U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of EDWARD W. SPOHR and DEPARTMENT OF DEFENSE, DEFENSE FINANCE & ACCOUNTING SERVICE, Denver, CO

Docket No. 03-1173; Submitted on the Record;
Issued September 10, 2003

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS, MICHAEL E. GROOM

The issue is whether appellant has more than a 62 percent impairment of the left upper extremity, 58 percent impairment of the right upper extremity and 21 percent impairment of the left lower extremity, for which he received schedule awards.

On November 30, 1992 appellant, then a 52-year-old accounting technician, sustained an injury at work when he pulled out a drawer of savings bonds, which became unbalanced. To keep from dropping the drawer, he twisted his left wrist. The Office of Workers' Compensation Programs accepted his claim for left wrist contusion and left wrist sprain. The Office later accepted left wrist reflex sympathetic dystrophy (RSD). Appellant received compensation for disability as well as a 1994 schedule award for a four percent permanent impairment of his left arm.

On October 4, 1995 the Office expanded its acceptance of appellant's claim to include RSD of the right upper and left lower extremities. On October 23, 1995 appellant received a schedule award for a nine percent permanent impairment of his right arm and a one percent permanent impairment of his left leg. On May 1, 1998 the Board set aside this schedule award and remanded the case for further evaluation.[1]

After referral to Dr. Stanley H. Ginsburg, a Board-certified neurologist, and review by the Office medical adviser, the Office issued a schedule award on September 9, 1998 for an additional 49 percent impairment of the right arm (58 percent total) and an additional 20 percent impairment of the left leg (21 percent total). Appellant notified the Office that Dr. Ginsburg also measured and tested his left arm. He requested that the Office compare Dr. Ginsburg's evaluation of the left arm with the schedule award he received in 1994.

[1] Docket No. 96-691 (issued May 1, 1998).

Dr. Ginsburg clarified that he had not evaluated impairment of the left upper extremity, as it was not originally requested. The Office authorized such an evaluation, which he performed on May 17, 1999. Based on this evaluation, the Office issued a schedule award on June 15, 1999 for an additional 58 percent permanent impairment of the left arm (62 percent total).

On December 26, 2001 appellant indicated that he was requesting another schedule award.[2] Appellant stated that he could not find a suitable job because his full-body RSD continued to spread and intensify. He alleged a great increase of pain in his shoulders, back and trunk of his body, as well as his right leg and foot.[3] To support his request, he submitted an October 10, 2001 functional limitations assessment, a December 11, 2001 attending physician's form report and a January 18, 2000 medical report on his physical restrictions. He later submitted treatment notes from January 9 and March 13, 2002.[4]

On May 20, 2002 the Office requested that appellant's treating physician, Dr. L. Barton Goldman, a specialist in physical medicine and rehabilitation, evaluate the permanent impairment of appellant's right and left arm/wrist and left leg as a result of his November 30, 1992 employment injury.

Dr. Goldman evaluated appellant on June 19 and July 10, 2002. He then reported as follows:

> "I am enclosing copies of [T]able 16-16 from the A.M.A., *Guides* [The American Medical Association, *Guides to the Evaluation of Permanent Impairment*] [f]ifth [e]dition, to clarify whether this patient meets CRPS [complex regional pain syndrome] criteria per these *Guides*. He has had an ongoing clinical diagnosis of CRPS type I, centralized involving all four limbs, which of course, based on the most recent published research and guidelines entails applying a central neurologic impairment rating, which appears to be not allowed under the federal guidelines. Moreover, because the patient will not undergo bone scan due to his needle phobia, he does not meet the criteria of eight or more probably CRPS signs and symptoms on evaluation this summer or in the recent past. Therefore, CRPS impairment rating guidelines as outlined on page 496 of the A.M.A., *Guides*, [f]ifth [e]dition, cannot be applied, specifically in light of these findings."

Dr. Goldman reported that the pertinent diagnosis for appellant's impairment rating was chronic bilateral upper extremity and left lower extremity pain, particularly at the shoulders, left

[2] Appellant formally filed a claim for a schedule award on May 22, 2002.

[3] The Office has not accepted a causal relationship between appellant's right leg and foot condition and the incident that occurred at work on November 30, 2002.

[4] None of this evidence offered an evaluation or rating of permanent impairment.

knee and right fifth digit.[5] As he did not feel that he could apply the CRPS recommendations from the A.M.A., *Guides* (5th ed. 2001), he elected instead to apply primarily range of motion, strength and osteoarthritis parameters to what were the most objective and documented injuries in the record involving appellant's bilateral shoulders, right fifth digit and left knee. Dr. Goldman concluded that appellant had a 25 percent impairment of the left upper extremity, a 24 percent impairment of the right upper extremity and a 48 percent impairment of the left lower extremity.

An Office medical adviser reviewed Dr. Goldman's assessment and recommended a second opinion. The Office referred appellant, together with copies of pertinent medical records and a statement of accepted facts, to Dr. Christopher G. Palmer, a Board-certified orthopedic surgeon, for a second opinion on appellant's injury-related impairment.

On January 17, 2003 Dr. Palmer reported that appellant had reached maximum medical improvement a number of years earlier. He reported that the most accurate way to rate appellant's impairment was to use the procedure described on page 496 of the A.M.A., *Guides*, fifth edition, for determining impairment of a type 1 CRPS:

> "In rating the upper extremity impairment resulting from his loss of motion there is an additive 11 percent range of motion in each upper extremity. There is a five percent impairment related to loss of forward flexion, four percent related to loss of abduction, one percent for internal rotation and one percent for extension.
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> "The next step in rating his impairment was to use Table 18-10A in selecting the appropriate severity grade within the range of motion shown. None of these grades hit him perfectly, [as] he has subjectively much more pain than he has loss of tactile sensibility. Thus, I gave him a subjective 30 percent sensory deficit. Using the combined tables values of 11 and 30 percent, gives a combined value of 38 percent for each upper extremity.
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> "Although he was given an impairment rating for his knee in the past, there appears to be a preexisting degenerative knee condition and he was noted to have full range of motion and no loss of strength in that knee, so I do not feel it is appropriate to rate that extremity as an additional impairment from his work[-]related injury."

On February 15, 2003 an Office medical adviser reviewed appellant's record and reported that he would endorse Dr. Goldman's assessment because the ratings reflected current, not additional, impairment.

In a decision dated March 7, 2003, the Office denied appellant's request for increased schedule awards. The Office noted that Dr. Goldman rated appellant's left shoulder impairment

[5] He also diagnosed bilateral chronic adhesive capsulitis of the shoulders as a result of appellant's 1992 work-related injury, chronic cervical and thoracic myofascial pain syndrome as a result of appellant's 1992 work-related injury, gait dysfunction, activities of daily living dysfunction, chronic pain disorder with general medical condition and psychological factors and history of right hand strain.

at 25 percent, but the Office previously paid 62 percent, a difference of 37 percent. Also Dr. Goldman rated appellant's right shoulder/wrist/fifth digit impairment at 24 percent, but the Office previously paid 58 percent, a difference of 34 percent. Notwithstanding Dr. Goldman's rating of 48 percent for the left leg, which was 27 percent more than was previously paid for that extremity, the Office denied an additional schedule award:

> "[C]onsidering all the affected extremities related to your condition of reflex sympathetic dystrophy and the correct total number of days of entitlement, you have been overpaid 1,006.32 days. You were previously paid compensation for 3,044.16 days or 434.88 weeks, for the previous impairment ratings. The correct number of days of entitlement is 2,037.84 days or 291.12 weeks, based upon the weight of the medical evidence.
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> "Since you have already received previous ratings and paid compensation for these impairments there is no further entitlement to compensation."

The Board finds that appellant has not met his burden of proof to establish that he is entitled to an additional schedule award for his left or right arm.

A claimant seeking compensation under the Federal Employees' Compensation Act[6] has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence.[7] Section 8107 provides that if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[8]

Appellant received schedule awards for permanent impairment of his left and right arm and of his left leg. He now claims an additional schedule award because his full-body RSD continues to spread and intensify. Appellant bears the burden of proof, therefore, to establish that he has more than a 62 percent permanent impairment of the left arm, more than a 58 percent permanent impairment of the right arm or more than a 21 percent permanent impairment of the left leg causally related to the traumatic incident that occurred on November 30, 1992 when he pulled out a drawer of savings bonds and twisted his left wrist.[9]

Dr. Goldman, a specialist in physical medicine and rehabilitation and appellant's treating physician, reported that the CRPS impairment rating guidelines outlined on page 496 of the A.M.A., *Guides*, fifth edition, could not be applied. Applying instead primarily range of motion, strength and osteoarthritis parameters to what he considered were the most objective and documented injuries in the record involving appellant's bilateral shoulders, right fifth digit and left knee, Dr. Goldman concluded that appellant had a 25 percent impairment of the left upper

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[6] 5 U.S.C. §§ 8101-8193.

[7] *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

[8] 5 U.S.C. § 8107(a).

[9] *See Philip N.G. Barr*, 33 ECAB 948 (1982) (the Act provides that a schedule award be payable for a permanent impairment resulting from an employment injury).

extremity, a 24 percent impairment of the right upper extremity and a 48 percent impairment of the left lower extremity.

Dr. Palmer, a Board-certified orthopedic surgeon and Office second opinion physician, reported that the most accurate way to rate appellant's impairment was to use the procedure described on page 496 of the A.M.A., *Guides*, fifth edition, for determining impairment of a Type 1 CRPS. He concluded that appellant had a 38 percent permanent impairment of each upper extremity and that it was not appropriate to rate the left lower extremity as an additional impairment from the employment injury.

On examination, neither physician reported an impairment of the left or right arm that was greater than that for which appellant previously received a schedule award. Neither physician reported more than a 62 percent permanent impairment of the left arm or more than a 58 percent permanent impairment of the right. As the record lacks any medical opinion evidence to support that appellant is entitled to an additional schedule award for his left or right arm, he has not met his burden of proof with respect to those extremities. The Board will affirm the Office's March 7, 2003 decision with respect to the left and right arm.

However, the Board further finds that this case is not in posture for decision on whether appellant is entitled to an additional schedule award for his left leg. There is a conflict in medical opinion necessitating referral to an impartial medical specialist pursuant to 5 U.S.C. § 8123(a).

Section 8123(a) of the Act provides in 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."[10]

Drs. Goldman and Palmer disagreed on how to evaluate appellant's impairment under the fifth edition of the A.M.A., *Guides* and disagreed on whether appellant had an additional impairment of the left leg from the accepted injury. To resolve this conflict, the Office shall refer appellant, together with the medical record and a statement of accepted facts, to an appropriate impartial medical specialist for a well-reasoned opinion on the extent of impairment of the left leg causally related to the accepted employment injury. After such further development of the evidence as may be necessary, the Office shall issue an appropriate final decision, on whether appellant is entitled to an additional schedule award for his left leg.

[10] 5 U.S.C. § 8123(a).

The March 7, 2003 decision of the Office of Workers' Compensation Programs is hereby affirmed with respect to additional impairment of the left and right arm and is set aside with respect to the left leg. The case is remanded for further action consistent with this opinion.

Dated, Washington, DC
September 10, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member