United States Department of Labor
Employees' Compensation Appeals Board

B.H., Appellant	)	
and	)	**Docket No. 07-214**
	)	**Issued: May 9, 2007**
U.S. POSTAL SERVICE, MARKET STREET POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 31, 2006 appellant filed a timely appeal from an October 20, 2006 decision of the Office of Workers' Compensation Programs regarding a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has established that she sustained greater than a five percent impairment of the right upper extremity, for which she received a schedule award. On appeal, she contends that she has additional impairment due to weakness as found by an impartial medical examiner.

FACTUAL HISTORY

This is appellant's second appeal before the Board.[1] By decision dated June 15, 2006, the Board remanded the case to the Office for further development regarding whether appellant

[1] Docket No. 06-258 (issued June 15, 2006).

sustained greater than a five percent impairment of the right upper extremity, for which she received a schedule award on November 8, 2005. The Board found that Dr. Evan Kovalsky, a Board-certified orthopedic surgeon and impartial medical examiner, failed to use Table 16-15 of the fifth edition of the American Medical Associations, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).[2] In his June 17, 2005 report, Dr. Kovalsky did not convert a nine percent sensory impairment into an upper extremity impairment due to median nerve involvement. The Office issued the November 8, 2005 schedule award without first requesting a clarifying report from Dr. Kovalsky. The law and the facts of the case as set forth in the Board's prior decision and are hereby incorporated by reference.[3]

In a September 19, 2006 letter, the Office requested that Dr. Kovalsky submit a supplemental report. The Office noted that he had not used Table 16-15 to convert the nine percent sensory impairment to an upper extremity impairment. The Office enclosed copies of the Office medical adviser's report, Dr. Kovalsky's prior report and reports from Dr. Richard J. Mandel, a Board-certified orthopedic surgeon and second opinion physician, and Dr. George L. Rodriguez, an attending Board-certified physiatrist.

In a September 21, 2006 report, Dr. Kovalsky stated that appellant continued to have pain, abnormal sensation and subjective weakness in the right upper extremity despite normal electromyography (EMG) and nerve conduction velocity studies. He explained that patients with "clinically present" symptoms of carpal tunnel syndrome could have normal EMG studies. Dr. Kovalsky combined a 10 percent sensory deficit from Table 16-10, page 482[4] of the A.M.A., *Guides* and a 10 percent motor deficit from Table 16-11, page 484.[5] He added these impairments together, then combined them "with the 45 percent upper extremity impairment from Table 16-15, which is the percentage for median nerve involvement distal to the forearm." Dr. Kovalsky did not include his mathematical calculations or offer a final percentage of impairment.

On October 16, 2006 the Office referred Dr. Kovalsky's report and the medical record to an Office medical adviser to determine if appellant had sustained greater than a five percent permanent impairment of the right arm. The Office medical adviser submitted an October 16, 2006 report finding a nine percent impairment of the right upper extremity. Referring to Table

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[2] A.M.A., *Guides* 492, Table 16-15 (fifth edition) is entitled "Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to *Combined* 100 percent Deficits of the Major Peripheral Nerves."

[3] Appellant submitted additional evidence following the November 8, 2005 schedule award decision. In a February 9, 2006 report, Dr. Joseph J. Thoder, an attending Board-certified orthopedic surgeon, prescribed permanent restrictions against lifting and carrying more than 10 pounds. Appellant could "perform tasks such as climbing, kneeling, bending, stooping, twisting and fine manipulation only on an intermittent basis." Dr. Thoder stated that appellant could work 40 hours a week. On May 2, 2006 appellant accepted a permanent modified-duty assignment as a full-time modified clerk within Dr. Thoder's restrictions.

[4] According to A.M.A., *Guides* 482, Table 16-10 (fifth edition) a Grade 4 impairment, representing a sensory deficit of 0 to 25 percent, is characterized as "Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations of pain, that is forgotten during activity."

[5] A.M.A, *Guides* 484, Table 16-11 (fifth edition) is entitled "Determining Impairment of the Upper Extremity Due to Motor and Loss-of-Power Deficits Resulting From Peripheral Nerve Disorders Based on Individual Muscle Rating."

16-10, the medical adviser found a Grade 4 sensory deficit of the median nerve,[6] corresponding to a 23 percent impairment. He then found that according to Table 16-15, page 492, the maximum sensory deficit for median nerve impairment below the mid-forearm was 39 percent. The medical adviser then multiplied the Grade 4 impairment of 23 percent by the maximum allowance for median nerve sensory deficit of 39 percent, resulting in a 9 percent impairment of the right upper extremity. He explained that on June 17, 2005, "Dr. Kovalsky found some evidence of median nerve irritation with a positive Tinel's and Phalen's testing" as well as EMG studies showing ongoing median nerve involvement bilaterally. Regarding loss of strength secondary to carpal tunnel syndrome, the medical adviser opined that Dr. Kovalsky found "weakness secondary to pain, not a true weakness secondary to median nerve dysfunction." The Office medical adviser explained that weakness due to pain was not ratable under the A.M.A., *Guides*.

By decision dated October 20, 2006, the Office granted appellant a schedule award for an additional four percent permanent impairment of the right upper extremity or a total of nine percent impairment. The period of the award ran from October 5 to December 31, 2005.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a mater which rests in the sound discretion of the Office. 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* has been adopted by the Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[8] As of February 1, 2001, schedule awards are calculated according to the fifth edition of the A.M.A., *Guides*, published in 2000.[9]

[6] A.M.A., *Guides* 482, Table 16-10 (fifth edition) is entitled "Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting from Peripheral Nerve Disorders." Section a. of Table 16-10 classifies impairment by grade according to the description of sensory deficit or pain and gives ranges for converting the grade of deficit into a percentage of impairment. A Grade 4 impairment, representing a sensory deficit of 0 to 25 percent, is characterized as "Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations of pain, that is forgotten during activity."

[7] 5 U.S.C. §§ 8101-8193.

[8] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[9] *See* FECA Bulletin No. 01-05 (issued January 29, 2001) (schedule awards calculated as of February 21, 2001 should be evaluated according to the fifth edition of the A.M.A., *Guides*. Any recalculations of previous awards which result from hearings, reconsideration or appeals should, however, be based on the fifth edition of the A.M.A., *Guides* effective February 1, 2001).

The standards for evaluation the permanent impairment of an extremity under the A.M.A., *Guides* are based on loss of range of motion, together with all factors that prevent a limb from functioning normally, such as pain, sensory deficit and loss of strength. All of the factors should be considered together in evaluating the degree of permanent impairment.[10] Chapter 16 of the fifth edition of the A.M.A., *Guides* provides a detailed grading scheme and procedure for determining impairments of the upper extremities due to pain, discomfort, loss of sensation or loss of strength.[11]

Section 8123 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.[12] In situations where there exist opposing medical reports of virtually equal weight and rationale and 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 upon a proper factual background, must be given special weight.[13]

Where the Office secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[14] If the specialist is unwilling or unable to clarify or elaborate on his or her opinion as requested, the case should be referred to another appropriate impartial medical specialist.[15] Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Act[16] will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[17] While an Office medical adviser may review the opinion of an impartial medical specialist, the resolution of the conflict is the responsibility of the impartial medical specialist.[18]

[10] *See Paul A. Toms*, 28 ECAB 403 (1987).

[11] A.M.A., *Guides* 433-521 (5th ed. 2001), "The Upper Extremities."

[12] 5 U.S.C. § 8123; *see Charles S. Hamilton*, 52 ECAB 110 (2000).

[13] *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[14] *Harry T. Mosier*, 49 ECAB 688 (1998).

[15] *Guiseppe Aversa*, 55 ECAB 164 (2003).

[16] 5 U.S.C. § 8123(a).

[17] *Harold Travis*, 30 ECAB 1071 (1979).

[18] *See, e.g., Willie C. Howard*, 55 ECAB 564 (2004) (where the Office medical adviser concurred that the impartial medical specialists' impairment rating was appropriate under the fifth edition of the A.M.A., *Guides*).

ANALYSIS

On remand, the Office requested that Dr. Kovalsky, a Board-certified orthopedic surgeon and impartial medical examiner, submit a supplemental report. The Office explained to Dr. Kovalsky the necessity of using Table 16-15 of the A.M.A., *Guides* to determine the percentage of upper extremity impairment. Dr. Kovalsky submitted a September 21, 2006 report referencing various portions of the A.M.A., *Guides*. He stated that he combined a 10 percent sensory deficit from Table 16-10 with 10 percent motor deficit from Table 16-11. But then Dr. Kovalsky stated that he added these impairments together, finally combining them "with the 45 percent upper extremity impairment from Table 16-15, which is the percentage for median nerve involvement distal to the forearm." He did not provide any mathematical calculations or offer a final percentage of impairment.

The Office submitted Dr. Kovalsky's September 21, 2006 report to an Office medical adviser for review. However, the medical adviser did not discuss the incomplete nature of Dr. Kovalsky's opinion. Rather, he used Dr. Kovalsky's findings to determine a nine percent impairment of the right upper extremity. The Board has held that while an Office medical adviser may review the opinion of an impartial medical specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility.[19] The Office issued the October 20, 2006 schedule award for nine percent impairment of the right upper extremity based on the Office medical adviser's opinion.

The Board finds that the Office's reliance on the medical adviser's opinion was improper. As set forth above, if an impartial medical specialist is unable to clarify his opinion as requested, the case should be referred to another appropriate impartial medical specialist.[20] Dr. Kovalsky was unable to clarify his report as requested. He did set forth his application of the A.M.A., *Guides* regarding Table 16-15 or provide a final percentage of impairment. The case will be remanded to the Office for appointment of a new impartial medical examiner to resolve the outstanding conflict of medical opinion. Following this and any other development deemed necessary, the Office shall issue an appropriate decision in the case.

CONCLUSION

The Board finds that the case is not in posture for a decision. The case must be remanded to the Office for further development.

[19] *Willie C. Howard, supra* note 18.

[20] *Guiseppe Aversa, supra* note 15.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 20, 2006 is set aside and the case remanded for further development consistent with this decision.

Issued: May 9, 2007
Washington, DC

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

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

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