United States Department of Labor
Employees' Compensation Appeals Board

S.W., Appellant	)	
and	)	**Docket No. 13-502**
	)	**Issued: June 6, 2013**
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:
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 3, 2013 appellant,through her attorney, filed a timely appeal from a September 21, 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.

ISSUES

The issues are: (1) whether appellant met her burden of proof to establish that her bilateral shoulder condition was causally related to factors of her employment; and (2) whether appellant has more than fourpercent permanent impairment of either upper extremity, for which she received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On January 18, 2005 appellant, then a 48-year-old postal clerk, filed an occupational disease claim alleging that she suffered from bilateral carpal tunnel syndrome as a result of repetitive motion tasks of her employment.She first became aware of her condition on August 1, 2004 and realized it resulted from her employment on January 13, 2005. OWCP accepted appellant's claim for bilateral carpal tunnel syndrome. Appellantunderwent right carpal tunnel release on May 22, 2006 and left carpal tunnel release on July 20, 2006.She was placed on the periodic rolls. Appellant returned to light duty on October 17, 2006.

In a letter dated April 13, 2007, appellant, through counsel, requested that OWCP expand her claim to include bilateral shoulder conditions and a right rotator cuff tear. She stated that she was diagnosed with shoulder problems at the same time she was diagnosed with bilateral carpal tunnel syndrome.

In a March 15, 2005 report, Dr. Todd Lipschultz, a Board-certified orthopedic surgeon,related appellant's complaints of numbness and discomfort in both her hands and a new complaint of bilateral shoulder pain. Appellantstated that the shoulder pain began a few days ago when she lifted some boxes above her head. Upon examination of her shoulders, Dr. Lipschultz observed restrictions on the right and mildly positive impingement sign bilaterally but no weakness. He diagnosed bilateral shoulder tendinitis, right greater than left.

In a June 22, 2005 magnetic resonance imaging (MRI) scan examination of the right shoulder, Dr. David A. Roberts, a Board-certified diagnostic radiologist, observed a partial articular surface tear of the distal infraspinatus tendon and a trace amount of fluid in the subdeltoid bursa. He also noted mild changes of osteoarthritis in the acromioclavicular (AC) joint with moderate inferior spur formation. No full-thickness tear or retraction was identified. Dr. Roberts diagnosed partial infraspinatus tear and mild impingement.

In an August 23, 2005 report, Dr. Lipschultz examined appellant for complaints of bilateral hand numbness and shoulder discomfort. He noted that anMRI scan examination of her right shoulder revealed rotator cuff tendinitis with a probable tear. Dr. Lipschultz stated that appellant worked at the employing establishment for at least seven years doing keyboard work for five hours a day. He related that she was concerned that her shoulder symptoms could have developedfrom the repetitive heavy lifting above her shoulders that she did at work. Dr. Lipschultz opined that this certainly could be an etiology of her rotator cuff tear.

In an October 13, 2005 MRI scan of the left shoulder, Dr. William F. Muhr, a Board-certified diagnostic radiologist, observed hypertrophic change at the AC joint causing anatomic impression on the supraspinatus and tendinosis but no obvious cuff tear. He also noted mild subdeltoid bursal effusion and tendinosis of the subscapularis. Dr. Muhr diagnosed tendinosis of the supraspinatus and subscapularis and AC joint hypertrophic change.

By letter dated July 5, 2007, OWCP advised appellant that the evidence submitted appeared to indicate that she sustained a traumatic injury to her bilateral shoulders and recommended that she file a traumatic injury claim as it appeared that a new injury may have occurred.

On March 11, 2008 appellant requested a schedule award. In a November 18, 2007 report, Dr. David Weiss, an osteopath reviewed her history and conducted an examination. According to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), heopined that appellant had 50 percent combined right upper extremity impairment[2] and 37 percent combined left upper extremity impairment.[3] Dr. Weiss reported that she reached maximum medical improvement on November 18, 2007.In a February 20, 2008 report, the district medical adviser (DMA)disagreed with Dr. Weiss' report and stated that appellant had 10 percent impairment of either upper extremity.[4] He reported that she reached maximum medical improvement on November 18, 2007.

OWCP determined that a conflict in medical opinion existed between Dr. Weiss and the DMAand referred appellant's claim to Dr. Gary Neil Goldstein, a Board-certified orthopedic surgeon, for an impartial medical examination to determine the extent of appellant's permanent impairment in accordance with the fifth edition of the A.M.A., *Guides.*

In a November 25, 2008 report, Dr. Goldstein reviewed appellant's history, including the statement of accepted facts and noted that her claim was accepted for bilateral carpal tunnel syndrome. He conducted an examination and disagreed with Dr. Weiss' impairment rating. Dr. Goldstein noted that, according to page 495 of the fifth edition of the A.M.A., *Guides,*appellant had five percent impairment of the right upper extremity and four percent impairment of the left upper extremity. In a January 9, 2009 report, a DMA reviewed hisimpartial medical report and agreed with his impairment rating of five percent impairment of the right upper extremity and four percent impairment of the left upperextremity. He reported the date of maximum medical improvement was November 28, 2008.

On June 3, 2009 OWCP requested an updated report from Dr. Goldstein and an impairment rating according to the sixth edition of the A.M.A., *Guides* (2008).

In a September 9, 2009 report, Dr. Weissupdated his November 18, 2007 report with an impairment rating according to the sixth edition of the A.M.A., *Guides.*He reviewed appellant's history and provided findings from the 2007 examination. Dr. Weiss noted a *Quick*DASH disability score of 61 percent for each upperextremity. He diagnosed bilateral carpal tunnel

[2] Dr. Weiss determined that appellant had 20 percent permanent impairment for right lateral pinch deficit based on Table 16-33 and Table 16-34, page 509, 9 percent impairment for motor strength deficit based on Table 16-11 and Table 16-15, page 492 and 31 percent for Grade 2 sensory deficit of the right median nerve based on Table 16-10 and Table 16-15, page 492.

[3] Dr. Weiss determined that appellant had 9 percent permanent impairment for motor strength deficit left thumb abduction deficit based on Table 16-11 and Table 16-15, page 492 and 31 percent impairment for Grade 2 sensory deficit left median nerve based on Table 16-10 and Table 16-15, page 492.

[4] The DMA explained that according to the A.M.A., *Guides,* Grade 2 sensory deficits would not be recommended because it was not consistent with appellant's clinical functioning level. He recommended Grade 4 sensory level. According to Table 16-15, page 492, the DMA rated appellant at 39 percent for median nerve below mid forearm sensory deficit or pain "maximum." Utilizing Table 16-10, page 482, he also determined that she had Grade 4 or 25 percent impairment for distorted superficial tactile sensibility and diminished light touch with or without minimal abnormal sensations or pain that was forgotten during activity. The DMA determined that 25 percent of 39 percent equaled 9.75 percent or 10 percent permanent impairment for each upper extremity.

syndrome, status post open right and left carpal tunnel releases, chronic rotator cuff tendinopathy to the right shoulder with partial thickness rotator cuff tear, AC arthropathy with impingement to the right shoulder, chronic rotator cuff tendinopathy to the left shoulder, ACarthropathy with impingement to the left shoulder and biceps tendinitis to the right and left shoulder. Dr. Weiss explained that pursuant to Table 15-5 on page 402 of the sixth edition of the A.M.A., *Guides* appellant had class1 impairment due to right shoulder rotator cuff tear, which provided a default value of three percent impairment.[5] He utilized a grade modifier based on Functional History (GMFH) of 3 because she had a *Quick*DASH score of 61.[6] Dr. Weiss utilized a grade modifier based on Physical Examination (GMPE) and Clinical Studies (GMCS) of two each.[7] He applied the net adjustment formula (GMFH-CDX) + (GMPE - CDX) + (GMCS - CDX)[8] and found that appellant had a net adjustment of four. Dr. Weiss concluded that she had seven percent upper extremity for the right shoulder rotator cuff tear. For entrapment of the right wrist median nerve, he determined that shehad a grade modifierof three for test findings, history and physical examination, or a total of nine.[9] Dr. Weiss found that appellant had an average of three for a total of eight percent impairment for right carpal tunnel syndrome. He concluded that she had 14 percent combined right upper extremity impairment. For left shoulder rotator cuff tendinitis, Dr. Weiss determined that according to Table 15-5[10]appellant had class 1 diagnosis. He utilized a grade modifierof three based on functional history,[11]one based on physical examination[12]andtwo based on clinical studies,[13]which resulted in a net adjustment of three. Dr. Weiss found that appellant had five percent upper extremity impairment of the left shoulder. For her entrapment of the left wrist median nerve, he determined that she had a grade modifier of three each for test findings, history and physical examination for a total of nine.[14] Dr. Weiss found that appellant had an average of 3 for a total of eight percent impairment for left carpal tunnel syndrome. He concluded that she had 13percent combined left upper extremity impairment.

OWCP referred Dr. Weiss' report to OWCP's DMA, along with a statement of accepted facts. In a December 21, 2009 report, the DMAconcurred with Dr. Weiss that, pursuant to Table

[5] The Board notes that Dr. Weiss noted a value of 5. However, Table 15-5, page 402, of the sixth edition of the A.M.A., *Guides* provides a default value of three percent. Since Dr. Weiss' correctly calculated a net adjustment of seven percent after applying grade modifiers, the Board finds that this was harmless error.

[6] A.M.A.,*Guides* 406.

[7] *Id.* at408, 410.

[8] *Id.* at 411.

[9] *Id.* at 449.

[10] *Id.* at 403.

[11] *Id.* at 406.

[12] *Id.* at 408.

[13] *Id.* at 410.

[14] *Id.* at 449.

15-23, page 449 of the A.M.A., *Guides*, sixth edition, for entrapment neuropathy appellant had a grade modifier of three for history, physical findings of weakness of the thumb abductors and clinical studies for positive testing findings. He calculated a total of nine and an average of three, which provided an impairment rating of eight percent.The DMAconcluded that appellant had eight percent impairment of either upper extremity.[15] He noted, however, that because OWCP did not accept her bilateral shoulder conditions as work related, he could not agree with Dr. Weiss'impairment ratings for right shoulder rotator cuff tear and left shoulder tendinitis. The DMAnoted the date of maximum medical improvement as November 18, 2007.

In a January 16, 2010 report, Dr. Goldstein stated that appellant was able to work at the employing establishment without restrictions and passed every single one of the 11 quick questions. According to Table 15-39, page 435, of the sixth edition of the A.M.A., *Guides* he determined that she had approximately two to three percent impairment rating of each upper extremity.

In a March 29, 2010 report, the DMA reviewed Dr. Goldstein's January 16, 2010 report and disagreed with his findings. He noted that Dr. Goldstein only addressed the quicktable on page 435, which was not helpful in addressing the true permanent impairment of each upper extremity in accordance with the sixth edition of the A.M.A., *Guides.* The DMA concluded that the eight percent impairment of either upper extremity as calculated by Dr. Weiss was a correct application of the sixth edition of the A.M.A., *Guides.*

OWCP referred appellant's claim, along with a statement of accepted facts, to Dr. Stanley R. Askin, a Board-certified orthopedic surgeon, for a second-opinion examination to determine the extent of her permanent impairment according to the sixth edition of the A.M.A., *Guides*and whether she sustained a bilateral shoulder condition as a result of her accepted injury.In a July 7, 2010 report, Dr. Askin reviewed her history, including the statement of accepted facts and noted that her claim was accepted for bilateral carpal tunnel syndrome. He stated that there were no objective findings with respect to appellant's accepted bilateral carpal tunnel syndrome injury. Dr. Askin observed full range of motion of both shoulders despite complaints of pain with overhead activity. He noted that MRIscans of both shoulders revealed age-appropriate degenerative changes including partial rotator cuff tears. No crepitans on motion and no winging of the shoulders were noted. Appellant tested negative for Neer and Hawkins' test. Dr. Askin also observed full range of motion for elbows, forearms, fingers and thumbs. According to the sixth edition of Table 15-23 on page 449 of the A.M.A., *Guides*,he determined that appellant did not have any permanent impairment. Dr. Askin also stated that there was no reason to ascribe her shoulder complaints to the accepted bilateral carpal tunnel condition.

In a July 28, 2010 report, the DMA reviewed Dr. Askin's July 7, 2010 second-opinion report and disagreed with his findings. He explained that Dr. Askin did not properly apply Table 15-23, page 449, of the sixth edition of the A.M.A., *Guides*because he based his findings on the fact that appellant told him her hands were pretty good presently and did not refer to the grade modifiers of history, physical examination or clinical studies. The DMA reported

[15] The Board notes that the DMA stated that appellant had eight percent left lower extremity impairment, but this typographical error was later corrected to reflect eight percent left upper extremity impairment.

thatDr. Askin's report was of no value in resolving the conflict in medical opinion between Drs. Goldstein and Weiss.

In a September 1, 2010 supplemental report, Dr. Askin stated that appellant had no grade modifiers for history because she did not report any symptoms about her hands. He reported that she had a grade modifier 2 for physical examination because of decreased sensation. Dr. Askin calculated that the average of the grade modifiers was 1 but that the *Quick*DASH score of 61 suggested a grade modifier 2. According to Table 15-23, page 449, of the sixth edition of the A.M.A., *Guides,*he concluded that appellant had four percent impairment of either upper extremity.

In a September 14, 2010 report, the DMA reviewed Dr. Askin's September 1, 2010 supplemental report and agreed with his findingsthat appellant had four percent permanent impairment of either upper extremity.

In a decision dated November 23, 2010, OWCP granted a schedule award for four percent permanent impairment of each upper extremity. The award ran for a total of 24.96 weeks from September 24, 2009 to March 17, 2010.

On December 6, 2010 appellant's counsel submitted a request for a hearing, which was held on April 12, 2011. Appellant was represented by counsel,who requested that the issue of whether she sustained bilateral shoulder conditions as a result of her employment duties also be discussed. She stated that she began working at the employing establishment in February 1994 and did not have any problems with her wrists and shoulders. Appellant's duties involved processing mail on the machine with repetitive motions of loading the ledge, sweeping the mail off and putting them into trays. She reported that when she initially filed her claim for bilateral carpal tunnel syndrome she also experienced shoulder problems with lifting tubs of mail. Appellant's counsel noted that, in a September 24, 2009 report, Dr. Weiss provided an impairment rating according to the sixth edition of the A.M.A., *Guides* of 8 percent for carpal tunnel syndrome and 7 percent for appellant's right shoulder condition for a combined rating of 15 percent of the right upper extremity. For the left upper extremity, Dr. Weiss determined that she had 8 percent impairment for carpal tunnel syndrome and 5 percent for her left shoulder condition for a combined rating of 13 percent of the left upper extremity. Appellant's counsel noted that although the DMA did not accept the impairment rating for her alleged shoulder conditions, he concurred with Dr. Weiss' finding of eight percent impairment of each upper extremity for carpal tunnel syndrome. He alleged that an impairment rating of eight percent should have been awarded around December 2009.

By decision dated July 12, 2011, an OWCP hearing representative set aside the November 23, 2010 decision and remanded the case for referral to anotherimpartial medical examinationbecause Dr. Goldstein's January 16, 2011 impairment rating failed to resolve the conflict in medical opinion regarding appellant's degree of permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*. It also found that a conflict of medical opinion existed between appellant's physician and Dr. Askin regarding whether appellant sustained a bilateral shoulder condition causally related to her employment duties and remanded the case for referral to an impartial medical examination.

OWCP referred appellant's case, along with a statement of accepted facts, to Dr. George Glenn, Jr., a Board-certified orthopedic surgeon, to resolve the conflict in medical opinion. In a January 19, 2012 report, Dr. Glennreviewed her history, including the statement of accepted facts and noted that her claim was accepted for bilateral carpal tunnel syndrome. He stated that appellant began working for the employing establishment in February 1994 and related that her duties involved repetitive tasks with both of her hands and occasional lifting at or above shoulder level. Appellant explained that she was not primarily required to lift overhead until she worked the flat sorter machine in July 2002. She did not recall any specific history of trauma. Presently, appellant complained of a constant ache involving both of her shoulders with the right more severe than the left.

Examination of appellant's shoulders revealed perfectly normal and painless range of motion through all planes involving both shoulders. Internal rotation behind the back was to about T10 on the left and T12-L1 on the right. Hawkins and Kennedy test for impingement syndrome were normal bilaterally. Dr. Glenn stated that it appeared from the record that the onset of appellant's alleged bilateral shoulder problems began in March 2005. He reported that subsequent MRIscans revealed mild spur formation about the AC joint of the left shoulder and partial articular surface tear of the distal infraspinatus tendon with mild changes of osteoarthritis in the AC joint with moderate inferior spur formation. Dr. Glenn opined that these were manifestations of degenerative changes and not infrequently seen in individuals who did not particularly engage in overhead activities. He stated that appellant's current subjective complaints and physical findings were completely consistent with a bilateral degenerative osteoarthritis condition involving the AC joints. Dr. Glenn explained that the findings described in the routine MRI scans suggested that they were present long before the reported March 2005 onset of symptoms of the shoulders and that one could not uncommonly find these changes in individuals who did not indulge in repetitive or excessive overhead activities. He concluded that, although a diagnosis was established, appellant's bilateral shoulder condition was not causally related by either direct presentation or material aggravation to her work duties.

Examination ofappellant's elbows, wrists and fingers revealed active range of motion and no areas of palpable tenderness involving either upper extremity distal to the shoulder areas. No evidence of thenar or hypothenar atrophy or loss of muscle strength was found. Dr. Glenn reported that appellant complained of numbness in both the right and left hand from the wrist distal with the reverse Phalen's test but did not complain with the standard Phalen's test for carpal tunnel syndrome. Compression test, Tinel's response and Wright's and Roo maneuvers were normal. Dr. Glenn stated that it appeared from the history that appellant was treated appropriately for bilateral carpal tunnel syndrome, including surgery, which produced no residual symptoms involving the right hand and only some aching in the left wrist. He explained that according to the sixth edition of the A.M.A., *Guides,*section 15.4f, page 432,a diagnosis of entrapment neuropathy only needed grade modifiers to determine impairment rating. Under Table 15-23, page 449, Dr. Glenn determined that appellant's *Quick*DASH score provided a functional scale grade modifier 2, which provided a default value of five percent. He reported grade modifiersof two for electrodiagnostic testing, one for functional history because of her responses to the Activities of Daily Living and Pain Disability questionnaires and zero for physical findings because her examination was normal. Dr. Glenn calculated that these grade modifiers provided an average of one. Thus, he concluded that appellant had four percent

permanent impairment of either upper extremity. Dr. Glenn reported that she reached maximum medical improvement on November 18, 2007.

In a February 29, 2012 report, a DMA reviewed Dr. Glenn's January 19, 2012 impartial medical report. He noted a default value of twoand grade modifiers of two for electrodiagnostic testing, one for functional history and zero for physical findings, which provided an average of one. The DMA concurred with Dr. Glenn's conclusion that, according to Table 15-23, page 449, of the sixth edition of the A.M.A., *Guides,* appellant had four percent permanent impairment of either upper extremity. He stated that the date of maximum medical improvement would be January 19, 2012, the date of Dr. Glenn's report.

By decision dated March 14, 2012, OWCP denied appellant's request to expand her claim to include a bilateral shoulder condition finding that the medical evidence failed to establish that her bilateral shoulder condition was causally related to her employment duties. It also found that the medical evidence did not establish that she had more than four percent impairment of either upper extremity.

On March 20, 2012 appellant's counsel submitted a request for a hearing, which was held on July 13, 2012. Counsel alleged that Dr. Glenn's report was based on an incomplete history because he only had a general description of appellant's work duties as described in the SOAF, instead of specific time frames for how many hours a day and how many days a week the duties were performed. He also pointed out that Dr. Glenn's opinion was not wellrationalized because he generally described her normal range of motion instead of providing exact measurements and did not explain why her work duties could not have caused her bilateral shoulder condition. Counsel further stated that there was no conflict to be resolved regarding permanent impairment of carpal tunnel syndrome prior to the adoption of the sixth edition of the A.M.A., *Guides.*

In a July 10, 2012 report, Dr. Weiss reviewed Dr. Glenn's January 19, 2012 impartial medical report and disagreed with his findings. He contended that his September 24, 2009 impairment evaluation of eight percent permanent impairment of either upper extremity was correct because he properly applied the impairment rating for carpal tunnel syndrome under page 449 of the sixth edition of the A.M.A., *Guides.* Dr. Weiss reported grade modifiers of three for clinical findings according to electromyogram and nerve conduction studies; three for functional history because of her activities of daily living; and three for physical examination because his evaluation revealed grade 3 strength deficit in the left and right hand. He also alleged that he properly determined an impairment rating of seven percent of the right shoulder for a partial infraspinatus tendon tear and five percent impairment of the left shoulder for tendinitis.

In a decision dated September 21, 2012, an OWCP hearing representative affirmed the March 14, 2012 decision denying appellant's request to expand her claim and for increased schedule award. It determined that OWCP properly found that the weight of the medical opinion rested with Dr. Glenn's report who found that her bilateral shoulder condition was not causally related to her employment and that shedid not have more than four percent impairment of either upper extremity.

LEGAL PRECEDENT-- ISSUE 1

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative and substantial evidence[16] including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he or she claims compensation is causally related to that employment injury.[17] In an occupational disease claim, appellant's burden requires submission of the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[18]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[19] The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[20]

If there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[21] In cases where OWCP has referred appellant to an impartial medical examiner to resolve a conflict in medical evidence, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[22]

ANALYSIS-- ISSUE 1

OWCP accepted that appellant sustained work-related bilateral carpal tunnel syndrome as a result of her employment duties as a postal clerk, for which she underwent bilateral carpal tunnel releases. In a letter dated April 13, 2007, appellant requested that OWCP expand her claim to include bilateral shoulder conditions and a right rotator cuff tear.In an August 23, 2005

[16] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan,* 20 ECAB 55, 58 (1968).

[17] *M.M.,* Docket No. 08-1510 (issued November 25, 2010); *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton,* 40 ECAB 1143, 1145 (1989).

[18] *R.H.*, 59 ECAB 382 (2008); *Ernest St. Pierre*, 51 ECAB 623 (2000).

[19] *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *D.I.*, 59 ECAB 158 (2007).

[20] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams,* 41 ECAB 465 (2005).

[21] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[22] *B.P.*, Docket No. 08-1457 (issued February 2, 2009); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

report, Dr. Lipschultz stated that there could be a relationship between herright shoulder rotator cuff tear and her work duties. In a July 7, 2010 report, Dr. Askin, a second opinion examiner, determined that appellant's bilateral shoulder condition was not causally related to her employment duties. In a decision dated July 12, 2011, an OWCP hearing representative found that a conflict in medical opinion existed between herphysician and Dr. Askin regarding whether her bilateral shoulder condition was causally related to her employment and remanded the case for referral to an impartial medical examiner. In a January 19, 2012 report, Dr. Glenn, selected as the impartial medical examiner, determined that appellant's bilateral shoulder condition was not causally related to her employment duties as a postal clerk. By decisions dated March 14 and September 21, 2012, OWCP found that the medical evidence was insufficient to establish that she sustained a bilateral shoulder condition as a result of her employment.

The Board finds that Dr. Glenn's January 19, 2012 report is sufficiently detailed and well reasoned to constitute the weight of the medical opinion evidence. Dr. Glenn provided an accurate history of injury and reviewed appellant's records. He related that her duties involved repetitive tasks with both of her hands and occasional lifting at or above her shoulder level. Dr. Glenn noted that the onset of appellant's alleged bilateral shoulder problems began in March 2005 and that MRIscans revealed mild spur formation about the AC joint of the left shoulder and partial articular surface tear of the distal infraspinatus tendon with mild changes of osteoarthritis in the AC joint with moderate inferior spur formation. He explained that these were manifestations of degenerative changes. Upon examination, Dr. Glenn observed normal and painless range of motion. Hawkins and Kennedy testing for impingement syndrome were normal bilaterally. Hestated that appellant's current subjective complaints and physical findings were completely consistent with a bilateral degenerative osteoarthritis condition involving the AC joints. Dr. Glenn concluded that her bilateral shoulder condition was not causally related to her work duties.

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.[23] Dr. Glenn reviewed appellant's history and had accurate knowledge of the relevant facts. He conducted an examination and concluded that her bilateral shoulder condition was not causally related to her employment duties. The Board finds that Dr. Glenn's medical opinion, as set forth in the January 19, 2012 report, was found to be probative and reliable evidence. Accordingly, Dr. Glenn's opinion constituted the special weight of evidence and is sufficient to deny appellant's claim.

On appeal, appellant alleges that Dr. Glenn's impartial medical report was not wellrationalized because he did not discuss her job duties and the physical requirements of the clerk positions to determine if these job duties caused or aggravated her bilateral shoulder condition.As noted above, however, Dr. Glenn accurately described her work duties and provided a well-reasoned medical opinion explaining that her shoulder condition was degenerative in nature and not causally related to her employment. The Board finds that

[23] *Id.*

appellant has not provided reasoned medical opinion evidence to establish that her bilateral shoulder condition was causally related to factors of her employment.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

LEGAL PRECEDENT -- ISSUE 2

The schedule award provision of FECA[24] and its implementing regulations 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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides*, (sixth edition), has been adopted by OWCP as the appropriate standard for evaluating schedule losses and the Board has concurred in such adoption.[25] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[26]

Impairment due to carpal tunnel syndrome is evaluated under the schedule found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[27] 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 level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[28]

If there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[29] In cases where OWCP has referred appellant to an impartial medical examiner to resolve a conflict in medical evidence, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[30]

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[24] 5 U.S.C. §§ 8101-8193.

[25] *R.D.*, 59 ECAB 127 (2007); *Bernard Babcock, Jr.*, 52 ECAB 143 (2000); *see also* 20 C.F.R. § 10.404.

[26] FECA Bulletin No. 09-03 (issued March 15, 2009); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[27] A.M.A.,*Guides*449 (6th ed. 2008).

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

[29] *Supra* note 24.

[30] *Supra* note 25.

ANALYSIS -- ISSUE 2

OWCP granted schedule awards for four percent permanent impairment of each upper extremity. Appellant requested additional schedule award. By decision dated July 12, 2011, an OWCP hearing representative remanded the case for referral to an impartial medical examination to resolve conflict in medical opinion between Dr. Weiss, appellant's physician and Dr. Askin, the secondopinion examiner, regarding the degree of permanent impairment of appellant's upper extremities. In a January 19, 2012 report, Dr. Glenn, a Board-certified orthopedic surgeon and impartial medical examiner, determined that appellant had four percent impairment of either upper extremity. By decisions dated March 14 and September 21, 2012, OWCP determined that she did not establish that she sustained greater than four percent impairment of either upper extremity.

The Board finds that OWCP properly relied on the January 19, 2012 report of Dr. Glenn in denying appellant's request for increased schedule award. Dr. Glenn's impartial medical report is sufficiently detailed and well reasoned to constitute the weight of the medical opinion evidence. In a January 19, 2012 report,he concluded that appellant had four percent impairment of either upper extremity according to the sixth edition of the A.M.A., *Guides.* Upon examination of her hands, Dr. Glenn observed active range of motion and no areas of palpable tenderness in appellant's elbows, wrists and fingers. Compression, Tinel's response and Wright's and Roo maneuvers revealed normal testing. Dr. Glenn stated that although appellant had developed bilateral carpal tunnel syndrome as a result of her employment, she was treated appropriately, which included surgery and did not have any residual symptoms involving the right hand and only some aching in the left wrist. According to Table 15-23, page 449, of the sixth edition of the A.M.A., *Guides,* he determined that her*Quick*DASH score of 61 provided a functional grade modifier 2, which provided a default value of five percent. Dr. Glenn reported grade modifierof two for electrodiagnostic testing, one for functional history because of her responses to the Activities of Daily Living and Pain Disability questionnaires and zero for physical findings because her examination was normal. He calculated that these grade modifiers provided an average of one. Dr. Glenn concluded that appellant had four percent permanent impairment of either upper extremity.

As previously noted, 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.[31] The Board finds that Dr. Glenn referred to the proper tables and determined grade modifiers according to his examination findings and review of the medical record. Because Dr. Glenn properly applied the relevant procedures of the sixth edition A.M.A.,*Guides,* the Board finds that his opinion constituted the special weight of evidence and is sufficient to deny appellant's request for a schedule award greater than four percent of either upper extremity.

The Board further finds that the medical evidence submitted after Dr. Glenn's impartial medical report was insufficient to overcome the weight of this report or to create a conflict in medical evidence. In a July 10, 2012 report, Dr. Weiss stated that appellant had eight percent

[31] *Solomon Polen,* 51 ECAB 341 (2000).

permanent impairment of either upper extremity, seven percent impairment of the right shoulder for a partial infraspinatus tendon tear and five percent impairment of the left shoulder for tendinitis. Because he was on one side of the conflict which Dr. Glenn resolved, the additional report is insufficient to overcome the weight accorded Dr. Glenn's report as the impartial medical examiner or to create a new conflict.[32]

On appeal, appellant alleges that Dr. Glenn's impartial medical report was not wellrationalized and was insufficient to carry the special weight of medical evidence. As mentioned above, his opinion was based on accurate history and contained medical rationale in support of his opinion on impairment. Appellant also alleges that OWCP should have relied on the DMA'sDecember 21, 2009 and March 29, 2010 reports, which determined that she had eight percent impairment of either upper extremity as calculated by Dr. Weiss because there was no conflict in medical evidence regarding the eight percent impairment for bilateral carpal tunnel syndrome.The record reveals, however, that at the time of these DMA opinions a conflict of opinion did exist between appellant's treating physician and the February 20, 2008 DMA report. When a case is referred to a referee physician to resolve a conflict, it is the referee, not the DMA, who must resolve the conflict. The weight of the medical evidence cannot rest with any physician other than the referee physician.[33] Accordingly, the DMA's opinion that appellant had eight percent impairment of either upper extremity for bilateral carpal tunnel syndrome did not resolve the existing conflict in medical opinion and OWCP properly referred the case to another impartial medical examiner in order to resolve the conflict.

The Board finds that appellant did not submit sufficient medical evidence to show that she has more than four percent impairment of either upper extremity, for which she received schedule awards.

Appellant may request a schedule award or an 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 not met her burden of proof to establish that her bilateral shoulder condition was causally related to factors of her employment. The Board also finds that she did not meet her burden of proof to establish that she has more than four percent permanent impairment of either upper extremity, for which she received schedule awards.

[32] *Dorothy Sidwell,* 41 ECAB 857 (1990).

[33] *See C.K.,* Docket No. 11-2094 (issued July 2, 2012); *W.C.,* Docket No. 11-659 (issued March 22, 2012).

ORDER

IT IS HEREBY ORDERED THATthe September 21, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 6, 2013
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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