

On November 17, 2003 appellant's attending physician, Dr. Arthur Vasen, a Board-certified orthopedic surgeon, performed a left nerve tenosynovectomy in the forearm and left ulnar nerve decompression in the forearm with neurolysis in the forearm.

Dr. Lance A., a Board-certified orthopedic surgeon, performed a second opinion evaluation on behalf of the Office on April 21, 2004. He reviewed the statement of accepted facts and noted that appellant was unable to flex his second, third and fifth fingers and attributed these findings to his employment injury. Dr. Markbrieter recommended that appellant seek a consultation with a hand specialist.

On December 16, 2005 Dr. Michael Coyle, a Board-certified orthopedic surgeon, performed a neurolysis of the median and ulnar nerves in the left forearm, fasciotomy of muscle herniation flexor digitorum superficialis ring finger and muscle belly left forearm, extensor tenolysis and tenosynovectomy of forearm flexor tendons, flexor carpi radialis, flexor carpi ulnaris, flexor pollicis longus, flexor digitorum superficialis, index, middle, ring and little fingers and flexor digitorum profundus index, middle, ring and little fingers.

In a report dated March 23, 2006, Dr. Coyle stated that appellant had reached maximum medical improvement and could resume full activities. He noted that appellant had numerous complaints including pain in his left shoulder, but demonstrated full range of motion in his left shoulder, elbow, wrist and hand. Dr. Coyle stated that appellant had minimal swelling in his distal forearm secondary to his surgery and that he moved his fingers well with full flexion and extension. He noted that appellant became upset when informed that he could return to work and opined that appellant had strong psychological overlay with symptom magnification.

By decision dated August 23, 2006, the Office terminated appellant's compensation benefits effective August 6, 2006. Appellant, through his attorney, requested an oral hearing. He withdrew this request on January 23, 2007.

In a report dated October 11, 2006, Dr. David Weiss, an osteopath, examined appellant and provided a history of injury. He noted that appellant reported left forearm, hand, little, middle and index finger pain and swelling daily. Dr. Weiss found that appellant had an abnormal left fist presentation lacking five centimeters (cm) of closure to the distal palmar crease in the little finger and three cm of closure in the middle and index fingers. He found marked extension lag in the index, ring, middle and little fingers. Appellant's left wrist had 30 degrees of dorsiflexion, 20 degrees of palmar flexion and 10 degrees of radial and ulnar deviation. Range of motion for his fingers demonstrated metacarpal phalangeal extension-flexion of negative 20 to 80 degrees in the index finger, negative 20 to 45 degrees in the middle finger, negative 20 to 70 degrees in the ring finger and negative 20 to 30 degrees in the little finger. Distal interphalangeal joint extension in the index, middle and ring fingers was 0 to 35 degrees. Dr. Weiss found marked impairment of the tendons involving the index, middle and little fingers with normal range of motion of the left elbow. He found a strength deficit of 50 percent in the left hand. Dr. Weiss concluded that appellant had 95 percent impairment of the left upper extremity due to loss of range of motion and sensory deficits in the left hand and wrist.

In a letter dated June 5, 2007, the Office informed appellant's attorney that the following conditions had been accepted as due to appellant's employment injury: contusions of the left

hand; crush injury of the left fingers; injury to the nerve roots, spinal plexuses and nerves of the left shoulder and arm; median nerve lesions; ulnar nerve lesion, tendon injury and crush injury of the left forearm.

The district medical adviser reviewed Dr. Weiss' report on July 30, 2007 and found that appellant had 19 percent impairment due to loss of range of motion of the left wrist; 34 percent impairment of the left hand due to loss of range of motion and 54 percent impairment due to sensory deficits for a total impairment rating of 76 for the upper extremity.

The Office found a conflict of medical opinion evidence between Dr. Weiss and the district medical adviser. In scheduling the impartial medical examination, it bypassed Dr. Mark Seckler, a Board-certified orthopedic surgeon, on the grounds that his office advised that if the file was too thick he did not want to do the examination. The Office also bypassed Dr. Elliot Semet, a Board-certified orthopedic surgeon, as his computer system was not operational. It referred appellant to Dr. Ian Fries, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a report dated September 14, 2007, Dr. Fries noted that appellant had been deaf since birth and was partially mute with his speech barely understandable. Appellant was accompanied by his mother and he could not verify the accuracy of their communications although it appeared satisfactory. Dr. Fries noted appellant's history of injury as noted in the statement of accepted facts as well as reviewing the medical records. He stated that the 95 percent impairment rating by Dr. Weiss was exaggerated as this was roughly equivalent to an amputation close to the shoulder. On physical examination, Dr. Fries found full range of motion of the neck, left shoulder and left elbow. He stated that appellant reported radiating pain down the left forearm with percussion of the ulnar nerve at the left elbow cubital tunnel, olecranon, medial epicondyle and lateral epicondyle and that he could not tolerate Phalen's positions. Dr. Fries found that passive attempts to move appellant's index, middle and little fingers caused forearm pain, but no pain resulted from moving the thumb and ring finger. He stated, "[Appellant] has a typical mannequin sign. Dorsi and volar flexion of the left wrist causes no change in position of the index, middle and little fingers. This confirms that he is actively adjusting the position of his fingers." Dr. Fries stated that he could not measure range of motion in the wrist or fingers due to complaints of pain and that accurate muscle testing could not be accomplished. He noted, however, that appellant had no visible atrophy of the thenar, hypothenar, interossei or forearm muscles. Appellant reported abnormal appreciation of light touch and dysesthesias from his elbow to the tips of four fingers in a glove pattern. Dr. Fries confirmed appellant's statements of total loss of sensation in the volar and dorsal ring finger. He noted that double touch was experienced as one touch over all fingers except the ring finger that was anesthetic. Dr. Fries diagnosed left little finger crush injury, left forearm exploration and symptom magnification and fabrication with a possible underlying psychiatric condition. He found that appellant had reached maximum medical improvement on May 23, 2006. Dr. Fries stated that appellant's current physical examination was "substantially restricted by claimed pain and hypersensitivity." He found that appellant's passive and active motion measurements and strength testing could not be measured accurately. Dr. Fries stated:

"[Appellant] has many nonphysiological findings. He demonstrates full active and passive motion of his ring finger and yet barely moves his index, middle and

little fingers. This is anatomical inexplicable as the extensor digitorum communis and flexor digitorum profundus move all four ulnar fingers simultaneously. [Appellant] is clearly activating muscles to the allegedly paretic fingers preventing motion when moving his ring finger. Similarly, passive wrist motion results in no motion of his index, middle and little fingers; confirmation is he can actively control these three fingers.

“[Appellant’s] sensory claims are bogus. He asserts total anesthesia of his ring finger. However, there are no objective findings of anhydrosis, atrophy, nail changes, loss of rugae nor injury. [Appellant] uses the ring finger actively for pinch.

“[Appellant] also claims substantial loss of sensation in his remaining fingers, measured at greater than 10 millimeters. However, he then claims inability to distinguish one from two touches over these four fingers. This is a sham test and his response is a fabrication.

“While [appellant] claims constant swelling of his left hand and forearm, this is inconsistent with measurements of his fingers, hand and forearm. Only left wrist circumference is one half [cm] large than the right -- consistent with surgery.

“The only verifiable objective finding is his surgical scar.”

Dr. Fries agreed with Dr. Coyle’s assessment that appellant had significant psychological overlay, symptom magnification and exaggeration. He found that Dr. Weiss’ measurements were not verifiable and noted that schedule award calculations on this undependable data would not be appropriate. Dr. Fries concluded that appellant had three percent impairment of his left upper extremity due to pain in accordance with Chapter 18 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). He noted however “[Appellant] pain may be considered unratable as his behavior during the evaluation raises [questions] of credibility and findings are atypical of well-accepted medical conditions.” Dr. Fries also granted appellant two percent impairment due to his forearm surgical scarring.

The district medical adviser reviewed this report on November 10, 2007 and agreed with Dr. Fries regarding appellant’s assessment for pain. However, he stated, “[T]here does not appear to be justification for the scar award....” The district medical adviser concluded that appellant had three percent impairment of his left upper extremity.

By decision dated January 22, 2008, the Office granted appellant a schedule award for three percent impairment of his left upper extremity.

Through his attorney, appellant requested an oral hearing on January 31, 2008. At the oral hearing on May 15, 2008, appellant’s attorney disagreed with Dr. Fries’ findings. He contended that the Office had not properly selected Dr. Fries through the physician’s directory. Appellant’s attorney also argued that Dr. Fries’ report was not well rationalized and should not be accorded the weight of the medical opinion evidence.

By decision dated August 7, 2008, the hearing representative affirmed the January 22, 2008 decision. He found that the selection of Dr. Fries was proper and that the Office relied on the impartial specialist's opinion in rating appellant's permanent impairment.

Appellant's attorney contends on appeal that Dr. Fries was not properly selected as an impartial medical specialist as other physicians were bypassed for insubstantial reasons. He argued that Dr. Fries demonstrated bias against the opinion of Dr. Weiss, that Dr. Fries failed to provide an adequate examination or that a supplemental report was necessary as Dr. Fries did not provide an adequate explanation for his impairment rating, including appellant's scar.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act¹ and its implementing regulations² 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 regulations as the appropriate standard for evaluating schedule losses.³ Effective February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.⁴

Before the A.M.A., *Guides* can be utilized, a description of appellant's impairment must be obtained from his physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.⁵

The fifth edition of the A.M.A., *Guides* allows for impairment percentage to be increased by up to three percent for pain by using Chapter 18, which provides a qualitative method for evaluating impairment due to chronic pain. If an individual appears to have a pain-related impairment that has increased the burden on his or her condition slightly, the examiner may increase the percentage up to three percent. However, examiners should not use Chapter 18 to

¹ 5 U.S.C. § 8107.

² 20 C.F.R. § 10.404 (1999).

³ *Id.*

⁴ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a) (August 2002).

⁵ *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

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*.⁶

The Act provides that, if there is a 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.⁷ The implementing regulations states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician of an Office medical adviser or consultant, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.⁸ A physician selected by the Office to serve as an impartial medical specialist should be wholly free to make a completely independent evaluation and judgment. To achieve this, the Office has developed specific procedures for the selection of impartial medical specialists designed to provide safeguards against any possible appearance that the selected physician's opinion is biased or prejudiced. The procedures contemplate that impartial medical specialists will be selected from Board-certified specialists in the appropriate geographical area on a strict rotating basis in order to negate any appearance that preferential treatment exists between a particular physician and the Office.⁹ The Federal (FECA) Procedure Manual (the procedure manual) provides that the selection of referee physicians (impartial medical specialists) is made through a strict rotational system using appropriate medical directories. The procedure manual provides that the Physicians Directory System (PDS) should be used for this purpose wherever possible.¹⁰ The PDS is a set of stand-alone software programs designed to support the scheduling of second opinion and referee examinations.¹¹ The PDS database of physicians is obtained from the American Board of Medical Specialties which contains the names of physicians who are Board-certified in certain specialties. 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 proper factual and medical background must be given special weight.¹²

ANALYSIS

The Board finds that the Office properly determined that there was a conflict of medical opinion evidence between Dr. Weiss for appellant and the district medical adviser regarding the

⁶ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); A.M.A., *Guides*, 571, 18.3(b); *P.C.*, 58 ECAB ___ (Docket No. 07-410, issued May 31, 2007); *Frantz Ghassan*, 57 ECAB ___ (Docket No. 05-1947, issued February 2, 2006).

⁷ 5 U.S.C. §§ 8101-8193, 8123.

⁸ 20 C.F.R. § 10.321.

⁹ *B.P.*, 60 ECAB ___ (Docket No. 08-1457, issued February 2, 2009).

¹⁰ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4b (May 2003).

¹¹ See *supra* note 10 at Chapter 3.500.7 (September 1995, May 2003).

¹² *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

extent of appellant's permanent impairment. Dr. Weiss advised that appellant had 95 percent impairment due to loss of range of motion and sensory deficits of the left hand and wrist. The district medical adviser found 76 percent impairment of the upper extremity due to sensory deficits and loss of range of motion. Due to this disagreement, the Office properly referred him to Dr. Fries, a Board-certified orthopedic surgeon, to resolve the conflict.

The Board notes that counsel for appellant contends that Dr. Fries was not properly selected to serve as the impartial medical specialist as the Office bypassed two other physicians. However, the Office noted the reason for bypassing those physicians. Dr. Seckler, a Board-certified orthopedic surgeon, was not willing to examine appellant because of the size of his case file. Dr. Semet's office was unable to schedule an appointment in a timely manner due to computer difficulty. The Office conformed with its procedures for scheduling an impartial medical examiner appointments. As noted in procedure manual, if a physician is unwilling to accept an impartial referral, the claims examiner is to annotate the fact in the record. There is no evidence to establish that the reasons provided by Dr. Seckler or Dr. Semet for not accepting the referral were insubstantial. The reason for the selection of Dr. Fries are well documented and do not establish bias or favoritism.¹³ The Board finds that Dr. Fries was properly selected as the impartial medical examiner. Appellant's attorney also alleged that Dr. Fries demonstrated bias against Dr. Weiss as he dismissed his impairment rating as exaggerated. The impartial medical examiner is to reach an independent finding based on his examination. This necessitates disagreeing with one of the physicians who created the conflict. While Dr. Fries' comments were dismissive, they do not establish bias against appellant.

The Board finds that the case is not in posture for decision as Dr. Fries did not adequately explain the basis for his schedule award determination in his September 14, 2007 report. Dr. Fries awarded appellant two percent impairment due to his left wrist surgical scar. The Act provides schedule awards for scarring only for serious disfigurement of the face, head or neck.¹⁴ Therefore, appellant is not entitled to an impairment rating for his wrist scar. Dr. Fries also awarded him three percent impairment due to pain in accordance with Chapter 18 of the A.M.A., *Guides*. In regard to this impairment, he further stated, "[H]is pain may be considered unratable as his behavior during the evaluation raises [questions] of credibility and findings are atypical of well-accepted medical conditions." Dr. Fries also stated that he confirmed appellant's statement of total loss of sensation in the volar and dorsal aspects of his ring finger. He did not provide an impairment rating for this sensory deficit. It is not clear from Dr. Fries' report whether he believes that appellant has any established impairment rating due to his accepted employment injuries.

On remand, the Office should request a supplemental report addressing any objective impairment based on a new evaluation of his physical impairment due to loss of range of motion loss of strength and sensory deficit. Dr. Fries should also address whether any impairment due to pain has been established. After this and such additional development as the Office deems necessary, the Office should issue an appropriate decision.

¹³ See *Donals Peisner*, 39 ECAB 1167 (1988).

¹⁴ 5 U.S.C. § 8107(c)(21).

CONCLUSION

The Board finds that the case is not in posture for a decision regarding the extent of appellant's permanent impairment for schedule award purposes.

ORDER

IT IS HEREBY ORDERED THAT the August 7, 2008 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this opinion of the Board.

Issued: September 30, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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