United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 09-92**
	)	**Issued: August 19, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Newport, VA, Employer	)	

Appearances:
Jeffrey P. Zeelander, 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 October 15, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs' July 23, 2008 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 six percent permanent impairment of the left upper extremity for which he received a schedule award.

FACTUAL HISTORY

On June 10, 2003 appellant, then a 34-year-old city carrier, filed an occupational disease claim for a left rotator cuff tear due to carrying his mailbag while working. The Office accepted the claim for left rotator cuff tear and left carpal tunnel syndrome. It authorized arthroscopic surgeries on September 16, 2004 and October 19, 2005 and left carpal tunnel release on July 19, 2006. Appellant did not stop work.

Appellant came under the treatment of Dr. Thomas M. Stiles, a Board-certified orthopedist. On September 16, 2004 Dr. Stiles performed arthroscopic surgery of the left shoulder with debridement of the rotator cuff and the humeral attachment and diagnosed rotator cuff tear of the left shoulder. In reports dated September 29, 2004 to August 11, 2005, he noted appellant's complaints of snapping of the left shoulder with worsening pain and recommended a repeat arthroscopy. On October 19, 2005 Dr. Stiles performed an arthroscopic surgery of the left shoulder with subacromial debridement and bursectomy and open rotator cuff repair. He diagnosed left shoulder rotator cuff tear, with tendinitis of the supraspinatus tendon and rather marked adhesive bursitis. Dr. Stiles subsequently noted that appellant developed carpal tunnel syndrome associated with multiple surgeries and repetitive use of his left hand before the surgeries. On July 19, 2006 he performed a carpal tunnel decompression with neurolysis of the ulnar and median nerve. A left shoulder arthrogram dated June 19, 2006 revealed a prior rotator cuff repair, large subacromial spur and minimal articular surface partial tear.

Appellant submitted reports from Dr. Stiles dated November 7, 2006 to August 16, 2007 who treated him for left shoulder pain radiating into his triceps and impingement. On May 8, 2007, Dr. Stiles opined that appellant had 21 percent impairment of the left arm pursuant to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,*[1] (A.M.A., *Guides*). He noted that appellant had five percent impairment rating for left carpal tunnel syndrome;[2] 70 degrees of flexion for seven percent impairment; 70 degrees of abduction for five percent impairment; internal rotation of 45 degrees for three percent impairment; external rotation of 20 degrees for one percent impairment. On September 13, 2007 appellant filed a claim for a schedule award.

The Office referred Dr. Stiles' report and the case record to the Office's medical adviser who, in a report dated October 31, 2007, noted appellant reached maximum medical improvement with regard to the shoulder on October 19, 2006. With regard to impairment of the left upper extremity due to loss of range of motion, he determined that functional capacity evaluation figures of June 6, 2007 were more detailed, with definitive range of motions in all planes as compared to Dr. Stiles' report of May 8, 2007 and therefore more reliable. The medical adviser opined that using shoulder ranges of motion from the functional capacity evaluation would yield 11 percent impairment. With regard to impairment due to carpal tunnel syndrome, the medical adviser found that Dr. Stiles failed to provide a detailed sensory and motor examination of the median distribution including two-point discrimination which was imperative to adequately assess any residual impairment from carpal tunnel syndrome. He recommended further diagnostic studies and referral to a second opinion physician before rendering an opinion as to maximum medical improvement regarding carpal tunnel syndrome.

On December 28, 2007 the Office referred appellant for a second opinion to Dr. Philip LeNoach, a Board-certified orthopedist, for determination of permanent impairment. In a February 20, 2008 report, Dr. LeNoach indicated that he reviewed the records provided to him and examined appellant. He diagnosed rotator cuff tear of the left shoulder repaired arthroscopically followed by open rotator cuff repair revision, chronic left shoulder pain,

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

[2] *Id.* at 495.

permanent loss of motion of the left shoulder and release of the median and ulnar nerve left wrist with residual loss of motion of the thumb. Dr. LeNoach opined that appellant reached maximum medical improvement with regard to both conditions on May 8, 2007. He noted findings for the left shoulder of forward flexion was 140 degrees for three percent impairment[3] and active abduction was 110 degrees for three percent impairment.[4] Dr. LeNoach noted full strength for flexion, abduction and external rotation on the left side. He noted examination of the left hand revealed a six-centimeter well-healed, nonsensitive scar, with no paresthesia, numbness or tingling present, sensation was light to touch grip strength was slightly less than the right hand and a four-centimeter restriction in active adduction.

Appellant submitted reports from Dr. Stiles dated December 5, 2007 to June 18, 2008 who noted good range of motion of the left shoulder with crepitation when elevated and opined that appellant reached maximum medical improvement. An electromyogram dated April 2, 2008 revealed no abnormalities.

In an addendum report dated April 11, 2008, Dr. LeNoach noted forward flexion was 140 degrees for three percent impairment[5] and active abduction was 110 degrees for three percent impairment[6] for a total of six percent impairment of the left arm due to shoulder range of motion deficit under the A.M.A., *Guides*. With regard to the left hand he noted a four-centimeter adduction loss in the thumb for four percent impairment of the thumb in accordance with Table 16–8B.[7] Dr. LeNoach noted an EMG of the left upper extremity on April 2, 2008 revealed no abnormalities.

In a June 2, 2008 report, an Office medical adviser noted that appellant reached maximum medical improvement on July 19, 2007. He concurred with Dr. LeNoach and found that appellant had six percent impairment of the left upper extremity for residuals due to loss of motion of the left shoulder. The Office medical adviser noted that Dr. LeNoach provided references to the A.M.A., *Guides* and properly evaluated the impairment of the shoulder. With regard to the impairment rating for the hand, the medical adviser noted that there was no accepted condition as it related to appellant's hand. With regard to the carpal tunnel syndrome, he concurred with Dr. LeNoach's determination that an updated EMG revealed no abnormalities and therefore no impairment.

In a July 23, 2008 decision, the Office granted appellant a schedule award for six percent permanent impairment of the left upper extremity. The period of the award was from July 19 to November 27, 2007.

[3] *Id.* at 476, Figure 16-40.

[4] *Id*. at 477, Figure 16-43.

[5] *Id.* at 476, Figure 16-40.

[6] *Id.* at 477, Figure 16-43.

[7] *Id.* at 459.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[8] and its implementing regulations[9] 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 regulations as the appropriate standard for evaluating schedule losses.

ANALYSIS

On appeal, appellant contends that he has more than six percent permanent impairment of the left arm and that the Office should accept the impairment found by Dr. Stiles. The Office accepted appellant's claim for left rotator cuff tear and left carpal tunnel syndrome. It authorized arthroscopic surgery which was performed on September 16, 2004 and October 19, 2005 and left carpal tunnel release which was performed on July 19, 2006. The Board finds that there is a conflict in medical opinion between the second opinion physician and Office medical adviser and appellant's treating physician, Dr. Stiles.

In his reports dated February 20 and April 11, 2008, Dr. LeNoach, the second opinion physician, noted findings upon physical examination of the left shoulder of forward flexion of 140 degrees for three percent impairment[10] active abduction of 110 degrees for three percent impairment;[11] and four percent impairment for the left thumb. The Board notes that Dr. LeNoach's findings for the left thumb would not be appropriate in this case as appellant's condition was not accepted for a thumb injury and impairment ratings are not granted for nonaccepted conditions.[12] The Office medical adviser, who in a report dated June 2, 2008, concurred with Dr. LeNoach in calculating six percent impairment for loss of range of motion of the left shoulder.

In contrast, Dr. Stiles on May 8, 2007 also applied the A.M.A., *Guides* and found that appellant sustained a 21 percent impairment rating of the left arm. He noted that appellant had

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] A.M.A., *Guides* 476, Figure 16-40.

[11] *Id.* at 477, Figure 16-43.

[12] *See Alice J. Tysinger*, 51 ECAB 638 (2000) (for conditions not accepted by the Office as being employment related, it is the employee's burden to provide rationalized medical evidence sufficient to establish causal relation, not the Office's burden to disprove such relationship). There would also be no basis for rating loss of thumb motion due to appellant's accepted carpal tunnel syndrome as the Board has found that the fifth edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory deficits only. *B.P.*, 60 ECAB ___ (Docket No. 08-1457, issued February 2, 2009).

five percent impairment rating for left carpal tunnel syndrome;[13] seven percent impairment for 70 degrees of flexion;[14] five percent impairment for 70 degrees of abduction;[15] three percent impairment for 45 degrees of internal rotation[16] and one percent impairment for 20 degrees of external rotation.[17] The Board notes that Dr. Stiles' findings with regard to carpal tunnel syndrome were not supported by the record, specifically, he failed to provide a detailed sensory and motor examination of the median distribution including two point discrimination and abnormal EMG findings in support of the impairment rating.[18] The impairment rating by Dr. Stiles for loss of range of motion for the left shoulder would be 16 percent. The Board notes that Dr. Stiles' findings with regard to loss of range of motion of the left shoulder were greater than that determined by Dr. LeNoach and the medical adviser and would provide appellant with a greater impairment than that granted by the Office. Dr. Stiles supported an increased impairment rating of the left arm, while the second opinion physician and Office medical adviser opined that appellant sustained no more than a six percent permanent impairment of the left upper extremity.

Section 8123(a) of the Act provides in pertinent part: "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."[19] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.[20] The Board finds that the Office should have referred appellant to an impartial medical specialist to resolve the medical conflict regarding the extent of permanent impairment arising from appellant's accepted employment injury.

Therefore, to resolve the conflict in the medical opinion the case will be remanded to the Office for referral of appellant, to an impartial medical specialist for a determination regarding the extent of appellant's left upper extremity impairment as determined in accordance with the relevant standards of the A.M.A., *Guides*.[21] After such further development as the Office deems necessary, an appropriate decision should be issued regarding the extent of appellant's left upper extremity impairment.

[13] *Id.* at 495.

[14] *Id.* at 476, Figure 16-40.

[15] *Id*. at 477, Figure 16-43.

[16] *Id.* at 479, Figure 16-46

[17] *Id.*

[18] *See id.* at 495.

[19] 5 U.S.C. § 8123(a).

[20] *William C. Bush*, 40 ECAB 1064 (1989).

[21] *See Harold Travis*, 30 ECAB 1071, 1078-79 (1979).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the July 23, 2008 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision.

Issued: August 19, 2009
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