003 and in a March 1, 2004 decision, the Office modified the May 6, 2003 decision to find that she was entitled to wage-loss compensation for February 20, 2003 only. On April 20, 2004 appellant filed a schedule award claim.

By decision dated May 3, 2004, the Office granted 18 percent schedule award on the right arm and 10 percent on the left arm. Appellant received the award by lump-sum payment.

On May 5, 2004 appellant, through her attorney, requested a hearing that was held on February 14, 2005. In a May 11, 2005 decision, an Office hearing representative found a conflict between Dr. Nicholas P. Diamond, appellant's attending osteopath, and the Office medical adviser. The case was remanded to the Office for referral to an impartial medical specialist.[1]

The Office referred appellant to Dr. Walter W. Dearolf, a Board-certified orthopedic surgeon, selected as the impartial medical specialist. In a report dated June 22, 2005, Dr. Dearolf found that appellant had reached maximum medical improvement and provided examination findings and analysis in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[2] He advised right shoulder flexion was 100 degrees, a five percent impairment; abduction 90 degrees, a four percent impairment; adduction 60 degrees, no impairment; and full external rotation, no impairment. Dr. Dearolf stated that internal rotation was to the L5 region for a three percent impairment with pain and weakness with resisted abduction and normal external rotation, biceps and triceps strength. He found positive Tinel's and Phalen's signs on right. Appellant's December 11, 2002 electromyographic (EMG) study showed a mild sensory neuropathy. Under Table 16-15 she had a 39 percent sensory deficit which, when multiplied by a 25 percent Grade 3 deficit from Table 16-10, yielded a 10 percent deficit for CTS of the right arm. Dr. Dearolf opined that appellant was entitled to an additional 3 percent right upper extremity impairment for pain, for a total right upper extremity impairment of 25 percent. Examination of the left shoulder demonstrated flexion of 110 degrees for a 5 percent impairment, abduction 90 degrees for a 4 percent impairment, adduction 60 degrees for no impairment and external rotation full for no impairment with internal rotation also to the L5 region for a 3 percent impairment with an additional 3 percent impairment for pain, for a total 15 percent left upper extremity impairment.

By letter dated July 5, 2005, the Office informed Dr. Dearolf that CTS had not been accepted as employment related and an impairment rating for this condition should not be included. In a supplementary report dated August 23, 2005, Dr. Dearolf advised that, as CTS was not work related, appellant's total right upper extremity impairment was 15 percent.

[1] Dr. Diamond concluded that appellant had a 54 percent right upper extremity impairment and a 31 percent impairment on the left. The Office medical adviser concluded that appellant had an 18 percent impairment on the right: 10 percent for loss of motion, 5 percent for carpal tunnel syndrome (CTS) and 3 percent for pain. On the left he concluded that appellant had a 10 percent impairment for loss of motion.

[2] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

By decision dated September 2, 2005, the Office found that appellant was not entitled to an additional schedule award for her right upper extremity. In a September 12, 2005 decision, appellant was awarded an additional 5 percent left upper extremity impairment, for a total 15 percent left upper extremity impairment.

On September 30, 2005 appellant, through her attorney, requested a hearing regarding both decisions. At the March 3, 2006 hearing, counsel contended that he could not tell how Dr. Dearolf was selected and that, as appellant's CTS was preexisting, she was entitled to a schedule award for any impairment caused by this condition.

In a June 8, 2006 decision, an Office hearing representative found that Dr. Dearolf had been properly selected to perform an impartial evaluation. The September 12, 2005 decision, finding that appellant was entitled to an additional five percent left upper extremity impairment was affirmed. The hearing representative remanded the case to the Office to award appellant an additional seven percent for the impairment. He noted that Dr. Dearolf had initially concluded that appellant was entitled to a 25 percent right upper extremity impairment and that, as she had previously received a schedule award for an 18 percent impairment of her right upper extremity, she was entitled to an additional 7 percent. In a June 21, 2006 decision, appellant was awarded an additional 7 percent right upper extremity impairment, for a total 25 percent right upper extremity impairment.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulations[4] 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. The Act, however, 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.[5]

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.[6] Section 16.4 provides that in evaluating abnormal motion both active and passive motion measurements are necessary to evaluate the joint motion under the appropriate charts and these should be added to obtain the total motion impairment.[7] Section 16.8a of the A.M.A., *Guides* provides that in a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered

[3] 5 U.S.C. §§ 8101-8193.

[4] 20 C.F.R. § 10.404.

[5] *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[6] A.M.A., *Guides*, *supra* note 2 at 433-521.

[7] *Id.* at 451-52.

adequately by other methods, the loss of strength may be rated separately. An example of such situation would be loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated.[8]

Regarding CTS, the A.M.A., *Guides* provide:

> "If, after an *optimal recovery time* following surgical decompression, an individual continues to complain of pain, paresthesias, and/or difficulties in performing certain activities, three possible scenarios can be present--
>
> > (1) Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTS is rated according to the sensory and/or motor deficits as described earlier.
> >
> > (2) Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS is still present, and an impairment rating not to exceed [five] percent of the upper extremity may be justified.
> >
> > (3) Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength, and nerve conduction studies: there is no objective basis for an impairment rating."[9]

Section 16.5b of the A.M.A., *Guides* describes the methods for evaluating upper extremity impairments due to peripheral nerve disorders and provides that the severity of the sensory or pain deficit and motor deficit should be classified according to Tables 16-10a and 16-11a respectively. The values for maximum impairment are then to be discerned, utilizing the appropriate table for the nerve structure involved. The grade of severity for each deficit is then to be multiplied by the maximum upper extremity impairment value for the nerve involved to reach the proper upper extremity impairment for each function. Mixed motor and sensory or pain deficits for each nerve structure are then to be combined.[10] The A.M.A., *Guides* provides that in evaluating the hand, the total range of motion percentages should be combined with the percentages for sensory loss.[11]

Chapter 18 of the A.M.A., *Guides* allows for an impairment percentage to be increased by up to three percent for pain and provides a qualitative method for evaluating impairment due to chronic pain. However, Chapter 18 should not be used to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment

[8] *Id*. at 508.

[9] *Id.* at 495.

[10] *Id.* at 481.

[11] *Janae J. Triplette*, 54 ECAB 792 (2003).

systems given in other chapters of the A.M.A., *Guides*. Office procedures state that a separate pain calculation under Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain as outlined in Chapter 13, 16 and 17 of the fifth edition of the A.M.A., *Guides*.[12]

Section 8123(a) of the Act provides that if 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.[13] When 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.[14]

ANALYSIS

The Board finds this case is not in posture for decision. The Office properly determined that a conflict in medical evidence was created between the opinions of Dr. Diamond, appellant's attending osteopath who found a 54 percent right upper extremity impairment and a 31 percent left upper extremity impairment, and the Office medical adviser who concluded that appellant had an 18 percent impairment on the right and a 10 percent impairment on the left.[15] The Office referred appellant to Dr. Dearolf for an impartial evaluation.

Dr. Dearolf found that appellant was entitled to a five percent impairment for 100 degrees of right shoulder flexion and a 4 percent impairment for 90 degrees of abduction under Figures 16-40 and 16-43 of the A.M.A., *Guides*, respectively, and that appellant's adduction of 60 degrees and full external rotation would not entitle her to an impairment rating for decreased right upper extremity range of motion.[16] He addressed her CTS on the right, finding that she had a 39 percent sensory deficit under Table 16-15 which, when multiplied by the 25 percent Grade 3 deficit as described in Table 16-10,[17] yielded an additional 10 percent right upper extremity impairment, for a total 15 percent right upper extremity impairment. Regarding the left upper extremity, Dr. Dearolf found that appellant's shoulder flexion of 110 degrees yielded a five percent impairment and abduction of 90 degrees yielded a 4 percent impairment under Figures 16-40 and 16-43 respectively. Appellant's adduction of 60 degrees and full external rotation did

[12] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); A.M.A., *Guides* at section 18.3(b); *T.H.*, 58 ECAB ____ (Docket No. 06-1500, issued January 31, 2007).

[13] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[14] *Manuel Gill*, 52 ECAB 282 (2001).

[15] *Supra* note 1.

[16] A.M.A., *Guides*, *supra* note 2 at 476-77.

[17] *Id.* at 482, 492.

not entitle her to an impairment rating for decreased left upper extremity range of motion.[18] This totaled nine percent left upper extremity impairment.

The Board notes that Dr. Dearolf did not provide an adequate explanation for his finding three percent impairments for internal rotation of each upper extremity as he did not provide range of motion measurements in accordance with the A.M.A., *Guides*.[19] Moreover, according to section 18.3(b) of the A.M.A., *Guides*, examiners should not use this chapter to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.[20] Office procedures provide that Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain.[21] Appellant's right upper extremity pain had been considered under the sensory deficit analysis for her CTS and she would therefore not be entitled to an additional three percent for pain. Regarding the left upper extremity, the physician did not explain why appellant's condition could not be adequately rated under Chapter 16 relevant to upper extremity impairments.[22]

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 defect in the original report.[23] The case will therefore be remanded to the Office to secure a supplementary report from Dr. Dearolf to provide proper analysis for internal rotation of each upper extremity in accordance with the A.M.A., *Guides* and for a further explanation as to why appellant's left upper extremity cannot be adequately assessed in accordance with Chapter 16 of the A.M.A., *Guides*. After such further development as it deems necessary, the Office shall issue an appropriate decision.[24]

CONCLUSION

The Board finds that this case is not in posture for decision.

[18] *Id*. at 476-77.

[19] The analysis for shoulder range of motion deficits in internal rotation can be found at Figure 16-46, *id.* at 479.

[20] A.M.A., *Guides*, *supra* note 2 at 517.

[21] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003); *see T.H.*, *supra* note 12.

[22] *See P.C.*, 58 ECAB ____ (Docket No. 07-410, issued May 31, 2007).

[23] *See Adrienne L. Curry*, 53 ECAB 750 (2002).

[24] The Board notes that appellant submitted evidence subsequent to the June 21, 2006 schedule award decision. The Board cannot consider this evidence, however, as its review of the case is limited to the evidence which was before the Office at the time of its final decision. 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated June 21 and 8, 2006 be set aside and the case remanded to the Office for proceedings consistent with this opinion of the Board.

Issued: January 18, 2008
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