United States Department of Labor
Employees' Compensation Appeals Board

R.R., Appellant	)	
and	)	**Docket No. 12-1184**
	)	**Issued: April 10, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Vineland, 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:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On May 7, 2012 appellant, through counsel, filed a timely appeal from a January 18, 2012 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 this case.

ISSUE

The issue is whether appellant has more than a 13 percent permanent impairment to his left arm.

FACTUAL HISTORY

Appellant, a 53-year-old mail carrier, twisted his low back and left shoulder on December 28, 2004 while stepping from the rear bumper of his mail vehicle. He filed a claim for benefits, which OWCP accepted for lumbosacral and left shoulder sprain. OWCP subsequently

[1] 5 U.S.C. § 8101 *et seq.*

accepted the conditions of left carpal tunnel syndrome, lesion of the ulnar nerve, adhesive capsulitis of the left shoulder, precipitation of preexisting degenerative disc disease and left shoulder superior labral tear from anterior to posterior (SLAP) tear. Appellant retired from the employing establishment on February 1, 2008.

On February 18, 2005 appellant underwent ultrasound testing. Dr. John P. Salvo, a specialist in orthopedic surgery, interpreted the results. He diagnosed a full thickness traumatic rotator cuff tear of the left shoulder.

On March 30, 2005 appellant underwent arthroscopic surgery, with subacromial decompression and debridement of the left shoulder, to repair the left shoulder rotator cuff tear, left shoulder subacromial impingement and the left shoulder SLAP tear.

On October 18, 2005 appellant underwent an electromyelogram (EMG) which found: (1) bilateral ulnar neuropathies at the level of the wrists, moderate in severity and associated with ongoing axonal degeneration; (2) left ulnar neuropathy at the level of the elbow, mild in severity; (3) and median nerve entrapment at the level of the wrists; *i.e.*, carpal tunnel syndrome, bilaterally, mild in severity and associated with mild degrees of axonal degeneration.

On April 21, 2006 appellant underwent surgical release of the left carpal tunnel syndrome, left cubital tunnel syndrome and the ulnar nerve compression of Guyon's canal.

On May 29, 2007 OWCP referred appellant for a second opinion evaluation by Dr. Zohar Stark, Board-certified in orthopedic surgery, who examined appellant on June 7, 2007, noting appellant's left shoulder showed range of motion loss, with a forward flexion of 260 degrees; abduction of 140 degrees; extension of 30 degrees; adduction of 40 degrees; internal rotation of 70 degrees; and external rotation 90 degrees. Dr. Stark advised that appellant's left elbow revealed a positive Tinel's test on percussion over the cubital canal; examination of his left wrist showed a positive Tinel's test for involvement of the median nerve; he also demonstrated reduced sensation in the fourth and fifth fingers on the left. He did not provide a specific rating of permanent impairment.

In a June 3, 2008 report, Dr. Steven Allon, Board-certified in orthopedic surgery, examined appellant at the request of counsel. He found that appellant had a 57 percent left upper extremity impairment pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (fifth edition) (A.M.A., *Guides*). Dr. Allon stated that on examination of the left shoulder range of motion showed a forward elevation of 130 out of 180 degrees, with tightness; abduction of 110 out of 180 degrees with pain; cross over adduction of 65 out of 75 degrees; external rotation of 85 out of 90 degrees; and internal rotation of 85 out of 90 degrees. With regard to manual muscle strength testing of the upper extremities, he stated that appellant's supraspinatus and triceps graded at 3 out of 5 on the left; the deltoid graded a four out of five on the left. Regarding the left elbow, Dr. Allon's examination showed a positive Tinel's sign with radiation of paresthesia to the mild ulnar forearm; varus stress testing produced pain at the medial epicondyle region.

Dr. Allon stated that on examination appellant's left wrist and hand indicated a positive Tinel's sign which produced paresthesia into the fourth and fifth fingers, a positive Phalen's sign

and a positive carpal compression test. He also administered grip strength testing performed *via* Jamar Hand Dynamometer which showed 42 kilograms of force strength in the right hand versus 22 kilograms of force strength in the left hand. Dr. Allon stated that pinch key testing reveals 8 kilograms of force strength in the right hand versus 5.5 kilograms in the left hand. He further noted that appellant complained of constant low back pain and stiffness on a daily basis.

Dr. Allon rated: a 3 percent upper extremity impairment for loss of flexion; a 6 percent impairment for loss of abduction; a 10 percent impairment for left shoulder resection arthroplasty; a 20 percent impairment for left lateral pinch deficit; a 31 percent impairment for a grade 2 sensory deficit left median nerve; and a 6 percent impairment for a grade 2 sensory deficit of the left ulnar nerve, or a total 57 percent left upper extremity impairment.

On August 4, 2008 appellant filed a Form CA-7 claim for a schedule award.

In a report dated September 15, 2008, an OWCP medical adviser stated that there was a conflict regarding the findings on examination of Dr. Stark and Dr. Allon. He opined that it was difficult to understand how the marked sensory changes in the extremities could have occurred in less than one year. The medical adviser recommended referral to an impartial medical examiner to resolve the discrepancy in the examination findings.

OWCP referred appellant to Dr. Howard Zeidman, Board-certified in orthopedic surgery, for a referee medical examination. In a report dated December 18, 2008, Dr. Zeidman found that appellant had a 10 percent impairment of the left upper extremity based on loss of motion and sensory impairment pursuant to the fifth edition of the A.M.A., *Guides*.

By decision dated March 13, 2009, OWCP granted appellant a schedule award for a 10 percent permanent impairment of the left arm. It ran for the period January 18, 2008 to July 24, 2009, for a total of 31.20 weeks of compensation.

By decision dated October 14, 2009, an OWCP hearing representative set aside the March 13, 2009 decision and remanded the case for further development of the medical evidence. She directed OWCP to update the statement of accepted facts and request a supplemental report from Dr. Zeidman.

Dr. Zeidman subsequently submitted reports dated November 19, 2009, April 7 and July 29, 2010. He did not provide an evaluation of appellant's left upper extremity impairment under the sixth edition of the A.M.A., *Guides*.

On October 15, 2010 an OWCP medical adviser found that as Dr. Zeidman failed to provide sufficient information or documentation to support the left upper extremity impairment rating, referral to a new impartial medical examiner was recommended.

On December 10, 2010 OWCP referred the claimant for an impartial evaluation with Dr. Ronald Gerson, Board-certified in orthopedic surgery. In a report dated February 16, 2011, Dr. Gerson found that appellant had a 13 percent left upper extremity impairment pursuant to the sixth edition of the A.M.A., *Guides*. The rating was based on his accepted left shoulder, left ulnar nerve and left carpal tunnel conditions. With regard to the left shoulder, section 15.2 at page 387 of the A.M.A., *Guides* stipulated that the examiner should choose a rating based on one

principle diagnosis per region in cases where there are multiple diagnoses. Dr. Gerson stated that appellant had a class 1 impairment at Table 15-5, the shoulder regional grid at page 402 of the A.M.A., *Guides* for rotator cuff injury, partial thickness tear based on the March 30, 2005 surgical report. Applying the net adjustment formula at section 15, pages 406, 410 and 411 of the A.M.A., *Guides*,[2] he found that appellant had a default impairment of class 1 based on rotator cuff injury, partial thickness tear, which yielded a grade C impairment. Dr. Gerson found that the grade modifier at Table 15-7, page 406 for functional history was 2, for a moderate problem based on pain symptoms with normal activity and medication to control symptoms; the grade modifier for physical examination at Table 15-8, page 408 was 2, for a moderate problem due to a moderate decrease in range of motion compared with the uninjured, right shoulder; the grade modifier for clinical studies at Table 15-9, page 410 was 2, based on a February 18, 2005 ultrasound indicating a full thickness tear of the left rotator cuff. Pursuant to Table 15-21, page 411, Dr. Gerson subtracted the grade modifier of 1 from grade 2 for functional history, physical examination and clinical studies, which yielded a net adjusted grade of one + one + one -- a total adjusted grade of three, which moved the default impairment from grade C to grade E, which was a two percent impairment of the left upper extremity for the left shoulder condition.[3]

Regarding the accepted left ulnar lesion, Dr. Gerson rated a seven percent impairment pursuant to Table 15-23, page 449 of the A.M.A., *Guides*, the table used for calculating entrapment/compression neuropathy impairment.[4] Under the heading of "Test Findings," he stated that the October 18, 2005 needle EMG study showed findings of denervation changes in the ulnar innervated muscles of the left hand. Dr. Gerson advised that, pursuant to page 488 of the A.M.A., *Guides*,[5] the finding of axon loss, under the heading of Ulnar Neuropathy at the Elbow, would yield a grade modifier of 3. Under the heading of "History," he stated that appellant complained of constant symptoms in the ulnar distribution of the left fourth and fifth fingers, which produced a grade modifier of 3. Dr. Gerson stated that, under the heading of "Physical Findings," appellant showed decreased sensation to two-point discrimination in the ulnar nerve distribution of the left hand with no weakness or atrophy, which yielded a grade modifier of 2. Pursuant to the rating process set forth at page 448 of the A.M.A., *Guides*,[6] he determined that the average value for these modifiers, was 3 + 3 + 2, divided by 3, which equaled 2.66, rounded off to a grade modifier of 3 = 3; this would yield a mid-range impairment of 8 under Table 15-23. Dr. Gerson stated that appellant's *Quick*DASH test score was 39, which, under the heading of "Functional Scale" at Table 15-23, constituted a mild grade modifier of 1, which reduced the impairment rating for left ulnar neuropathy to seven percent.

Dr. Gerson rated impairment for the accepted diagnosis of left carpal tunnel syndrome by relying on Table 15-23 at page 449. Under the heading of "Test Findings," he found that the October 18, 2005 EMG test results showed positive findings in the abductor pollicis brevis

[2] A.M.A., *Guides* 406, 410-11.

[3] *Id.* at 403.

[4] *Id.* at 449.

[5] *Id.* at 488.

[6] *Id.* at 448.

muscle. In accordance with page 487 of the A.M.A., *Guides*,[7] the finding of axonal loss, under the heading of Carpal Tunnel Syndrome, would yield a grade modifier of 3. Under the heading of "History," he stated that appellant complained of mild intermittent symptoms in the median nerve distribution with pain at the base of the thumb, which produced a grade modifier of 1. Dr. Gerson stated that, under the heading of "Physical Findings," the physical examination in the median nerve distribution showed decreased two-point discrimination at the third finger of 7 millimeters. He found that this yielded a grade modifier 2 under page 446 of the A.M.A., *Guides*[8] under the heading of "Physical Findings," which states that the selection of the grade modifier for physical findings is based on documentation of significant objective sensory and motor findings; under this section decreased sensation means decreased two-point discrimination, greater than six millimeters, for compression involving the median or ulnar nerve. As appellant showed decreased two-point discrimination of seven millimeters in the third finger, Dr. Gerson rated a grade modifier of 2 for physical findings. Pursuant to the rating process set forth at page 448, as noted above, he determined that the average value for these modifiers, based on adding 3 + 1 + 2, divided by 3, equaled 2; this produced a mid-range impairment of 5 under Table 15-23. Given that appellant's *Quick*DASH test score was 39, this yielded a mild grade modifier of 1, which reduced the impairment rating for left carpal tunnel syndrome to four percent.

In a report dated March 21, 2011, an OWCP medical adviser noted that combining the left arm impairments identified by Dr. Gerson totaled 13 percent impairment of appellant's left arm pursuant to the sixth edition of the A.M.A., *Guides*. He combined the left shoulder impairment of two percent, impairment of the left ulnar nerve was seven percent and left-sided carpal tunnel syndrome was four percent.

By decision dated July 29, 2011, OWCP granted appellant an additional schedule award for a three percent left upper extremity impairment, or 9.36 weeks from July 25 to September 28, 2011. The decision did not adjudicate the issue of any impairment to the legs.

By letter dated August 10, 2011, appellant, through his attorney, requested an oral hearing, which was held on November 16, 2011. At the hearing, counsel contended that appellant had a left lower extremity impairment which had been overlooked by OWCP and advised that appellant was not currently contesting OWCP's schedule award for the left upper extremity. He further contended that referral to a referee medical examiner was not warranted as there was no conflict regarding the degree of impairment of appellant's left arm. Counsel asserted that Dr. Gerson's report did not provide sufficient findings regarding the left lower extremity and indicated that further development of the medical evidence was warranted regarding an impairment rating for the left lower extremity.

Following the hearing, appellant submitted a November 4, 2011 report from Dr. David Weiss, an osteopath; however, OWCP only received the first page of this report. The first page of this report concluded that appellant's left upper extremity impairment rating remained at eight percent for entrapment neuropathy of the left median nerve at the wrist.

[7] *Id*. at 487.

[8] *Id.* at 446.

By decision dated January 18, 2012, an OWCP hearing representative affirmed the July 29, 2011 schedule award.[9]

LEGAL PRECEDENT

The schedule award provision of FECA[10] and its implementing regulations[11] 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[12] The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.[13]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[14] Under the sixth edition for upper extremity impairments, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[15] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[16]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[17] In Table 15-23, grade modifier levels (ranging from zero to four) are described for the categories test findings, history and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier levels and to identify a default rating value. The default

[9] The hearing representative found that there was an outstanding issue regarding whether appellant was entitled to a schedule award for the left lower extremity. This issue is not part of the instant appeal.

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404. Effective May 1, 2009, OWCP began using the A.M.A., *Guides* (6th ed. 2009).

[12] *Id.*

[13] *Veronica Williams*, 56 ECAB 367, 370 (2005).

[14] A.M.A., *Guides*, *supra* note 3 at 3, Section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[15] *Id.* at 385-419

[16] *Id.* at 411.

[17] *Id.* at 449.

rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[18]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[19]

ANALYSIS

OWCP accepted the conditions of left carpal tunnel syndrome, lesion of the ulnar nerve, adhesive capsulitis of the left shoulder, precipitation of preexisting degenerative disc disease and left shoulder SLAP tear. On September 15, 2008 it found that there was a conflict in the medical evidence between Drs. Stark and Allon regarding the different sensory changes to the extremities found on examination. This required referral to an impartial medical examiner to resolve the discrepancy in examination findings. On appeal, appellant's attorney contends that there was no conflict in opinion regarding an impairment rating under the A.M.A., *Guides*. He argues that Dr. Gerson, the referee medical examiner, should be considered a second opinion physician and not as an impartial specialist. Further, it was contended that the November 4, 2011 report from Dr. Weiss created a conflict requiring referral to an impartial medical examiner. The Board notes that a conflict in medical evidence was found regarding the findings on physical examination between Dr. Stark and Dr. Allon, as to the nature and extent of sensory loss to the upper extremity. An impairment rating could not be determined without resolution of this discrepancy. The Board finds that OWCP properly determined that a conflict arose which required referral to an impartial medical examiner. As Dr. Zeidman was unable to resolve the conflict of medical opinion, OWCP properly referred appellant to Dr. Gerson.

The Board finds that the February 16, 2011 report of Dr. Gerson is well reasoned, contains findings based on a thorough physical examination and sets forth impairment ratings based on the applicable tables and protocols of the sixth edition of the A.M.A., *Guides*. The Board finds that Dr. Gerson's report is sufficient to warrant the special weight of an impartial examiner.[20] OWCP properly found in its July 29, 2011 decision that appellant was not entitled to no greater than a schedule award for a 13 percent left upper extremity impairment.

Using the primary formula required by the sixth edition of the A.M.A., *Guides* and the net adjustment formula outlined at pages 406 to 411 of the A.M.A., *Guides*, Dr. Gerson properly determined that appellant's diagnosis of partial rotator cuff tear was a class 1 impairment for functional history at Table 15-7, a class C impairment. He then applied the net adjustment formula at pages 406, 410 and 411 of the A.M.A., *Guides*, finding that appellant had a grade modifier of 2 for functional history, physical examination and clinical studies. Dr. Gerson

[18] *Id.* at 448-50.

[19] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[20] It is well established that the opinion of an impartial medical specialist is to be given special weight. *See Anna M. Delaney*, 53 ECAB 384 (2002).

subtracted the grade modifier of 1 from the above categories for a total net adjusted grade of three, which resulted in a change from a grade C to grade E impairment. This equated to a two percent impairment of the left upper extremity at Table 15-5, page 403. As this finding was rendered in accordance with the applicable tables and protocols in the A.M.A., *Guides* for rating left upper extremity impairments based on shoulder impairments, the Board finds that Dr. Gerson properly rated a two percent left upper extremity impairment for appellant's accepted left shoulder condition.

Regarding appellant's left ulnar lesion condition, Dr. Gerson appropriately utilized section Table 15-23 of the A.M.A., *Guides*. He found that appellant had a grade modifier of 3 for test findings, relying on a finding of axon loss based on the October 18, 2005 EMG needle study, which showed denervation changes in the ulnar innervated muscles of the left hand; a grade 3 modifier for history based on constant symptoms in the ulnar distribution of the fourth and fifth fingers; and a grade 2 modifier for physical findings, based on decreased sensation to two-point discrimination in the ulnar nerve distribution of the left hand with no weakness of atrophy. Dr. Gerson totaled the modifiers and found an average of 2.66, which he rounded up to 3, resulted in a default rating of eight percent left upper extremity impairment. Appellant's *Quick*DASH score of 39 yielded a functional scale grade modifier of 1, which adjusted the impairment rating to seven percent. This rating was in accordance with the A.M.A., *Guides* as Dr. Gerson relied on the proper sections of Chapter 15, located at pages 448, 449, 487 and 488, which outlined the proper procedures for ratings based on left ulnar neuropathy.

With regard to a rating for left carpal tunnel syndrome, Dr. Gerson advised that appellant had a grade modifier of 3 for test findings, based on a positive findings for abductor pollicis brevis muscle/axonal loss; a grade 1 modifier for history for mild intermittent symptoms in the median nerve distribution with pain at the base of the thumb; and a grade 2 modifier for physical findings, based on documentation of sensory deficit/compression of the median nerve of 7 millimeters in his third finger. He then properly totaled the modifiers and found an average of 2. Factoring in appellant's *Quick*DASH score of 39, which produced a grade modifier 1 for functional scale, Dr. Gerson rated a four percent impairment for carpal tunnel syndrome. This rating was proper, as Dr. Gerson relied on the appropriate sections and tables of the A.M.A., *Guides* pertaining to rating impairment based on carpal tunnel syndrome and sufficiently explained how he arrived at his four percent impairment rating for the left upper extremity. The medical adviser subsequently used the Combined Values Chart to rate 13 percent total impairment based on Dr. Gerson's ratings.

The Board finds that the record supports that appellant has no more than a 13 percent left upper extremity impairment, for which he received a schedule award. The Board finds that Dr. Gerson's referee report represents the weight of medical opinion. There is no other medical evidence of record addressing the extent of his permanent impairment under the appropriate edition of the A.M.A., *Guides*, which supports any greater impairment. As appellant previously received a schedule award for a 10 percent impairment of the left upper extremity, he was entitled to an increased award of 3 percent. OWCP properly found in its January 18, 2012 decision that appellant had no additional permanent impairment of the left upper extremity. As noted, the hearing representative remanded the issue of lower extremity impairment to OWCP for further development. Absent a final decision, it is not an issue presently on this appeal.

CONCLUSION

The Board finds that appellant has no more than a 13 percent permanent impairment of the left upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the January 18, 2012 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: April 10, 2013
Washington, DC

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

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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