United States Department of Labor
Employees' Compensation Appeals Board

E.A., Appellant	)	
	)	**Docket No. 09-266**
and	)	**Issued: September 10, 2009**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Bellmawr, NJ, 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
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On November 5, 2008 appellant, through her attorney, filed a timely appeal from a November 30, 2007 merit decision of the Office of Workers' Compensation Programs denying her claim for an increased schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than a 25 percent permanent impairment of the right upper extremity and a 10 percent permanent impairment of the left upper extremity for which she received schedule awards.

FACTUAL HISTORY

On August 21, 2003 appellant, then a 52-year-old clerk, filed an occupational disease claim alleging that she sustained right shoulder impingement syndrome with adhesive capsulitis and bilateral carpal tunnel syndrome due to factors of her federal employment. The Office

accepted her claim for bilateral carpal tunnel syndrome and right shoulder supraspinatus tendinitis. It authorized a right shoulder arthroscopy and bilateral carpal tunnel releases.[1]

On August 10, 2005 appellant filed a claim for a schedule award. She submitted an impairment evaluation dated October 21, 2004 from Dr. David Weiss, an osteopath, who is Board-certified in family practice. Citing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*), Dr. Weiss opined that appellant had a 10 percent impairment due to a right shoulder resection arthroplasty of the acromioclavicular (AC) joint,[2] 1 percent impairment due to loss of right shoulder flexion,[3] 1 percent impairment due to loss of right shoulder abduction[4] and 20 percent impairment to right lateral pinch deficit,[5] for a combined 29 percent right upper extremity impairment. Dr. Weiss then added 3 percent for pain to find a right upper extremity impairment of 32 percent.[6] He found that appellant had 20 percent impairment on the left for lateral pinch strength deficit[7] and 3 percent impairment due to pain for a total left upper extremity impairment of 23 percent.[8] Dr. Weiss opined that appellant reached maximum medical improvement on October 21, 2004.

On January 2, 2006 Dr. Henry J. Magliato, a Board-certified orthopedic surgeon and Office medical adviser, reviewed Dr. Weiss' report. He noted that pinch testing was not a reliable basis on which to rate impairment and excluded the pinch strength deficit. The Office medical adviser found that appellant had 2 percent right shoulder impairment due to loss of forward flexion and adduction[9] and 18 percent impairment for loss of strength in the supraspinatus and deltoid. He added 3 percent for pain to find 31 percent right upper extremity impairment.[10] For the left side, the Office medical adviser determined that appellant had a three percent permanent impairment due to pain.[11]

On February 9, 2006 the Office referred appellant to Dr. David A. Bundens, a Board-certified orthopedic surgeon, to resolve the conflict in medical opinion between Dr. Weiss and

[1] On September 30, 2003 appellant underwent a right shoulder subacromial decompression and repair of the right rotator cuff. She had a right carpal tunnel release on January 26, 2004 and a left carpal tunnel release on March 1, 2004.

[2] A.M.A., *Guides* 506, Table 16-27.

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

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

[5] *Id*. at 509, Tables 16-33, 16-34.

[6] *Id*. at 574, Table 18-1.

[7] *Id*. at 509, Tables 16-33, 16-34.

[8] *Id*. at 574, Table 18-1.

[9] *Id*. at 476, 477, Figures 16-40, 16-43.

[10] *Id*. at 574.

[11] *Id*.

the Office medical adviser regarding the extent of her permanent impairment. In a report dated February 21, 2006, Dr. Bundens measured range of motion of the right shoulder as 150 degrees forward flexion, 70 degrees extension, 110 degrees abduction, 40 degrees adduction, 90 degrees external rotation and 100 degrees internal rotation. On examination of the hands and wrists, he found normal range of motion but "pain with maximal flexion bilaterally." Dr. Bundens measured strength testing on the right of 12, 23, 18 and 17 pounds and on the left of 27, 44, 37 and 35 pounds. He found normal Tinel's sign and Phalen's test on examination. Dr. Bundens diagnosed a history of bilateral carpal tunnel syndrome and a right shoulder rotator cuff tear. Utilizing the A.M.A., *Guides*, he determined that appellant had two percent impairment for loss of flexion and three percent impairment for loss of adduction, for a total impairment due to loss of range of motion of five percent.[12] Dr. Bundens found that appellant had a maximum impairment due to pain of the glenohumeral joint of 60 percent, which he multiplied by a graded 25 percent to find 15 percent impairment.[13] He further determined that appellant had five percent impairment due to hand weakness.[14] Dr. Bundens added the impairment findings and concluded that appellant had 25 percent right upper extremity impairment. On March 3, 2006 an Office medical examiner reviewed his report and concurred with his findings.

By decision dated August 1, 2006, the Office granted appellant a schedule award for a 25 percent permanent impairment of the right upper extremity. The period of the award ran for 78 weeks from October 21, 2004 to April 19, 2006.

On August 7, 2006 appellant, through her representative, requested an oral hearing. A hearing was held on December 14, 2006. On March 2, 2007 the hearing representative set aside the August 1, 2006 schedule award. She found that the impartial medical examiner should have addressed whether appellant had impairments due to either her acromioclavicular joint resection or loss of pinch strength.

On March 15, 2007 the Office requested a supplemental report from Dr. Bundens, who reviewed the operative report on April 11, 2007 and found that appellant was not entitled to an impairment for a distal clavicle resection as the surgeon "did not do a formal Mumford procedure -- he just resected the osteophytes that were extending antero-inferiorly to decompress the rotator cuff that was later repaired."

On May 8, 2007 Dr. Bundens reevaluated appellant using a pinch meter. He determined that appellant had 17 percent upper extremity impairment due to a pinch strength deficit.[15] Dr. Bundens added the 15 percent due to pain and the 5 percent impairment due to loss of motion to the 17 percent impairment for pinch strength loss to find that appellant had a 37 percent permanent impairment of the upper extremity.

[12] *Id*. at 476, 477, Figures 16-40, 16-43.

[13] *Id*. at 499, 482, Tables 16-18, 16-10.

[14] *Id*. at 509, Table 16-34.

[15] *Id*. at 589, Table 16-34.

On June 6, 2006 Dr. Magliato opined that Dr. Bundens erroneously combined the right and left upper extremity strength loss before determining appellant's right upper extremity impairment rather than calculating each loss separately. He found that appellant had 20 percent right upper extremity impairment for loss of pinch strength and a 10 percent left upper extremity impairment for loss of pinch strength.

On June 13, 2007 another Office medical adviser determined that, under Table 16-34 on page 509 of the A.M.A., *Guides*, appellant had a 10 percent left upper extremity impairment and a 20 percent right upper extremity impairment.

By decision dated June 18, 2007, the Office granted appellant a schedule award for a 10 percent permanent impairment of the left upper extremity. On June 25, 2007 appellant, through her attorney, requested an oral hearing. Following a preliminary review of the record, on September 6, 2007 the hearing representative set aside the June 18, 2007 decision. He found that Dr. Bundens' report was insufficiently rationalized to constitute the weight of the evidence as he erred in calculating the extent of appellant's impairment due to loss of pinch strength and did not discuss whether she was entitled to an additional impairment for pain. The hearing representative remanded the case for the Office to obtain a supplemental report from Dr. Bundens.

On September 25, 2007 Dr. Bundens explained how he calculated appellant's impairment due to loss of strength and requested clarification regarding the proper method. Regarding pain, he indicated that appellant did not need a separate award and noted that he mentioned pain when determined that she had a 15 percent impairment due to her rotator cuff tear under Table 16-18 on page 499.

On October 15, 2007 Dr. Magliato reviewed Dr. Bundens' supplemental report. He indicated that Dr. Bundens realized that he "erroneously combined the strength loss index for both extremities and then translated that figure into a schedule award loss of the individual extremity." Dr. Magliato related that the Office should use the calculations he made in his June 6, 2007 report of 10 percent for the left upper extremity and 20 percent for the right upper extremity as it was consistent with the A.M.A., *Guides*.

By decision dated November 30, 2007, the Office determined that appellant had no more than a 25 percent permanent impairment of the right upper extremity and a 10 percent permanent impairment of the left upper extremity for which she had received schedule awards.

On appeal, appellant's attorney argues that it was error for the Office to have Dr. Magliotto review Dr. Burdens report as he was one of the physicians who initially created the conflict. He further argues that Dr. Bunden's opinion is not well rationalized.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act,[16] and its implementing federal regulations,[17] 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 for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[18] 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, 2001.[19]

Section 8123(a) 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.[20] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[21] In situations where the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original opinion. If the specialist is unwilling or unable to clarify and elaborate on his or her opinion, the case should be referred to another appropriate impartial medical specialist.[22]

Regarding carpal tunnel syndrome, the A.M.A., *Guides* provide:

> "If, after an *optimal recovery time*, following surgical decompression, an individual continues to complain of pain, paresthesias and/or difficulties in performing certain activities, three possible scenarios can be present:
>
> > (1) Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTS [carpal tunnel syndrome] is rated according to the sensory and/or motor deficits as described earlier.

[16] 5 U.S.C. § 8107.

[17] 20 C.F.R. § 10.404.

[18] *Id*. at § 10.404(a).

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

[20] 5 U.S.C. § 8123(a).

[21] *David W. Pickett*, 54 ECAB 272 (2002); *Barry Neutuch*, 54 ECAB 313 (2003).

[22] *See Guiseppe Aversa*, 55 ECAB 164 (2003).

(2) Normal sensibility and opposition strength with abnormal sensory and or motor latencies or abnormal EMG [electromyogram] testing of the thenar muscles: a residual CTS is still present and an impairment rating not to exceed five percent of the upper extremity may be justified.

(3) Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength, and nerve conduction studies: there is no objective basis for an impairment rating."[23] (Emphasis in the original.)

ANALYSIS -- ISSUE 1

The Office accepted that appellant sustained bilateral carpal tunnel syndrome and a supraspinatus tendon of the right shoulder. It determined that a conflict existed between Dr. Weiss appellant's attending physician, and Dr. Magliato, the Office medical adviser, regarding the extent of her permanent impairment of the upper extremities. The Office referred appellant to Dr. Bundens for resolution of the conflict.

When there exists a conflict in medical opinion and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[24] The Board finds, however, that Dr. Bundens' report is not in accordance with the A.M.A., *Guides* and is not entitled to special weight as the impartial medical examiner. The Office accepted the claim for a right shoulder condition and bilateral carpal tunnel syndrome. For the right shoulder, Dr. Bundens utilized the A.M.A., *Guides* and found that appellant had a 5 percent impairment due to loss of flexion and adduction[25] and a 15 percent impairment due to pain in the glenohumeral joint.[26] For the right hand, he determined that appellant had 17 percent impairment due to loss of pinch strength.[27] The A.M.A., *Guides*, however, provides that, in evaluating an impairment due to carpal tunnel syndrome following surgical decompression, three scenarios are possible: if positive clinical findings of median nerve dysfunction are present, impairment is rated according to sensory or motor deficits, with normal sensibility and opposition strength or abnormal sensory or motor latencies or abnormal electromyogram testing, an impairment rating not to exceed five percent may be justified; finally, with normal sensibility, opposition strength and nerve conduction studies, there is no objective basis for an impairment rating.[28] Dr. Bundens incorrectly evaluated appellant's impairment due to carpal tunnel syndrome based on a pinch strength deficit rather than the provisions of the A.M.A., *Guides* on page 495. The A.M.A., *Guides* instruct the evaluator to consider only sensory and motor deficits

[23] A.M.A., *Guides* 495.

[24] *Darlene R. Kennedy*, 57 ECAB 414 (2006).

[25] *Id.* at 476, 477, Figures 16-40, 16-43.

[26] *Id*. at 499, 482, Tables 16-18, 16-10.

[27] *Id*. at 509, Table 16-34.

[28] *Id*. at 495.

when rating an impairment due to carpal tunnel syndrome.[29] Office procedures also specifically provide that upper extremity impairments secondary to carpal tunnel syndrome and other entrapment neuropathies should be calculated using section 16.5d and Tables 16-10, 16-11 and 16-15.[30] Dr. Bundens impairment rating does not conform to the A.M.A., *Guides*. His opinion does not resolve the conflict and is not entitled to the special weight accorded a referee physician. As the Office sought clarification from Dr. Bundens, on remand it should refer appellant to a new impartial medical examiner.[31]

CONCLUSION

The Board finds that the case is not in posture for decision.[32]

[29] *Id*. at 494; *Robert V. Disalvatore*, 54 ECAB 351 (2003).

[30] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808 (March 1995).

[31] In situations where the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original opinion. If the specialist is unwilling or unable to clarify and elaborate on his or her opinion, the case should be referred to another appropriate impartial medical specialist. *See Guiseppe Aversa*, *supra* note 22.

[32] On appeal, appellant's attorney argues that the Office erred in having Dr. Magliato review Dr. Bundens' reports. Dr. Magliato, the same Office medical adviser who created the conflict with Dr. Weiss, reviewed Dr. Bundens' report. Office procedures, however, provide that where a referee examination is arranged to resolve a conflict created between a claimant's physician and an Office medical adviser regarding a schedule award issue, the same Office medical adviser should not review the referee specialist's report. Rather, another Office medical adviser or consultant should review the file. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (August 2002); *see also Richard R. LeMay*, 56 ECAB 341 (2005).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 30, 2007 is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: September 10, 2009
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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