United States Department of Labor
Employees' Compensation Appeals Board

L.D., Appellant	)	
	)	
and	)	**Docket No. 08-2288**
	)	**Issued: September 11, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Bedford Park, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 19, 2008 appellant filed a timely appeal of the June 9, 2008 decision of the Office of Workers' Compensation Programs finding 17 percent impairment of the left upper extremity and denying him an increased impairment rating of the right upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than a 17 percent permanent impairment of the left upper extremity and an 11 percent permanent impairment of the right upper extremity for which he received schedule awards.

FACTUAL HISTORY

On January 30, 2002 appellant, then a 48-year-old letter carrier, filed a traumatic injury claim alleging that on January 17, 2002 he slipped and fell on ice landing on his left side while collecting mail from a box on the street. He did not stop work. On March 7, 2002 the Office

accepted appellant's claim for cervical strain and herniated cervical disc with nerve root impingement.[1]

On December 26, 2003 appellant filed a schedule award claim. On September 13, 2005 the Office requested an impairment rating from his treating physician. In reports dated April 8, 2006, Dr. Jacob Salomon, a surgeon, diagnosed poststatus laminectomy at C4-5 and C5-6 with cervical radiculopathy, left worse than right and cervical spondylosis with cervical arthropathy. He noted that appellant had completed an outcome assessment form, which he utilized in conjunction with Tables 16-10, 16-11 and 16-13 on pages 482, 484 and 489 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001) to rate impairment of the upper extremities. In a separate April 8, 2006 report, Dr. Salomon assessed appellant's motor and sensory impairments in both arms in the C5-6 distribution pursuant to the A.M.A., *Guides*. He identified the nerves involved in each arm and applied the A.M.A., *Guides* in concluding that appellant had 46 percent impairment of the left arm and 22 percent impairment of the right arm.

In a May 24, 2006 report, an Office medical adviser reviewed the record and determined that appellant's left upper extremity impairment resulted from the accepted conditions. He advised that the date of maximum medical improvement was June 9, 2004, approximately one year after appellant's surgery. The Office medical adviser also found that appellant had a one percent permanent impairment to his left upper extremity.[2]

By decision dated September 20, 2006, 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 9 to 30, 2004.[3]

On October 5, 2006 appellant requested an oral hearing. By decision dated January 12, 2007, an Office hearing representative remanded the case for further development as the Office medical adviser had not been provided with Dr. Salomon's April 8, 2006 report for review.

In a February 3, 2007 report, the Office medical adviser reviewed Dr. Salomon's April 8, 2006 report and found an 11 percent impairment of each upper extremity. His findings were based on percentages awarded for Grade 4 pain in the distribution of the C5 and C6 nerve root, Grade 4 motor deficit distribution in the C5 nerve root and Grade 3 motor deficit distribution at the C6 nerve root, according to Tables 15-14 through 15-17 on pages 421 and 424 of the A.M.A., *Guides*.

By decision dated February 26, 2007, the Office granted a schedule award for 11 percent permanent impairment for each the right and left upper extremities. The awards took into

[1] On April 15, 2003 the Office accepted a recurrence claim beginning on January 15, 2003. It also accepted procedures for C4-5 discectomy and decompression, which was performed on June 24, 2003.

[2] The Office medical adviser did not review Dr. Salomon's April 8, 2006 report in assessing impairment.

[3] This was an amended schedule award to reflect a 75 percent compensation, which revised the Office's September 19, 2006 decision reflecting a 66 2/3 percent compensation rate.

account the one percent previously awarded for the left upper extremity. The period of the awards ran for 65.52 weeks from July 1, 2004 to October 2, 2005.

On March 23, 2007 appellant requested an oral hearing that was held on August 29, 2007.

In an April 11, 2007 report, Dr. Salomon explained why his impairment rating differed from that of the Office medical adviser. He noted that the medical advisers' ratings for the percentages for pain of a nerve root and of a motor deficit of a nerve root were less. Dr. Salomon explained that the percentages he picked were based on a narrative outcome assessment form completed by appellant. He advised that he considered his findings valid and that they were in conformance with the A.M.A., *Guides*. Based on these findings, Dr. Salomon found that appellant had a 22 percent permanent impairment of the right upper extremity and a 46 percent impairment of the left upper extremity.

On November 15, 2007 an Office hearing representative vacated the February 26, 2007 decision and remanded the case for further medical development. On December 10, 2007 another Office medical adviser reviewed the reports of Dr. Salomon and the previous medical adviser and noted that each physician relied on tables in the A.M.A., *Guides*, that provided for impairment of affected nerve roots. The Office subsequently determined that there was a conflict in the medical evidence between the Office medical adviser and Dr. Salomon.

On April 2, 2008 the Office referred appellant, with a statement of accepted facts, to Dr. Julie Wehner, a Board-certified orthopedic surgeon, for a referee evaluation to determine the impairment due to his work injury.

In an April 30, 2008 report, Dr. Wehner provided a history of injury and medical treatment. Upon examination, she found that appellant's neck range of motion was self-limiting and there was no atrophy at the elbow, deltoid or supraspinatus area. Dr. Wehner diagnosed cervicalgia status post C4-5 fusion. She advised that appellant's left shoulder rotator cuff problem was not related specifically to the cervical spine. Dr. Wehner found evidence of left cubital tunnel syndrome with ulnar nerve impingement likely due to some other activities as C4-5 cervical disc problems would not cause numbness to appellant's fourth and fifth digits, while cubital tunnel fit this distribution of nerve impingement. She indicated that examination of his right upper extremity revealed mild cubital tunnel which was an impingement at the elbow and, therefore, was not a work-related injury or related to the cervical spine area. Dr. Wehner determined that the pain in appellant's left shoulder overlapped what was referred from his neck and what was inherent to his shoulder. She utilized the A.M.A., *Guides* and found that he had a five percent C5 nerve root sensory deficit for left shoulder pain according to Table 16-13 on page 489. Dr. Wehner determined that appellant had a Grade 4 pain deficit at 25 percent according to Table 16-10 on page 482. She multiplied 5 percent by 25 percent and concluded that he had a 1 percent upper extremity permanent impairment. Dr. Wehner further noted that she did not find a motor impairment of the cervical spine. She did not include the right upper extremity in the impairment ratings because her findings were not related to the cervical spine or work injury.

On May 12, 2008 the Office requested that Dr. Wehner clarify her impairment rating of appellant's upper extremities and include all work-related and nonwork-related impairments. In a May 23, 2008 report, Dr. Wehner noted that appellant had an abnormal range of motion of the

left shoulder with active abduction of 100 degrees, which was four percent impairment from Figure 16-43 on page 477. She also noted that there was no loss of adduction. Dr. Wehner found 120 degrees forward flexion, four percent impairment and full extension, citing Figure 16-40 on page 476. She also found 30 degrees internal rotation or four percent impairment based on Figure 16-46 on page 479 and 90 degrees of external rotation, a zero percent impairment. Dr. Wehner added the loss of left shoulder range of motion and to total 12 percent impairment. Regarding appellant's left elbow cubital tunnel, she determined a nerve sensory deficit of Grade 2, based on his abnormal sensations and moderate pain that may prevent activities on the left side, which she assessed a 70 percent deficit, citing Table 16-10 on page 482. Dr. Wehner also noted an ulnar nerve lesion at the cubital tunnel and determined a seven percent sensory deficit for the ulnar nerve above the mid forearm according to Table 16-15 on page 492. She multiplied 70 percent by the 7 percent sensory deficit and found 4.9 percent impairment rating for the left elbow cubital tunnel. For appellant's right elbow cubital tunnel, Dr. Wehner determined a nerve sensory deficit of Grade 4, for which she assessed 10 percent, per Table 16-10 on page 482 and a 7 percent sensory deficit for an ulnar nerve above the mid forearm according to Table 16-15 on page 492. She multiplied 10 percent by 7 percent sensory deficit, which resulted in 0.7 percent impairment rating for the right cubital tunnel. Dr. Wehner found that, for the cubital tunnel syndrome, appellant had one percent impairment on the right and five percent impairment on the left. She concluded that he had a total of one percent impairment of the right upper extremity. Using the Combined Values Chart on page 604, Dr. Wehner combined 5 percent for left cubital tunnel with 12 percent for rotator cuff disease to derive at 16 percent impairment for the left upper extremity. When combined to the previous 1 percent impairment rating of the left upper extremity for nerve root pain, it resulted in 17 percent impairment for the left upper extremity.

By decision dated June 9, 2008, the Office denied appellant's claim for an increased schedule award for the right arm finding that there was insufficient evidence to establish additional permanent impairment to the right arm and that the weight of the medical evidence rested with Dr. Wehner. It amended appellant's left arm schedule award with an additional 6 percent impairment or a total award of 17 percent. The period of the award was for 18.72 weeks and ran from October 3, 2005 to February 11, 2006 and took into account appellant's previous schedule awards.

Appellant appealed to the Board and requested oral argument, which was scheduled for May 14, 2009. He did not appear for the scheduled oral argument.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[4] 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 sounds discretion of the Office. For consistent results and to ensure equal justice, the

[4] 5 U.S.C. §§ 8101-8193. *See* 5 U.S.C. § 8107.

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.[5]

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.[6]

ANALYSIS

A conflict in medical opinion arose between Dr. Salomon, appellant's treating physician, and an Office medical adviser, as to the degree of permanent impairment to his upper extremities. Dr. Salomon determined that appellant had a 46 percent left upper extremity impairment and a 22 percent right upper extremity impairment based on the criteria of the A.M.A., *Guides* for sensory deficits, loss of sensation, atrophy and weakness of appellant's C5 and C6 nerve root. An Office medical adviser found an 11 percent permanent impairment for each upper extremity based on pain and motor deficit distribution in the C5 and C6 nerve root according to the A.M.A., *Guides*. The Office properly referred appellant to Dr. Wehner, a Board-certified orthopedic surgeon, for a referee medical evaluation on the percentage of permanent impairment.[7] It properly requested a supplemental report from Dr. Wehner to provide a rating of appellant's upper extremities that included all impairments.[8]

Dr. Wehner's reports dated April 30 and May 23, 2008 provided impairment findings for appellant's left and right upper extremities and the corresponding calculations. She measured appellant's left shoulder range of motion as abduction of 100 degrees for four percent impairment,[9] no loss of adduction, flexion of 120 degrees for four percent impairment,[10] full extension, internal rotation of 30 degrees for four percent impairment and external rotation of

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

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

[7] The Act's implementing regulations state 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).

[8] *See V.G.*, 59 ECAB ___ (Docket No. 07-2179, issued July 14, 2008) (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).

[9] *See* A.M.A., *Guides* 477, Figure 16-43.

[10] *See id.* at 476, Figure 16-40.

90 degrees for no impairment.[11] Dr. Wehner added the percentages to total 12 percent range of motion impairment of the left shoulder. For appellant's left elbow cubital tunnel, she described a nerve sensory deficit of Grade 2 at 70 percent[12] and a sensory maximum impairment of 7 percent for the ulnar nerve above the mid forearm.[13] By multiplying 70 percent by 7 percent, Dr. Wehner derived 4.9 percent which was rounded to 5 percent impairment.[14] She opined that there were no motor deficits. To determine appellant's total left upper extremity impairment, Dr. Wehner utilized the Combined Values Chart[15] to combine 12 percent range of motion impairment, 5 percent cubital tunnel impairment and 1 percent C5 nerve root pain impairment previously determined in her April 30, 2008 report to a total of 17 percent.

Dr. Wehner also calculated impairment for appellant's right elbow cubital tunnel. She described appellant's nerve sensory deficit as Grade 4 for 10 percent.[16] She also noted a maximum sensory impairment of 7 percent for the ulnar nerve above the mid forearm.[17] Dr. Wehner multiplied 10 percent by 7 to derive 0.7 percent impairment, which was rounded to 1 percent impairment of the right elbow cubital tunnel. She noted that this was also the total impairment for appellant's right upper extremity.

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.[18] The Board finds that, the report of Dr. Wehner, the referee medical specialist, is entitled to such weight. She had the entire case record and a statement of accepted facts at her disposal, she examined appellant and related her findings and she offered an opinion that was sufficiently well rationalized to resolve the conflict that had arisen.[19] Dr. Wehner also properly calculated the impairment percentages for appellant's upper extremities according to the A.M.A., *Guides*.

The Board finds that the weight of the medical evidence establishes that appellant has no more than 17 percent impairment of the left upper extremity or 11 percent impairment of the right upper extremity.

---

[11] *See id.* at 479, Figure 16-46.

[12] *See id.* at 482, Table 16-10.

[13] *See id.* at 492, Table 16-15.

[14] *J.Q.*, 59 ECAB ___ (Docket No. 06-2152, issued March 5, 2008) (the policy of the Office is to round the calculated percentage of impairment to the nearest whole number).

[15] *See* A.M.A., *Guides* 604.

[16] *See supra* note 12.

[17] *See supra* note 13.

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

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

On appeal, appellant asserts that the schedule award for his upper extremities should be increased as his impairment was due to an accepted work-related injury. He further asserts that Dr. Salomon's impairment rating reflects the true state of his condition. As noted, the Office found that a conflict existed in the medical evidence between Dr. Salomon and an Office medical adviser and, therefore, appellant was properly referred to Dr. Wehner for a referee evaluation to resolve the conflict. Dr. Wehner's opinion was given special weight because it was well rationalized, had proper calculations and was based on findings from her own independent examination and the entire case record. As she determined that appellant had a 17 percent left upper extremity impairment and a 1 percent right upper extremity impairment, appellant is not entitled to an increased schedule award. Appellant also asserts that his employment injury limits his activities. However, the Board has held that factors such as limitations on daily activities do not go into the calculation of a schedule award.[20]

CONCLUSION

The Board finds that appellant has no more than 17 percent impairment of the left upper extremity or 11 percent impairment of the right upper extremity, for which he has received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated June 9, 2008 is affirmed.

Issued: September 11, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[20] *E.L.*, 59 ECAB ___ (Docket No. 07-2421, issued March 10, 2008).