

2005 she realized it was employment related.¹ The Office accepted the claim for right carpal tunnel syndrome and authorized right carpal tunnel surgery, which was performed on August 19, 2005. By letters dated September 15 and October 3, 2005, the Office placed appellant on the periodic rolls for temporary total disability. Appellant returned to work on November 21, 2006.²

On February 12, 2007 appellant filed a claim for a schedule award for her right carpal tunnel condition.

On January 11, 2007 Dr. Bryce Benbow, a treating osteopath, reported full right elbow flexion, lacking 5 to 10 degrees of right elbow extension, negative wrist Tinel's sign, a negative wrist Phalen's test and 5/5 bilateral hand grip strength. He stated that appellant had "[s]ensory to light touch is intact in both upper extremities in the median and ulnar nerve distribution."

On January 22, 2007 Dr. Mike Shah, an examining Board-certified internist, provided findings on examination and diagnosed carpal tunnel syndrome and elbow ulnar neuropathy. He found a positive wrist Tinel's sign and "decreased sensation to two point discrimination in thumb, index and pinkie fingers by 50 percent." Range of motion of the right elbow included 140 degrees flexion, -18 degrees extension, 82 degrees supination and 90 degrees pronation." Right wrist range of motion included 70 degrees flexion, 60 degrees extension, 28 degrees ulnar deviation and 26 degrees radial deviation. Dr. Shah found that appellant had a total 16 percent impairment of her right upper extremity based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed.). Using Table 16-11, page 484 and Table 16-15, page 492, he concluded that appellant had five percent impairment for right ulnar motor loss based on a Grade 4 motor strength. Dr. Shah then found appellant had a 3 percent impairment for right ulnar sensory loss "[5 percent maximum ring finger using [T]able 16-15 page 492 times 10 percent for [G]rade 4 motor using Table 16-11 page 484]" Lastly, he found an 8 percent right upper extremity impairment for right median sensory loss "(16 percent maximum thumb and index finger using [T]able 16-15 page 492 times 50 percent for [G]rade 3 motor using Table 16-11 page 484)."

On February 16, 2007 the Office medical adviser reviewed the reports of the treating physicians, Drs. Benbow and Shah, and found a discrepancy in the physical findings regarding appellant's right hand motor and sensory deficits made by these treating physicians. He

¹ This was assigned claim number 16-2091550. The employing establishment noted appellant had three other compensation claims. Claim number 16-2072441 with a March 4, 2001 date of injury, claim number 16-2000600 with an August 1, 1999 date of injury and claim number 16-0333734 with an April 28, 1999 date of injury. The Office accepted appellant's April 28, 1999 claim left shoulder contusion and assigned it claim number 16-0333734. On August 17, 2001 it issued a schedule award for a nine percent permanent impairment of the left upper extremity. The Office accepted appellant's February 1, 2000 occupational disease claim for left carpal tunnel syndrome and left elbow neuritis on August 11, 2000 and authorized left carpal tunnel release surgery, which was performed on May 21, 2002. This was assigned claim number 16-2000600. On December 21, 2004 the Office issued a schedule award for a six percent permanent impairment of the left upper extremity.

² On January 31, 2007 the Office issued a loss of wage-earning capacity decision based upon appellant's modified mail handler job. It determined that appellant had no wage loss as her actual earnings met or exceeded the current wage of her date-of-injury job.

recommended referring appellant for a second opinion evaluation on appellant's current physical findings.

The Office referred appellant to Dr. Robert E. Holladay, a Board-certified orthopedic surgeon, for a second opinion medical evaluation. Dr. Holladay submitted an April 5, 2007 report, in which he provided an accurate factual medical background. He reported that physical examination of the right upper extremity revealed 70 degrees of elbow flexion, 24 degrees elbow extension, 80 degrees elbow supination and pronation bilaterally, 70 degrees wrist flexion and 60 degrees wrist extension. Dr. Holladay noted that appellant had normal opposition, abduction and adduction of the thumbs, a decreased sensation in the right median and ulnar distribution, a negative Tinel's sign and a negative bilateral Phalen's test. Using Figure 16-24, page 472 he determined that appellant had one percent impairment for 135 degrees flexion and two percent impairment for a -24 degrees extension for a total three percent impairment for right elbow range of motion. For appellant's right median and ulnar nerve distribution impairment, Dr. Holladay concluded that she had a five percent total impairment. In reaching this determination, he found:

“We go to page 492, [F]igure 16-15 and find the median nerve below the mid forearm -- the maximum sensory loss is 39 percent. We then got to page 482, [T]able 16-10 for grading of the sensory loss. [Appellant] will have a [G]rade-4 with the range of 1 [to] 25 percent. I will grade the sensory loss at 10 percent. We multiply the 39 percent for total sensory loss with the 10 percent grading which results in a 3.9 percent or round up to a 4 percent sensory loss on the median nerve.

“We return to 492, [T]able 16-15 and find the ulnar nerve below the mid forearm with a total sensory loss of seven percent. We then got to table 16-10 on page 482 and again grade the sensory loss at [G]rade-4 which I would assign 10 percent impairment. We multiply the 7 percent for total sensory loss with the 10 percent grading which results in a 0.7 percent which is rounded up to 1 percent impairment for ulnar sensory loss.”

Using the Combined Values Table at page 604, Dr. Holladay combined the four percent median sensory loss with the one percent ulnar sensory loss to find a total five percent sensory impairment. He then combined the five percent sensory impairment with the three percent loss of range of motion to find a total eight percent impairment of the right upper extremity.

The Office medical adviser reviewed Dr. Holladay's April 5, 2007 second opinion report on April 18, 2006 and agreed with his impairment determination.

By decision dated May 21, 2007, the Office granted appellant a schedule award for 24.96 weeks from April 5 to September 26, 2007 based on an eight percent impairment of the right upper extremity.

ISSUE -- CLAIM NUMBER 16-2072411

The issue is whether the Office properly denied appellant's request to expand her claim to include the condition of lipoma.

FACTUAL HISTORY --CLAIM NUMBER 16-2072411

On March 4, 2004 appellant filed a traumatic injury claim alleging that on the date she injured her left leg and thigh when a table fell on her left leg.³ The Office accepted the claim for left thigh contusion and left knee internal derangement.

On August 11, 2005 Dr. Benbow, a treating osteopath, diagnosed left leg lipoma. A physical examination revealed a six to seven centimeter swelling “inferior to her knee on the left.”

On September 9, 2005 Dr. R. Robert Ipolito, a treating Board-certified plastic surgeon with a subspecialty in hand surgery, noted appellant “sustained a crush injury to her left leg on the job” and had complaints of “a palpable mass and loss of contour to her left leg.” He diagnosed “status post crush injury to the left upper medial leg with mass measuring 6x4 c[enti]m[eters].”

On November 16, 2005 Dr. Farooq I. Selod, a second opinion Board-certified orthopedic surgeon, based upon an employment injury history, physical examination and review of the medical records, provided findings on examination. A physical examination revealed “a swelling that appears to be lipomatosis that measure three [inches] by three [inches] in size medially in the proximal third of the left.” In a December 1, 2005 report, Dr. Selod opined that appellant’s lipoma was unrelated to the March 4, 2004 employment injury. In a December 1, 2005 addendum, he opined that conditions related to the March 4, 2004 employment injury included left knee internal derangement and left thigh contusion.

On January 31, 2006 the Office referred appellant to Dr. Robert E. Holladay, a Board-certified orthopedic surgeon, to resolve the conflict in the medical opinion evidence between Dr. Selod and Dr. Benbow.⁴

On February 17, 2006 Dr. Holladay, based upon a physical examination, history and review of medical reports, concluded that appellant’s lipoma was unrelated to her accepted March 4, 2004 employment injury. A physical examination revealed “evidence of a mildly tender lipoma on the proximal and medial aspect of the left tibia.” Dr. Holladay opined that this condition was unrelated to the accepted March 4, 2004 employment injury as “[l]ipomas are commonly and frequently seen conditions of benign fatty tumors” which “are not caused by direct trauma.” He opined that it was “a coincidental finding in relationship to the contusion of the left lower extremity.”

In a decision dated December 6, 2006, the Office found the evidence insufficient to establish that appellant sustained a lipoma of her left knee due to the March 4, 2004 employment injury. It found the report of impartial medical examiner, Dr. Holladay, represented the weight of the evidence and, thus, denied her request to expand her claim to include the condition of a left leg lipoma.

³ This was assigned claim number 16-2072441.

⁴ The record does not contain a copy of the questions to be answered by the physician.

On March 5, 2007 appellant requested reconsideration and submitted a February 26, 2007 report by Dr. Benbow in support of her request. Dr. Benbow opined that appellant's "lipoma is more likely than not, to have resulted from the trauma that she sustained to her leg on [March] 4[, 20]04." In support of this conclusion, he stated:

"The location of the patient's pain and lipoma is the exact location of her initial injury. Lipomas can be insidious and take a while to develop and declare themselves. In other words, it can take weeks to months before they enlarge enough to become visible. This appears to be the case with [appellant] and accounts for why this was n[o]t diagnosed immediately. And most importantly it is well documented in the literature that **lipomas can be traumatic.**" (Emphasis in the original.)

By decision dated July 16, 2007, the Office denied appellant's request for modification on the denial of her request to expand her accepted March 4, 2004 employment injury to include the condition of lipoma.

LEGAL PRECEDENT -- CLAIM NUMBER 16-2091550

The schedule award provision of the Act⁵ and its implementing regulation⁶ 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.⁷ Effective February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁸

Section 8123(a) of the Federal Employees' Compensation Act provides in pertinent 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.⁹ When there are opposing reports of virtually equal weight and rationale, the case

⁵ 5 U.S.C. §§ 8101-8193.

⁶ 5 U.S.C. § 8107.

⁷ 20 C.F.R. § 10.404. See *J.C.*, 58 ECAB ____ (Docket No. 07-1165, issued September 21, 2007); *Thomas O. Bouis*, 57 ECAB 602 (2006).

⁸ 20 C.F.R. § 10.404; see *E.P.*, 58 ECAB ____ (Docket No. 07-1244, issued September 25, 2007); *Jesse Mendoza*, 54 ECAB 802 (2003).

⁹ 5 U.S.C. § 8123(a); *R.C.*, 58 ECAB ____ (Docket No. 06-1676, issued December 26, 2006); *Darlene R. Kennedy*, 57 ECAB 414 (2006).

must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.¹⁰

ANALYSIS -- CLAIM NUMBER 16-2091550

The Office accepted appellant's January 20, 2005 claim for right carpal tunnel syndrome and authorized right carpal tunnel surgery. The Board finds that the case is not in posture for decision due to a conflict in medical opinion between Dr. Shah, appellant's physician, and Dr. Holladay, the second opinion physician.

In a report dated January 27, 2007, Dr. Shah applied the A.M.A., *Guides* and determined that appellant had a 16 percent impairment of the right upper extremity due to combined motor and sensory impairments in her wrist and elbow and range of motion impairment in her ring finger. The Office referred appellant to Dr. Holladay who also applied the A.M.A., *Guides* finding that there was no impairment with regard to appellant's ring finger and a negative wrights Tinel's sign. Dr. Holladay found eight percent right upper extremity impairment based on sensory and motor deficits. The Office medical adviser agreed with Dr. Holladay's findings.

Both Dr. Shah and Dr. Holladay used the A.M.A., *Guides* in reaching their conclusions. However, their opinions conflict as to the ratings provided following physical examination of appellant. Dr. Shah found a positive wrist Tinel's sign and decreased sensation in the thumb, index and pinkie fingers. He also found appellant's right elbow range of motion to include 140 degrees flexion, 82 degrees, supination, -18 degrees extension, 90 degrees pronation and wrist range of motion to be 60 degrees extension, 70 degrees flexion, 26 degrees radial deviation and 28 degrees ulnar deviation. Dr. Holladay concluded that appellant had normal opposition, abduction and adduction of the thumbs and a negative Tinel's sign. He found appellant's range of motion to include 70 degrees elbow flexion, 24 degrees elbow extension, 80 degrees elbow supination and pronation bilaterally, 70 degrees wrist flexion and 60 degrees wrist extension. The Board finds that there is a conflict in medical opinion requiring further development of the medical evidence.

The case will be remanded to the Office to refer appellant to an appropriate impartial medical specialist for a determination regarding the extent of impairment to his upper extremities. After such development as the Office deems necessary, an appropriate decision should be issued regarding the extent of any impairment to her right upper extremity.

LEGAL PRECEDENT -- CLAIM NUMBER 16-2072411

To establish a causal relationship between the condition as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence based on a complete medical and factual background supporting such a causal relationship.¹¹ Causal relationship is a medical issue and the medical evidence required to

¹⁰ *M.S.*, 58 ECAB ____ (Docket No. 06-797, issued January 31, 2007).

¹¹ *M.W.*, 57 ECAB 710 (2006); *John D. Jackson*, 55 ECAB 465 (2004).

establish a causal relationship is rationalized medical evidence.¹² Rationalized medical evidence is evidence which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the diagnosed condition and the specific employment factors identified by the claimant.¹³ Neither the mere fact that a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.¹⁴

Section 8123(a) of the Federal Employees' Compensation Act provides in pertinent 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.¹⁵ When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.¹⁶

ANALYSIS -- CLAIM NUMBER 16-2072411

The Office accepted that appellant sustained a left thigh contusion and left knee internal derangement as a result of her accepted March 4, 2004 employment injury. The question on appeal is whether appellant sustained a lipoma on her left leg as a result of the March 4, 2004 employment injury

However, the Board notes that the Office incorrectly determined that a conflict existed as at the time of the referral there was no conflict in the medical opinion evidence on the issue of whether appellant's lipoma was employment related. Drs. Benbow, Ipollito and Selod all diagnosed a lipoma on the left leg. However, none of them addressed the issue of the cause of the lipoma. As there was no opinion addressing whether appellant's left leg lipoma was due to the accepted March 4, 2004 employment injury, there was no conflict at the time of the referral to Dr. Holladay. As there was no conflict in the medical opinion evidence, Dr. Holladay is a second opinion referral physician rather than an impartial medical specialist.

On February 17, 2006 Dr. Holladay, based upon a physical examination, history and review of medical reports, concluded that appellant's lipoma was unrelated to her accepted March 4, 2004 employment injury. In support of this conclusion, he stated that "[l]ipomas are commonly and frequently seen conditions of benign fatty tumors" and "are not caused by direct trauma." Dr. Holladay concluded that it was "a coincidental finding in relationship to the contusion of the left lower extremity."

¹² *D.E.*, 58 ECAB ____ (Docket No. 07-27, issued April 6, 2007); *Mary J. Summers*, 55 ECAB 730 (2004).

¹³ *Phillip L. Barnes* 55 ECAB 426 (2004); *Leslie C. Moore*, 52 ECAB 132 (2000).

¹⁴ *V.W.*, 58 ECAB ____ (Docket No. 07-234, issued March 22, 2007); *Ernest St. Pierre*, 51 ECAB 623 (2000).

¹⁵ 5 U.S.C. § 8123(a); *R.C.*, *supra* note 9; *Darlene R. Kennedy*, *supra* note 9.

¹⁶ *M.S.*, *supra* note 10.

In a February 26, 2007 report, Dr. Benbow opined that appellant's lipoma was due to the March 4, 2004 employment-related injury. In support of this conclusion, he noted that "it is well documented in the literature that **lipomas can be traumatic.**" (Emphasis in the original.) Moreover, the location of the lipoma and appellant are indicative that the condition occurred as a result of the March 4, 2004 employment injury. Dr. Benbow related that "[l]ipomas can be insidious and take a while to develop and declare themselves," which is what occurred in appellant's case.

The Board finds a conflict in the medical opinion between Dr. Benbow and Dr. Holladay.¹⁷ Dr. Benbow found that appellant's left leg lipoma was causally related to her March 4, 2004 employment injury. Dr. Holladay opined that appellant's left leg lipoma was unrelated to the March 4, 2004 employment. The Board will remand the case to the Office for appropriate development of the medical record to determine whether appellant's left leg lipoma was causally related to her March 4, 2004 employment injury. On remand, the Office should prepare a statement of accepted facts and a list of questions and refer appellant to an appropriate Board-certified physician for an impartial medical opinion. Following this and any other further development as deemed necessary, the Office shall issue an appropriate decision on appellant's claim.

CONCLUSION

The Board finds that this case is not in posture for decision due to a conflict in the medical evidence on the degree of impairment of appellant's right upper extremity. The Board also finds that the case is not in posture for decision due to an unresolved conflict in the medical opinion evidence on whether appellant's left leg lipoma is a result of her accepted March 4, 2004 employment injury

¹⁷ *Bryan O. Crane*, 56 ECAB 713 (2005).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated July 16 and May 21, 2007 are set aside and the case remanded for further proceedings consistent with the above opinion.

Issued: October 16, 2008
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