

sustained left lateral epicondylitis. By letter dated January 20, 2004, the Office accepted appellant's claim for aggravation of left lateral epicondylitis.

In a medical report dated January 13, 2005, Dr. Nicholas Diamond, an osteopath, diagnosed appellant with: (1) post-traumatic left elbow lateral epicondylitis/tennis elbow; (2) status post left elbow lateral epicondylectomy/tennis elbow release; (3) left wrist tenosynovitis; and (4) left wrist dorsal ganglion cyst. He found that appellant's work-related injury was "the competent producing factor for her subjective and objective findings." Dr. Diamond rated appellant's impairment pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as follows:

| | | |
|------------------------------------------------|---|-------------------------|
| "Range of motion deficit left elbow pronation | = | 1 percent ¹ |
| "Range of motion deficit left elbow extension | = | 1 percent ² |
| | | 2 percent |
| "Left elbow resection arthroplasty radial head | = | 10 percent ³ |
| "Left grip strength deficit | = | 20 percent ⁴ |
| "Combined left upper extremity | = | 29 percent |
| "For the pain-related impairment | = | 3 percent ⁵ |
| "Total left upper extremity | = | 32 percent. |

On May 2, 2005 appellant filed a claim for a schedule award.

By letter dated May 31, 2005, the Office referred appellant to Dr. Robert Allen Smith, a Board-certified orthopedic surgeon, for a second opinion. In a medical report dated June 9, 2005, Dr. Smith concluded that appellant had a zero percent impairment of her left upper extremity based on the A.M.A., *Guides*. He noted that there was "no strength loss, no range of motion loss, no neurologic findings, no atrophy and no signs of joint derangement."

By letter dated August 11, 2005, the Office referred appellant for an appointment with Dr. Walter W. Dearolf, III, a Board-certified orthopedic surgeon, to resolve the conflict between appellant's physician, Dr. Diamond, and the second opinion physician, Dr. Smith, with regard to the extent of impairment to appellant's left upper extremity. In a medical report dated

¹ A.M.A., *Guides* 474, Figure 16-37.

² *Id.* at 472, Figure 16-34.

³ *Id.* at 506, Table 16-27.

⁴ *Id.* at 509, Table 16-34.

⁵ *Id.* at 574, Table 18-1.

September 19, 2005, Dr. Dearolf agreed with Dr. Smith that Dr. Diamond misstated the procedure performed on appellant in that he documented a left elbow resection arthroplasty of the radial head and gave her a 10 [percent] deficit for this. He noted that appellant did not have a resection arthroplasty but rather, had a lateral epicondyle release and epicondylectomy and that, therefore, this would negate the 10 percent deficit he attributed to that test. Dr. Dearolf noted that appellant did not, on examination, show signs of carpal tunnel syndrome and that a magnetic resonance imaging (MRI) scan of December 13, 2003 revealed no rotator cuff tear and a small joint effusion. He noted that appellant's lateral epicondylitis had resolved and that her symptoms in the left upper extremity were unrelated to lateral epicondylitis. Dr. Dearolf concluded that appellant does have residual weakness of grip strength and continued symptoms about the left shoulder, but that her A.M.A., *Guides* impairment rating would be zero as he saw no evidence of any mention of the shoulder being an accepted injury.

By memorandum dated October 14, 2005, the Office asked the Office medical adviser to determine whether appellant had a left upper extremity impairment due to the accepted condition. In a report dated October 14, 2005, the Office medical adviser opined:

“Dr. Diamond[,] in his letter of [January 13, 2005,] incorrectly stated that there was a left elbow resection arthroplasty of the radial head resulting in a 10 percent impairment. This is incorrect because resection of the radial head did not occur. Instead[,] what occurred was resection of the lateral epicondyle.

“In addition, Dr. Diamond states that there is a two percent schedule award based on deficit of supination/pronation. Both Dr. Smith and Dr. Dearolf agree that there is full range of motion with no range of motion deficit. Dr. Smith and Dr. Dearolf both conclude that the schedule award should be zero percent.

“In reading the history section of each of the three reports, in Dr. Smith's report[,] it is noted that appellant takes Motrin or Advil for elbow, shoulder and wrist discomfort and in Dr. Dearolf's report[,] he notes that [appellant] still gets tingling in her fingers and pain which is in an area more near her shoulders, although she has had some elbow pain, as well. Dr. Diamond notes that [appellant] has ongoing pain. In [his] report, [Dr. Diamond] suggests an award of three percent for pain-related impairment. This is based on the [A.M.A., *Guides*], page 574, [F]igure 18-1. Three percent would be the maximum award for pain. However, it does not appear that [appellant] has a significant amount of pain around her elbow, but she does have some.

“It is for this reason that I would recommend that she be awarded a two percent [s]chedule [a]ward left upper extremity impairment based upon pain alone, page 574, [F]igure 18-1.

By decision dated January 12, 2006, the Office issued a schedule award for a two percent impairment of the left upper extremity.

On January 18, 2006 appellant requested a hearing before an Office hearing representative which was held on May 26, 2006.

In a decision dated July 17, 2006, the hearing representative affirmed the Office's decision of January 12, 2006.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act⁶ and its implementing regulations⁷ 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 to all claimants, good administrative practice necessitates 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 implementing regulation as the appropriate standard for evaluating schedule losses.⁸

In situations where there are 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 on a proper factual background, must be given special weight.⁹

ANALYSIS

Appellant's claim was accepted for aggravation of left lateral epicondylitis. Due to the conflict between her physician, Dr. Diamond, and the second opinion physician, Dr. Smith, with regard to the extent of appellant's impairment to her left upper extremity, the Office referred appellant to Dr. Dearolf for an impartial medical examination. Dr. Dearolf rejected the conclusion of appellant's physician that she had sustained a 32 percent impairment to her left upper extremity. Initially, he properly noted that Dr. Diamond erroneously indicated that appellant had a left elbow resection arthroplasty of the radial head for which he suggested a 10 percent impairment as a result thereof. However, as properly noted by Dr. Smith, Dr. Dearolf and the Office medical adviser, appellant did not have a resection arthroplasty but rather, had a lateral epicondyle release and epicondylectomy. Accordingly, appellant was not entitled to a 10 percent rating for this operation. Although Dr. Diamond found that she had a two percent impairment for range of motion deficit in the left elbow, Dr. Dearolf found that appellant had full range of motion of her elbow. As the opinion of the impartial medical specialist is entitled to special weight, the Board finds that appellant was not entitled to an award based on limited range of motion of the elbow. Dr. Diamond found that appellant had a left grip strength deficit of 20 percent. The Office medical adviser properly noted that Dr. Diamond should not have used grip strength in combination with range of motion pursuant to the A.M.A., *Guides*.¹⁰ Furthermore,

⁶ 5 U.S.C. § 8107.

⁷ 20 C.F.R. § 10.404.

⁸ See *id.*; *Jacqueline Harris*, 54 ECAB 139 (2002).

⁹ *Gloria J. Godfrey*, 52 ECAB 486 (2001).

¹⁰ A.M.A., *Guides* 526, Table 17-2.

the impartial medical examiner noted no award based on grip strength. Accordingly, the Board finds that appellant is not entitled to an impairment rating based on grip strength. With regard to pain, Dr. Diamond would have allowed a three percent impairment for pain. Dr. Smith commented that appellant's reports of pain were based entirely on subjective factors. The impartial medical examiner did not note an impairment due to pain, but did note that appellant experiences tingling in her fingers as well as some elbow pain. The Office medical adviser reviewed these reports and determined that appellant had some pain around her elbows and recommended that appellant be issued a schedule award for two percent of the left upper extremity based on pain alone pursuant to the A.M.A., *Guides*.¹¹ The Board finds that the Office medical adviser's opinion that appellant had no more than a two percent impairment of her left upper extremity based on the A.M.A., *Guides* is supported by the evidence of record and, in particular, the opinion of the impartial medical examiner who was retained to resolve the conflict in the evidence.

Appellant's attorney's argument that Dr. Dearolf's opinion is flawed because he did not take measurements with regard to, *inter alia*, appellant's range of motion is without merit as Dr. Dearolf found that appellant had full range of motion. Also, Dr. Dearolf found that appellant's lateral epicondylitis had resolved. Appellant's attorney also asserted that there was no proof that Dr. Dearolf, the impartial medical examiner, was selected properly from the physician director system pursuant to section 3.500.7 of the procedure manual.¹² However, he submitted no evidence to support his assertion that any particular aspect of the selection created bias. The Board has held that an impartial medical specialist properly selected under the Office's rotational procedures will be presumed unbiased and the party seeking disqualification bears the substantial burden of proving otherwise; mere allegations are insufficient to establish bias.¹³ Appellant's mere allegation that Dr. Dearolf was not properly selected does not establish the fact. Therefore, the Board finds this argument to be without merit.

CONCLUSION

The Board finds that appellant has not established that she has more than two percent impairment of her left upper extremity, for which she received a schedule award.

¹¹ *Id.* at 574, Figure 18-1.

¹² See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.7 (September 1995).

¹³ See *William Fidurski*, 54 ECAB 146 (2002).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 17, 2006 is affirmed.

Issued: November 26, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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