



electrical connector. By letter dated February 25, 1999, the Office accepted his claim for electrical shock to the left elbow.<sup>1</sup> The Office paid appropriate benefits.

In a progress note dated April 20, 1999, Dr. Peter V. Ciani, appellant's treating Board-certified family practitioner, indicated that appellant had "resolved epicondylitis" and "100 percent improvement." However, he did note in his May 1, 2000 report that subsequently appellant had flare-ups of his right epicondylitis.

On January 4, 2001 appellant filed a claim for a schedule award. In a medical report of an examination conducted on March 7, 2001, Dr. Ciani noted that appellant had "chronic right elbow epicondylitis secondary to more probably than not thermal injury from electric shock" caused by the injury of December 29, 1998. He noted that appellant's right elbow had palpable tenderness over the lateral epicondyle with full range of motion in the elbow. He further noted:

"To resistive pronation and supination there is increased tenderness. Lateral pinch is measured at 6.8 kg [kilograms] on the right and 13.6 kg [kilograms] on the left. Grip is measured at 22 kg on the right and 54 kg on the left. This was at the second position of Jamar dynamometer. Enclosed are computerized measurements of forearm pronation and supination. Forearm supination on the right is 25-pounds maximum, on the left 43-pounds maximum. Forearm pronation is 33-pounds bilaterally. No atrophy or neurologic signs are elicited."

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"Using the [American Medical Association,] *Guides to the Evaluation of Permanent Impairment*, Fifth Edition, and calculating strength loss based on grip measurements equals 54 percent and strength loss based on computerized pronation equals 41 percent. Using [T]able 16.34 on page 509, his strength loss index equals a 20 percent upper extremity joint impairment and referring to [T]able 16.8 on page 499, 0.20 times 0.70 equals .14 upper extremity impairment or 14 percent. Calculating whole person impairment would be 0.20 times 0.42 equals .084 or eight percent whole person impairment."

The Office asked the Office medical adviser to determine appellant's functional loss of the right arm for schedule award purposes. By memorandum dated June 8, 2001, the Office medical adviser indicated:

"The date of maximal medical improvement is April 20, 1999 according to Dr. Ciani, in which his report states 'resolved epicondylitis'. He says that to resistive testing grip was remeasured at 60 kg bilaterally with no pain. It would be inexplicable why this condition would deteriorate between that time and the time of his examination of March 7, 2001, nearly two years later. The impairment rating for epicondylitis that was given by Dr. Ciani of 14 percent appears high, 20

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<sup>1</sup> A subsequent note in the record indicates that the initial reports were incorrect and that appellant's injury was actually to his right elbow.

percent which is my calculation was according to his notes would also appear high for this particular condition.”

The Office medical adviser opined that it would be appropriate to have an impartial medical examination to assess appellant’s grip strength due to the fact that this condition was resolved two years before the recent examination and also that the expectation of this much impairment from epicondylitis is highly unlikely, especially when appellant had normal grip strength two years earlier.

By letter dated April 25, 2002, the Office referred appellant to Dr. William Thieme, a Board-certified orthopedic surgeon, for an impartial medical examination. In a report dated May 9, 2002, Dr. Thieme opined:

“Despite the fact that a diagnosis of lateral epicondylitis has been made in the past and carried through the record, the picture now does not appear to be a lateral epicondylitis. Rather, it appears the injury was to the origin of the common extensors and was probably a thermal injury. This examiner believes the apparent diminution in grip strength in the right hand is probably volitional rather than objective. This is reflected in the fact that the extreme variation in the measurements I obtained, even in the presumably sound left upper extremity and also the lack of measured muscle wasting in the right upper extremity. Further, the patient’s complaint of sensory loss in the right upper extremity does not conform to anatomic nerve distribution. For these reasons, I believe an estimation of permanent impairment cannot be reasonably based on strength measurements. Since the patient’s continuing problems are with pain and tenderness, I believe it’s appropriate to determine the impairment of the upper extremity according to the description of pain. Accordingly, I refer to Table 16-10 page 482 in the A.M.A. Guides to the Evaluation of Permanent Impairment, Fifth Edition. From that I judge that the patient’s grade is Grade III due to slight pain that interferes with some activities. I judge the sensory deficit to be 50 percent and according to Table 16-15 on page 492, I find that the maximum percent of upper extremity impairment due to sensory deficit or pain of the radial nerve at the elbow with sparing of the triceps is 5 percent. Multiplying 5 percent by 50 percent yields an impairment of 2.5 percent. In summary, I believe the patient has a work-related injury to the right elbow, which I judge to have a permanent impairment of 2.5 percent.

In response to an Office query, Dr. Thieme indicated that the award for impairment should be for the right upper extremity and that the date of maximum medical improvement was August 20, 1999.

By memorandum dated April 15, 2004, the Office requested that the Office medical adviser determine the functional loss of the right upper extremity for schedule award purposes. By letter dated April 19, 2004, the Office medical adviser indicated:

“The injury was due to 1000 volts DC to the lateral aspect of the right elbow. Rating is based on exam by Dr. Thieme on May 9, 2002 and the fifth edition of the [A.M.A., *Guides*]. Previous rating was based on epicondylitis and Dr. McCollum August 8, 2001 stated he could not see any rationale as to why an electrical shock would cause epicondylitis. Loss of muscle strength cannot be rating in the presence of painful conditions and is used when there is due to actual muscle injury (508). The weakness in the right arm grip was not reproducible and Dr. Thieme stated was volitional. There was some numbness in thenar eminence of the right hand. He rated on basis of pain and sensory loss which is a reasonable injury from electrical injury. Rating was based on [G]rade 3 sensory deficit to the radial nerve (distorted superficial tactile sensibility -- diminished light touch and two point discrimination with some abnormal sensations or slight pain [T]able 16-10, p 482). Grade 3 is estimated at 50 percent ([T]able 16-10, p. 482) times the maximum sensory deficit to the radial nerve with sparing of the triceps of five percent ([T]able 16-10, p 482) times the maximum sensory deficit to the radial nerve with sparing of the triceps of five percent ([T]able 16-15, p. 492) which equals 2.5 percent or round to 3 percent. There was no rating on basis of epicondylitis or muscle strength deficit.

[MAXIMUM MEDICAL IMPROVEMENT] OCCURED AUGUST 20, 1999. THERE IS [A] 3 PERCENT IMPAIRMENT OF THE RIGHT UPPER EXTREMITY. THE DETERMINATION OF DR. THIEME IS REASONABLE AND CONFIRMED.” (Emphasis in the original.)

By decision dated May 11, 2004, the Office issued a schedule award of three percent impairment of the right arm.

### **LEGAL PRECEDENT**

The schedule award provision of the Federal Employees’ Compensation Act<sup>2</sup> and its implementing regulation<sup>3</sup> sets 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

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<sup>2</sup> 5 U.S.C. § 8107(a)-(c).

<sup>3</sup> 20 C.F.R. § 10.404.

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.<sup>4</sup>

It is well established that, when 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.<sup>5</sup>

### ANALYSIS

In the instant case, the Office properly determined appellant's entitlement to a schedule award based on the opinion of the impartial medical examiner, Dr. Thieme, as interpreted by the Office medical adviser. Appellant's physician, Dr. Ciani, rated appellant with 14 percent permanent impairment of the right elbow based on strength loss. However, the Office medical adviser noted that Dr. Ciani, in his April 20, 1999 report, indicated "resolved epicondylitis" with resistive testing grip measured at 60 kg bilaterally with no pain. The Office medical adviser noted that it would be inexplicable why appellant's condition would deteriorate between that time and the time of Dr. Ciani's March 7, 2001 examination.

The Office medical adviser recommended an impartial medical examination to assess the grip strength based on the fact that the condition was resolved two years before appellant's examination and also that the expectation of this much impairment from epicondylitis is highly unlikely.

In order to resolve the conflict between Dr. Ciani and the Office medical adviser, appellant's case was referred to an impartial medical examiner, Dr. Thieme, who noted that the apparent diminution in grip strength in the right hand was probably volitional rather than objective, and that appellant's complaint of sensory loss in the right upper extremity does not conform to anatomic nerve distribution. Because of these issues, Dr. Thieme believed that a permanent impairment could not reasonably be based on strength measurements; he recommended that appellant's award be based on his pain and tenderness. Dr. Thieme noted that pursuant to Table 16-10, page 482 of the A.M.A., *Guides*, appellant had a classification of Grade 3 pain based on slight pain that interferes with some activities. The A.M.A., *Guides*, allow percentage of sensory deficit based on grade three between 26 percent and 60 percent; Dr. Thieme estimated appellant's sensory deficit at 50 percent. Dr. Thieme then properly noted that the maximum percent of upper extremity impairment due to sensory deficit or pain of the radial nerve at the elbow with sparing of the triceps is five percent, pursuant to Table 16-15, page 492 of the A.M.A., *Guides*. Multiplying 5 percent by 50 percent he noted that appellant had an impairment rating of 2.5 percent to the right elbow. A different Office medical adviser then reviewed appellant's case and his calculations coincided with those of Dr. Thieme; however, the Office medical adviser rounded the 2.5 impairment figure up to 3 percent impairment, the amount of the schedule award issued by the Office. Dr. Thieme's opinion as interpreted by the Office medical adviser constitutes the weight of the medical evidence. Dr. Ciani does not explain why appellant's condition deteriorated after his April 20, 1999 examination.

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<sup>4</sup> See *Mark A. Holloway*, 55 ECAB \_\_\_\_ (Docket NO. 03-2144, issued February 13, 2004).

<sup>5</sup> *Jacqueline Brash*, 52 ECAB 252, 254 (2001); *Harrison Combs, Jr.*, 45 ECAB 716, 727 (1994).

Furthermore, as Dr. Thieme was the impartial medical examiner, his opinion is entitled to special weight.

**CONCLUSION**

Appellant has not established that he sustained an impairment to his right arm of greater than three percent.

**ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated May 11, 2004 is hereby affirmed.

Issued: December 9, 2004  
Washington, DC

Colleen Duffy Kiko  
Member

Willie T.C. Thomas  
Alternate Member

A. Peter Kanjorski  
Alternate Member