United States Department of Labor
Employees' Compensation Appeals Board

K.E., Appellant	)	
and	)	**Docket No. 09-749**
	)	**Issued: November 4, 2009**
DEPARTMENT OF TRANSPORTATION, TRANSPORTATION SECURITY ADMINISTRATION, Swanton, OH, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 26, 2009 appellant filed a timely appeal of the November 18, 2008 decision of an Office of Workers' Compensation Programs' hearing representative who found that she had no more than one percent impairment of her left arm. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

This issue is whether appellant has more than a one percent impairment of her left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On January 7, 2003 appellant, then a 23-year-old transportation security screener, filed a traumatic injury claim alleging that on December 21, 2002 she sustained a left forearm strain

while lifting an oversized hard-sided suitcase. She did not stop work.[1] On May 16, 2003 the Office accepted appellant's claim for flexor carpi ulnaris tendinitis. It paid appropriate benefits.

In an April 6, 2005 report, Dr. Jay Johnson, a Board-certified orthopedic surgeon, found that appellant's left wrist and elbow had a full range of motion and no swelling. He noted tenderness along the dorsum of the ulnar and radial side and along the ulnar side in the central portion. Dr. Johnson diagnosed unidentified left wrist pain. In reports dated November 16, 2005 and February 7, 2006, Dr. Paul Donahue, a Board-certified hand surgeon, found full wrist range of motion. He also found pain with extension and ulnar deviation of the wrist with slight popping. Appellant also sought treatment from Dr. Robert Anderson, a Board-certified orthopedic surgeon and associate of Dr. Donahue, who on March 9 and June 1, 2006, noted full wrist flexion and extension and no evidence of acute or chronic inflammatory changes within her wrist based on diagnostic testing. On July 17, 2006 Dr. Richard Timming, a Board-certified physiatrist, found full range of motion of her shoulder, elbow, wrist and fingers with no deformities.

On September 8, 2006 appellant filed a schedule award claim. In a November 7, 2006 report, Dr. Beth Baker, a Board-certified internist to whom appellant was referred by Dr. Timming, found that she had reached maximum medical improvement (MMI) in 2002 and had no impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001). Dr. Baker advised that appellant reported pain of varying intensity in the left arm. She advised that appellant was currently working regular duty at a bookstore. Dr. Baker noted that appellant had undergone an extensive workup including a left wrist arthrogram, bone scan and wrist magnetic resonance imaging scan that were unremarkable.

In a March 4, 2007 report, an Office medical adviser reviewed the record and determined that appellant had reached MMI on June 21, 2003, approximately six months after the injury. The medical adviser noted that physical examination was unremarkable, wrist range of motion was essentially normal, grip strength and two-point discrimination were normal and radiographs and advanced imaging of the wrist was normal. Appellant did have intermittent pain about the left wrist made worse with lifting heavy objects. The Office medical adviser found that she had one percent impairment to the left arm based on Grade 4 for pain in the distribution of ulnar nerve according to Tables 16-10 and 16-15 on pages 482 and 492 respectively of the A.M.A., *Guides.*

In a March 15, 2007 decision, the Office granted a schedule award for one percent permanent impairment of the left upper extremity. The period of the award ran for 3.12 weeks from June 21 to July 12, 2003. The Office reissued the decision on September 7, 2007, as the March 15, 2007 decision was not sent to appellant's attorney.

In an August 23, 2007 report, Dr. Dee Ann Bialecki-Haase, a family medicine specialist, noted appellant's history of injury and the nature of treatment sought. On examination, Dr. Bialecki-Haase found no observable swelling or deformity of the forearm, wrist or hand. She

[1] Appellant subsequently stopped work on August 9, 2003 to move to Minnesota to attend graduate school. She also pursued a claim for a recurrence of disability which the Office denied.

noted slight atrophy of the left hypothenar musculature compared to the right. Dr. Bialecki-Haase did not find any carpal crepitus or instability. She advised that, based on Table 16-32 on page 509 of the A.M.A, *Guides*, the average grip strength for the minor left hand for appellant's age group was 28 kilograms. Dr. Bialecki-Haase further advised that appellant's strength loss index percentage was 21 percent, resulting in 10 percent impairment of the left arm according to Table 16-34 on page 509.

On September 11, 2007 appellant requested a telephone hearing. On December 12, 2007 an Office hearing representative vacated the September 7, 2007 decision and remanded the case for further development. She found that Dr. Bialecki-Haase's report should be reviewed by an Office medical adviser.

In a December 24, 2007 report, a new Office medical adviser reviewed the medical record and reiterated that appellant had one percent impairment of the left upper extremity. Although Dr. Bialecki-Haase found 10 percent impairment, the prior medical evidence of record showed normal grip strength. Given this inconsistency, the medical adviser agreed with the previous medical adviser finding that appellant's true abilities were closer to those noted in prior medical reports rather than the findings of Dr. Bialecki-Haase. The Office subsequently determined that a conflict in the medical evidence arose between the Office medical adviser and Dr. Bialecki-Haase.

On March 17, 2008 the Office referred appellant with a statement of accepted facts to Dr. David Falconer, a Board-certified orthopedic surgeon, for a referee examination to determine the extent of permanent impairment to her left arm.

In an April 14, 2008 report, Dr. Falconer reviewed the history of injury and medical treatment. Upon examination, he noted that visual inspection of the hand, wrist and forearm was unremarkable. Dr. Falconer advised that appellant had full, unrestricted range of motion over the fingers, wrist, forearm and elbow. He found 0 to 90 degrees of metacarpophalangeal (MCP), interphalangeal (IP) and proximal interphalangeal motion of all fingers two through five, with 75 degrees of distal interphalangeal motion in fingers two through five. Dr. Falconer found normal physiologic range of motion of the thumb MCP and IP joints, full abduction opposition and extension adduction of the thumb carpometacarpal joint. He found 90 degrees of wrist flexion, 90 degrees of wrist extension, 35 degrees of ulnar deviation, 50 degrees of radial deviation and 90 degrees of pronation and supination in both hands. Dr. Falconer noted maximum pain over the ulnar edge of the joint at the ulnar margin of the extensor carpi ulnaris sheath and the foveal notch. He noted mild crepitation with ulnar deviation and grind. Dr. Falconer noted no increase of pain with radial deviation, which stressed the extensor carpi ulnaris tendon. He conducted functional testing indicating that appellant's grip strength of the minor left hand, in pounds, was between 50 and 58 in the first session, between 52 and 55 in the second session and between 40 and 48 in the third session. Dr. Falconer noted that the average minor handgrip strength for females between ages 20 to 29 is 49.9 pounds. He determined that based on appellant's age of 28 years, these results fell within the average grip strength of the minor hand for her age range, according to Table 16-32 on page 509 of the A.M.A, *Guides*. Dr. Falconer opined that she had excellent functional strength. Based on these findings, he determined that appellant had no ratable impairment under strength loss index. Appellant was previously found to have one percent impairment for paresthesias and tingling in the ulnar nerve

distribution. Dr. Falconer opined that, based on his review of appellant's functional strength, his own examination findings, the absence of restricted range of motion or any specified ratable permanent conditions, no additional impairment was warranted or appropriate. He advised that she reached maximum medical improvement by June 21, 2003, approximately six months after injury as her symptoms have been static, unchanging and permanent since that time.

In a May 11, 2008 report, an Office medical adviser agreed with Dr. Falconer's opinion that appellant had one percent permanent impairment of the left upper extremity as her physical examination was unremarkable and wrist range of motion was near normal. He also noted that MMI was reached on June 21, 2003.

In a decision dated May 22, 2008, the Office denied an additional schedule award, finding one percent permanent impairment of the left arm.

On May 29, 2008 appellant requested an oral hearing, which was held on September 10, 2008. The Office hearing representative kept the record open for 30 days to allow her to submit additional evidence.

In a November 18, 2008 decision, the hearing representative affirmed the May 22, 2008 decision finding that the weight of the medical evidence rested with Dr. Falconer who found that appellant did not sustain greater than one percent permanent impairment of the left arm.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations 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 loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 Office for evaluating schedule losses and the Board has concurred in such adoption.[3]

Section 8123(a) of the Act provides that when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict. When there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a), to resolve the conflict in the medical evidence.[4]

[2] 5 U.S.C. §§ 8101-8193. *See* 5 U.S.C. § 8107.

[3] *See* 20 C.F.R. § 10.404; *R.D.*, 59 ECAB ___ (Docket No. 07-379, issued October 2, 2007).

[4] *Richard R. Lemay*, 56 ECAB 341 (2005); *see* 5 U.S.C. 8123(a).

ANALYSIS

A conflict of medical evidence arose between Dr. Bialecki-Haase, appellant's treating physician, and an Office medical adviser, as to the extent of permanent impairment to her left upper extremity. Dr. Bialecki-Haase determined that appellant had 10 percent left upper extremity impairment based on the criteria of the A.M.A., *Guides* for grip strength. An Office medical adviser found one percent permanent impairment of the left upper extremity based on normal grip strength findings and the previous medical adviser's opinion. The Office properly referred appellant to Dr. Falconer for a referee medical evaluation on the extent of permanent impairment.[5]

In an April 14, 2008 report, Dr. Falconer conducted a broad range of testing of appellant's left upper extremity, all of which revealed no impairment. His findings for her minor left handgrip strength consisted of between 50 and 58 pounds in the first session, between 52 and 55 pounds in the second session and between 40 and 48 pounds in the third session. When these findings are converted to kilograms, as shown in the A.M.A., *Guides*, they yield between 22.7 and 26.3 kilograms, 23.6 and 24.9 kilograms and 18.1 and 21.8 kilograms respectively. Dr. Falconer noted that the average grip strength for a minor hand of a female between ages 20 to 29 is 22.7 kilograms, according to Table 16-32 on page 509 of the A.M.A., *Guides*. He opined that his findings revealed no significant functional strength loss in appellant's nondominant left hand and noted that she had excellent functional strength. Dr. Falconer also found that her left wrist had full, unrestricted range of motion of flexion and extension, ulnar and radial deviation and pronation and supination. His findings also revealed full range of motion over appellant's fingers, forearm and elbow. Dr. Falconer noted that one percent impairment had previously been accepted for paresthesias and tingling in the ulnar nerve distribution and concluded that his examination findings revealed no basis for any additional impairment. In a May 11, 2008 report, an Office medical adviser agreed with Dr. Falconer's report.

When a case is referred to a referee medical specialist for the purpose of resolving a conflict in medical opinion, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[6] The Board finds that Dr. Falconer's report is entitled to such weight. He had the entire case record and a statement of accepted facts at his disposal, he examined appellant and conducted a broad range of testing and he offered an opinion that was sufficiently well rationalized to resolve the conflict that had arisen.[7] He properly determined that appellant had no more than one percent impairment of the left arm.

---

[5] The Act's implementing regulations states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case. *See* 20 C.F.R. § 10.321(b); *R.H.*, 59 ECAB ___ (Docket No. 07-2124, issued March 7, 2008).

[6] *Y.A.*, 59 ECAB ___ (Docket No. 08-254, issued September 9, 2008).

[7] *See Sherry A. Hunt*, 49 ECAB 467 (1998).

The weight of the medical evidence established that appellant has no more than a one percent permanent impairment of the left upper extremity for which she received a schedule award.

CONCLUSION

The Board finds that appellant has no more than a one percent permanent impairment of the left upper extremity for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decisions dated November 18 and May 22, 2008 are affirmed.

Issued: November 4, 2009
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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