United States Department of Labor
Employees' Compensation Appeals Board

R.B., Appellant	)	
and	)	**Docket No. 09-1868**
	)	**Issued: June 18, 2010**
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
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On July 14, 2009 appellant filed a timely appeal from the September 8, 2008 merit decision of the Office of Workers' Compensation Programs awarding schedule award compensation. 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 met her burden of proof to establish that she had more than a 13 percent permanent impairment of her left arm and a 3 percent permanent impairment of her right arm, for which she received schedule awards.

FACTUAL HISTORY

The Office accepted that on March 19, 2002 appellant, then a 49-year-old mail processor sustained traumatic bursitis of her left shoulder while in the performance of duty. She returned to work following the injury. On October 25, 2004 appellant filed a claim for a schedule award due to this injury.

In an April 12, 2004 report, Dr. David Weiss, an attending osteopath, determined that appellant had a 24 percent permanent impairment of her left arm and a 17 percent permanent impairment of her right arm under the standards of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001). His assessment was based on sensory loss associated with the C5, C6 and C7 nerve roots in both arms. On April 7, 2006 the Office medical adviser, a Board-certified orthopedic surgeon, opined that appellant had a 13 percent impairment of her left arm based on limitation upon flexion, extension and abduction of the left arm, as measured by Dr. Weiss. He indicated that sensory deficits related to cervical nerve roots should not be included in the calculation.

The Office determined that a conflict in medical opinion existed between Dr. Weiss and the Office medical adviser and referred appellant to Dr. George Glenn, a Board-certified orthopedic surgeon, for an impartial medical examination. Dr. Glenn opined that she had a 10 percent permanent impairment of her left arm, but another Office medical adviser found that she had a 12 percent permanent impairment of her left arm based on a different calculation of her limited left arm motion. In a December 27, 2007 decision, the Office granted appellant a schedule award for a 12 percent permanent impairment of her left arm.

In a March 5, 2008 decision, an Office hearing representative set aside the Office's December 6, 2007 decision. She found that Dr. Glenn had not been chosen through the appropriate rotational system for choosing impartial medical specialists. The Office hearing representative found that the case should be remanded for proper referral to a new impartial medical specialist for further evaluation and resolution of the outstanding conflict in the medical evidence regarding appellant's permanent impairment. She further noted that appellant had a separate claim which was accepted for bilateral carpal tunnel and that she had also filed for a schedule award under this claim. The Office hearing representative directed the Office to combine the files so that appellant's left upper extremity impairment could be determined based upon both the accepted left shoulder bursitis and the carpal tunnel syndrome.

On remand, the Office referred appellant to Dr. Howard Zeidman, a Board-certified orthopedic surgeon, for an impartial medical examination and opinion on her permanent impairment. It combined the two files as directed. On May 15, 2008 Dr. Zeidman indicated that, on physical examination, appellant's neck had diffuse nonlocalized tenderness with no spasm. There was range of motion of about half of what might be expected but this was inconsistent on repetition of the evaluation. Dr. Zeidman indicated that range of motion of the left shoulder was less than the right shoulder and that the left shoulder could abduct to 90 degrees with good adduction. The right shoulder abduction was possible to 140 degrees and there was good adduction. Dr. Zeidman stated that flexion was possible to 90 degrees at the left shoulder with good extension and that flexion was possible to 145 degrees at the right shoulder with good extension. Internal and external rotations were symmetrical bilaterally with minimal losses in both. On neurologic examination all reflexcs were symmetrically diminished but present and limbs were symmetrical in length and circumference. Dr. Zeidman indicated that on manual muscle testing there was a weakness bilaterally symmetrical in both extremities but this again was variable from evaluation to evaluation. Sensory functions were diminished in the radial aspect bilaterally as compared to the ulna but not in an anatomical distribution. Rather, these were generalized, diffuse and not specifically localized. Dr. Zeidman indicated that the Tinel's sign showed no radiation of pain but pain was noted at the wrists at the points of percussion.

Dr. Zeidman indicated that appellant's left shoulder adduction of 90 degrees equaled 4 percent impairment, that his left shoulder flexion of 90 degrees equaled a 6 percent loss and that these values combined to a 10 percent loss. He further indicated that, with regard to the accepted bilateral carpal tunnel problem, there is a paucity of objective physical findings to support any permanent residua but there was some electromyogram (EMG) evidence of some residual nerve involvement. Dr. Zeidman indicated that appellant, therefore, appeared to fall under the second category for evaluating carpal tunnel syndrome impairment as delineated on page 495 of the A.M.A., *Guides*. He stated:

> "In the absence of consistent findings on examination, it is difficult to be completely precise but I would estimate that the average figure, therefore, would suggest 2½ percent per extremity or a total of 5 percent. Thus, for the left upper extremity combining the 10 percent at the shoulder and 2½ percent at the wrist, the total would be 12½ percent for the left upper extremity and an additional 2½ percent for the right upper extremity based upon the carpal tunnel residua."

Dr. Zeidman rounded up these respective figures to find that appellant had a 13 percent permanent impairment of her left arm and a 3 percent permanent impairment of her right arm.

An Office medical adviser indicated that he agreed with Dr. Zeidman's assessment that appellant had a 13 percent permanent impairment of her left arm and a 3 percent permanent impairment of her right arm. In a September 8, 2008 decision, the Office granted her a schedule award for a three percent permanent impairment of her right arm and an additional one percent award for permanent impairment of her left arm.[1]

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] 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.[4] It is well established that in determining the amount of a schedule award for a member of the body that

[1] Although the Office hearing representative had set aside the Office's December 27, 2007 decision granting a schedule award for a 12 percent permanent impairment of the left arm, appellant had already received compensation reflecting this degree of impairment.

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] *Id*.

sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[5]

The A.M.A., *Guides* evaluates the permanent impairment caused by carpal tunnel syndrome by determining whether such a condition falls within one of three categories discussed in section 16.5d.[6] Under the first category, if there are positive clinical findings of median nerve dysfunction and an electrical conduction delay, the condition is rated under the standards found earlier in Chapter 16 for evaluating sensory or motor deficits due to peripheral nerve disorders. Under the second category, if there is normal sensibility (evaluated by two-point discrimination and Semmes-Weinstein monofilament testing) and normal opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles, an impairment rating not to exceed five percent of the upper extremity may be justified. Under the third category, if there is normal sensibility, opposition strength and nerve conduction studies, there is no objective basis for an impairment rating.[7]

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."[8] In situations where 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.[9] In a situation where the Office secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[10]

ANALYSIS

The Office accepted that appellant sustained left shoulder bursitis and bilateral carpal tunnel syndrome. After development of appellant's claim for entitlement to schedule award compensation, the Office properly determined that a conflict in medical opinion existed between Dr. Weiss, an attending osteopath, and the Office medical adviser, a Board-certified orthopedic

[5] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b (June 1993). This portion of Office procedure provides that the impairment rating of a given scheduled member should include "any preexisting permanent impairment of the same member or function."

[6] *See* A.M.A., *Guides* 495.

[7] *Id.*

[8] 5 U.S.C. § 8123(a).

[9] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[10] *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232, 238 (1988).

surgeon,[11] and then referred her to Dr. Zeidman, a Board-certified orthopedic surgeon, for an impartial medical examination.[12]

Based on the May 15, 2008 report of Dr. Zeidman, the Office determined that appellant had a 13 percent permanent impairment of her left arm and a 3 percent permanent impairment of her right arm. It granted her schedule award compensation based on this assessment. The Board finds the opinion of Dr. Zeidman is in need in further clarification.

With respect to appellant's bilateral carpal tunnel syndrome, Dr. Zeidman indicated that she appeared to fall under the second category for evaluating carpal tunnel syndrome impairment as delineated on page 495 of the A.M.A., *Guides*. He noted that there was a paucity of objective physical findings to support any permanent residua but there was some EMG evidence of some residual nerve involvement. Dr. Zeidman did not adequately explain his choice of evaluating carpal tunnel impairment under category 2 on page 495. The record reflects that appellant exhibited some clinical signs of median nerve dysfunction, including pain in the median nerve distribution and it remains unclear why her carpal tunnel impairment would not be more appropriately evaluated under category 1 on page 495. Even if it were determined that, category 2 was the appropriate category for this assessment, Dr. Zeidman did not adequately explain why she had 2½ percent impairment in each arm. He merely stated, "In the absence of consistent findings on examination, it is difficult to be completely precise but I would estimate that the average figure, therefore, would suggest 2½ percent per extremity or a total of 5 percent." Moreover, Dr. Zeidman did not fully explain why he chose to combine a 10 percent impairment rating for limited left shoulder motion with his impairment rating for left carpal tunnel syndrome.

The Board further notes that it appears that Dr. Zeidman only performed cursory testing for sensory and strength losses. Dr. Zeidman indicated that on neurologic examination all reflexes were symmetrically diminished but present. He indicated that on manual muscle testing there was a weakness bilaterally symmetrical in both extremities but this was variable from evaluation to evaluation. Dr. Zeidman provided no further details of how he accomplished this testing and, in the absence of detailed findings, it is unclear whether he fully complied with the specific standards of the A.M.A., *Guides* for evaluating sensory and strength losses.[13]

[11] In an April 12, 2004 report, Dr. Weiss determined that appellant had a 24 percent permanent impairment of her left arm and a 17 percent permanent impairment of her right arm based on sensory loss associated with the C5, C6 and C7 nerve roots in both arms. In contrast the Office medical adviser found on April 7, 2006 that appellant had a 13 percent impairment of her left arm based on limitation upon flexion, extension and abduction of the left arm.

[12] An Office hearing representative correctly determined that the prior referral to Dr. Glenn, a Board-certified orthopedic surgeon, was not conducted under the appropriate rotational standards for selecting impartial medical specialists. *See* Federal (FECA) Procedure Manual, *supra* note 5, Chapter 3.500.4, 7 (March 1994, May 2003); FECA Bulletin No. 00-01 (issued November 5, 1999).

[13] *See* A.M.A., *Guides* 480-94. There is some evidence in the record that appellant had bilateral cervical radiculopathies and Dr. Zeidman did not adequately evaluate whether this would lead to additional impairment ratings. There also was some indication that appellant sustained work-related cervical injuries in 2002, but the record is not entirely clear on this point. As noted above, it is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included. *See supra* note 5.

For the above-described reasons, the opinion of Dr. Zeidman is in need of clarification and elaboration. Therefore, in order to resolve the continuing conflict in the medical opinion, the case will be remanded to the Office for referral of the case record, a statement of accepted facts and, if necessary, appellant, to Dr. Zeidman for a supplemental report regarding her permanent arm impairment. If Dr. Zeidman is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[14] After such further development as the Office deems necessary, an appropriate decision should be issued regarding appellant's permanent arm impairment.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant met her burden of proof to establish that she had more than a 13 percent permanent impairment of her left arm and a 3 percent permanent impairment of her right arm, for which she received schedule awards. The case is remanded to the Office for further development of the medical evidence to be followed by an appropriate decision regarding appellant's entitlement to schedule award compensation.

[14] *Harold Travis*, 30 ECAB 1071, 1078 (1979).

ORDER

IT IS HEREBY ORDERED THAT the September 8, 2008 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: June 18, 2010
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board