United States Department of Labor
Employees' Compensation Appeals Board

J.E., Appellant	)	
and	)	**Docket No. 08-2205**
	)	**Issued: May 11, 2009**
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:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 6, 2008 appellant filed a timely appeal from October 19, 2007 and May 6, 2008 decisions of the Office of Workers' Compensation Programs adjudicating his claim for a schedule award. Pursuant to 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 10 percent impairment to his right upper extremity or more than 20 percent impairment to his left lower extremity.

FACTUAL HISTORY

On May 15, 2004 appellant, then a 53-year-old postal police officer, filed a claim for a traumatic injury alleging that he injured his left knee and right elbow when he was assaulted by a criminal suspect and fell to the ground. His claim was accepted for a left knee strain and fractured right elbow. It was subsequently expanded to include a left knee fracture. Appellant returned to restricted duty on June 30, 2004. On September 22, 2004 he was released to full

duty. Appellant sustained recurrences of disability on April 24, June 1 and September 30, 2005 and January 28 and May 17, 2006. A July 18, 2005 electromyogram (EMG) and nerve conduction study (NCS) revealed mild bilateral carpal tunnel syndrome, which his attending physician did not find clinically significant. On May 17, 2006 appellant underwent left knee arthroscopic surgery. On February 9, 2007 he filed a claim for a schedule award.

In reports dated July 24, 2004 to July 26, 2005, Dr. Robert R. Bachman, an attending Board-certified orthopedic surgeon, stated, regarding appellant's right elbow, he had some pain on palpation over the olecranon area of the right elbow, decreased sensation in the fourth and fifth fingers, pain on palpation of the cubital groove and positive Tinel's sign in the cubital groove and increased paresthesias in the elbow. Regarding his healed left femur fracture, he had minimal pain on palpation around the knee joint. There was no effusion, range of motion was normal and musculature was good. The left thigh circumference was one-half inch less than the right thigh. Dr. Bachman diagnosed a contusion of the right elbow with residual mild ulnar neuritis and a healed articular fracture, nondisplaced, of the medial femoral condyle of the left knee. A July 18, 2005 EMG and NCS revealed bilateral carpal tunnel syndrome that was not clinically significant.

In a November 7, 2006 report, Dr. David Weiss, a Board-certified family practitioner and osteopathic physician, reviewed the medical history and provided findings on physical examination.[1] He diagnosed chronic contusion to the right elbow and post-traumatic ulnar nerve dysfunction at the cubital tunnel of the right elbow, post-traumatic left knee injuries including medial condylar fracture, internal derangement, chondromalacia patella, synovitis and he noted left knee arthroscopic surgery on May 17, 2006. Regarding the right upper extremity, appellant had tenderness over the aspect of the posterior olecranon of the elbow, positive Tinel's sign at the cubital tunnel producing pins and needles sensation into the fourth and fifth fingers, grip strength of 42 kilograms (kg) of force at Level 3 and pinch key testing of 8 kg obtained by Jamar Hand Dynamometer. There was diminished light touch sensibility over the median nerve and the ulnar nerve. Regarding the left lower extremity, patellofemoral compression produced pain and crepitance and patellar apprehension and inhibition signs produced pain. There was tenderness along the undersurface of the medial patellar facet, over the medial and lateral joint lines and over the medial femoral condyle. Manual muscle strength testing revealed 4/5 for the left quadriceps muscle. Dr. Weiss calculated that appellant had 24 percent impairment to the right upper extremity, including 10 percent for Grade 4 median nerve sensory deficit and 6 percent impairment for a Grade 2 ulnar nerve sensory deficit based on Table 16-10 at page 482 and Table 16-15 at page 492 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) and 10 percent for lateral pinch deficit based on Tables 16-33 and 16-34 at page 509. He calculated 23 percent impairment for the left lower extremity, including 13 percent for right thigh quadriceps muscle atrophy 48 centimeters (cm) 8 percent for left calf (gastrocnemius muscle) atrophy 39 cm and 3 percent for pain-related impairment based on Table 18-1 at page 574.

[1] Dr. Weiss noted that appellant had bilateral carpal tunnel syndrome that was related to his previous job as a mail-sorting clerk, which required repetitive use of his hands.

On May 22, 2007 Dr. Henry J. Magliato, a Board-certified orthopedic surgeon and an Office medical adviser, reviewed the report of Dr. Weiss and calculated that appellant had 10 percent right upper extremity impairment, based on a 20 percent loss of grip strength (lateral pinch) of the right elbow, according to Table 16-33 and 16-34 at page 509 of the A.M.A., *Guides*.[2] He stated that the median and ulnar nerve sensory deficit in the right hand were unrelated to the accepted right elbow fracture. Dr. Magliato noted that Dr. Weiss attributed appellant's bilateral carpal tunnel syndrome to his previous job as a postal clerk and this condition was not accepted as part of his May 15, 2004 employment injury.[3] He calculated 20 percent impairment to appellant's left lower extremity, which included 17 percent for atrophy of the quadriceps muscle (11 percent impairment based on 2.5 cm) and atrophy of the calf muscle (6 percent for 1.5 cm), according to Table 17-6 at page 530 and 3 percent for pain based on Table 18-1 at page 574. Dr. Magliato indicated that he disagreed with Dr. Weiss' selection of the upper end of the range provided for atrophy on the scale provided on page 530.

By decision dated October 19, 2007, the Office granted appellant a schedule award for 10 percent right upper extremity impairment or 31.20 weeks and 20 percent left lower extremity impairment or 57.60 weeks.[4] Appellant requested an oral hearing before an Office hearing representative that was held on February 27, 2008. In a March 5, 2008 statement, he described the incident on May 15, 2004. Appellant stated that he was guarding a suspect taken into custody by another officer when the suspect tried to escape by pushing appellant out of the way and into a wall. He grabbed the suspect but he resisted causing them both to fall to a concrete floor landing. Appellant sustained a fracture of the left femur bone and bruising and swelling of his right elbow. He stated that he experienced constant pain in the knee and elbow and, after 15 minutes of activity, pain caused his left knee to collapse.

By decision dated May 6, 2008, an Office hearing representative affirmed the October 19, 2007 decision.[5]

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[2] *See* Federal (FECA) Procedural Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (October 2005) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[3] Carpal tunnel syndrome does not involve the ulnar nerve, only the median nerve.

[4] The Federal Employees' Compensation Act provides for 312 weeks of compensation for 100 percent loss or loss of use of an upper extremity. 5 U.S.C. § 8107(c)(1). Multiplying 312 weeks by 10 percent equals 31.20 weeks of compensation. The Act provides for 288 weeks of compensation for 100 percent loss or loss of use of a lower extremity. 5 U.S.C. § 8107(c)(2). Multiplying 288 weeks by 20 percent equals 57.60 weeks of compensation.

[5] Subsequent to the May 6, 2008 Office decision, additional evidence was associated with the file. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal. The Board notes that, in the May 6, 2008 decision, the hearing representative stated that a review of fiscal records revealed that the schedule award was based on a recurrent pay rate. However, a review of the record before the Board does not reveal that a recurrent pay rate date was used. The pay rate date used for the schedule award was the date of injury pay rate.

LEGAL PRECEDENT

Section 8107 of the Act[6] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[7]

Section 8123(a) of the Act provide that "if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary [of Labor] shall appoint a third physician who shall make an examination."[8] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.

ANALYSIS

Dr. Weiss diagnosed chronic contusion to the right elbow and post-traumatic ulnar nerve dysfunction at the cubital tunnel of the right elbow.[9] He diagnosed appellant's employment-related left knee injuries as a medial condylar fracture, internal derangement, chondromalacia patella, synovitis and noted that he underwent left knee arthroscopic surgery on May 17, 2006. Regarding the right upper extremity, Dr. Weiss described tenderness at the olecranon area of the elbow, positive Tinel's sign at the cubital tunnel producing pins and needles sensation into the fourth and fifth fingers, grip strength of 42 kg of force at Level 3 and pinch key testing of 8 kg. There was sensory deficit of the median nerve and ulnar nerves.[10] Regarding the left lower extremity, Dr. Weiss noted that patellofemoral compression produced pain and crepitance and patellar apprehension and inhibition signs produced pain. There was tenderness along the undersurface of the medial patellar facet, over the medial and lateral joint lines and over the medial femoral condyle. Manual muscle strength testing revealed 4/5 for the left quadriceps muscle. Dr. Weiss calculated that appellant had 24 percent impairment to the right upper extremity, including 10 percent for Grade 4 median nerve sensory deficit and 6 percent impairment for a Grade 2 ulnar nerve sensory deficit based on Table 16-10 at page 482 and Table 16-15 at page 492 of the A.M.A., *Guides* and 10 percent for grip strength deficit (lateral pinch) based on Tables 16-33 and 16-34 at page 509. He calculated 23 percent impairment for

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

[8] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

[9] As noted, Dr. Weiss indicated that appellant's bilateral carpal tunnel syndrome was related to his previous job, not to the accepted May 15, 2004 right upper extremity and left lower extremity employment injuries.

[10] Dr. Bachman's reports support the findings of an ulnar nerve sensory deficit. He stated that appellant had pain on palpation over the olecranon area of the right elbow and decreased paresthesias. Dr. Bachman had pain on palpation of the cubital groove and positive Tinel's sign in the cubital groove and decreased sensation in the fifth finger (the little finger is serviced by the ulnar nerve).

the left lower extremity, including 13 percent for right thigh quadriceps muscle atrophy measured at 48 cm and 8 percent for left calf muscle atrophy measured at 39 cm and 3 percent for pain-related impairment based on Table 18-1 at page 574.

Dr. Magliato reviewed the report of Dr. Weiss and calculated that appellant had 10 percent right upper extremity impairment, based on a 20 percent loss of grip strength (lateral pinch) of the right elbow, according to Table 16-33 and 16-34 at page 509 of the A.M.A., *Guides*. He was in agreement with Dr. Weiss as to appellant's grip strength impairment. Dr. Magliato stated that the median and ulnar nerve sensory deficits in the right upper extremity were unrelated to the accepted right elbow fracture because Dr. Weiss attributed appellant's carpal tunnel syndrome to a previous job and this condition was not accepted as part of his May 15, 2004 employment injury. Although, the nonwork-related carpal tunnel syndrome involves the median nerve, it does not involve the ulnar nerve. Therefore, Dr. Magliato was not correct in dismissing appellant's right ulnar nerve condition as related to his bilateral carpal tunnel syndrome. Dr. Bachman found evidence of ulnar nerve deficit and Dr. Weiss indicated that the ulnar nerve sensory deficit was related to the accepted right elbow fracture. Consequently, there is disagreement between Dr. Weiss and Dr. Magliato regarding impairment to the right upper extremity due to ulnar nerve sensory deficit. Regarding the finding by Dr. Weiss of impairment due to median nerve sensory deficit, he did not explain how this was related to appellant's accepted right elbow fracture, rather than to the nonwork-related bilateral carpal tunnel syndrome. Dr. Magliato calculated 20 percent impairment to appellant's left lower extremity which included 17 percent for atrophy of the quadriceps muscle (11 percent impairment based on 2.5 cm) and atrophy of the calf muscle (6 percent for 1.5 cm), according to Table 17-6 at page 530 and 3 percent for pain based on Table 18-1 at page 574. As noted, Dr. Weiss calculated 13 percent impairment due to left lower extremity muscle atrophy.

Regarding left lower extremity impairment due to pain based on Chapter 18 of the A.M.A., *Guides*, neither Dr. Weiss nor Dr. Magliato provided rationale for assigning impairment based on this chapter. The A.M.A., *Guides* warns that examiners should not use Chapter 18 to rate pain-related impairment for any condition that can be adequately rated on the basis of the body and organ impairment rating systems given in other chapters.[11] Moreover, as the A.M.A., *Guides* explains: "The impairment ratings in the body organ system chapters make allowance for expected accompanying pain."[12] Dr. Weiss and Dr. Magliato did not adequately explain why appellant's condition could not be rated in other chapters of the A.M.A., *Guides* or how his condition falls within one of the several situations identified under Chapter 18.3a (When This Chapter Should Be Used to Evaluate Pain-Related Impairment).[13]

The Board finds that there is a conflict in medical opinion between Dr. Weiss and Dr. Magliato regarding appellant's impairment of his right upper and left lower extremities. Therefore, the issue of appellant's impairment requires further development. Accordingly, the Office should refer appellant to an impartial medical specialist for a thorough physical

[11] A.M.A., *Guides* 571.

[12] *Id*. at 20.

[13] *Id*. at 570-71.

examination and evaluation of his right upper extremity and left lower extremity impairment. After such further development as it deems necessary, the Office should issue an appropriate decision.[14]

CONCLUSION

The Board finds that this case is not in posture for a decision. On remand, the Office should refer appellant to an impartial medical specialist to resolve the conflict in the medical evidence as to his right upper extremity and left lower extremity impairment. After such further development as it deems necessary, the Office should issue an appropriate decision on appellant's schedule award claim.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated May 6, 2008 and October 19, 2007 are set aside and the case remanded for further action consistent with this decision of the Board.

Issued: May 11, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

[14] On remand, the Office should also determine whether it used the correct pay rate in calculating appellant's schedule award. The record shows that it used appellant's date-of-injury pay rate. Section 8107 of the Act provides that compensation for a schedule award shall be based on the employee's "monthly pay." *See* 5 U.S.C. § 8107(a). For all claims under the Act, compensation is to be based on the pay rate as determined under section 8101(4) which defines "monthly pay" as:

> "The monthly pay at the time of injury or the monthly pay at the time disability begins or the monthly pay at the time compensable disability recurs, if the recurrence begins more than six months after the injured employee resumes regular full-time employment with the United States, whichever is greater…." *See* 5 U.S.C. § 8101(4).

The Office should determine whether appellant's rate of pay at the time of his May 17, 2006 surgery (recurrent pay rate) is higher than his date of injury pay rate.