United States Department of Labor
Employees' Compensation Appeals Board

J.C., Appellant	)	
and	)	**Docket No. 08-1778**
	)	**Issued: March 11, 2009**
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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 10, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs March 5, 2008 decision of a hearing representative regarding appellant's 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 nine percent permanent impairment of both the right and left upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On May 12, 2004 appellant, then a 49-year-old letter carrier filed a traumatic injury claim alleging that on April 29, 2004, while delivering mail, he slipped and fell on his back injuring his

left foot, back, neck, shoulders and left knee.[1] The Office accepted appellant's claim for cervical strain and bilateral shoulder strains and expanded his claim to include cervical radiculopathy at C6 and C7. Appellant stopped work on May 4, 2004 and returned on May 12, 2004 and worked intermittently thereafter.

A magnetic resonance imaging (MRI) scan of the left shoulder dated May 26, 2004 revealed supraspinatus tendinopathy and a small partial thickness tear. An MRI scan of the right shoulder dated May 28, 2004 revealed a chronic full thickness tear of the supraspinatus tendon. An MRI scan of the cervical spine dated June 23, 2004 revealed disc degeneration and disc bulging at the C5-6 and C6-7 levels. An electromyogram (EMG) dated August 11, 2004 revealed mild carpal tunnel syndrome and subacute C7-8 radiculopathy.

On November 2, 2004 the Office referred appellant for a second opinion to Dr. Robert F. Draper, Jr., a Board-certified orthopedist. In a November 17, 2004 report, Dr. Draper indicated that he reviewed the records provided to him and examined appellant. He diagnosed cervical strain, preexisting degenerative cervical disease with disc protrusions, disc bulging at C5-6 and C6-7, right shoulder strain, preexisting degenerative changes of the humeral head, preexisting osteoarthritis of the right acromioclavicular joint, left shoulder strain, preexisting degenerative change of the humeral head and preexisting osteoarthritis of the left shoulder. Dr. Draper noted that 50 percent of appellant's complaints were associated with preexisting degenerative cervical disc disease and preexisting osteoarthritis of the bilateral shoulders and 50 percent was related to the April 29, 2004 work injury. He opined that appellant could return to work full time with restrictions.

On August 15, 2005 the Office reduced appellant's compensation to reflect her actual earnings as a full-time limited-duty letter carrier effective February 26, 2005.

On February 27, 2006 appellant filed a schedule award claim. In a June 9, 2005 report, Dr. David Weiss, an osteopath, noted that appellant reached maximum medical improvement on June 9, 2005. Cervical spine examination revealed tenderness over the posterior midline from C3-7 and range of motion was carried through with pain. Right shoulder examination revealed focal acromioclavicular joint point tenderness, circumduction was positive for crepitance, range of motion for forward elevation measured 160 degrees, abduction measured 90 degrees, adduction measured 65 degrees, external rotation measured 80 degrees and internal rotation measured 35 degrees. Left shoulder examination showed focal acromioclavicular joint point tenderness and circumduction was positive for crepitance. Dr. Weiss noted that, based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,*[2] (A.M.A., *Guides*), appellant had 41 percent impairment of the right arm and 50 percent impairment of the left arm. He calculated that right shoulder flexion of 160 degrees yielded one percent impairment, abduction of 90 degrees yielded four percent impairment and

[1] The record indicates that appellant has filed other injury claims. On August 23, 1998 she sustained an injury which was accepted for right ankle sprain/strain, file number xxxxxx994. A July 13, 1992 injury was accepted for lumbar sprain/strain, file number xxxxxx524. A March 13, 1993 injury was accepted for left side abrasion, file number xxxxxx872. A July 7, 1998 injury was accepted for neck and shoulder strain, file number xxxxxx383.

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

internal rotation of 35 degrees yielded four percent impairment. Dr. Weiss found a Grade 3 sensory deficit of the right arm C6 nerve root for 5 percent impairment, Grade 3 sensory deficit of the right C7 nerve root for 3 percent impairment and 30 percent impairment for a right grip strength deficit. For the left arm he found three percent impairment for 140 degrees of flexion, six percent impairment for 90 degrees of abduction and one percent impairment for 70 degrees of internal rotation. Dr. Weiss further found a Grade 3 sensory deficit of the left C5 nerve root for 3 percent impairment, a Grade 3 sensory deficit of the left C6 nerve root for 5 percent impairment, a Grade 3 sensory deficit of the right C7 nerve root for 3 percent impairment, a Grade 4 motor strength deficit left thumb abduction for 9 percent impairment and 30 percent impairment for left grip strength deficit.

In a June 9, 2006 report, an Office medical adviser found that appellant had three percent left arm impairment. He noted that Dr. Weiss' calculation was nonspecific as he did not list the diagnoses he was rating. The medical adviser indicated that he used the findings of Dr. Draper, the second opinion physician, to calculate the impairment for loss of shoulder range of motion because he believed these figures reflected appellant's best effort. He found zero percent impairment for the right shoulder flexion of 180 degrees, abduction of 190 degrees, internal rotation of 90 degrees and external rotation of 90 degrees. For the left shoulder the medical adviser found zero percent impairment for flexion of 180 degrees, abduction of 180 degrees, internal rotation of 90 degrees and external rotation of 90 degrees. He indicated that with respect to cervical root deficits at C5-6, Dr. Weiss' findings and impairment contradicted the objective findings by the second opinion physician and noted that the only objective bases for cervical nerve root impairment was the EMG evidence for C7 nerve root radiculopathy and therefore appellant would have a sensory deficit of the left C7 nerve root of three percent impairment. The medical adviser referenced the appropriate tables and charts in the A.M.A., *Guides.*

The Office found that a medical conflict existed between the opinions of Dr. Weiss and the Office medical adviser regarding appellant's permanent impairment. To resolve the conflict, on July 26, 2006, the Office referred appellant to a referee physician, Dr. Menachem M. Meller, a Board-certified orthopedic surgeon.

In an August 16, 2006 report, Dr. Meller noted reviewing the record and appellant's history. On examination he noted normal symmetric reflexes, excellent grip and pinch strength, normal radial and ulnar nerves and negative Tinel's sign at the cubital, carpal and radial tunnels. Range of motion testing of the shoulders revealed flexion of 140 degrees on the right for three percent impairment,[3] extension measured 50 degrees on the right for zero percent impairment,[4] abduction measured 120 degrees on the right for three percent impairment,[5] adduction measured 35 degrees on the right for zero percent impairment,[6] external rotation measured 70 degrees on the right for zero percent impairment[7] and internal rotation measured 75 degrees on the right for

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

[4] *Id.*

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

[6] *Id.*

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

one percent impairment.[8] With regard to the left shoulder flexion measured 140 degrees for three percent impairment,[9] extension measured 45 degrees on the left for one percent impairment,[10] abduction measured 115 degrees on the left for three percent impairment,[11] adduction measured 35 degrees on the left for zero percent impairment,[12] external rotation measured 65 degrees on the left for zero percent impairment[13] and internal rotation measured 80 degrees on the left for zero percent impairment.[14] Regarding radiculitis, Dr. Meller found no findings to support ongoing impairment or disability relating to neurologic dysfunction including radiculitis or radiculopathy. He further noted that he found no evidence of impairment or limitations with regards to carpal tunnel syndrome or compression neuropathy of any type. Dr. Muller opined that sensory deficit and weakness were not objectively present, would not be causally related to the work injury and were inconsistent with the EMG findings of August 11, 2004, which revealed subacute C7-8 radiculopathy on the left and did not support impairment relating to the left C5-6 and C7 nerve roots or the right C6 and C7 nerve roots. He opined that in accordance with the A.M.A., *Guides* appellant sustained a seven percent upper extremity bilaterally based on loss of range of motion for the shoulders due to the accepted work-related injury.

In an October 13, 2006 decision, the Office granted appellant a schedule award for 7 percent permanent impairment of the left and right upper extremities. On October 18, 2006, appellant requested an oral hearing.

On January 9, 2007 an Office hearing representative vacated the October 13, 2006 decision. The hearing representative found that Dr. Meller did not cite tables and charts in the A.M.A., *Guides* in support of his impairment determination and did not provide specific findings for pinch and grip strength. The Office was instructed to obtain a supplemental report from Dr. Meller.

On February 6, 2007 the Office requested a supplemental report from Dr. Meller, specifically asking that he clarify his impairment determination. In a March 6, 2007 report, Dr. Meller noted that impairment due to loss of range of motion of the bilateral shoulder for flexion was three percent pursuant to Figure 16-40 of the A.M.A., *Guides.* He noted that internal rotation was calculated at 1 percent on the right and zero percent on the left and external rotation was zero percent bilaterally pursuant to Figure 16-46 of the A.M.A., *Guides.* Dr. Meller noted that impairment for abduction and adduction was calculated using Figure 16-43 and noted that adduction was interpolated between zero and one and was adjusted up one fraction in one

[8] *Id.*

[9] *See supra* note 3.

[10] *Id.*

[11] *See supra* note 5.

[12] *Id.*

[13] *See supra* note 7.

[14] *Id.*

evaluation and down one fraction in the next evaluation with the outcome being identical. He further noted that he adjusted internal rotation for the right shoulder and extension of the left shoulder up to one percent, which was to compensate for the adjustment downward in adduction. Dr. Meller noted that appellant's grip strength was excellent and measured 5 on a 5 point strength scale and indicated that, under section 16-8, page 508 of the A.M.A., *Guides*, decreased grip strength was not ratable. He noted that appellant did not have any verifiable neurologic deficit or decreased muscle strength.

By decision dated April 12, 2007, the Office denied appellant's request for an additional schedule award. On April 18, 2007 appellant requested an oral hearing.

On July 3, 2007 the hearing representative set aside the April 12, 2007 decision and remanded the matter for further development. He instructed the Office to refer Dr. Meller's reports to an Office medical adviser to determine whether the A.M.A., *Guides* were properly applied.

In a July 29, 2007 report, an Office medical adviser opined that appellant had nine percent impairment of the left and right upper extremities. He noted that range of motion of the shoulders revealed flexion of 140 degrees on the right for three percent impairment,[15] extension measured 40 degrees on the right for one percent impairment,[16] abduction measured 120 degrees on the right for three percent impairment,[17] adduction measured 35 degrees on the right for one percent impairment[18] not zero percent as noted by Dr. Meller, external rotation measured 70 degrees on the right for zero percent impairment[19] and internal rotation measured 75 degrees on the right for one percent impairment.[20] With regard to the left shoulder flexion measured 140 degrees for three percent impairment,[21] extension measured 40 degrees on the left for one percent impairment,[22] abduction measured 115 degrees on the left for three percent impairment,[23] adduction measured 35 degrees on the left for one percent impairment[24] not zero percent as noted by Dr. Meller, external rotation measured 60 degrees on the left for zero percent impairment[25]

[15] *Supra* note 3.

[16] *Id.*

[17] *Supra* note 5.

[18] *Id.*

[19] *Supra* note 7.

[20] *Id.*

[21] *Supra* note 3.

[22] *Id.*

[23] *Supra* note 5.

[24] *Id.*

[25] *Supra* note 7.

and internal rotation measured 80 degrees on the left for zero percent impairment.[26] Totaling these range of motion impairments yielded nine percent impairment for the right arm and eight percent impairment for the left arm. The medical adviser further noted that appellant's condition was accepted for cervical radiculopathy at C6-7 where radiculopathy was clinically documented at the C7 nerve root on the left by an EMG and MRI scan and therefore opined that appellant was entitled to a schedule award for C7 nerve root involvement. He noted that appellant had one percent impairment for Grade 4 pain in the C7 distribution on the left.[27] The medical adviser combined this with eight percent for loss of motion to arrive at nine percent impairment of the left arm.

In a decision dated August 20, 2007, the Office granted appellant a nine percent impairment of the right and left upper extremities. It noted that he was entitled to an additional two percent impairment for both the right and left upper extremity. Appellant requested an oral hearing which was held on December 11, 2007.

In a decision dated March 5, 2008, the hearing representative affirmed the August 20, 2007 Office decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[28] and its implementing regulations[29] 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 nine percent permanent impairment of each arm. The Office accepted appellant's claim for cervical strain and bilateral shoulder strains and expanded his claim to include cervical radiculopathy at C6 and C7. It properly found that a conflict in the medical evidence existed between appellant's attending physician, Dr. Weiss, who disagreed with the Office medical adviser, concerning the extent of appellant's impairment of the upper extremities. Consequently, the Office referred appellant to Dr. Meller to resolve the conflict.

[26] *Id.*

[27] *Id.* at 424, Table 15-15, 15-17.

[28] 5 U.S.C. § 8107.

[29] 20 C.F.R. § 10.404.

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.[30]

The Board finds that, under the circumstances of this case, the opinion of Dr. Meller in his August 16, 2006 and March 6, 2007 reports 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 a nine percent impairment of the left and right upper extremities.

Dr. Meller reviewed appellant's history and reported findings. He noted range of motion of the shoulders revealed flexion of 140 degrees on the right for three percent impairment,[31] extension measured 50 degrees on the right for a zero percent impairment,[32] abduction measured 120 degrees on the right for a three percent impairment,[33] external rotation measured 70 degrees on the right for a zero percent impairment[34] and internal rotation measured 75 degrees on the right for a one percent impairment.[35] The Board notes that Dr. Meller stated that adduction of 35 degrees provided zero percent impairment;[36] however, the A.M.A., *Guides*, section 16.4i, page 474, provides that impairment values for motion measurements falling between those shown in the pie chart may be adjusted or interpolated proportionally in the corresponding interval. Thus, 35 degrees of adduction yields one percent impairment of the right and left arms. For the left shoulder, flexion measured 140 degrees for a three percent impairment,[37] extension measured 45 degrees on the left for one percent impairment,[38] abduction measured 115 degrees on the left for a three percent impairment,[39] adduction measured 35 degrees on the left for one percent impairment[40] as noted above, external rotation measured 65 degrees on the left for zero percent impairment[41] and internal rotation measured 80 degrees on the left for zero percent impairment.[42] Dr. Meller noted that, with regard to radiculitis, he found no neurologic findings to support ongoing impairment or disability relating to neurologic dysfunction including

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

[31] *See supra* note 3.

[32] *Id.*

[33] *See supra* note 5.

[34] *See supra* note 7.

[35] *Id.*

[36] *Id.*

[37] *See supra* note 3.

[38] *Id.*

[39] *See supra* note 5.

[40] *Id.*

[41] *See supra* note 7.

[42] *Id.*

radiculitis or radiculopathy. He further noted that he found no evidence of impairment or limitations for carpal tunnel syndrome or compression neuropathy of any type. Dr. Meller opined that sensory deficit and weakness were not objectively present although the EMG findings of August 11, 2004 revealed subacute C7-8 radiculopathy on the left.

In an October 16, 2007 report, the Office medical adviser applied the A.M.A., *Guides* to Dr. Meller's findings and found that appellant had nine percent permanent impairment of the left and right arms. He concurred with Dr. Meller's determination for the shoulder range of motion findings except for noting that correct application of the A.M.A., *Guides*, as noted, provide that adduction of 35 degrees yields one percent impairment. However, the medical adviser incorrectly noted that extension measured 40 degrees for the right and left shoulder for one percent impairment,[43] rather, Dr. Meller noted extension for the right shoulder measured 50 degrees for zero percent impairment and 45 degrees on the left for a one percent impairment.[44] Based on lost range of motion, appellant would be entitled to eight percent impairment for the right arm and eight percent impairment for the left upper extremity. The medical adviser further noted that appellant's condition was accepted for cervical radiculopathy at C6-7 and radiculopathy was clinically documented at the C7 nerve root on the left by an EMG and MRI scan. He opined that appellant was entitled to a schedule award for C7 nerve root involvement. The medical adviser also calculated that appellant had one percent impairment of the left arm for sensory deficit or pain in the distribution of the C7 nerve root, under Table 15-17 of the A.M.A., *Guides*.[45] He advised that, for sensory deficit or pain, appellant would be classified as Grade 4, for a 25 percent sensory deficit or pain,[46] in the distribution of C7 nerve root.[47] The A.M.A., *Guides* provides that the maximum allowed for total impairment of the C7 nerve root is five percent. The Board notes that when the maximum for the C7 nerve root, 5 percent, is multiplied by the 25 percent allowed for a Grade 4 sensory deficit, this yields 1.25 percent impairment, rounded to 1 percent, for sensory loss.[48] These impairments total eight percent impairment of the right arm and nine percent impairment of the left arm.

The Board finds that the reports of Dr. Meller establish that there is no basis under the A.M.A., *Guides* for an award greater than the nine percent impairment previously granted.

On appeal, appellant asserts that the medical adviser improperly resolved the conflict of opinion after referral to a referee physician. The Board finds this argument to be without merit. To properly resolve a medical conflict, it is the impartial medical specialist who should provide a reasoned opinion as to the extent of permanent impairment in accordance with the A.M.A.,

[43] *See supra* note 3.

[44] The Board also notes that Dr. Meller measured external rotation of the left shoulder of 65 degrees not 60 degrees as not by the medical adviser; however, this measurement also results in zero percent impairment. *See id*. at 479, Figure 16-46.

[45] *Id.* at 424, Figure 15-17.

[46] *Id.* at 424, Figure 15-15.

[47] *Id.* at 552, Figure 15-17.

[48] *Id.* at 482, 552, Table 16-10, 17-37.

Guides. An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.[49] In this case, the referee physician resolved the conflict of opinion. The medical adviser applied the findings of the referee physician to the A.M.A., *Guides*. He corrected an error by Dr. Meller in applying the A.M.A., *Guides*, noting that, although Dr. Meller calculated zero percent impairment for adduction of 35 degrees[50] for the left and right upper extremity, section 16.4i, page 474, of the A.M.A., *Guides*, provides that motion measurements falling between those shown in the pie chart may be adjusted or interpolated proportionally in the corresponding interval which would allow for one percent impairment rating. The medical adviser also corrected an error by Dr. Meller in applying the A.M.A., *Guides*, noting that appellant's condition was accepted for cervical radiculopathy at C6 and C7 and he would be entitled to a one percent impairment for Grade 4 pain in the distribution of the C7 nerve root on the left, which would allow for an impairment rating of nine percent for the left upper extremity.[51] Thus, the findings of Dr. Meller establish that appellant has no greater permanent impairment than that awarded by the Office.

CONCLUSION

The Board finds that appellant has no more than nine percent permanent impairment of the right and left upper extremity.

[49] *See Richard R. LeMay*, 56 ECAB 341(2005) (where the Board found that the Office medical adviser may review the opinion of the referee physician; however, the resolution of the conflict is the responsibility of the impartial specialist). *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.5(c)(1) (provides that an Office medical adviser may review the report of a referee specialist where determination of a schedule award is involved and that the medical adviser may note any medical errors found, such as improper application of the A.M.A., *Guides*).

[50] *See supra* note 5.

[51] To the extent that the Office medical adviser went outside of Dr. Meller's findings, with regard to rating pain due to cervical radiculopathy, this is harmless error as this increased the amount of appellant's permanent impairment.

ORDER

IT IS HEREBY ORDERED THAT the March 5, 2008 and August 20, 2007 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: March 11, 2009
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