United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 10-980**
	)	**Issued: February 14, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Chester Heights, 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:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 25, 2010 appellant filed a timely appeal from a December 1, 2009 schedule award decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determinations in this case.

ISSUE

The issue is whether appellant has more than 13 percent impairment of the right upper extremity for which he received schedule awards.

On appeal, appellant's attorney argued that the referee examiner's report is incomplete and unrationalized; therefore, a conflict remains regarding the degree of his right upper extremity impairment. He further asserts that the conditions of C5-6 radiculopathy, brachial plexus, ulnar and radial nerve compromise are preexisting and should be considered in the impairment analysis.

FACTUAL HISTORY

This case was previously before the Board. In a May 4, 2006 decision, the Board affirmed a September 27, 2005 schedule award decision granting appellant a five percent permanent impairment of the right upper extremity.[1] The law and facts of the previous Board decision are incorporated herein by reference.

A December 18, 2006 x-ray of the cervical spine demonstrated disc space narrowing at C5-6 and C6-7. An April 10, 2007 somatosensory evoked potential test of the median, ulnar and radial nerves was interpreted as normal or not identified. Electromyogram (EMG) studies on January 7, 2007 and January 31, 2008 showed evidence of bilateral C5-6 radicular changes with bilateral median, ulnar and radial nerve and brachial plexus compromise.

On January 7, 2008 appellant filed a claim for an additional schedule award. In a September 27, 2007 report, Dr. David Weiss, an osteopath, found that, in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[2] appellant had 32 percent right arm impairment. This consisted of a 5 percent impairment under Figure 16-18 and Figure 16-31 due to right wrist range of motion (ROM) deficits in flexion and ulnar deviation, a 20 percent impairment due to lateral pinch deficit under Table 16-33 and Table 16-34 and a Grade 4 sensory deficit of the right median nerve under Table 16-10 and Table 16-15 of 10 percent deficit. In a February 22, 2008 report, Dr. Morley Slutsky, an Office medical adviser, reviewed the medical evidence including the report of Dr. Weiss. He advised that maximum medical improvement was reached on September 27, 2007. Dr. Slutsky did not agree with Dr. Weiss' calculations for loss of right wrist motion and right hand grip strength but agreed that, under Table 16-10 and Table 16-15, appellant had a 10 percent right upper extremity impairment for sensory impairment of the median nerve.

The Office determined that a conflict in medical evidence arose between Dr. Weiss and Dr. Slutsky. It referred appellant to Dr. Donald F. Leatherwood, II, a Board-certified orthopedic surgeon, for an impartial medical evaluation. In a May 27, 2008 report, Dr. Leatherwood reviewed the employment injury, appellant's complaint of recurrent right hand pain, numbness and tingling with poor grip and the medical record. Physical examination demonstrated full ROM of the shoulders, elbows, pronation, supinations, wrists, thumbs and fingers of the left hand. On the right, there was a lag in full flexion of metacarpophalangeal (MP) joint motion starting at the index finger with discrepancies of 20 degrees, 10 degrees and 10 degrees and otherwise full motion. Strength was 5/5. Cervical spine motion was reduced approximately 60 percent in all planes. Examination of the right upper extremity demonstrated somewhat increased two-point discrimination, a negative Tinel's sign, and a positive carpal tunnel

[1] Docket No. 06-595 (issued May 4, 2006). Appellant, 68 years old, is a retired part-time flexible window clerk. On June 15, 1999 he filed an occupational disease claim for right carpal tunnel syndrome that was accepted on August 11, 1999. On September 3, 1999 Dr. James L. Colombo, Board certified in plastic surgery and surgery of the hand, performed a right carpal tunnel release. He advised that appellant could return to full duty with no restrictions on November 4, 1999.

[2] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

compression test. Dr. Leatherwood opined that appellant had a residual deficit due to his employment-related right carpal tunnel syndrome and no other diagnoses related to his employment. He evaluated appellant's impairment in accordance with the fifth edition of the A.M.A., *Guides* and found that, under Figure 16-25, the deficit in motion at the MP joint yielded a 10 percent deficit for the index finger and a 7 percent deficit for the long, ring and small fingers which, using Table 16-1, converted to a 2 percent deficit in the hand for the index finger and a 1 percent deficit each for the long, ring and small fingers, for a total 5 percent deficit of the hand which, under Table 16-2, yielded a 5 percent right upper extremity impairment for motion deficit. Dr. Leatherwood then found that appellant had Grade 3 right thumb and index finger sensory deficits due to minor, diminished two-point discrimination in the two fingers for an overall 30 percent sensory deficit under Table 16-10. He then found that, under Table 16-15, for the thumb, the maximum percentages were 7 and 11 for radial and ulnar sides respectively which, when multiplied by 30 percent, yielded right upper extremity impairments of 2 and 3 percent. Dr. Leatherwood found that the index finger had maximums of 5 and 4, for radial and ulnar respectively which, when multiplied by 30 percent, yielded right upper extremity impairments of 2 and 1 percent. He added the 5 percent upper extremity motion deficit with the four scores for sensory deficit, or 8 percent, finding a total 13 percent right arm impairment.

By report dated July 7, 2008, Dr. Arnold T. Berman, Board certified in orthopedic surgeon and an Office medical adviser, reviewed the medical evidence. He advised that Dr. Leatherwood did not properly apply the A.M.A., *Guides* because he did not use the guidelines for carpal tunnel syndrome found on page 495 or calculate decreased digital sensation. Dr. Berman stated that the more appropriate methodology would be to calculate a decreased sensation of the entire median nerve if the median nerve showed a decrease in sensation, as in this instance. He found that, under page 495 of the A.M.A., *Guides*, appellant was rated as scenario number 1, based on median nerve dysfunction and that, in accordance with Table 16-15, for deficits of the median nerve below mid forearm, a maximum percent upper extremity impairment due to sensory deficit or pain was 39 percent. Dr. Berman utilized Table 16-10, and found a Grade 4 impairment of 25 percent, which he multiplied by the maximum 39 percent to equal a 10 percent right upper extremity impairment which he noted represented an increase of 5 percent over the previously awarded 5 percent.

In a September 15, 2008 schedule award, appellant received an additional five percent impairment of his right arm, for 109.2 days, to run from May 27 to September 13, 2008.

Appellant, through his attorney, timely requested a hearing and in a January 7, 2009 decision, an Office hearing representative noted that a referee opinion should be used to resolve a conflict in medical evidence. The hearing representative set aside the September 15, 2008 schedule award decision.

In a supplemental report dated February 12, 2009, Dr. Leatherwood noted that he did not mention the carpal tunnel syndrome guidelines on page 495 of the A.M.A., *Guides* and agreed that appellant fit into scenario 1, but that this would not change his calculations. He opined that appellant's overall deficit in hand motion at the MP joints, including the small finger, was a residual of his carpal tunnel problem, explaining that just because the median nerve did not go to the small finger did not mean that a median nerve problem could not result in reduced motion at this joint, secondary to its common involvement with all the other joints of the hand.

Dr. Leatherwood reiterated that appellant had a five percent loss of use under Figure 16-25 and Table 16-1 of the fifth edition of the A.M.A., *Guides*. He advised that there was an error in his initial calculations, noting that appellant had an 11 percent deficit for index and 6 percent deficit for the other fingers, but that this did not change the overall 5 percent deficit for loss of hand motion when calculated under Table 16-1. Dr. Leatherwood reiterated that appellant had an 8 percent sensory deficit of right upper extremity based on the radial and ulnar sides of the thumb and index finger only, with no sensory deficits of the other fingers, for deficits of 2 and 3 percent for the thumb and 1.5 and 1.2 percent for the index finger, or a 7.7 percent total which, when rounded up, yielded an 8 percent sensory deficit of the right upper extremity. He noted that, under Table 16-2, a 5 percent motion impairment of the hand was also a 5 percent impairment of the extremity, and that, in accordance with the Combined Values Chart, a 5 percent motion deficit and an 8 percent sensory deficit yielded a total 13 percent right upper extremity impairment, as reflected in his May 27, 2008 report. Dr. Leatherwood noted that the methods utilized by Dr. Berman and himself were not grossly different, but differed in relatively minor detail.

In an April 19, 2009 report, Dr. Berman advised that he did not necessarily agree with Dr. Leatherwood's detailed findings and rationale to support that appellant had a 13 percent right upper extremity impairment.

By decision dated April 28, 2009, appellant was granted a schedule award for an additional three percent right upper extremity impairment, for a period of 9.36 weeks, to run from September 14 to November 18, 2008.

On May 1, 2009 appellant, through his attorney, requested a hearing that was held on August 18, 2009. Counsel argued that appellant had preexisting cervical radiculopathy as demonstrated on EMG studies in January 2007 and January 2008 that were not considered by Dr. Leatherwood, whose opinion was insufficient to resolve the conflict.

In a December 1, 2009 decision, an Office hearing representative affirmed the April 28, 2009 decision. She found that the weight of the medical evidence rested with the opinion of Dr. Leatherwood.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[3] and its implementing federal regulations,[4] 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, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[5] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id*. at § 10.404(a).

to calculate schedule awards.[6] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[7]

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[8] Office procedures provide that to support a schedule award, the medical evidence should establish that the impairment has reached a permanent and fixed state and indicate the date on which this occurred ("date of maximum medical improvement"), describe the impairment in sufficient detail to include, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment, and the percentage of impairment should be computed in accordance with the fifth edition of the A.M.A., *Guides*. The procedures further provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for opinion concerning the nature and percentage of impairment, and the Office medical adviser should provide rationale for the percentage of impairment specified.[9]

Section 8123(a) of the Act provides that, 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] When the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[11]

ANALYSIS

The Board finds the weight of the medical evidence rests with the opinion of Dr. Leatherwood who provided an impartial opinion on the extent of permanent impairment. The Office determined that a conflict in the medical evidence was created between the opinions of Dr. Weiss, an attending osteopath and Dr. Slutsky, an Office medical adviser, regarding the degree of appellant's right upper extremity impairment. It properly referred appellant to Dr. Leatherwood, Board certified in orthopedic surgery, for an impartial evaluation.[12]

In a May 27, 2008 report, Dr. Leatherwood reviewed the employment injury, the medical record, and noted appellant's complaints of right hand pain, numbness and tingling. He provided

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

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

[8] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(d) (August 2002).

[10] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[11] *Manuel Gill*, 52 ECAB 282 (2001).

[12] *Id.*

findings on physical examination of full ROM of the shoulders, elbows, pronation, supinations, wrists, thumbs and fingers of the left hand with diminished cervical spine motion. On the right there was a lag in full flexion of MP joint motion of the fingers. Right upper extremity strength was 5/5, and sensory examination demonstrated somewhat increased two-point discrimination, a negative Tinel's sign, and a positive carpal tunnel compression test. Dr. Leatherwood diagnosed a residual deficit due to appellant's employment-related right carpal tunnel syndrome and no other diagnoses related to his employment. He evaluated appellant's impairment in accordance with the fifth edition of the A.M.A., *Guides* and found that, under Figure 16-25,[13] the deficit in motion at the MP joint yielded a 10 percent deficit for the index finger and a 7 percent deficit for the long, ring and small fingers which, using Table 16-1,[14] converted to a 2 percent deficit in the hand for the index finger and a 1 percent deficit each for the long, ring and small fingers, for a total 5 percent deficit of the hand which, under Table 16-2,[15] yielded a 5 percent right upper extremity impairment for motion deficit. Dr. Leatherwood found that appellant had Grade 3 right thumb and index finger sensory deficits due to minor, diminished two-point discrimination in the two fingers for an overall 30 percent sensory deficit under Table 16-10.[16] He determined that, under Table 16-15,[17] for the thumb, the maximum percentages were 7 and 11 for the radial and ulnar sides respectively which, when multiplied by 30 percent, yielded right upper extremity impairments of 2 and 3 percent. Dr. Leatherwood found that the index finger had maximums of 5 and 4, for radial and ulnar respectively which, when multiplied by 30 percent, yielded right upper extremity impairments of 2 and 1 percent for the index finger.[18] He added the 5 percent upper extremity motion deficit with the four scores for sensory deficit, finding a total 13 percent right upper extremity impairment.

In a supplementary report dated February 12, 2009, Dr. Leatherwood acknowledged he did not address the carpal tunnel syndrome guidelines in his previous report but that appellant fit into scenario 1 as found on page 495 of the A.M.A., *Guides*. This would not change his rating; however, because the median nerve motion at the finger joints, secondary to its common involvement with all the other joints of the hand. Dr. Leatherwood reiterated his finding that appellant had a five percent loss of use under Figure 16-25 and Table 16-1 of the fifth edition of the A.M.A., *Guides*. He noted that there was an error in his initial calculations because appellant had an 11 percent deficit for index and 6 percent deficit for the other fingers, but that this did not change the overall 5 percent deficit for loss of hand motion when calculated under Table 16-1. Dr. Leatherwood again opined that appellant had an 8 percent sensory deficit of the right upper extremity which, when combined with the 5 percent motor impairment, yielded a total 13 percent right upper extremity impairment, as reflected in his May 27, 2008 report.

[13] A.M.A., *Guides*, *supra* note 2 at 464.

[14] *Id*. at 438.

[15] *Id*. at 439.

[16] *Id*. at 482.

[17] *Id*. at 492.

[18] Office procedures provide that the calculated percentage of impairment is to be rounded to the nearest whole point. Results should be rounded down for figures less than 0.5 and up for 0.5 and over. Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3b (October 2004); *see E.L.*, 59 ECAB 405 (2008).

On April 19, 2009 Dr. Berman, an Office medical adviser, reviewed the medical evidence. Although he did not fully agree with Dr. Leatherwood's impairment rating, he provided detailed rationale for finding 13 percent impairment of the right upper extremity impairment.

The Board finds that, as Dr. Leatherwood provided a comprehensive, well-rationalized opinion in which he clearly explained his impairment rating, his report is entitled to the special weight accorded an impartial examiner and therefore constitutes the weight of the medical evidence.[19] Appellant therefore did not meet his burden of proof to establish that he is entitled to schedule awards greater than those awarded.

As to appellant's contention on appeal, there is no evidence of record to support that he had preexisting cervical radiculopathy of the ulnar, radial and median nerves and brachial plexus. The EMG studies done in January 2007 and January 2008 that demonstrated cervical radiculopathy were done eight and nine years after the claim was filed. Appellant therefore did not meet his burden of proof to establish that cervical radiculopathy was a preexisting condition.

CONCLUSION

The Board finds that appellant did not establish that he has more than a 13 percent impairment of the right upper extremity for which he received schedule awards.

[19] *See Sharyn D. Bannick*, 54 ECAB 537 (2003).

ORDER

IT IS HEREBY ORDERED THAT the December 1, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 14, 2011
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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