United States Department of Labor
Employees' Compensation Appeals Board

D.G., Appellant	)	
	)	
and	)	**Docket No. 10-1936**
	)	**Issued: July 5, 2011**
U.S. POSTAL SERVICE, PALATINE PROCESSING & DISTRIBUTION CENTER, Palatine, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 20, 2010 appellant filed a timely appeal of the March 4, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP) involving schedule awards for each upper extremity and a May 5, 2010 nonmerit decision denying her request for reconsideration. Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of this case.

ISSUES

The issues are: (1) whether appellant has more than nine percent impairment of the right upper extremity and two percent impairment of the left upper extremity, for which she received schedule awards; and (2) whether OWCP properly denied appellant's request for reconsideration of the merits of her claim pursuant to 5 U.S.C. § 8128(a).

[1] 5 U.S.C. § 8101 *et seq.*

On appeal, appellant contended that she was entitled to a schedule award for greater impairment to her right upper extremity.

FACTUAL HISTORY

On March 1, 2007 appellant, then a 46-year-old mail processing clerk, filed an occupational disease claim alleging that on November 14, 2006 she realized that her carpal tunnel and cubital tunnel syndromes were caused by her federal employment.[2] She engaged in repetitive activities which included working on "DBCS" machines for nine years, lifting trays that weighed 5 to 15 pounds, loading mail onto a ledge, sweeping mail into trays, lifting full trays over her head and stacking them high. On June 5, 2007 OWCP accepted appellant's claim for bilateral carpal tunnel syndrome and epicondylitis and right cubital tunnel syndrome.

On July 10, 2007 appellant stopped work. On October 26, 2007 she underwent right carpal tunnel and antecubital tunnel release, which was performed by Dr. Victor M. Romano, an attending Board-certified orthopedic surgeon. Dr. Mark J. Sokolowski, a Board-certified orthopedic surgeon, released appellant to return to modified-duty work on November 12, 2007. Appellant did not return to work. On December 11, 2007 Dr. Romano released her to return to work with no restrictions as of December 12, 2007.[3]

On December 24, 2007 appellant filed a claim for a schedule award. In a December 11, 2007 medical report, Dr. Romano advised that she had reached maximum medical improvement. He determined that appellant had 10 percent impairment of the right upper extremity due to weakness, atrophy, pain or loss of sensation. Dr. Romano advised that she could return to full-duty work with no restrictions.

In a February 11, 2008 report, Dr. Herbert H. Engelhard, III, a Board-certified neurologist, noted that appellant had tingling and needle sensations in her arms and legs. He listed his findings on physical and neurological examination, which included diffuse weakness of 5/5 and increased tone. Dr. Engelhard diagnosed Chiari malformation and recommended surgery.

On March 18, 2008 Dr. Robert W. Wysocki, OWCP's medical adviser, reviewed the medical evidence. He noted the findings of Dr. Romano and Dr. Engelhard and stated that the physicians did not provide sufficient detail to determine the extent of permanent impairment to appellant's right and left upper extremities. Dr. Wysocki noted that clinical findings did not accompany Dr. Romano's impairment evaluation. He stated that Dr. Engelhard did not provide any details regarding the tingling and needle sensation in appellant's arms and legs and her

[2] Subsequent to the filing of the instant claim, appellant on September 21, 2008 filed an occupational disease claim assigned File No. xxxxxx949 alleging that she sustained Arnold Chiari malformation, two spinal cysts and bulging discs as a result of heavy overhead lifting during the past 14 years which put stress and pressure on her spine, pulling her brain stem down into her spine. By decision dated September 8, 2009, the Board affirmed OWCP's November 12, 2008 decision denying her claim. (Docket No. 09-386, issued September 9, 2009).

[3] By decision dated March 10, 2008, OWCP terminated appellant's wage-loss compensation on the grounds that she was no longer totally disabled for work based on Dr. Romano's December 11, 2007 report. It informed her that she was still entitled to medical benefits for the accepted conditions.

diffuse weakness. Given appellant underlying Chiari malformation, Dr. Wysocki stated that these details were important for an impairment determination.

By letter dated April 1, 2008, OWCP advised appellant that the medical evidence of record did not establish that she had reached maximum medical improvement. It advised her to file a schedule award claim when such status had been reached.

On May 12, 2008 Dr. David H. Garelick, OWCP's medical adviser, reviewed the medical evidence. He stated that it was not clear as to what medical and scientific bases Dr. Romano used to determine that appellant had 10 percent right upper extremity impairment. Based on the absence of documentation supporting weakness, sensory loss or pain, Dr. Garelick advised that there was no objective basis upon which to award any right or left upper extremity impairment. He concluded that appellant had no impairment to either her right or left upper extremity. Dr. Garelick further concluded that she reached maximum medical improvement on December 11, 2007.

On June 2, 2008 OWCP found a conflict in the medical opinion evidence between Dr. Romano and Dr. Garelick regarding the extent of appellant's permanent impairment. By letter dated June 12, 2008, it referred her, together with a statement of accepted facts and medical record, to Dr. Michael I. Vender, a Board-certified orthopedic surgeon, for an impartial medical examination. Dr. Vender was asked to determine the extent of appellant's bilateral upper extremity impairment based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

In a July 17, 2008 report, Dr. Vender reviewed a history of the accepted right upper extremity injuries and medical treatment. On physical examination, he reported full extension and flexion of the right elbow. There was a scar in the medial aspect of the right elbow. There was also decreased sensation to light touch posteriorly. Range of motion of the right wrist was symmetric to the left side. There was a hard to visualize longitudinal scar over the carpal tunnel. There was a diffuse abnormality to two-point discrimination involving all fingers and thumb. There was give way weakness throughout the hand. Range of motion of the fingers was normal. A-1 pulley areas were nontender. X-rays of the right elbow were normal. X-rays of the right wrist were most remarkable for increased scapholunate interval and flexion of the scaphoid that were probably a normal variant particular to appellant. Dr. Vender advised that appellant was status post right carpal tunnel and right cubital tunnel releases of the right elbow. He stated that the normal x-ray findings correlated with the impression of lack of significant abnormalities that were possibly related to her prior carpal and cubital tunnel syndromes. Dr. Vender advised that appellant had reached maximum medical improvement. There was no need for further medical treatment. Dr. Vender noted that an evaluation of appellant's loss of sensation and motor strength was difficult to perform and appeared to be unreliable. He, however, stated that, if there was an assumption of some loss of sensation related to appellant's thumb, she had one percent impairment of the hand, which represented one percent impairment of the upper extremity and one percent impairment of the whole person.

On September 3, 2008 Dr. Amon Ferry, OWCP's medical adviser, reviewed Dr. Vender's July 17, 2008 findings. He disagreed with Dr. Vender's one percent right upper extremity impairment rating. Dr. Vender did not discuss specific findings of impairment. He

also did not reference the fifth edition of the A.M.A., *Guides*. Dr. Ferry stated that he could not comment on how he calculated his one percent impairment rating. He concluded that there was no justification for this award.

In a September 18, 2008 decision, OWCP denied appellant's schedule award. It accorded determinative weight to Dr. Ferry's September 3, 2008 opinion that she had no impairment to her upper extremities.

On May 20, 2009 appellant, through her attorney, requested reconsideration.

In an April 9, 2009 report, Dr. Jeffrey F. Wirebaugh, a Board-certified family practitioner, obtained a history of the employment-related injuries and medical treatment. He noted appellant's right upper extremity complaints which included severe loss of hand grip strength. Appellant was unable to open jars or do anything else that required her to grip and make a twisting or turning movement. She experienced numbness in her index finger with any repetitive activity. Appellant had numbness over the pinky finger and the pinky finger side of her ring finger. She had pain over the outside of her elbow with repetitive elbow motion especially against any resistance. Appellant complained about numbness and tingling in her left palm and occasionally into her left index finger with repetitive or sustained hand/wrist activity. Dr. Wirebaugh listed his findings on physical examination and determined that she had 8.5 percent impairment of the right upper extremity and 2 percent impairment of the left upper extremity based on the sixth edition of the A.M.A., *Guides*. He concluded that appellant had reached maximum medical improvement.

On June 15, 2009 Dr. Garelick reviewed the medical evidence. He stated that based on a normal postoperative electromyogram study, give-way weakness and diffuse sensory abnormalities, many of the objective findings described in Dr. Wirebaugh's report were not reliable. Dr. Garelick determined that appellant had three percent impairment of the right upper extremity and no impairment of the left upper extremity. He concluded that she reached maximum medical improvement on July 17, 2008.

In a decision dated July 2, 2009, OWCP set aside the September 18, 2008 decision. It granted appellant a schedule award for three percent impairment of the right upper extremity based on Dr. Garelick's June 15, 2009 medical opinion. The period of the award was from July 17 through September 20, 2008.

On August 3, 2009 appellant requested a telephonic hearing with OWCP's hearing representative.

In a September 29, 2009 decision, OWCP's hearing representative set aside the July 2, 2009 decision and remanded the case to OWCP for further development of the medical evidence. She rescinded the acceptance of appellant's claim for lateral epicondylitis, finding that appellant had never been treated for this condition. The hearing representative found that there was no conflict in the medical opinion evidence between Dr. Romano and Dr. Garelick as Dr. Garelick only advised that the medical evidence was insufficient to determine the extent of appellant's permanent impairment based on his review of Dr. Romano's report. OWCP's hearing representative, thus, determined that Dr. Vender was a second opinion physician. She then found

a conflict in the medical opinion evidence between Dr. Romano, Dr. Wirebaugh and Dr. Vender regarding the extent of appellant's upper extremity impairment.

By letter dated January 22, 2010, OWCP referred appellant, together with a statement of accepted facts and the medical record, to Dr. William A. Heller, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a February 9, 2010 report, Dr. Heller obtained a history of appellant's employment-related injuries and medical treatment. On physical examination of the right upper extremity, he reported intact active range of motion including, 0 to 130 degrees of flexion related to the elbow, 130 degrees each of flexion and extension and 50 degrees each of radial and ulnar deviation of the wrist. Forearm rotation was intact with greater than 80 degrees of pronation and supination. There was no evidence of significant pain or tenderness to gentle palpation of the right upper extremity from the level of the elbow to the fingers. Vascular status was intact with intact capillary refill, turgor and a negative Allen's test for vascular ischemia. Intrinsic and extrinsic musculature tone and bulk were intact without evidence of atrophy or contracture. Dr. Heller was unable to perform sensory testing due to complete lack of appellant's cooperation. He attempted a two-point and sharp/dull discrimination testing, but was unable to obtain consistent responses. Appellant stated that her recent chemotherapy made it impossible for her to cooperate with sensation testing. She was unable to perform any type of grip strength testing that registered on the dynamometer machine due to her recent chemotherapy treatment for ovarian cancer. Dr. Heller reviewed previous evaluations in the medical record which suggested normal or near normal sensation and strength after appellant's surgery. He reviewed electrodiagnostic studies performed on July 11, 2008 after her cubital and carpal tunnel releases which were normal and showed no evidence of bilateral carpal and cubital tunnel syndrome or ulnar neuropathy. A cervical magnetic resonance imaging scan revealed nonwork-related Chiari malformation.

Dr. Heller advised that it was no longer possible to rate appellant's permanent impairment based on the accepted conditions of bilateral cubital and carpal tunnel syndromes. Appellant's current loss of use of the right upper extremity, whether or not it represented any true underlying organic musculoskeletal pathology, was related to nonwork-related conditions including, ovarian cancer and subsequent chemotherapy, as well as, syringomyelia and Chiari malformation which required corrective surgery. Dr. Heller stated that his examination revealed her inability to generate any significant strength with her right hand during grip strength testing. Appellant's sensation testing showed a profound loss of sensation. Dr. Heller stated that these findings were completely beyond what was noted previously in examinations performed by Dr. Wirebaugh and Dr. Vender. He was, therefore, unable to provide a specific impairment rating relating to the work-related conditions based on the A.M.A., *Guides*. Dr. Heller deferred to Dr. Vender's opinion and stated that based on the available medical records from previous examinations and normal electrodiagnostic studies it appeared that appellant had recovered full function of the median and ulnar nerves in her right upper extremity after surgery. No residual impairment existed at the time of Dr. Vender's examination.

In a March 4, 2010 decision, OWCP granted appellant a schedule award for two percent impairment of the left upper extremity and nine percent impairment of the right upper extremity, less the three percent previously paid based on the July 2, 2009 schedule award. It accorded

determinative weight to Dr. Wirebaugh's April 9, 2009 report, finding that he provided a well-rationalized opinion and properly utilized the sixth edition of the A.M.A., *Guides*. OWCP noted Dr. Heller's comment that he was unable to rate appellant's impairment due to her ovarian cancer and subsequent chemotherapy treatment. It stated that since he was unable to resolve the conflict in medical opinion, it would again review the reports of Dr. Vender and Dr. Wirebaugh. OWCP stated:

> "Taking into consideration that Dr. Wirebaugh provided a physical examination of [appellant] as well as the fact that it appears that [she] cannot [sic] undertake a new examination due to her ovarian cancer and subsequent chemotherapy it is determined that his report of April 9, 2009 will hold the weight of the medical evidence."

On April 15, 2010 appellant requested reconsideration.

In a May 5, 2010 decision, OWCP denied appellant's request for reconsideration. It found that she failed to raise a substantive legal question or submit new and relevant evidence.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA[4] and its implementing regulations[5] set forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[6] However, neither FECA nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, OWCP adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[7]

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 (known as a referee physician or impartial medical specialist) who shall make an examination.[8] In cases where OWCP has referred appellant to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[9]

[4] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[5] 20 C.F.R. § 10.404.

[6] 5 U.S.C. § 8107(c)(19).

[7] *Supra* note 5.

[8] 5 U.S.C. § 8123(a); *see S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[9] *Gloria J. Godfrey*, 52 ECAB 486 (2001); *B.P.*, Docket No. 08-1457 (issued February 2, 2009).

The Board case precedent provides that, when OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the deficiency in his original report. Only when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is incomplete, vague, speculative or lacking in rationale, should OWCP refer the claimant to a second impartial specialist.[10]

The Board has held that, to properly resolve a conflict in medical opinion, it is the impartial medical specialist who should provide a reasoned opinion as to a permanent impairment to a scheduled member of the body in accordance with the A.M.A., *Guides*. OWCP's medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.[11]

ANALYSIS -- ISSUE 1

The Board finds that this case is not in posture for decision. In the instant case, OWCP ultimately referred appellant to Dr. Heller, an impartial medical specialist, to resolve the conflict in medical opinion evidence between Dr. Romano and Dr. Wirebaugh, attending physicians, and Dr. Vender, OWCP's referral physician, regarding the extent of her upper extremity impairment.

In a February 9, 2010 report, Dr. Heller found that appellant had no residual impairment of the right upper extremity. He was unable to accurately evaluate her sensory loss and grip strength due to her lack of cooperation. Appellant advised Dr. Heller that she was unable to cooperate with testing due to her recent chemotherapy for ovarian cancer. Dr. Heller reviewed normal diagnostic test results that were obtained after her October 26, 2007 surgery and found no evidence of bilateral carpal and cubital tunnel syndrome or ulnar neuropathy. He advised that it was impossible to rate appellant's permanent impairment based on the accepted conditions of bilateral cubital and carpal tunnel syndromes. Dr. Heller stated that her current loss of use of the right upper extremity, whether or not it represented any true underlying organic musculoskeletal pathology, was related to nonwork-related conditions including, ovarian cancer and subsequent chemotherapy, as well as, syringomyelia and Chiari malformation. He advised that appellant did not have any significant strength in her right hand during grip strength testing. Dr. Heller further advised that her sensation testing showed a profound loss of sensation. He related that these findings were completely beyond the findings of Dr. Wirebaugh and Dr. Vender. Dr. Heller opined that he was unable to provide a specific impairment rating regarding the accepted work-related conditions based on the A.M.A., *Guides*. He relied on Dr. Vender's examination findings and concluded that appellant had no residual impairment at the time of Dr. Vender's examination. Dr. Heller's report does not provide sufficient medical explanation to support his conclusion. He must resolve the medical conflict and cannot simply defer to the opinion of

[10] *See Nancy Keenan*, 56 ECAB 687 (2005); *Margaret Ann Connor*, 40 ECAB 214 (1988).

[11] *See Richard R. LeMay*, 56 ECAB 341 (2005); *Thomas J. Fragale*, 55 ECAB 619 (2004).

another physician on the matter.[12] The impartial medical specialist must provide a well-reasoned opinion to resolve the issue regarding the extent of appellant's upper extremity permanent impairment.

OWCP, in its March 4, 2010 schedule award decision, noted that Dr. Heller was unable to resolve the conflict in medical opinion due to his inability to rate appellant's right upper extremity impairment due to her ovarian cancer and subsequent chemotherapy treatment. Instead of seeking clarification from him or referring appellant to another impartial medical specialist, it improperly relied on the medical opinion of Dr. Wirebaugh, an attending physician, who opined that she had nine percent impairment of the right upper extremity and two percent impairment of the left upper extremity.[13] An attending physician cannot resolve a conflict in medical opinion.

The Board will remand the case for a supplemental report from Dr. Heller. If Dr. Heller is unwilling or unable to explain the basis of his impairment rating pursuant to the A.M.A., *Guides*, the case should be referred to another impartial medical specialist. Following this and such further development of the evidence as may be necessary, OWCP shall issue an appropriate final decision on the extent of impairment to appellant's upper extremities.

CONCLUSION

The Board finds that this case is not in posture for decision as to the extent of appellant's right and left upper extremity impairment.[14] The medical evidence requires further development.

[12] *Frederick Justiniano*, 45 ECAB 491 (1994) (the impartial specialist made statements such as "I must agree with [the referral physician's] conclusion that the patient has an underlying personality disorder" and "I also agree such adjustment disorder would have long since resolved without residuals").

[13] *See* cases cited *supra* note 10.

[14] In light of the Board's disposition of the first issue, the second issue is moot.

ORDER

IT IS HEREBY ORDERED THAT the May 5 and March 4, 2010 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: July 5, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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