

for right shoulder strain, rotator cuff tear, right rotator cuff repair, right carpal tunnel syndrome and right carpal tunnel release. Appellant received appropriate compensation benefits.¹

In an October 5, 1998 report, Dr. Kevin E. McGovern, a treating physician and a Board-certified orthopedic surgeon, opined that appellant's right rotator cuff tear and right carpal tunnel syndrome were surgically corrected and that she was capable of returning to full duty. Appellant subsequently requested a schedule award.

On January 8, 2001 the Office referred appellant for a second opinion, along with a statement of accepted facts, a set of questions and the medical record to Dr. German H. Nader, a Board-certified orthopedic surgeon.

In an undated report, Dr. Nader described appellant's history of injury and treatment, and provided an impairment rating in which he advised that she was entitled to an award of 17 percent to the right upper extremity. He explained that he arrived at this rating by noting that appellant had median nerve residuals at the wrist and that, according to Table 16 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001) (A.M.A., *Guides*), appellant would receive 10 percent. Furthermore, Dr. Nader advised that, because appellant had weakness in the rotator cuff comprised of a Grade 4 for a motor deficit, then appellant would be entitled to 25 percent according to Table 12. He further explained that, according to Table 13, appellant had a 30 percent motor deficit which would result in a 7 percent impairment of the upper extremity. Dr. Nader determined that this would equate to a total of a 17 percent impairment of the upper extremity and opined that appellant reached maximum medical improvement six months post surgery or repair.

On April 1, 2003 the Office medical adviser determined that appellant was entitled to an impairment of 20 percent to the right upper extremity. He noted that appellant was entitled to an impairment of 10 percent for her right rotator cuff tear according to Table 16-18² and 10 percent for her carpal tunnel syndrome according to Table 16-15.³

In a decision dated May 19, 2003, the Office granted appellant a schedule award for 20 percent impairment of the right upper extremity. The award covered a period of 62.40 weeks from May 9, 2001 to July 19, 2002.

On June 11, 2003 appellant requested a hearing.

In a June 6, 2003 report, Dr. Hampton J. Jackson, a Board-certified orthopedic surgeon and treating physician, explained that he did not understand Dr. Nader's impairment rating. He referred to the A.M.A., *Guides* and determined that appellant was entitled to an impairment of 26 percent to the right upper extremity for the right shoulder and a 42 percent impairment due to carpal tunnel syndrome.

¹ The Office subsequently found that the work-related disability had ceased effective January 30, 2000.

² A.M.A., *Guides* 499.

³ *Id.* at 492.

In a September 17, 2003 electromyography (EMG) scan and nerve conduction velocity (NCV) study, Dr. Daniel R. Ignacio, a Board-certified physiatrist, determined that appellant had borderline distal sensory latencies of the right median nerve with normal proximal conduction velocity across the right shoulder, normal NCV of bilateral ulnar and radial nerves and abnormal EMG findings with evidence of denervation of the selected muscles of the right arm, shoulder and cervical paraspinal muscles along the right C5 and C6 distribution. He also indicated that appellant had right C5-6 nerve root irritation and chronic stable right carpal tunnel syndrome with improvement compared to a previous nerve conduction study.

In a November 3, 2003 decision, the Office hearing representative set aside the May 19, 2003 schedule award for further development. He found that the Office medical adviser's report was incomplete as no medical examination findings were utilized to determine appellant's impairment.

On November 25, 2003 the Office medical adviser explained that the recent diagnostic studies of Dr. Ignacio were not considered reliable or independent. He recommended referral to a physician not associated with appellant's treating physician. The Office medical adviser noted that, in order to rate the right rotator cuff tear, actual measured ranges of motion were required.

On January 9, 2004 the Office referred appellant, together with a statement of accepted facts and the medical record, to Dr. Michael Joly, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve a conflict in opinion between Dr. Jackson and Dr. Nader regarding the percentage of impairment to her right upper extremity.

In an April 7, 2004 report, Dr. Joly noted appellant's history of injury and treatment and conducted an examination. He determined that there was no clinical evidence of right wrist impairment despite the EMG/NCV studies documenting persistent carpal tunnel syndrome. Dr. Joly noted that appellant's right wrist was "doing very well." He indicated that appellant had minimal limitation of right shoulder function and explained that the majority of appellant's present symptoms appeared to be cervical in nature. Dr. Joly opined that the evidence did not support an additional impairment of the right arm. He explained that there was no clinical evidence of right wrist impairment and that appellant's residual right upper extremity weakness and decreased sensation did not follow a dermatomal pattern. Dr. Joly explained that an additional impairment rating should not be based on EMG/NCV studies as they "tended to be abnormal after successful surgery for carpal tunnel syndrome." He opined that appellant had a nine percent impairment of the right upper extremity based upon the A.M.A., *Guides* and reached maximum medical improvement related to her rotator cuff repair in November 1989 and in February 1997 after her right carpal tunnel release. Dr. Joly explained that appellant had only a slight restriction in her range of motion which would warrant a four percent impairment because she had 130/30 degrees for flexion to extension and referred to Figures 16-38, 39 and 40.⁴ He advised that appellant would be entitled to three percent because of limited abduction to adduction of 130/30 degrees and referred to Figures 16-41, 42 and 43.⁵ Dr. Joly

⁴ *Id.* at 475, 476.

⁵ *Id.* at 477.

also explained that appellant would be entitled to an impairment of two percent for slightly restricted external rotation to internal rotation of 60/30 and referred to Figures 16-44, 45 and 46.⁶

In a June 14, 2004 report, the Office medical adviser reviewed the report of Dr. Joly. He noted that appellant reached maximum medical improvement on April 7, 2004. The Office medical adviser noted that the only ratable impairment described by Dr. Joly for the right shoulder was restricted range of motion. He noted that flexion of the right shoulder of 130 degrees was equal to a three percent permanent impairment and that extension of the right shoulder of 30 degrees warranted a one percent permanent impairment of the right upper extremity pursuant to Figure 16-40.⁷ The Office medical adviser noted that a reduction of the right shoulder of 130 degrees warranted a two percent permanent impairment of the right upper extremity pursuant to Figure 16-43.⁸ He referred to Figure 16-46⁹ and indicated that external rotation of 60 degrees was equal to a zero percent permanent impairment of the right upper extremity, whereas internal rotation of 30 degrees was equal to a two percent permanent impairment of the right upper extremity. Regarding the wrist, the Office medical adviser referred to Figure 16-28 and 31¹⁰ and noted that appellant had dorsiflexion and plantar flexion of 60 degrees, radial deviation of 20 degrees and ulnar deviation of 30 degrees, which did not indicate entitlement to impairment. He explained that the total percentage “in aggregate” allowed for a 10 percent permanent impairment of the right upper extremity, which differed from the impartial medical examiner by 1 percent but explained that this was “allowable in the statistical scheme of things.”

By decision dated June 17, 2004, the Office denied appellant’s request for an additional schedule award.

On July 16, 2004 appellant requested an oral hearing, which was held on December 7, 2004.

In an October 15, 2004 report, Dr. Jackson opined that he did not believe that there was any significant change from his examination and ratings given on June 6, 2003. He noted that the strength index for appellant was equivalent to a 20 percent impairment of the right upper extremity and was the same for pinch of only two kilograms. Furthermore, Dr. Jackson noted that appellant had another 20 percent impairment of her right upper extremity and concurred with Dr. Nader’s findings. He explained that, pursuant to Table 16, appellant was entitled to a 10 percent impairment, Table 12 a 25 percent impairment, and Table 13 with a 30 percent impairment.¹¹ Dr. Jackson referred to page 604 of the A.M.A., *Guides* and opined that this would correlate to a 42 percent impairment of the right arm. He opined that his calculations remained

⁶ *Id.* at 478, 479.

⁷ *Id.* at 476.

⁸ *Id.* at 477.

⁹ *Id.* at 479.

¹⁰ *Id.* at 467, 469.

¹¹ He did not refer to the specific chapter that he was utilizing in the A.M.A., *Guides*.

the same for the impairment of the right shoulder, which: was an additional 26 percent impairment and when combined with the 42 percent, the total impairment of the shoulder, hand and wrist condition equated to 57 percent of the right arm. In a December 2, 2004 report, Dr. Jackson opined that his opinion remained that appellant was entitled to an impairment of 57 percent due to the multiple injuries she received from the work injury.

By decision dated March 1, 2005, the Office hearing representative affirmed the June 17, 2004 decision. The Office hearing representative found the report of Dr. Joly represented the special weight of medical opinion. Furthermore, he found that the reports of Dr. Jackson were insufficient to overcome the special weight or to create a new conflict with that of Dr. Joly, the impartial medical examiner.

On July 19, 2005 appellant, through her attorney, requested reconsideration.

In a January 6, 2005 report, Dr. Jackson noted that he had previously evaluated appellant and recommended an impairment of 57 percent to the right upper extremity and noted that appellant also had a separate impairment for “pain alone.” He explained that appellant had findings in the right shoulder, right elbow, right hand and wrist that were persistent. There was no change in appellant’s grip strength and lateral pinch strength. Dr. Jackson noted that his findings were the same and that he had “rereferred to the fifth guides to the evaluation of permanent impairment published by the [A.M.A., *Guides*] and reconsulted Table 16-31 through Table 16-34 for calculating physical impairment based on loss of strength specifically grip and lateral pinch strength.” He explained that his ratings were still the same and opined that appellant had a 20 percent impairment of the arm for loss of grip strength and a 20 percent impairment of the right arm for loss of lateral pinch strength. Dr. Jackson referred to Tables 16-31 to 16-34.¹² He also indicated that, for her loss of strength and lateral pinch, appellant was entitled to a 40 percent impairment of the arm. Dr. Jackson also noted that appellant had “observable pain behaviors.” They included that appellant held and supported her affected arm, frequent shifts of posture, and moving in a guarded and protected fashion. Dr. Jackson determined that her global pain behavior warranted a score of five and completed Table 18-4¹³ to determine appellant’s impairment associated with pain, Dr. Jackson explained that appellant had a total pain-related impairment score of 55.04 according to Table 18-6 and 18-7¹⁴ and advised that appellant was in the second highest impairment class titled moderately severe impairment and opined that her “pain is totally related. This patient only has pain in her right upper extremity.” Dr. Jackson also noted that appellant continued to be entitled to 6 percent for instability and a 20 percent impairment according to Table 16-35¹⁵ due to loss of strength in the flexion, extension, abduction, internal rotation and external rotation. Dr. Jackson opined that the total combined impairment of appellant’s right upper extremity was equal to 76 percent.

¹² *Id.* at 509.

¹³ *Id.* at 576, 577.

¹⁴ *Id.* at 584.

¹⁵ *Id.* at 510.

In an October 12, 2005 report, the Office medical adviser reviewed the medical records, noting that the basis for appellant's impairment rating was due to loss of motion in her shoulder. He noted that flexion was equal to 130 degrees and resulted in a three percent impairment with extension of 30 degrees resulting in one percent impairment. The Office medical adviser noted that abduction of 130 degrees resulted in a two percent impairment, while adduction to 30 degrees resulted in a one percent impairment. He also indicated that external rotation to 60 degrees resulted in zero percent impairment while internal rotation to 30 degrees resulted in four percent impairment. The Office medical adviser explained that this would result in a total impairment of 11 percent to the right upper extremity for loss of motion at the shoulder. He referred to Figures 16-40, 16-43 and 16-46.¹⁶ The Office medical adviser explained that appellant was not entitled to any impairment for her carpal tunnel syndrome. He referred to Chapter 16 of the A.M.A., *Guides*,¹⁷ the paragraph on carpal tunnel syndrome and explained that there was no basis for an impairment rating for any residuals due to entrapment of the median nerve related to appellant's carpal tunnel syndrome because there was no documentation on EMG and nerve conduction studies of any residuals of the carpal tunnel syndrome. Furthermore, the Office medical adviser explained that wrist ranges of motion submitted by Dr. Joly were normal. He noted that Dr. Hampton submitted an impairment rating for loss of grip strength, but explained that loss of grip strength could not be considered to be an additional impairing factor in rating carpal tunnel syndrome. The Office medical adviser explained that the "only basis for rating an impairment for carpal tunnel syndrome is residual entrapment of the median nerve itself" and there was no evidence of any residual entrapment of the median nerve. He opined that appellant's total impairment rating was 11 percent and that appellant did not have any increase in impairment beyond the 20 percent which was previously awarded.

By decision dated November 28, 2005, the Office denied modification of the March 1, 2005 decision.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act¹⁸ sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.¹⁹ The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.²⁰ The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.²¹

¹⁶ *Id.* at 476, 477, and 479.

¹⁷ *Id.* at 495.

¹⁸ 5 U.S.C. §§ 8101-8193.

¹⁹ 5 U.S.C. § 8107.

²⁰ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

²¹ A.M.A., *Guides* (5th ed. 2001); 20 C.F.R. § 10.404.

Section 8123(a) of the 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.²² 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.²³ In situations where a case is referred to an impartial medical specialist for the purpose of resolving a conflict in medical opinion, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, will be given special weight.²⁴

In a situation 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.²⁵

ANALYSIS

The Office accepted that appellant sustained an employment-related right shoulder strain, right rotator cuff repair, right carpal tunnel syndrome and right carpal tunnel release. In a decision dated May 19, 2003, the Office granted appellant a schedule award for 20 percent impairment of the right upper extremity. However, on November, 3, 2003, the Office hearing representative set aside the Office's May 19, 2003 schedule award decision. A conflict subsequently arose regarding the extent of appellant's impairment between appellant's treating physician, Dr. Jackson, who opined that appellant was entitled to an impairment of 57 percent to the right upper extremity and Dr. Nader, the second opinion physician, who opined that appellant was entitled to 17 percent impairment to the right upper extremity. The Office and appellant were referred for an impartial medical examination with Dr. Joly, a Board-certified orthopedic surgeon.

In an April 7, 2004 report, Dr. Joly conducted a physical examination and advised that there was no clinical evidence of right wrist impairment despite the EMG/NCV studies documenting persistent carpal tunnel syndrome. He explained that EMG/NCV studies "tended to be abnormal after successful surgery for carpal tunnel syndrome" and noted that her right wrist was "doing very well." Dr. Joly also determined that appellant had minimal limitation of right shoulder function, and noted that appellant's residual right upper extremity weakness and decreased sensation did not follow a dermatomal pattern. He noted that appellant only had a slight restriction in her range of motion of the right shoulder which was equal to 130/30 degrees for flexion to extension and advised that this would equate to a four percent impairment according to Figures 16-38, 39 and 40.²⁶ Dr. Joly advised that appellant would be entitled to

²² 5 U.S.C. § 8123(a).

²³ *Williams C. Bush*, 40 ECAB 1064, 1975 (1989).

²⁴ *See Jaja K. Asaramo*, 55 ECAB 200 (2004).

²⁵ *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232, 238 (1988); *Harold Travis*, 30 ECAB 1071, 1078 (1979).

²⁶ A.M.A., *Guides* 475, 476.

three percent because of limited abduction to adduction of 130/30 degrees and referred to Figures 16-41, 42 and 43.²⁷ He also explained that appellant would be entitled to an impairment of two percent for slightly restricted external rotation to internal rotation of 60/30 and referred to Figures 16-44, 45 and 46.²⁸ However, for 30 degrees of internal rotation, the Board notes that appellant would be entitled to an impairment of four percent instead of the noted two percent.²⁹ While Dr. Joly opined that appellant had a nine percent permanent impairment of the right upper extremity based upon the A.M.A., *Guides*, the Board notes that, with the error related to the value for 30 degrees of internal rotation, appellant would be entitled to an additional 2 percent and thus his calculation amounted to an impairment of 11 percent to the right upper extremity. The Board finds that Dr. Joly's report is based upon a proper factual background and sufficiently well rationalized such that it is entitled to special weight and establishes that appellant was entitled to an impairment of 11 percent to the right upper extremity.

The Office medical adviser utilized the report of Dr. Joly and noted that appellant reached maximum medical improvement on April 7, 2004. He concurred with the findings provided by Dr. Joly and explained that the only ratable condition that appellant was entitled to receive was for the right shoulder, due to restricted range of motion. As noted above, the Office medical adviser's findings corresponded with those of Dr. Joly, who was accorded the special weight, and indicate that appellant was not entitled to receive any further impairment.

Appellant subsequently submitted additional reports dated October 15, 2004 and January 6, 2005 from Dr. Jackson who essentially reiterated his previous findings. The Board notes that a subsequently submitted report of a physician on one side of a resolved conflict of medical opinion is generally insufficient to overcome the weight of the impartial medical specialist or to create a new conflict of medical opinion.³⁰ Dr. Jackson did not provide sufficient explanation for the opinions he expressed. The Board, therefore, finds that these reports are insufficient to establish entitlement to a greater impairment. In his January 6, 2005 report, Dr. Jackson added that appellant was entitled to a 20 percent impairment of the upper extremity for loss of grip strength and a 20 percent impairment of the right upper extremity for loss of lateral pinch strength and referred to Tables 16-31 to 16-34.³¹ However, the A.M.A., *Guides* provides that "in compression neuropathies, additional impairment values are not given for decreased grip strength."³² Additionally, the A.M.A., *Guides* provides that loss of strength may be rated separately if such a deficit has not been considered adequately by other rating methods.

²⁷ *Id.* at 477.

²⁸ *Id.* at 478, 479.

²⁹ The Board notes that this is harmless error, as the total impairment allotted would equate to 11 percent, and does not show that appellant would be entitled to an increased impairment over the 20 percent that she had previously received.

³⁰ *Richard O. Brien*, 53 ECAB 234 (2001).

³¹ A.M.A., *Guides* 509.

³² See page 494, the fifth edition of the A.M.A., *Guides*; see also *Robert V. Disalvatore*, 54 ECAB 351 (2003) (where the Board found that the fifth edition of the A.M.A., *Guides* provides that impairment for carpal tunnel syndrome be rated on motor and sensory impairments only).

An example of this situation would be loss of strength caused by a severe muscle tear that healed leaving a palpable muscle defect. If the rating physician determines that loss of strength should be rated separately in an extremity that presents other impairments, the impairment due to loss of strength could be combined with the other impairments, only if based on unrelated etiologic or pathomechanical causes. Otherwise, the impairment ratings based on objective anatomic findings take precedence. The A.M.A., *Guides* further provides that decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximum force. A.M.A., *Guides* 508, section 16.8a.

He also noted that appellant was entitled to a rating for pain and referred to Chapter 18 and Table 18-4,³³ to determine appellant's impairment associated with pain. However, according to section 18.3(b) of the A.M.A., *Guides*, "examiners should not use this chapter to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*."³⁴ Office procedures provide that Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain (Chapters 13, 16 and 17).³⁵ As noted, Dr. Jackson was previously on one side of the conflict, and his report is generally insufficient to overcome the weight of the impartial medical specialist or to create a new conflict of medical opinion.³⁶ Dr. Jackson did not provide sufficient explanation for the opinions he expressed.

The Office medical adviser reviewed the medical evidence and found no basis to attribute additional impairment. He explained the range of motion findings, which as noted above, totaled no more than 11 percent to the right upper extremity.³⁷ The Office medical adviser further explained that appellant was not entitled to any impairment for her carpal tunnel syndrome and referenced Chapter 16 of the A.M.A., *Guides*. The Board notes that Office procedures³⁸ provide that upper extremity impairment secondary to carpal tunnel syndrome and other entrapment neuropathies should be calculated using section 16.5d and Tables 16-10, 16-11 and 16-15.³⁹ The Office medical adviser explained that there was no basis for an impairment rating for any residuals due to entrapment of the median nerve at the wrist related to appellant's carpal tunnel syndrome because there was no reliable documentation on EMG and nerve conduction studies of any residuals of the carpal tunnel syndrome. Furthermore, the Office medical adviser explained that the measured ranges of motion submitted by Dr. Joly were normal at the wrist. Furthermore, he noted that appellant's physician failed to provide any specific basis for his impairment rating.

³³ A.M.A., *Guides* 576, 577.

³⁴ *Id.* at 571, Section 18.3b (5th ed. 2001); see *Richard B. Myles*, 54 ECAB 379 (2003).

³⁵ See FECA Bulletin 01-05 (issued January 31, 2001): Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

³⁶ *Richard O Brien*, 53 ECAB 234 (2001).

³⁷ He referred to Figures 16-40, 16-43 and 16-46.³⁷

³⁸ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808 (August 2002) (March 1995).

³⁹ A.M.A., *Guides* 491, 482, 484, 492, respectively; *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

There is no other evidence of an additional impairment as a result of any of appellant's accepted conditions. Accordingly, the Board finds that the evidence supports that appellant has an eleven percent impairment of the right upper extremity. She has not established entitlement to a schedule award greater than the 20 percent awarded by the Office.

CONCLUSION

The Board finds that appellant does not have more than a 20 percent impairment of her right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 28, 2005 is hereby affirmed.

Issued: March 20, 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