United States Department of Labor
Employees' Compensation Appeals Board

A.H., Appellant	)	
and	)	**Docket No. 11-2080**
	)	**Issued: July 26, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 23, 2011, appellant, through her attorney, filed a timely appeal from a June 21, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 the case.

ISSUE

The issue is whether appellant has more than four percent impairment of her right arm for which she received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board. By decision dated August 10, 2010, the Board found the case not in posture for decision as referral to an impartial medical specialist was

[1] 5 U.S.C. §§ 8101-8193.

necessary.[2] The Board found a conflict in medical opinion existed between Dr. Nicholas Diamond, an osteopath and OWCP's medical adviser with regard to the extent of appellant's permanent impairment to the right arm. As such, the Board directed that OWCP refer appellant for an impartial medical examination. The Board set aside the December 17, 2008 and June 1, 2009 OWCP's decisions and remanded the case for further development. The facts and the history as set forth in the prior decision are incorporated by reference.[3]

To resolve the conflict, on September 20, 2010, OWCP referred appellant to a referee physician, Dr. Menachem M. Meller, a Board-certified orthopedic surgeon.[4]

In an October 19, 2010 report, Dr. Meller indicated that he reviewed the records provided to him and performed a physical examination of appellant. He noted a history of her work-related injury and advised that she had reached maximum medical improvement. Dr. Meller diagnosed subjective complaints of pain of the right shoulder, right forearm and hand and left mid forearm. He noted no midline or paravertebral spasm or tenderness, no myofascial trigger points, normal symmetry and contour of the shoulders. Shoulder flexion was 145 degrees on the right and 130 degrees on the left; Dr. Meller noted the right shoulder flexed more than the noninjured shoulder. External rotation was 90 degrees bilaterally, abduction was to 90 degrees bilaterally and internal rotation was 75 degrees bilaterally. Appellant had intact sensibility from C5-T1, normal symmetric reflexes at the biceps, triceps and brachioradialis. Dynamometer testing was not consistent for maximal effort. There was normal and symmetric elbow, forearm, wrist and hand motion and excellent grip and pinch strength.

For the shoulder and shoulder girdle area, there was no pectoralis discomfort, no winging of the scapula and no crepitus on scapulothoracic motion. Dr. Meller noted that appellant had normal cervical spine motion and normal functional motion which was bilaterally symmetric to the shoulders, elbows, wrists and hands, with no evidence of impingement, instability, joint arthrosis or rotator cuff dysfunction. He noted that, under Table 15-5, Shoulder Regional Grid: Upper Extremity Impairment, Impingement Syndrome, appellant had no impairment and was class 0 with no objective abnormal findings at maximum medical improvement. Dr. Meller noted that there was no impairment for undergoing surgery and advised that the clinical photographs demonstrated better flexion, abduction and external rotation on the involved side and the absence of any impingement signs. He noted some restriction on internal rotation but attributed it to either volitional restriction or nonwork-related subsequent developments unrelated to the accepted injury. Dr. Meller found no focal motor loss in the arms to corroborate with Dr. Diamond's findings regarding the supraspinatus or deltoid and opined that any weakness

[2] Docket No. 09-2168 (issued August 10, 2010).

[3] On December 21, 1999 appellant, then a 56-year-old manual distribution clerk, injured his right shoulder when lifting mail. OWCP accepted her claim for right shoulder strain and cervical radiculitis and authorized arthroscopic surgery on the right shoulder which was performed on September 29, 2000. Appellant retired in March 2007. By decision dated December 17, 2008, OWCP granted her a schedule award for four percent impairment of the right arm.

[4] Appellant's counsel inquired about documentation regarding the selection for Dr. Meller and asked to be allowed to participate in selecting the impartial specialist. Counsel did not note any specific objection to Dr. Meller's selection.

recorded by Dr. Diamond was either volitional or transient and not present at maximum medical improvement. He noted no dermatomal sensory deficit, reflex asymmetry or results of specialized neurological tests to support neurologic injury or neurological deficit at maximum medical improvement. Dr. Meller found no evidence of instability and assigned no impairment. He noted age-related arthritis of the cervical spine and basal joint of her right thumb. Dr. Meller found an objectively normal cervical spine examination on range of motion, tenderness, spasm and strength which did not yield an impairment rating pursuant to Table 17-2, Cervical Spine Regional Grid: Spine Impairments.

In a November 11, 2010 report, OWCP's medical adviser reviewed the medical evidence and opined that appellant reached maximum medical improvement on July 3, 2008. Under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), he correlated Dr. Meller's examination findings to a four percent impairment to the right arm. The medical adviser noted that there were two methodologies to be considered in rating a case under the A.M.A., *Guides*, the diagnosis-based impairment or range of motion method. He noted that the greater of the two methods was the most appropriate. The medical adviser noted that, pursuant to section 15.2, Diagnosis-Based Impairment, Table 15-5, Shoulder Regional Grid, Ligament/Bone/Joint, for the diagnosed rotator cuff injury, partial thickness tear, appellant was a class 1 (CDX) rating for residual loss, functional with normal motion with a default rating of three percent arm impairment. He noted that, pursuant to the Adjustment Grid: Functional History (GMFH), Table 15-7, she was assigned a grade modifier 1 for pain symptoms with strenuous vigorous activity and medications to control symptoms. With regard to Physical Examination (GMPE) adjustment, appellant was not assigned a grade modifier as the physical examination was unreliable and the reported motion loss was equal bilaterally. With regard to the Clinical Studies (GMCS) adjustment, she was assigned a grade modifier 2 as the diagnostic studies confirmed the diagnoses of a rotator cuff tear. The medical adviser noted that the adjustments were for functional history grade modifier 1, physical examination was not applicable and clinical studies was 2 for a net adjustment of +1. This resulted in a grade D and four percent upper extremity impairment.

Using the range of motion method for impairment evaluation, Table 15-34, Shoulder Range of Motion, the medical adviser found that both extremities should be examined for comparison between the affected and unaffected side or determine the baseline. He noted that Dr. Meller clearly described appellant's shoulder motion measurements as equal bilaterally and attributed her restriction to either volitional restriction or nonwork-related subsequent developments unrelated to the accepted work-related activities and therefore concluded that it was inconsistent with the A.M.A., *Guides* to assess permanent impairment using the range of motion method. The medical adviser further noted that, with regard to cervical radiculitis, pursuant to Chapter 17, The Spine and Pelvis, appellant would have zero percent impairment as Dr. Meller found no motor or sensory deficits in the upper extremities that would result in ratable impairment. He concluded that she had four percent right arm impairment. The medical adviser noted that appellant had a prior award of four percent right upper extremity impairment and therefore was not entitled to an additional award.

Appellant submitted a report from Dr. Scott Fried, an osteopath, dated November 11, 2010, who diagnosed osteoarthritis of the thumb, tear of the right wrist ligament, radial and median neuropathy on the right, brachial plexopathy, cervical radiculopathy, thoracic neuritis,

right shoulder arthroscopy and partial thickness rotator cuff tear. Dr. Fried recommended massage therapy.

By decision dated November 18, 2010, OWCP denied appellant's claim for an additional schedule award beyond the four percent schedule award previously paid. It found that the findings of Dr. Meller and OWCP's medical adviser were the weight of the medical evidence and they did not support any increased impairment.

On November 23, 2010 appellant requested an oral hearing. On April 11, 2011 she withdrew her request for an oral hearing and requested a review of the written record.

In a decision dated June 21, 2011, an OWCP hearing representative affirmed the November 18, 2010 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations[6] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[9]

No schedule award is payable for a member, function or organ of the body not specified in FECA or in the implementing regulations.[10] FECA and the implementing regulations do not provide for the payment of a schedule award for the permanent loss of use of the back or the body as a whole.[11] The Board notes that section 8101(19) specifically excludes the back from the definition of organ.[12] However, a claimant may be entitled to a schedule award for

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

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

[9] FECA Bulletin No. 09-03 (issued March 15, 2009).

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

[11] *See Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[12] 5 U.S.C. § 8101(19).

permanent impairment to an upper or lower extremity even though the cause of the impairment originated in the neck, shoulders or spine.[13]

ANALYSIS

On appeal, appellant contends that she is entitled to a schedule award greater than four percent permanent impairment of the right upper extremity. OWCP accepted her claim for sprain of the right shoulder strain and cervical radiculopathy and authorized arthroscopic shoulder surgery on September 29, 2000. It previously issued appellant a schedule award for four percent impairment of the right arm. On August 10, 2010 the Board found that a conflict existed in the medical evidence between her physician, Dr. Diamond and an OWCP medical adviser concerning the extent of her impairment. Consequently, OWCP referred appellant to Dr. Meller to resolve the conflict.

Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[14] The Board finds that, under the circumstances of this case, the opinion of Dr. Meller is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight and establishes that appellant is not entitled to an additional schedule award.

Dr. Meller noted a history of appellant's work-related injury. He noted that examination of the upper extremities revealed no midline or paravertebral spasm or tenderness, normal symmetry and contour of the shoulders. Dr. Meller noted range of motion findings and found that appellant had intact sensibility from C5-T1 and normal symmetric reflexes. Dynamometer testing was not consistent for maximal effort. With regard to the shoulder and shoulder girdle area there was no pectoralis discomfort, no winging of the scapula and no crepitus on scapulothoracic motion. Dr. Meller noted that appellant had normal cervical spine motion and normal functional motion which was bilaterally symmetric to the shoulders, elbows, wrists and hands, with no evidence of impingement, instability, joint arthrosis or rotator cuff dysfunction. Under Table 15-5, Shoulder Regional Grid: Upper Extremity Impairment, Impingement Syndrome, appellant had no impairment for a class 0 with no objective abnormal findings. Dr. Meller found no focal motor loss in the upper extremities. He also found no basis for any sensory or neurological impairment. Dr. Meller noted an objectively normal cervical spine examination on range of motion, tenderness, spasm and strength which did not yield an impairment rating pursuant to the Table 17-2, Cervical Spine Regional Grid: Spine Impairments.

The medical adviser reviewed the medical record and, in his report of November 11, 2010, found no basis on which to attribute any increased impairment of the right arm, based on the findings presented by Dr. Meller.[15] Using Dr. Meller's measurements and findings, he

[13] *Thomas J. Engelhart, supra* note 10.

[14] *Aubrey Belnavis,* 37 ECAB 206 (1985). *See* 5 U.S.C. § 8123(a).

[15] While the Dr. Meller was an impartial specialist, it is appropriate for an OWCP medical adviser to review the clinical findings of the treating physician to determine the permanent impairment. *See* Federal (FECA) Procedure Manual, *supra* note 8, *Medical Examinations,* Chapter 3.500.5(c) (March 1994); *Richard R. LeMay*, 56 ECAB 341 (2005).

utilized the Shoulder Regional Grid, Table 15-5, A.M.A., *Guides*, page 402 and identified a class 1 impairment based on rotator cuff injury, partial-thickness tear, with residual loss, functional with normal motion, which had a default value, C, of three percent upper extremity impairment.[16] The medical adviser noted that, pursuant to the Adjustment Grid, for functional history, appellant was assigned a grade modifier 1 for pain symptoms with strenuous vigorous activity and medications to control symptoms.[17] With regard to physical examination adjustment, appellant was not assigned a grade modifier as the physical examination was unreliable and the reported motion loss was equal bilaterally.[18] With regard to the clinical studies adjustment, she was assigned a grade modifier 2 as the diagnostic studies confirmed the diagnoses of a rotator cuff tear. Applying the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) = net adjustment[19] resulted in a modifier of 1, which resulted in a grade adjustment from C to D.[20] The corresponding upper extremity impairment for a class 1, grade D rotator cuff partial-thickness tear is four percent.[21] The medical adviser noted that Dr. Meller clearly described appellant's shoulder motion measurements as equal bilaterally and attributed her restriction to possible volitional restriction and therefore concluded that under the A.M.A., *Guides* there was no permanent impairment using the range of motion method. He further noted that, with regard to cervical radiculitis, pursuant to Chapter 17, The Spine and Pelvis, appellant would have no impairment as Dr. Meller found no motor or sensory deficits in the arms that result in ratable impairment.

The Board finds that the medical adviser properly applied the A.M.A., *Guides* to Dr. Meller's examination findings to rate appellant's right arm impairment. Both the referee physician, Dr. Meller, and the medical adviser, reviewed the medical evidence and agreed that she had no additional impairment for the right upper extremity under the sixth edition of the A.M.A., *Guides*. The weight of medical evidence establishes the extent of permanent impairment in this case.

On appeal, counsel contends that OWCP improperly permitted the medical adviser to resolve the conflict of opinion in this case which was contrary to OWCP's procedures and case law. The Board notes that, in this case, the medical adviser applied the referee physician's findings and notes that, although he determined that appellant sustained four percent impairment, he also found no basis to support impairment greater than what was previously granted to her. Appellant also asserts that she should have been allowed to participate in the selection of the impartial medical specialist. She contends that Dr. Meller was inappropriate to resolve the conflict of opinion in this case as he was found to be biased and was disqualified from another case by the Board. The Board notes that, pursuant to OWCP's procedures, a claimant who asks

[16] A.M.A., *Guides* 402, Table 15-5.

[17] *Id*. at 406 Table 15-7.

[18] *Id*. at 408 Table 15-8.

[19] *Id*. at 411.

[20] (1-1 + 0-1 + 2-1=1).

[21] *Supra* note 16.

to participate in selecting the referee physician or who objects to the selected physician should provide the reason for the objection.[22] Here, counsel generally asked to participate but provided no particular reason. There is no unqualified right to participate in the selection of an impartial specialist.[23] There is no evidence that Dr. Meller was improperly selected. In asserting bias by Dr. Meller, counsel cites to *J.S.* in which the Board found that Dr. Meller was not properly selected as an impartial specialist where appellant objected to the selection and also provided evidence of bias by Dr. Meller contemporaneous with Dr. Meller's selection.[24] Here, appellant submitted no evidence to the record supporting that Dr. Meller was biased. The Board has held that an impartial medical specialist properly selected by OWCP will be presumed unbiased and the party seeking disqualification bears the substantial burden of proving otherwise. Here, there is no evidence of record supporting that Dr. Meller was unqualified to render an impartial opinion at the time he examined appellant.[25]

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has four percent impairment of the right upper extremity, for which she received a schedule award.

[22] Federal (FECA) Procedure Manual, *supra* note 8, *OWCP Directed Medical Examinations*, Chapter 3.500.4(f) (July 2011).

[23] *Joseph R. Boutot*, 45 ECAB 560 (1993).

[24] Docket No. 10-2198 (issued July 26, 2011).

[25] The Board's review of the case is limited to the evidence that was in the case record that was before OWCP at the time of its final decision. 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the June 21, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 26, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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