United States Department of Labor
Employees' Compensation Appeals Board

H.S., Appellant	)	
and	)	**Docket No. 13-797**
	)	**Issued: July 22, 2013**
U.S. POSTAL SERVICE, GULF WINDS STATION, St. Petersburg, FL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 15, 2013 appellant filed a timely appeal from a September 5, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) granting him a schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than a 27 percent permanent impairment of the right upper extremity and a 27 percent permanent impairment of the left upper extremity, for which he received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board. In a decision dated September 23, 2009, the Board set aside December 12, 2007 and July 3, 2008 OWCP decisions denying appellant's

[1] 5 U.S.C. § 8101 *et seq.*

claim for an increased schedule award.[2] The Board found that the opinion of the impartial medical examiner, Dr. Howard Schuele, a Board-certified orthopedic surgeon, was insufficient to establish the extent of the bilateral upper extremity impairment. In a decision dated December 23, 2011, the Board set aside an August 27, 2010 decision denying appellant's claim for an increased schedule award.[3] The Board found that the opinion of the impartial medical examiner, Dr. Gilberto Vega, a Board-certified orthopedic surgeon, was insufficient to resolve the conflict in medical opinion regarding the extent of any upper extremity impairment. Dr. Vega asserted that appellant's needed a magnetic resonance imaging (MRI) scan study to determine the extent of his right shoulder impairment but could not obtain one as he had a pacemaker. The Board found, however, that the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (6th ed. 2009) (A.M.A., *Guides*) provided a range-of-motion method for determining shoulder impairments. The Board remanded the case for OWCP to request that Dr. Vega rate the extent of appellant's bilateral shoulder impairment based on range of motion. The facts and circumstances of the case as set forth in the Board's prior decision are hereby incorporated by reference.

On January 23, 2012 OWCP referred appellant to Dr. Vega for a supplemental report. In a report dated February 15, 2012, Dr. Vega recommended an arthrogram of the shoulders in order to obtain the correct diagnosis to determine his impairment rating. On March 23, 2012 Dr. Larry D. Canton, an attending osteopath, recommended against appellant undergoing an arthrogram due to his "severe allergy to bee sting, his chronic use of anticoagulants as well as multiple cystic problems."

By letter dated April 12, 2012, OWCP advised Dr. Vega that appellant's attending physician recommended against an arthrogram and asked that he rate the shoulder impairment based on range of motion. In an April 20, 2012 response, Dr. Vega opined that rating appellant's disability using range of motion would not be valid. On May 15, 2012 OWCP's medical adviser noted that any study with the potential for harm should not be done for an impairment rating.

On July 19, 2012 OWCP referred appellant to Dr. Robert Elkins, a Board-certified orthopedic surgeon, for an impartial medical examination. In a report dated August 7, 2012, Dr. Elkins reviewed appellant's history of bilateral shoulder pain, right elbow soreness, left medial epicondylar pain, right carpal tunnel syndrome, left wrist pain, left finger numbness and left thumb pain. He discussed the medical evidence of record.[4] On examination, Dr. Elkins measured range of motion of the shoulders and wrists. He found a negative Tinel's sign of the

[2] Docket No. 08-2550 (issued September 23, 2009). OWCP accepted that appellant sustained bilateral shoulder arthritis, a sprain of the left arm and shoulder, a biceps tendon rupture and left ulnar neuropathy under file number xxxxxx265 and bilateral carpal tunnel syndrome and an aggravation of bilateral osteoarthritis of the base of the thumbs under file number xxxxxx357. It granted him a schedule award for a 12 percent permanent impairment of the right upper extremity and a 16 percent permanent impairment of the left upper extremity. OWCP combined both under file number xxxxxx357. By decision dated March 7, 2007, it granted appellant a schedule award for a 21 percent right upper extremity impairment and a 25 percent left upper extremity impairment.

[3] Docket No. 11-628 (issued December 23, 2011).

[4] Diagnostic studies performed on November 20, 2001 showed right carpal tunnel syndrome and bilateral ulnar nerve entrapment at the wrists. Diagnostic studies performed on July 8, 2010 showed bilateral medial neuropathy of the wrists and bilateral ulnar neuropathy.

wrists and elbows but "tenderness to a Tinel's sign over the ulnar groove on the left side" with a loss of sensation over the left fourth and fifth fingers and a loss of sensation of the right thumb. Dr. Elkins measured hand strength of 26 on the right and 13 on the left. He diagnosed chronic bilateral upper extremity pain, probable osteoarthritis and possible rotator cuff tendinitis of the shoulders, prior cervical radiculopathy at C5-6, adhesive capsulitis of the shoulders bilaterally, probable bilateral carpal and cubital tunnel syndrome and mild neurologic right hand changes with subjective sensory loss. Applying the A.M.A., *Guides*, Dr. Elkins identified the shoulder diagnosis as class 1 post-traumatic degenerative joint disease using the Shoulder Regional Grid set forth in Table 15-5, which yielded a default value of five percent. Applying a grade modifier of four for severe loss of motion, a grade modifier of one for Clinical Studies (GMCS) and a grade modifier of two for Functional History (GMFH), he concluded that appellant had a nine percent impairment of each shoulder. Dr. Elkins then identified a class 1 impairment due to epicondylitis using the Elbow Regional Grid set forth in Table 15-4 on page 398, which yielded a default value of one percent, which he adjusted upward to a two percent "for his Tinel's sign, chronic physical changes and tenderness." For the wrists, he identified the diagnosis as class 1 post-traumatic degenerative joint disease using the Wrist Regional Grid at Table 15-3 on page 395 of the A.M.A., *Guides*, for a default value of five percent. Dr. Elkins adjusted the impairment finding upward due to appellant's severe loss of motion, which he found yielded a nine percent permanent impairment on the right and left. He next rated appellant's carpal tunnel syndrome using Table 15-21 on page 438 as a class 1, which after applying the modifiers set forth in Table 23 on page 449 yielded an eight percent impairment of each extremity. Dr. Elkins further found a two percent upper extremity impairment due to loss of range of motion and post-traumatic degenerative joint disease of the thumbs. He combined the impairment ratings to find a 27 percent permanent impairment of each upper extremity.

On August 22, 2012 OWCP's medical adviser reviewed Dr. Elkin's report and concurred with his findings.

By decision dated September 5, 2012, OWCP granted appellant a schedule award for an additional 6 percent permanent impairment of the right upper extremity and an additional 2 percent permanent impairment of the left upper extremity, for total schedule awards of 27 percent for each extremity.

On appeal, appellant questioned how Dr. Elkins could provide an impairment rating given that he did not take x-rays. He asserted that Dr. Schuele found that he had a greater impairment than Dr. Elkins.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations[6] 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, FECA does not specify the manner in which the percentage of loss shall be determined. For

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, Physical Examination (GMPE) and GMCS.[9] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

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.[10]

ANALYSIS

On prior appeal the Board remanded the case for OWCP to obtain a supplemental report from Dr. Vega, the impartial medical examiner, regarding the extent of appellant's impairment of the upper extremities. The Board noted that Dr. Vega indicated that he was unable to rate the extent of any right shoulder impairment without an MRI scan study, which appellant was unable to undergo due to his pacemaker. The Board remanded the case for him to provide an impairment rating of the shoulders based on range of motion.

In response to OWCP's request for a supplemental report, Dr. Vega recommended an arthrogram of the shoulders; however, appellant submitted medical evidence supporting that an arthrogram was contraindicated. OWCP again requested a shoulder rating based on range of motion but Dr. Vega questioned the validity of such a rating. As Dr. Vega declined to clarify his report, it properly referred the case record to Dr. Elkins for a second impartial medical opinion.[11]

When a case is referred to an impartial medical examiner for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a prior factual and medical background, must be given special weight.[12] In a report dated August 7,

[7] *Id*. at § 10.404(a).

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also id.* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[9] A.M.A., *Guides* 494-531.

[10] *Barry Neutuch*, 54 ECAB 313 (2003); *David W. Pickett*, 54 ECAB 272 (2002).

[11] In situations where OWCP secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or elaboration, it has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original opinion. If the specialist is unwilling or unable to clarify and elaborate on his or her opinion, the case should be referred to another appropriate impartial medical specialist. *See Guiseppe Aversa*, 55 ECAB 164 (2003).

[12] *See Darlene R. Kennedy*, 57 ECAB 414 (2006).

2012, Dr. Elkins listed detailed findings on examination and diagnosed chronic bilateral upper extremity pain, probable osteoarthritis and possible rotator cuff tendinitis of the shoulders, prior cervical radiculopathy at C5-6, adhesive capsulitis of the shoulders bilaterally, probably bilateral carpal and cubital tunnel syndrome and mild neurologic right hand changes with subjective sensory loss. Using Table 15-5 of the Shoulder Regional Grid, he properly identified the diagnosis as class 1 post-traumatic degenerative joint disease, for a default value of five percent.[13] Dr. Elkins applied grade modifiers of four for physical examination based on appellant's loss of motion, a grade modifier of one for clinical studies and a grade modifier of two for functional history to find a net adjustment of two and a nine percent impairment for each shoulder.[14] For the elbow, he appropriately identified the diagnosis as class 1 epicondylitis, using Table 15-4, the Elbow Regional Grid, which yielded a default value of one percent. Dr. Elkins adjusted the default value upward based on physical findings to find a two percent impairment of each upper extremity due to elbow epicondylitis, the highest amount given under the A.M.A., *Guides* for residual symptoms of epicondylitis without consistent objective findings or a surgical release.[15] He next properly found a class 1 impairment due to degenerative joint disease of the wrists bilaterally using the Wrist Regional Grid at Table 15-3, for a default value of five percent. Dr. Elkins applied an adjustment for functional history due to loss of motion, to find a nine percent impairment due to degenerative joint disease of the wrist, the highest amount for that diagnosis possible under the sixth edition of the A.M.A., *Guides*.[16] He next evaluated appellant's carpal tunnel syndrome, which he found verified by diagnostic studies and on examination, pursuant to Table 15-21 on page 439.[17] Dr. Elkins classified the carpal tunnel syndrome as a mild class 1, with a default value of five percent according to Table 15-21 on page 438. He applied the grade modifiers from Table 15-23 and found an eight percent impairment of each upper extremity.[18] For the thumb, Dr. Elkins identified the diagnosis as post-traumatic degenerative joint disease, which he found yielded a six percent impairment of the digit and two percent impairment of the upper extremity according to Table 15-2 on page 393 of the A.M.A., *Guides*. He combined the impairment ratings to find a 27 percent impairment of each upper extremity. The Board finds that Dr. Elkins' opinion is based on a thorough examination and supports that appellant has no more than a 27 percent impairment of the right upper extremity

[13] A.M.A., *Guides* 405, Table 15-5.

[14] Utilizing the net adjustment formula discussed above, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) or (2-1) + (4-1) + (1-1) = 4, yielded an adjustment of four; however, the most an appellant can receive is an adjustment of two places over and a nine percent permanent impairment. *See supra* note 13.

[15] A.M.A., *Guides* 399, Table 15-4.

[16] *Id*. at 397, Table 15-3.

[17] The A.M.A., *Guides* provides that peripheral nerve impairments may be combined with diagnosis-based impairments as long as the diagnosis-based impairment "does not encompass the nerve impairment." *Id*. at 419.

[18] Carpal tunnel syndrome with positive electrodiagnostic evidence meeting the standards of Appendix 15-B on page 487 is evaluated under Table 15-23. The maximum allowed for grade 1 carpal tunnel syndrome under Table 15-23 is three percent. Dr. Elkins did not address whether the diagnostic studies met the standards of Appendix 15-B; however, any error is harmless as appellant would not receive a greater award for mild carpal tunnel syndrome under Table 15-23.

and a 27 percent permanent impairment of the left upper extremity.[19] There is no evidence supporting that appellant has a greater percentage impairment under the sixth edition of the A.M.A., *Guides*.

On appeal, appellant questioned how Dr. Elkins' opinion constituted the weight of the evidence given that he did not obtain x-rays. Dr. Elkins, however, reviewed the results of objective studies and listed detailed findings on examination; consequently, his opinion is entitled to special weight as the impartial medical examiner.[20]

Appellant further argued that Dr. Schuele found that he had a greater impairment. The Board, however, previously reviewed Dr. Schuele's report in its September 23, 2009 decision and found that it was insufficient to establish the extent of his bilateral upper extremity impairment.

CONCLUSION

The Board finds that appellant has no more than a 27 percent permanent impairment of the right upper extremity and a 27 percent permanent impairment of the left upper extremity.

[19] A.M.A., *Guides* 389, 604.

[20] *See R.R.*, Docket No. 12-1184 (issued April 10, 2013).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 5, 2012 is affirmed.

Issued: July 22, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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