

FACTUAL HISTORY

On January 11, 2007 appellant, then a 49-year-old welder, broke his left wrist in the performance of duty when one of the legs of a roller table he was moving collapsed, scissoring his left wrist. OWCP accepted his claim for closed fracture of the distal radius with ulna, left.

Appellant filed a claim for a schedule award. A conflict arose between his evaluating orthopedic surgeon, Dr. Steven M. Allon, who found a 33 percent impairment of the left upper extremity and OWCP's medical adviser, who found a 26 percent impairment. To resolve this conflict, OWCP referred appellant, together with the medical record and a statement of accepted facts, to Dr. Andrew B. Weiss, a Board-certified orthopedic surgeon.

Dr. Weiss evaluated appellant on June 15, 2009. He reviewed appellant's medical record and history. Dr. Weiss noted that appellant used acetaminophen for pain on an as-needed basis. Appellant complained of some left wrist pain and stated that he was somewhat better since the time of the accident.

Dr. Weiss described his findings on physical examination, which were entirely normal "with the exception of some, what I would consider, to be mild decreased sensation at the very tip of the left ring finger." He estimated that appellant had a one percent impairment of his left upper extremity due to this slight decreased sensation.

A second OWCP's medical adviser noted that Dr. Weiss referred to no table or pages in the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009) to show how he arrived at his rating.

In a supplemental report, Dr. Weiss explained that he used the sixth edition of the A.M.A., *Guides*, but his evaluation of appellant was completely normal by objective criteria, so there would be no impairment. "However, I did give one percent disability because of a slight decrease in sensation along the tip of the left ring finger. I am unable to find any tables that discuss slight decrease in sensation. If there are any, please point them out to me and I would be glad to review them."

A third OWCP's medical adviser reviewed Dr. Weiss' evaluation and found that appellant had no ratable impairment under the sixth edition of the A.M.A., *Guides*.

At OWCP's request, Dr. Allon evaluated appellant under the sixth edition of the A.M.A., *Guides*.² He found an 18 percent impairment of the left upper extremity by combining impairment for loss of motion with impairments for moderate sensory deficits of the left ulnar

² The evaluation was respectfully submitted "Steven M. Allon, M.D., orthopedic surgeon, musculoskeletal medicine," but the signature is that of an associate, Dr. Arthur Becan. Appellant's representative confirmed in his cover letter that it was Dr. Allon who provided the sixth edition analysis. The signature therefore appears to have been stamped incorrectly.

and radial nerves.³ The second OWCP medical adviser reviewed this evaluation and found that appellant's impairment was 19 percent.

On May 17, 2010 OWCP issued a schedule award for a 19 percent impairment of appellant's left upper extremity. On August 17, 2010 OWCP's hearing representative affirmed the case. He found: "While it is possible to make the argument that the weight of the medical evidence should rest with Dr. Weiss' referee report and thereby rescind and negate the entire schedule award, I will not do that and find that [OWCP] acted within its discretion."

On appeal, appellant's representative argues that appellant had a constitutionally protected property right to a schedule award under the fifth edition of the A.M.A., *Guides* and that OWCP deprived him of that property right without due process by delaying adjudication until the sixth edition became applicable. OWCP's hearing representative further argues that since OWCP found a conflict and referred the matter to Dr. Weiss, it should have sought clarification from Dr. Weiss or referred appellant to another referee physician under 5 U.S.C. § 8123(a).

LEGAL PRECEDENT

FECA authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body.⁴ Such loss or loss of use is known as permanent impairment. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.⁵

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.⁶ When there exist opposing medical reports of virtually equal weight and rationale, and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.⁷

³ Characteristic deformities and manifestations resulting from peripheral nerve lesions, such as restricted motion, have been taken into consideration by the A.M.A., *Guides* in the estimated impairment values shown. Therefore, when impairment results strictly from a peripheral nerve lesion, no other rating method is applied to that section to avoid duplication or unwarranted increase in the impairment estimation. A.M.A., *Guides*, 423 (6th ed. 2009).

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404. For impairment ratings calculated on and after May 1, 2009, OWCP should advise any physician evaluating permanent impairment to use the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

⁶ 5 U.S.C. § 8123(a).

⁷ *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

ANALYSIS

Diagnosis-based impairment is the primary method of evaluation for the upper extremity. The A.M.A., *Guides* provides grids, listing relevant diagnoses, for each region of the upper extremity. Once the impairment class is determined, based on the diagnosis, the grade is initially assigned the default value. The final impairment grade within the class is calculated using the grade modifiers or nonkey factors, including functional history, physical examination and clinical studies.⁸

Table 15-3, page 395 of the A.M.A., *Guides* is the regional grid for the wrist. Page 396 lists fracture as the relevant diagnosis. Two classes are provided: class 0, for no residual findings and class 1, for residual symptoms, consistent objective findings and/or functional loss, with normal motion. Class 0 represents no impairment of the upper extremity. The default value for class 1 is a three percent impairment, which could be adjusted up or down one or two percent depending on the grade modifiers. The greatest diagnosis-based impairment possible for a wrist fracture is five percent of the upper extremity. If motion loss is present, this impairment may be assessed alternatively using section 15.7, range of motion. A range of motion impairment stands alone and is not combined with a diagnosis-based impairment.⁹

Dr. Weiss, the orthopedic surgeon and impartial medical specialist, found no loss of motion. This leaves appellant with an impairment rating based on his diagnosed wrist fracture (Table 15-3, page 396). Although he did complain of some wrist pain and although Dr. Weiss did note a slight decrease in sensation at the very tip of the left right finger, appellant's physical examination was completely normal by objective criteria. The A.M.A., *Guides* states: "Subjective complaints without objective physical findings or significant clinical abnormalities are assigned class 0 and have usually no ratable impairment."¹⁰ As appellant's physical findings were completely normal by objective clinical criteria, according to Dr. Weiss, the impairment properly falls under class 0, no ratable impairment.

Dr. Weiss acknowledged that appellant had no impairment "at all" based on the A.M.A., *Guides*; nonetheless, he gave appellant a one percent rating for the slight decrease in sensation at the very tip of his left ring finger. He offered no recognized basis for such a rating.

OWCP selected Dr. Weiss under section 8123(a) of FECA to resolve a conflict on the extent of any permanent impairment resulting from appellant's January 11, 2007 employment injury. It provided him with appellant's medical record and a statement of accepted facts so he could base his opinion on a proper medical and factual history. As Dr. Weiss well explained that his findings on examination showed no impairment of the left upper extremity based on objective criteria, the Board finds that his reports are entitled to special weight in resolving the conflict between appellant's evaluating physician, Dr. Allon and the first OWCP medical adviser.

⁸ A.M.A., *Guides* 387.

⁹ *Id.* at 397 (noted at bottom of the grid).

¹⁰ *Id.* at 387.

Dr. Allon's subsequent rating of 18 percent did not create a second conflict or the need for a second impartial medical specialist.¹¹ Dr. Weiss represents the weight of the medical evidence.

OWCP's hearing representative decided that the weight of the medical evidence could rest with the impartial medical specialist, but rather than rescind or negate appellant's schedule award, he found that OWCP acted within its discretion to grant an award of 19 percent based on a different evaluation. To be clear, OWCP has no discretion to circumvent section 8123(a) of FECA. The weight of the medical evidence rests with the impartial medical specialist and establishes no ratable impairment. For this reason, the Board will set aside OWCP's hearing representative's August 17, 2010 decision to affirm a 19 percent award. The award, which ran through July 1, 2009, has been fully paid, and the hearing representative has indicated that OWCP intends to let it stand.

Appellant's representative argues on appeal that OWCP delayed its adjudication of appellant's schedule award claim until the sixth edition of the A.M.A., *Guides* became applicable on May 1, 2009, which deprived him of a property right under the fifth edition, citing *Goldberg v. Kelly*, 397 U.S. 254 (1970) and *Mathews v. Eldridge*, 424 U.S. 319 (1976). These cases held only that a claimant who was in receipt of benefits (in *Goldberg* welfare benefits and in *Mathews* social security benefits) could not have those benefits terminated without procedural due process.¹² In this case, appellant simply made a claim for a schedule award. He was not in receipt of schedule award benefits nor was OWCP attempting to terminate benefits. Appellant had no vested right to a schedule award under the fifth edition of the A.M.A., *Guides*.

CONCLUSION

The Board finds that appellant has no ratable impairment of his left upper extremity resulting from his January 11, 2007 employment injury.

¹¹ See *Margaret Ann Connor*, 40 ECAB 214 (1988) (where the Board found that reports from new physicians constituted new evidence and created a new conflict in medical opinion with the report of the impartial medical specialist).

¹² In *Mathews* the court held that an evidentiary hearing is not required prior to the termination of social security disability benefits, noting, among other things, that the disabled worker's need is likely to be less than that of a welfare recipient, so there is less reason to depart from the ordinary principle that something less than an evidentiary hearing is sufficient prior to adverse administrative action.

ORDER

IT IS HEREBY ORDERED THAT the August 17, 2010 decision of the Office of Workers' Compensation Programs is set aside and modified to reflect that appellant has no ratable impairment of his left upper extremity, causally related to the January 11, 2007 employment injury. The decision is affirmed as modified.

Issued: September 23, 2011
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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