

FACTUAL HISTORY

On January 17, 2009 appellant, then a 42-year-old letter carrier, injured his left elbow and back when he fell while delivering mail on January 17, 2009. He stopped work that day. An April 22, 2009 magnetic resonance imaging (MRI) scan study of the left elbow demonstrated intrasubstance tearing superimposed upon moderate grade common extensor tendinosis. OWCP accepted the conditions of left elbow contusion, left hip contusion and lumbosacral strain. Appellant was placed on the periodic compensation rolls. On June 11, 2009 Dr. William Asa Seeds, a Board-certified orthopedic surgeon, performed a left elbow extensor tendon repair.

Appellant returned to part-time modified duty on October 19, 2009. In a January 4, 2010 report, Dr. Seeds noted the accepted conditions and that appellant complained of occasional pain. Physical examination demonstrated full range of motion of all joints of the left upper extremity with no instability and 5/5 strength. Reflexes and sensation were intact. Dr. Seeds advised that appellant could return to full-time work and follow-up as needed. On January 5, 2010 appellant began full-time, full-duty work.

On September 24, 2010 appellant, through his attorney, requested a schedule award. In a September 8, 2010 report, Dr. William N. Grant, a Board-certified internist, performed an impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).² Dr. Grant advised that appellant had reached maximum medical improvement on the day of his examination. Appellant had a *QuickDASH* score of 77 for the left upper extremity. Regarding appellant's left elbow impairment, Table 15-33, Elbow/Forearm Range of Motion, provided that supination of 30 degrees yielded two percent upper extremity impairment; pronation of 20 degrees yielded three percent impairment; and that flexion and extension were within normal limits, for a total left elbow impairment of five percent. Regarding left arm epicondylitis, under Table 15-20, Brachial Plexus Impairment, appellant had a class 3 impairment due to complex regional pain syndrome, with a default impairment rating of 43 percent. He indicated that appellant had a functional history modifier of 3 due to a *QuickDASH* score and pain symptoms and a physical examination modifier of 3 due to a severe problem per Table 15-6, which yielded a net adjustment of zero, or a total 43 percent upper extremity impairment for brachial plexus injury. Dr. Grant combined the 43 percent brachial plexus impairment and the five percent elbow range of motion impairment, finding a total 46 percent left arm impairment. Regarding the right and left legs, he identified a class 2 impairment under Table 16-12, Peripheral Nerve Impairment, for a moderate motor deficit of the sciatic nerve, which had a default rating of 25 percent for each lower extremity. Dr. Grant concluded that his opinion was based on appellant's history, physical examination and the A.M.A., *Guides*.

In an October 14, 2010 report, Dr. Brian M. Tonne, an OWCP medical adviser and orthopedic surgeon, reviewed the medical record. He was unable to render an opinion regarding the extent of permanent impairment. Dr. Tonne noted that the accepted conditions were left elbow contusion, left hip contusion, and lumbosacral strain, which were mild, soft tissue injuries that would generally be expected to resolve within approximately six weeks. He also noted that

² A.M.A., *Guides* (6th ed. 2008).

appellant underwent surgery for an extensor tear, which was a more significant injury. Dr. Tonne discussed Dr. Grant's report, stating that he provided an impairment rating based upon the conditions of complex regional pain syndrome of the upper extremity and bilateral peripheral nerve impairments of the lower limbs, which had not been accepted as employment related. Further, Dr. Grant's opinion was not consistent with that of appellant's treating physician, Dr. Seeds, who noted on January 4, 2010 that appellant had normal, pain-free bilateral upper extremity range of motion and released him to full duty. Dr. Tonne was unable to provide an impairment rating based on Dr. Grant's report. He recommended a second-opinion evaluation.

On October 21, 2011 OWCP accepted enthesopathy of the left elbow region. On February 8, 2012 it referred appellant to Dr. Manhal Ghanma, a Board-certified orthopedic surgeon, for a second-opinion evaluation.³ In a February 23, 2012 report, Dr. Ghanma noted the history of injury and his review of the medical record. He provided examination findings and advised that maximum medical improvement was reached by January 5, 2011. Dr. Ghanma stated that appellant's left elbow evaluation was performed, based on the accepted condition of enthesopathy of the left elbow, and that the lower extremity evaluation was based on the accepted conditions of left hip contusion and the lumbosacral sprain. He advised that there was insufficient documentation in the medical record to support that appellant had any preexisting impairment of the left hip, the left elbow or the lumbosacral joint. Under Table 15-4, Elbow Regional Grid, of the sixth edition of the A.M.A., *Guides*, for a diagnosis of lateral epicondylitis, appellant had a class 1 impairment with a default grade of C, which yielded a five percent upper extremity impairment. Dr. Ghanma found a grade modifier of two for functional history, based on a *QuickDASH* score of 60; and modifiers of one for physical examination and clinical studies. He then applied the net adjustment formula, finding a plus one modifier, which represented six percent upper extremity impairment for the left elbow condition. With respect to appellant's lower extremities, Dr. Ghanma found that the left hip contusion was a class 0 impairment under Table 16-4, Hip Regional Grid, which yielded no impairment. Regarding the accepted lumbosacral strain, he advised that a review of the physical examination findings of both lower extremities demonstrated no joint abnormalities and no evidence of motor or sensory deficit that would entitle appellant to any impairment for the lower extremities. Dr. Ghanma concluded that appellant had six percent left upper extremity impairment and no impairment of either lower extremity.

On March 22, 2012 Dr. Nabil Angley, an OWCP medical adviser Board-certified in orthopedic surgery, reviewed the record. He agreed that maximum medical improvement was reached on January 5, 2010 and with Dr. Ghanma's conclusion that appellant had no impairment of either lower extremity. Under Table 15-4, appellant had a six percent right upper extremity impairment.

OWCP determined that a conflict in medical evidence was created between the opinions of Dr. Grant, an attending internist, and Dr. Ghanma who provided a second-opinion evaluation for OWCP, and Drs. Tonne and Angley, OWCP's medical advisers, regarding appellant's left

³ OWCP initially indicated that a conflict in medical evidence had been created between the opinions of Dr. Grant and Dr. Tonne. However, in an August 6, 2012 memorandum to file, OWCP indicated that Dr. Ghanma would be considered a second-opinion physician.

upper extremity impairment and referred appellant to Dr. James D. Brodell, a Board-certified orthopedic surgeon, for an impartial evaluation.

In a June 6, 2012 report, Dr. Brodell noted his review of the statement of accepted facts and the case record. He reported the history of injury and appellant's complaint of long-standing, intermittent aching and stiffness about the lateral aspect of the left elbow which was worse with repetitive use and in damp, cold weather, that he had a tendency to drop things, and that on rare occasion he had numbness and tingling in the fingers of the left hand. Dr. Brodell provided physical examination findings, noting that tenderness was present over the lateral epicondyle and extensor origin of the left elbow. Active and passive ranges of motion were normal, with increased pain with resisted wrist flexion and extension. There was no visible atrophy and no abnormal neurovascular findings. Dr. Brodell advised that he took AP and lateral x-rays of the left elbow which demonstrated no significant underlying bony or joint abnormality. He diagnosed lateral enthesopathy, left elbow, status postsurgical repair, and indicated that maximum medical improvement was reached on January 4, 2010 when appellant was released to full duty by Dr. Seeds. Dr. Brodell indicated that, under Table 15-4, for a diagnosis of epicondylitis, status postsurgical release, appellant had a class 1 impairment, which had a default value of five percent. He found modifiers of one for functional history and physical examination, noting that appellant reported very little difficulty with activities of daily living and had been working his regular job for several years, and that strength and elbow range of motion were normal on physical examination with no visible atrophy. Dr. Brodell indicated that the clinical studies modifier was zero, based on appellant's x-ray studies. He also noted that appellant had no symptoms or signs of a brachial plexus lesion or complex regional pain syndrome. Dr. Brodell applied the net adjustment formula, finding an adjustment of minus one to grade B and concluded that appellant had four percent impairment of the left arm.

In a July 10, 2012 report, Dr. Tonne, an OWCP medical adviser, agreed with Dr. Brodell's assessment that maximum medical improvement was reached on January 4, 2010. He indicated that Dr. Grant provided an impairment rating based on conditions that were not accepted as employment related, noting that he concluded that appellant had 46 percent left upper extremity impairment. Dr. Tonne also noted that Dr. Ghanma, OWCP's referral physician, found six percent left upper extremity impairment, whereas Dr. Brodell, the referee physician, opined that appellant had four percent left arm impairment. He indicated that the appropriate diagnosis to be used under Table 15-4 was lateral epicondylitis, status postsurgical release, which yielded a class 1 impairment diagnosis which had a default value of five percent. Dr. Tonne agreed with Dr. Brodell's conclusion that appellant had grade modifiers of one for functional history and physical examination but disagreed with Dr. Brodell's finding of a zero modifier for clinical studies. He, instead, found a modifier of one for clinical studies, noting that there was an MRI scan study that confirmed the accepted diagnosis. After applying the net adjustment formula, Dr. Tonne found a zero adjustment, or class 1, grade C, or five percent impairment of the left upper extremity.

In an August 6, 2012 decision, appellant was granted a schedule award for five percent impairment of the left arm, for a total of 15.6 weeks, to run from January 16 to May 5, 2010. Appellant, through his attorney, timely requested a hearing that was held on December 18, 2012. At the hearing, counsel argued that, as Dr. Ghanma found six percent left upper extremity

impairment, appellant should at least be awarded that amount. He also indicated that he felt 13 percent impairment would be more correct.

In a March 26, 2013 decision, an OWCP hearing representative affirmed the August 6, 2012 decision. The hearing representative found that, in his June 6, 2012 report, Dr. Brodell explained his conclusion that appellant had a four percent left upper extremity impairment under the A.M.A., *Guides*, and that Dr. Tonne, OWCP's medical adviser, discussed his conclusion that appellant was entitled to an additional percentage, based on the MRI scan diagnosis of lateral epicondylitis.

LEGAL PRECEDENT

The schedule award provision of FECA,⁴ and its implementing federal regulations,⁵ 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 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.⁶ For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁷ For decisions issued after May 1, 2009, the sixth edition will be used.⁸

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).⁹ Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).¹⁰ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).¹¹ The sixth edition of the A.M.A., *Guides* also provides that, under certain circumstances, range of motion may be selected as an alternative approach in rating impairment.

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404.

⁶ *Id.* at § 10.404(a).

⁷ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

⁸ FECA Bulletin No. 09-03 (issued March 15, 2009).

⁹ A.M.A., *Guides*, *supra* note 2 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

¹⁰ *Id.* at 385-419.

¹¹ *Id.* at 411.

An impairment rating that is calculated using range of motion may not be combined with a diagnosis-based impairment and stands alone as a rating.¹²

Section 8123(a) of FECA provides that, 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.¹³ The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination, and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.¹⁴ 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.¹⁵

OWCP procedures provide that if a case has been referred for a referee evaluation to resolve the issue of permanent impairment based on a conflict between appellant's physician and an OWCP medical adviser, it is necessary to route the file to a different OWCP medical adviser for review.¹⁶ The procedures further provide that, while an OWCP medical adviser may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility and not that of OWCP's medical adviser. OWCP's medical adviser should not resolve the conflict of medical opinion or attempt to clarify or expand the opinion of the medical referee. If clarification is necessary, a supplementary report should be obtained from the referee specialist.¹⁷

ANALYSIS

The Board finds that this case is not in posture for decision. OWCP accepted that appellant sustained a left elbow contusion, left hip contusion, lumbosacral strain and enthesopathy of the left elbow region. On August 6, 2012 appellant was granted a schedule award for a five percent impairment of the left arm.¹⁸

¹² *Id.* at 390. The A.M.A., *Guides* explains that diagnoses in the grid that may be rated using range of motion are followed by an asterisk.

¹³ 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

¹⁴ 20 C.F.R. § 10.321.

¹⁵ *V.G.*, 59 ECAB 635 (2008).

¹⁶ *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(g) (February 2013).

¹⁷ *Id.* at Chapter 2.808.6(g)(1, 2); *see K.O.*, Docket No. 11-814 (issued December 21, 2011); *Robert R. Lemay*, 56 ECAB 341 (2005).

¹⁸ Appellant has not argued that he is entitled to a schedule award for any lower extremity impairment.

In May 2012 OWCP determined that a conflict in medical evidence arose between Dr. Grant, an attending physician, and Drs. Ghanma and Angley and Tonne, an OWCP referral physician and OWCP's medical advisers. OWCP referred appellant to Dr. Brodell for an impartial evaluation.

In a report dated June 6, 2012, Dr. Brodell noted his review of the statement of accepted facts and medical record. He provided physical examination findings, diagnosed lateral enthesopathy of the left elbow, status postsurgical repair, and provided an impairment evaluation in accordance with the A.M.A., *Guides*. Dr. Brodell found that, under Table 15-4, Elbow Regional Grid,¹⁹ for a diagnosis of epicondylitis, status postsurgical release, appellant had a class 1 impairment, which had a default value of five percent.²⁰ He applied the grade modifiers and net adjustment formula,²¹ to find modifiers of one for functional history and physical examination, and a zero modifier for clinical studies. This yielded a net adjustment of minus one. Dr. Brodell then found that, in accordance with Table 15-4, this moved the default grade of C one position to the left, for a grade of B, which yielded a four percent impairment of the left lower extremity.

On July 10, 2012 Dr. Tonne, an OWCP medical adviser, reviewed Dr. Brodell's report. The record, however, establishes that he previously reviewed the record on October 14, 2010, and his opinion was cited by OWCP as being on one side of the conflict in medical evidence. Dr. Tonne agreed with Dr. Brodell's impairment findings, except that Dr. Tonne noted that appellant had a left elbow MRI scan study that confirmed the accepted diagnosis. He stated that appellant therefore had a modifier of 1 for clinical studies and concluded that, after applying the net adjustment formula, under Table 15-4 the default value or five percent was a more appropriate impairment rating. On August 6, 2012 appellant was granted a schedule award for five percent impairment. This was affirmed by an OWCP hearing representative on March 26, 2013.

The Board finds that Dr. Tonne, OWCP's medical adviser, previously reviewed the case in 2010 and was on one side of conflict in medical evidence. OWCP procedures and Board precedent support that where a referee examination is arranged to resolve a conflict created between a claimant's physician and an OWCP medical adviser with respect to a schedule award issue, the same OWCP medical adviser should not review the referee specialist's report. Rather, a different OWCP medical adviser or consultant should review the file.²² It was therefore error for OWCP to refer Dr. Brodell's June 6, 2012 report to Dr. Tonne.

Moreover, when a case has been referred for an impartial evaluation to resolve the issue of impairment, a medical adviser should not resolve the conflict of medical opinion or attempt to clarify or expand upon the opinion of the medical referee.²³ In this case, Dr. Tonne modified

¹⁹ A.M.A., *Guides*, *supra* note 2 at 398-400.

²⁰ *Id.* at 399.

²¹ *Id.* at 405-12.

²² See Federal (FECA) Procedure Manual, *supra* note 16; *Richard R. Lemay*, *supra* note 17.

²³ *Supra* note 17.

Dr. Brodell's opinion that appellant had four percent impairment. He found that appellant had a modifier of 1 for clinical studies and had a five percent left arm impairment.

The case will therefore be remanded for OWCP to obtain a supplemental report from Dr. Brodell, the impartial specialist, who should be provided with a copy of the August 22, 2009 left elbow MRI scan study and asked to further address appellant's modifier under clinical studies. Upon receipt of Dr. Brodell's supplemental report and such further development as deemed necessary, OWCP shall issue an appropriate decision.

CONCLUSION

The Board finds this case is not in posture for decision regarding the degree of appellant's left upper extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the March 26, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: February 24, 2014
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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