United States Department of Labor
Employees' Compensation Appeals Board

K.O., Appellant	)	
and	)	**Docket No. 11-814**
	)	**Issued: December 21, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Dallastown, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 13, 2011 appellant filed a timely appeal from the Office of Workers' Compensation Programs' (OWCP) schedule award decision dated February 8, 2011. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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 sustained more than a seven percent permanent impairment of her right arm for which she received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board. In a November 3, 2006 decision, the Board affirmed an OWCP decision finding that appellant had no more than 14 percent impairment of the larynx. The Board also set aside an OWCP decision finding that she had

[1] 5 U.S.C. § 8101 *et seq.*

seven percent impairment of the right arm and directed further medical development.[2] In a March 6, 2008 decision, the Board found the case not in posture for decision regarding the right arm schedule award and remanded the case for further medical development. In a September 2, 2009 decision, the Board found a conflict in the medical evidence regarding appellant's right arm impairment and remanded the case for referral to an impartial medical specialist.[3] On November 19, 2010 the Board issued an order remanding case in the matter. The Board found that an OWCP medical adviser exceeded his role when he substituted his judgment for that of the impartial medical specialist. The Board set aside OWCP's January 7, 2010 schedule award decision and remanded the case for a supplemental opinion from Dr. John F. Perry, a Board-certified orthopedic surgeon and impartial medical examiner, clarifying whether appellant had any other ratable abnormalities and the extent of appellant's impairment.[4] The facts and history contained in the prior appeals are incorporated by reference. Facts germane to the issue have been set forth as appropriate.

In an initial October 15, 2009 report, Dr. Perry utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2008) (A.M.A., *Guides*) and noted appellant's history of injury and treatment, examined her and diagnosed: status post arthrodesis C5-6, C6-7 and right shoulder and arm pain, with questionable etiology. He indicated that he did not detect any decreased sensation on examination. Dr. Perry noted that this would confirm the electromyography (EMG) scans which "failed to demonstrate any problem with the right little and ring fingers, the areas where [appellant] complained of numbness in the past." He also indicated that the "only abnormality found on the 2004 EMG was of slowing of the median nerve conduction velocity. It did not demonstrate any problem with the ulnar nerve and it did not demonstrate radiculopathy. *i.e.,* a problem coming from the cervical spine." Dr. Perry referred to page 445 of the A.M.A., *Guides,* the section pertaining to peripheral nerve impairment which indicates:

> "The diagnosis of a focal neuropathy syndrome must be documented by sensory and motor conduction studies and/or needle EMG in order to be ratable as impairment using this section. If nerve conduction testing has not been performed or does not meet this section's diagnostic criteria, there is no ratable impairment from this section."

He explained that, while the other physicians "calculated disability on the basis of a presumed neurologic deficit. *i.e*., sensory loss, yet neither EMG explains her past complaints of sensory loss, and I found none today. Furthermore, I found no restriction of shoulder motion." Dr. Perry also explained that, while appellant "moved her arm slowly, she was able to fully abduct and rotate the right shoulder." He opined that, based on available records, there was "no demonstrable pathologic process … identified in the right shoulder on the basis of any objective criteria." Dr. Perry reiterated that, "since there is no EMG verification of a sensory impairment

[2] Docket Nos. 06-984 and 1820 (issued November 3, 2006). OWCP accepted appellant's claim for right shoulder tendinitis and adhesive capsulitis, and cervical spine herniation and brachial neuritis. It authorized a discectomy and fusion for a right-sided C5-6 and a left-sided C6-7 herniated nucleus pulposus.

[3] Docket No. 08-1772 (issued September 2, 2009); Docket No. 07-1885 (issued March 6, 2008).

[4] Docket No. 10-745 (issued November 19, 2010).

based on cervical spine surgery, the symptoms cannot be explained on the basis of either an EMG or nerve conduction study and the range of motion of the shoulder is normal. I cannot provide any degree of functional impairment of the right arm. Any perceived sensory defect is not ratable based the A.M.A., *Guides*, sixth edition." Dr. Perry also noted that he did not address the cervical spine with regards to impairment because he was only asked to determine the issue of the right arm impairment.

In a December 15, 2009 report, an OWCP medical adviser noted appellant's history and reviewed Dr. Perry's report. The medical adviser explained that Dr. Perry referred to page 445 of the A.M.A., *Guides* which revealed that there was no ratable condition based upon the EMG verification of abnormalities. However, the medical adviser noted that appellant had other ratable abnormalities under the A.M.A., *Guides* and referred to Table 17-2; Cervical Spine Regional Grid Impairments, with a diagnosis of intervertebral herniated disc.[5] The medical adviser explained that appellant fell in the category of intervertebral disc herniation single level or multiple levels with or without surgery and a resolved radiculopathy or nonverifiable radicular complaints. The medical adviser opined that appellant would be in a category of class 1, grade C default value or a six percent impairment of the whole person. The medical adviser utilized the net adjustment grid and grade modifiers Table 17.6: Functional History Adjustment Grid, Table 17-7: Physical Examination Spine, and Table 17-9: Clinical Studies Adjustment, Spine.[6] The medical adviser concluded that appellant had four percent whole person impairment and referred to Table 15-11 Impairment Values Calculated from Upper Extremity Impairment and determined that appellant had seven percent impairment of the right upper extremity.[7] The medical adviser agreed with Dr. Perry's final conclusion although he did not use the appropriate methodology.

Following the Board's November 19, 2010 order remanding case, OWCP, in a December 8, 2010 letter, requested that Dr. Perry consider all accepted conditions and provide a reasoned report addressing whether appellant had other ratable impairment under the A.M.A., *Guides*.

In a January 6, 2011 report, Dr. Perry advised that he had reviewed the medical adviser's report regarding appellant's impairment rating. Regarding radiculopathy, he noted that appellant had negative EMG studies, which, he had previously concluded did not support any impairment rating. Additionally, Dr. Perry explained that appellant had full range of motion, and had no impairment on that basis. He advised that appellant was diagnosed with intervertebral disc herniation single level with or without surgery and resolved radiculopathy which resulted in a default value of six percent of the whole person. Dr. Perry advised that "I did not evaluate that in my report, and I did not argue that finding with [OWCP medical adviser]." He explained that he was "specifically asked to help settle a problem of impairment rating in which there was a discrepancy between two other observers and I utilized criteria with regard to the issue at hand." Dr. Perry further noted that the OWCP medical adviser was "using default criteria that, in my

[5] A.M.A., *Guides* 564.

[6] *Id*. at 575, 576, 581.

[7] *Id*. at 421.

opinion, are beyond the focus of [appellant]." He opined that he continued to believe that his reasoning with regard to appellant's disability rating "remains valid."

By decision dated February 8, 2011, OWCP denied appellant's claim for an increased schedule award. It found that she was entitled to no more than a seven percent permanent impairment of the right upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA[8] and its implementing regulations[9] 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, FECA 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. For decisions issued after May 1, 2009, the A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[10]

Although, the A.M.A., *Guides* include guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.[11] In 1960, amendments to FECA modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[12] Impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized.[13]

Section 8123(a) of FECA 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."[14] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] FECA Bulletin No. 09-03 (issued March 15, 2009). A.M.A., *Guides* (6th ed. 2008).

[11] *Pamela J. Darling*, 49 ECAB 286 (1998).

[12] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[13] *Patricia J. Penney-Guzman*, 55 ECAB 757 (2004).

[14] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan*, 45 ECAB 207, 210 (1993).

such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[15]

ANALYSIS

This case was previously remanded by the Board for referral to an appropriate specialist to resolve the conflict in the medical evidence between the treating physician, Dr. James J. Sullivan, a Board-certified physiatrist and an osteopath, who found a nine percent impairment of the right arm and the second opinion physician, Dr. William Smulyan, a Board-certified orthopedic surgeon, who opined that appellant had no more than seven percent impairment. OWCP referred appellant to Dr. John F. Perry, a Board-certified orthopedic surgeon, for an independent medical examination.

In an October 15, 2009 report, Dr. Perry noted appellant's history, utilized the A.M.A., *Guides*, examined her and determined that she did not have a ratable impairment. He referred to page 445 of the A.M.A., *Guides* and explained that a diagnosis of focal neuropathy syndrome must be documented by sensory and motor conduction studies and/or needle EMG in order to be ratable as impairment. Dr. Perry explained if nerve conduction testing was not performed or did not meet the section's diagnostic criteria, there was no ratable impairment. He determined that his examination was consistent with the EMG scans which did not document sensory loss. Dr. Perry also noted that, while other physician's provided findings, these were based on "a presumed neurologic deficit. *i.e*., sensory loss." He explained that neither EMG explained her past complaints of sensory loss, and he did not find any loss during his examination. Dr. Perry also indicated that appellant's range of motion of the shoulder was normal and he did not find any restriction of shoulder motion and despite the fact that she "moved her arm slowly;" "she was able to fully abduct and rotate the right shoulder." He determined that appellant did not have any demonstrable findings in the right shoulder based upon "any objective criteria." Dr. Perry also reiterated that there was "no EMG verification of a sensory impairment based on cervical spine surgery" and opined that her symptoms could not be explained on the basis of either an EMG or nerve conduction study. He advised that he did not address the cervical spine with regards to impairment because he was only asked to determine the issue of the right arm disability determinations.

In a December 15, 2009 report, OWCP's medical adviser reviewed Dr. Perry's report and provided an opinion that, while he agreed with the final conclusion, the appropriate methodology was not utilized. As noted, in the last appeal, the Board determined that OWCP's medical adviser exceeded his role in interpreting Dr. Perry's report and remanded the case for clarification.[16]

Board precedent provides that, when OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the

[15] *See Roger Dingess*, 47 ECAB 123, 126 (1995); *Juanita H. Christoph*, 40 ECAB 354, 360 (1988); *Nathaniel Milton*, 37 ECAB 712, 723-24 (1986).

[16] Docket No. 10-745 (issued November 19, 2010).

specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in his original report.[17]

In a January 6, 2011 report, Dr. Perry again utilized the A.M.A., *Guides* and provided rationale for his opinion. Regarding radiculopathy, he advised that appellant had negative EMG studies which, as previously noted, did not support an impairment rating. Dr. Perry also found that she had full range of motion, and thus had not impairment of range of motion. He also addressed appellant's cervical condition advising that she was diagnosed with intervertebral disc herniation single level with or without surgery and resolved radiculopathy which resulted in a default value of six percent of the whole person. Dr. Perry explained that he did not disagree with that finding; but such impairment was "beyond the focus" of her situation as he was asked to rate impairment of the arm.[18] He reiterated that his reasoning with regard to appellant's disability rating remained valid. The Board finds that Dr. Perry provided a reasoned opinion with regard to the extent of her impairment. The Board has held that, to properly resolve a conflict in medical opinion, it is the impartial medical specialist who should provide a reasoned opinion as to a permanent impairment to a scheduled member of the body in accordance with the A.M.A., *Guides*. Dr. Perry found no basis, under the A.M.A., *Guides,* to rate impairment of the right arm.

The Board finds that Dr. Perry's report is sufficiently well rationalized and based upon an accurate factual background such that it is entitled to special weight. His report establishes that appellant has not sustained more than a seven percent permanent impairment of her right upper extremity for which she has received a schedule award.

On appeal, appellant's representative alleges that the report of Dr. Perry is not credible but references no specific evidence of record to support his assertion. He also argues that a new conflict was created. However, as noted above, Dr. Perry was selected to resolve a conflict between the treating physician, Dr. Sullivan, who found a nine percent impairment of the right arm and the second opinion physician, Dr. Smulyan, who opined that appellant had no more than seven percent impairment. As explained, his report is entitled to receive special weight.

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish that she sustained more than a seven percent permanent impairment of her right upper extremity for which she received a schedule award.

[17] *April Ann Erickson*, 28 ECAB 336, 341-42 (1977).

[18] *See Tania R. Keka*, 55 ECAB 354 (2004); *James E. Mills*, 43 ECAB 215 (1991) (neither FECA nor its implementing regulations provide for a schedule award for impairment to the body as a whole).

ORDER

IT IS HEREBY ORDERED THAT the February 8, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 21, 2011
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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