United States Department of Labor
Employees' Compensation Appeals Board

A.T., Appellant	)	
and	)	**Docket No. 07-885**
	)	**Issued: June 24, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Palantine, IL, Employer	)	

Appearances:
Appellant, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 12, 2007 appellant filed a timely appeal from the merit decision of the Office of Workers' Compensation Programs dated October 26, 2006 denying his request for a schedule award of greater than 41 percent. He also filed a timely appeal of the January 12, 2007 nonmerit decision denying the request for an oral hearing. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2), the Board has jurisdiction to review the merits and nonmerits of this case.

ISSUES

The issues are: (1) whether appellant has established that he has greater than 44 percent of his right upper extremity, for which he received schedule awards; and (2) whether the Office properly denied appellant's request for an oral hearing.

FACTUAL HISTORY

On July 30, 2002 appellant, then a 42-year-old flat sorting machine clerk, filed an occupational disease claim alleging that he sustained an injury to his right shoulder as a result of loading mail and lifting and pulling all-purpose containers, hampers and Tub-packs as part of his

federal employment. He indicated that he first became aware of the disease or illness on June 17, 2002. By letter dated October 23, 2002, the Office accepted appellant's claim for right shoulder tendinitis, joint impingement and carpal tunnel syndrome. On November 12, 2002 appellant underwent a decompression of transverse carpal ligament for right carpal tunnel syndrome. On April 1, 2003 appellant underwent an arthroscopy on the right shoulder. The Office paid appropriate compensation and medical benefits.

On July 7, 2003 appellant filed a claim for a schedule award. By letter dated August 6, 2003, the Office stated that appellant was not entitled to a schedule award at that time as he was currently under the care of a physician and had not yet reached maximum medical improvement.

In a report dated June 17, 2003, Dr. D.A. Minnis, a chiropractor, diagnosed postsurgical release of right carpal tunnel syndrome with permanent residuals and applying the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), determined that appellant had a 40 percent impairment of the right upper extremity. He reached the same assessment in a report dated October 20, 2003.

In a medical note dated September 16, 2003, Dr. J. Michael Morgenstern indicated that appellant had reached maximum medical improvement and was scheduled to return to his regular work duties. The Office referred appellant's case to the Office medical adviser, who by note dated October 6, 2003 indicated that he had an impairment of the right upper extremity of 41 percent. He noted as follows:

> "Drs. Morgenstern and Minnis have submitted reports to the medical record for review. [Appellant] continues to complain of intermittent pain in the distribution of the scar on the right wrist that radiates into the right thumb. Physical examination demonstrated increased two-point discrimination in the right median nerve innervated digits awarding 25 percent RUE PPI [right upper extremity permanent partial impairment] for [G]rade 2 sensory deficit in the distribution of the median nerve according to [T]ables 16-15, p[age] 492 and [T]able 16-10, p[age] 482 of the [A.M.A., *Guides*, (5th ed.)]. Pinch strength measured 7.5 dg in the right hand which is normal according to [T]able 16-33, p[age] 509 of the A.M.A., *Guides.* Grip strength measured 18.2 kg [kilograms] which awards an additional 20 percent RUE PPI according to [T]ables 16-31 and 16-34, p[age] 509 of the A.M.A., *Guide*[*s*].
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> "Regarding to the [right] shoulder, [appellant] continues to complain of intermittent discomfort in the right shoulder especially with overhead activity allowing two PPI for [G]rade 3 in the distribution of the suprascapular nerve according [to] p[age] 492 and [T]able 16-10, p[age] 482 of the [A.M.A., *Guides*]. Physical examination demonstrated normal range of motion and strength in the right upper extremity.
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> "Use of the [C]ombined [V]alues [C]hart on p[age] 604 gives a right upper extremity of 41 percent. Date of MMI [maximum medical improvement] is estimated to have occurred as of September 16, 2003 when he was released from Dr. Morgenstern's care.

On October 6, 2003 appellant filed another claim for a schedule award. On January 8, 2004 the Office issued a schedule award in this case for a 41 percent impairment to the right upper extremity. Furthermore, in a decision dated September 22, 2004, the Office issued a schedule award to appellant for an additional three percent impairment to his right upper extremity in a different case. Accordingly, appellant has received a total schedule award for 44 percent impairment of his right upper extremity.

Appellant requested an oral hearing and by decision dated August 26, 2004, the Office hearing representative remanded the case for referral of him to a second opinion physician as he found that there was no report in the record that accurately reflected appellant's degree of impairment. He noted that the report of Dr. Minnis was insufficient to establish degree of impairment as Dr. Minnis was a chiropractor and is not considered a physician under the Federal Employees' Compensation Act as he was not treating a subluxation of the spine as demonstrated by x-ray. She further noted that Dr. Morgenstern had not provided a sufficient description of impairment to the shoulder upon which to base a schedule award.

On November 24, 2004 appellant filed a claim for an additional schedule award. In support thereof, he submitted a medical report dated November 20, 2004 wherein Dr. Jacob Salomon gave the results of his physical examination, which included range of motion measurements and muscle strength testing. Dr. Salomon stated:

> "I shall utilize the [A.M.A. *Guides*] and give the [appellant] a rating and feel the rating could best be attributed to the muscle strength weakness to best evaluate his impairment due to the fact that we have done it a few times [three] to [four] times and it was done by [two physicians] with the same results. We will utilize [T]able 16-35, page 510, [G]rade 4 for muscle weakness. So for flexion at [G]rade 4, [appellant] would be 6 percent, abduction at [G]rade 4 would be 3 percent and internal rotation at [G]rade 4 would be 2 percent to obtain 11 percent impairment rating due to muscle strength weakness of the right shoulder, this would then be combined by the 10 percent for the arthroscopic surgery on [T]able 16-7 of resection arthroplasty. Using the combined charts in the back of the book to obtain a total of 20 percent right shoulder impairment, then to obtain the total right PPI by combining all the other conditions. The carpal tunnel did not change so that was at 33 percent that will be 46 percent impairment that will combine by the previous impairment for the right elbow of 9 percent using the combined charts of the back of the book, to obtain a total right PPI of 54 percent. He stated that there was a previous rating given to him of 41 percent. If indeed this is tru[e] 41 percent would be subtracted from the above with the remainder being the current impairment rating that was not accounted for."

By letter dated January 13, 2005, the Office referred appellant for a second opinion evaluation. In a medical report dated April 14, 2005, Dr. Edward S. Forman listed his impressions as status post right shoulder arthroscopic subacromial decompression and status post

right carpal tunnel release. He found that appellant had a 33 percent permanent impairment of the right upper extremity. Dr. Forman stated:

> "According to [the] [A.M.A., *Guides*] [T]able 16-10 diminished light touch is broken into different grades. At this time it is felt that [appellant] had a [G]rade 4 sensory deficit. This translates to 0 to 25 percent according to the [A.M.A., *Guides*]. In addition, [T]able 16-15 also in the [A.M.A., *Guides*], documents that the maximum upper extremity (in layman's term arm) impairment is due to one side sensory deficit of the median nerve below the mid-forearm (the median nerve extending down below the elbow) is 39 percent. In calculating these percentages out the severity of the sensory deficit (25 percent) has been multiplied by the maximum allowable upper extremity impairment (the amount of impairment allowed for the arm) being 39 percent. An upper extremity impairment thus was obtained of 10 percent. Grip strength which was also tested at this time is then measured against [T]ables 16-31, 16-32 and 16-34 in the [f]ifth [e]dition of the [A.M.A., *Guides*] to the right grip strength deficit. These values were 49 kg minus 37 kg. This is divided by 49 kg equaling 24 percent of the strength loss. Using additional tables in the [A.M.A., *Guides*] on the [C]ombined [V]alues [C]hart on [p]age 604 corresponds to a partial permanent impairment for right carpal tunnel syndrome of 32 percent. In regard to [appellant's] [right] shoulder the PPI determination based on [his] complaint of persistent pain even though he does have full functional range of motion. According to [F]igures 15-40, 15-41, 15-43 and 15-46 document in the [A.M.A., *Guides*] there is no motor functional deficit or impairment. According to [T]able 16-2 also of the [f]ifth [e]dition of the [A.M.A., *Guides*] the suprascapular nerve corresponds with the supraspinatus (a large nerve in the shoulder which corresponds with the supraspinatus one of the four rotator cuff muscles) is consistent with a sensory deficit or pain of up to [five] percent maximum examination impairment. In addition in determining the impairment of the upper extremity (arm in layman's term) due to sensory deficit or pain according to [T]able 16-10, again in the [A.M.A., *Guides*, appellant] is a [G]rade 4 with 25 percent sensory deficit. Multiplying this by the [five] percent of the maximum upper extremity (arm) for impairment correlates with a [one] percent upper extremity partial permanent impairment for the shoulder. Thus, again using the [C]ombined [V]alues [C]hart on [p]age 604 of the [A.M.A., *Guides*, appellant] has been noted to have a 33 percent [PPI] of the right upper extremity."

On May 31, 2005 the Office found that appellant is not entitled to a greater schedule award to the right upper extremity.

On September 19, 2006 appellant filed a claim for an additional schedule award.[1]

[1] This claim references a date of injury of May 11, 2004, which would indicate that it was in reference to a different claim by appellant for an injury to his left upper extremity. However, the file number assigned by the Office was the file number for appellant's June 17, 2002 injury *i.e.*, file number 10-2013028.

By letter dated October 5, 2006, the Office asked the Office medical adviser to determine the extent of permanent impairment of the upper extremities pursuant to the A.M.A., *Guides*. The Office medical adviser noted that appellant already had received an award for a 44 percent permanent impairment to the right upper extremity. In a report dated October 9, 2006, the Office medical adviser opined:

> "From my review of the medical records, [appellant] has been generously awarded 41 RUE PPI primarily based on a sensory deficit and grip weakness as residua from his carpal tunnel surgery. While determining that PPI is often more art than science, I do not find substantive objective data to support any increase in this PPI after review of all the additional medical data….
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> "Therefore, there is no objective evidence to support any increase in the 41 percent RUE PPI already awarded. Date of MMI remains September 16, 2003."

By decision dated October 26, 2006, the Office denied appellant's claim for an additional schedule award to the right upper extremity.

In a form dated December 2, 2006 and postmarked December 8, 2006, appellant requested an oral hearing. By decision dated January 12, 2007, the Office denied appellant's request for an oral hearing as it was not timely filed. The Office further reviewed appellant's request under its discretionary powers and determined that the issue could equally well be addressed by requesting reconsideration from the Office and submitting evidence not previously considered.

LEGAL PRECEDENT

The schedule award provision of the Act[2] and its implementing regulations,[3] 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, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[4] Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2007.[5]

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] 20 C.F.R. § 10.404(a).

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

The standards for evaluation of the permanent impairment of an extremity under the A.M.A., *Guides* are based on loss of range of motion, together with all factors that prevent a limb from functioning normally, such as pain, sensory deficit and loss of strength. All of the factors should be considered together in evaluating the degree of impairment.[6] Chapter 16 of the fifth edition of the A.M.A., *Guides* provides a detailed grading scheme and procedures for determining impairments of the upper extremities due to pain, discomfort restricted motion, loss of sensation or loss of strength.[7] Chapter 16 specifies that flexion, extension, abduction, adduction, internal rotation and external rotation are all to be considered in evaluating impairments of shoulder motion.[8] The A.M.A., *Guides* provides specific grading schemes for rating upper extremity impairments due to restricted motion, including a lack of flexion and extension of the shoulder.[9]

Section 8123 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.[10]

ANALYSIS

Appellant has already received two schedule awards for impairment to his right upper extremity. On January 8, 2004 the Office issued a schedule award in this case for a 41 percent impairment of the right upper extremity. Furthermore, in a decision dated September 22, 2004, the Office issued a schedule award for an additional 3 percent impairment to the right upper extremity, for a total of 44 percent.

Dr. Minnis, appellant's chiropractor, determined that appellant was entitled to a 40 percent impairment of the right upper extremity, which is less than the amount he was awarded. At any rate, the Office properly determined that this report was not medical evidence as Dr. Minnis, a chiropractor, is not considered a physician under the Act.[11]

However, the Board finds that a conflict in medical opinion arose between the opinion of Dr. Salomon, appellant's physician, who opined that appellant had a 54 percent impairment of his right upper extremity and that of the second opinion physician, Dr. Forman, who found a 33 percent impairment of the right upper extremity.

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[6] *See Paul A. Toms*, 28 ECAB 403 (1987).

[7] A.M.A., *Guides*, Chapter 16, The Upper Extremities, pages 433-521 (5th ed. 2001).

[8] *Id.* at page 474, paragraph 16.4i, Shoulder Motion Impairment.

[9] Figure 16-40, page 476 of the A.M.A., *Guides* is entitled Pie Chart of Upper Extremity Motion Impairments Due to Lack of Flexion and Extension of Shoulder. Figure 16-43, page 477 of the A.M.A., *Guides* is entitled Pie Chart of Upper Extremity Motion Impairments Due to Lack of Abduction and Adduction of Shoulder. Figure 16-46, page 479 of the A.M.A., *Guides* is entitled Pie Chart of the Upper Extremity Motion Impairments Due to Lack of Internal and External Rotation of Shoulder.

[10] 5 U.S.C. § 8123; *see Charles S. Hamilton*, 52 ECAB 110 (2000).

[11] In the absence of a diagnosis of spinal subluxation, a chiropractor is not considered a physician and the report is of no probative value. *Thomas R. Horsfall*, 48 ECAB 180 (1996).

In determining that appellant had a 54 percent impairment of his right upper extremity, Dr. Salomon noted that, in the last impairment rating of appellant, he had a 33 percent impairment rating for carpal tunnel syndrome and that this rating had not deteriorated. He also noted that appellant's right elbow remained at 9 percent impairment. Dr. Salomon then found an 11 percent impairment based on a Grade 4 impairment to appellant's right shoulder; specifically noting 6 percent for flexion, 3 percent for abduction and 2 percent for internal rotation. He then noted a 10 percent impairment for arthroscopic surgery. Using the combined values tables, he indicated that this yielded a 20 percent right shoulder impairment. When Dr. Salomon combined this finding with the prior 33 percent impairment due to carpal tunnel syndrome he found a 46 percent impairment. He then combined the 9 percent impairment due to the right elbow and found that this yielded a 54 percent impairment.[12] Dr. Forman, however, found that appellant established a 33 percent impairment of his right upper extremity based on a 1 percent upper extremity impairment for the shoulder and a right carpal tunnel syndrome impairment of 32 percent. He then noted no motor functional deficit or impairment.[13] Finally, the Office medical adviser determined that there was no objective evidence to support an increase above the 41 percent schedule award for the right upper extremity previously awarded. Accordingly, there is an unresolved conflict between appellant's physician, Dr. Salomon, and the second opinion physician, Dr. Forman. The case must be remanded to the Office for referral to an impartial medical examiner for resolution of the conflict.

CONCLUSION

The case is not in posture for decision.[14]

[12] For support thereof, Dr. Salomon specifically mentions utilizing the A.M.A., *Guides*, Figures 16-46, page 510 and Table 16-7.

[13] Dr. Forman utilized the A.M.A., *Guides*, Figures 15-40, 15-41, 15-43 and 15-46 for determining no motor functional deficit or impairment. He utilized Table 16-10 to determine that appellant had a sensory deficit of 1 percent upper extremity impairment for the shoulder.

[14] In light of the resolution of this issue, the issue with regard to oral hearing is moot.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated October 26, 2006 and January 12, 2007 are vacated and this case is remanded to the Office for further consideration consistent with this opinion.[15]

Issued: June 24, 2008
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

[15] By decision dated February 15, 2007, the Office denied appellant's request for reconsideration. As appellant filed his appeal before this Board on February 12, 2007 and the Office and the Board cannot have jurisdiction over the same issue at the same time, this decision is null and void. Therefore, any decision issued during the pendency of appellant's appeal before this Board is null and void. *Douglas E. Billings*, 41 ECAB 880, 895 (1990).