U. S. DEPARTMENT OF LABOR

# Employees' Compensation Appeals Board

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In the Matter of STEPHEN R. MASICA and U.S. POSTAL SERVICE, MINNEAPOLIS INFORMATION SERVICE CENTER, Minneapolis, MN

*Docket No. 98-598; Submitted on the Record;*
*Issued October 5, 1999*

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DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
BRADLEY T. KNOTT

The issue is whether appellant has met his burden of proof to establish that he is entitled to a schedule award for permanent impairment of his right upper extremity.

The Board has duly reviewed the case record and finds that this case is not in posture for decision.

On May 25, 1991 appellant, then a 47-year-old computer systems analyst, filed a claim for occupational disease alleging that he had sustained injuries to his arms as a result of his federal employment duties. After a period of medical and factual development, on October 25, 1995, the Office of Workers' Compensation Programs accepted appellant's claim for lateral epicondylitis of both elbows and tendinitis of both hands and elbows and authorized appropriate compensation benefits.[1] On January 12, 1996 appellant filed a claim for a schedule award. In a decision dated August 27, 1996, the Office denied appellant's request for a schedule award. After a review of the written record, an Office hearing representative affirmed the denial of a schedule award by decision dated September 10, 1997.

Section 8107 of the Federal Employees' Compensation Act provides that if there is a permanent impairment involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[2] Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the American Medical Association, *Guides to the*

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[1] Appellant did not lose any time from work due to his medical condition but was approved for disability retirement effective November 17, 1995 and stopped work at that time.

[2] 5 U.S.C. § 8107.

*Evaluation of Permanent Impairment* as a standard for evaluating schedule losses and the Board has concurred in such adoption.[3]

In a report dated December 18, 1995, appellant's treating physician, Dr. John F. Bowar, a Board-certified physiatrist, noted that appellant is a C5 quadriplegic who developed employment-related chronic right arm pain "related to tendinitis and a peripheral nerve injury."[4] When asked by the Office to determine, pursuant to the A.M.A., *Guides*, whether appellant suffered from any permanent employment-related impairment, Dr. Bowar stated:

> "Unfortunately range of motion and exact sensory deficits are virtually impossible to quantify in the Fourth Edition of the A.M.A., Guidelines for Physical Impairment in view of his quadriplegia and the fact that there is no exact way of placing his problem in one category and I have attempted to give a 'best explanation' rating.
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> "It is my opinion that [appellant] has a peripheral nerve involvement of the radial right second digit and the ulnar side of the right thumb. I believe these are best described on Table 11, [p]age 48 as being in the 80 to 100 percent category or a Grade 5 in view of his inability to function at work without pain. It is my understanding this falls into Table 15, radial palmar digital of the index finger for a 5 percent and the ulnar/palmar of the thumb 11 percent deficit. This gives a combined rating under this scale of 16 percent.
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> "He, in addition, has chronic pain involving the right forearm extensor musculature to which Dr. Wengler refers. This unfortunately is [appellant's] primary means of using his hands, *i.e.*, an extensor and tendonesis effect. Because of the extensor tendon pain I would give him a 40 percent digit impairment from Table 29, [p]age 63, since it relates more to the function involving his entire wrist which is an upper extremity impairment of 60 percent and a whole person impairment of 36 percent.
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> "It is my understanding this gives him a combined rating of 40 percent of the whole body. I believe this is a fairly complex and confusing grading but it best explains his problems using the A.M.A., Guidelines of Impairment fourth edition."

In a follow-up report, Dr. Bowar stated that appellant had reached maximum medical improvement on June 30, 1995.

The Office referred appellant to Dr. Chris Tountas, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a report dated April 1, 1996, Dr. Tountas discussed the result of his physical examination, including appellant's active ranges of motion, and reviewed the

[3] *James J. Hjort*, 45 ECAB 595 (1994).

[4] Appellant's C5 quadriplegia is preexisting and nonemployment related. Appellant has complete lower body paralysis, necessitating the use of a wheelchair, and partial upper body paralysis.

relevant medical evidence of file. Dr. Tountas opined that appellant had reached maximum medical improvement on August 31, 1995 and concluded:

> "The findings indicate a very mild lateral epicondylitis and a strain or tendinitis of the metacarpophalangeal joint at the right index finger. These conditions are secondary to compensatory movements required in the right upper extremity for his work and activities of daily living. There are no findings on the left of recent pathology. All of the objective findings, however, that is relative to decreased strength atrophy of muscle, change in sensation, and limited motion are secondary to the C5 quadriplegia.
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> "There are subjective complaints of a chronic nature which are fairly localized but, which in my opinion, do not cause impairment….
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> "Based on the A.M.A., Guidelines for the evaluation of permanent impairment, there are none relative to any work-related conditions or diagnoses, that is epicondylitis or tendinitis. In my opinion there is no evidence for a digital nerve injury to the right hand."[5]

Subsequently, in conjunction with appellant's request for a review of the written record, appellant submitted additional medical evidence in support of his claim. In addition to updated reports from Dr. Bowar, who reiterated his earlier conclusions, appellant submitted several reports from Dr. Robert A. Wengler, a Board-certified orthopedic surgeon. Dr. Wengler initially saw appellant at the request of the Office with respect to appellant's original claim for occupational disease, but later continued to treat appellant. In his initial reports contained in the file, Dr. Wengler opined that he expected appellant's symptoms to subside if he were removed from exposure to the activities that aggravated them. He added, however, that "on occasions we see permanent symptoms even after the activities are discontinued…." In a letter to appellant dated January 2, 1997, Dr. Wengler referenced his earlier statements regarding the occasional permanency of conditions such as appellant's, indicated his concurrence with Dr. Bowar's earlier conclusions regarding the permanency of appellant's specific conditions, and expressed a willingness to reexamine appellant and amend his earlier opinions as appropriate. On February 3, 1997 Dr. Wengler reexamined appellant and listed his findings. In an April 7, 1997 letter to appellant Dr. Wengler expressed his conclusion with respect to the question of the permanency of appellant's condition, stating:

> "In response to your question, functional impairment ratings may be allowed on the basis of the A.M.A., Guide to Physical Impairment, fourth edition. It is my understanding that you have developed loss of sensation over the ulnar distribution of the right hand and the medial distribution of the index finger. According to the A.M.A., Guide, sensory loss for the ulnar distribution of the

[5] In his report, Dr. Tountas stated that an electromyogram performed on May 16, 1995 indicated mild right ulnar neuropathy localized to the elbow but showed no evidence of right medial neuropathy at the wrist (carpal tunnel syndrome). He further noted that the findings were compatible with chronic right C7 radiculopathy but showed no evidence of ongoing denervation, and that changes seen were compatible with central dysfunction involving C8-T1 innervated muscles.

thumb allows 11 percent whole body impairment of the upper extremity whereas loss of sensation of the radial distribution of the index finger allows five percent. The combined impairment rating for loss of sensation is 16 percent of the arm.

"The incapacitation that you are experiencing due to the flexor and extensor tendinitis of the elbow, even though limited to specific areas of the elbow, result in a major incapacitation with respect to the residual you had at that limb secondary to your paraplegia. Loss of the use of your wrist has resulted in 60 percent permanent partial impairment of function of the upper extremity as defined by Table 18 of page 58 of the Guide. The 60 percent loss of function of the upper extremity is equated to 36 percent whole body impairment.

"The 16 percent impairment of function of the arm resulting from the loss of sensation ciphers to 10 percent whole body impairment using the 60 percent conversion factor. The total rated impairment allowable for loss of use of the arm is 46 percent whole body impairment."

At the request of the Office, Dr. Neven A. Popovic, an Office medical adviser, reviewed the case record on August 6, 1997 and stated:

"I do not disagree with the claimant's treating physicians that he has a chronic medical problem with his upper extremities. However, looking at the available physical data and results of physical examinations by various physicians (as noted in the record) and by using the A.M.A., Guide fourth edition, I cannot assign any permanent partial impairment to the upper extremities as related to previously accepted work[-]related conditions of bilateral lateral epicondylitis of the elbows and tendinitis of the hands."

Section 8123 of 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.[6]

As a conflict in medical opinion exists between appellant's treating physicians, Drs. Bowar and Wengler,[7] who opined that appellant has an employment-related permanent impairment of the right upper extremity, and Drs. Tountas and Popovic, the Office referral physicians, who opined that appellant has no measurable employment-related permanent impairment of his upper extremities, this case must be remanded for further development of the medical evidence. Upon remand, the Office shall refer appellant to an impartial medical specialist to resolve whether appellant has a permanent impairment of the right upper extremity due to his accepted medical conditions, pursuant to the A.M.A., *Guides*. After such further development as necessary, the Office shall issue a *de novo* decision.

[6] *Shirley L. Steib*, 46 ECAB 309 (1994).

[7] The Board notes that although Dr. Wengler was initially an Office referral physician, as appellant subsequently returned to Dr. Wengler on his own, requesting evaluations and reports in support of his claim, the doctor is deemed appellant's physician; *see Mohamed Yunis*, 42 ECAB 325 (1991).

The decision of the Office of Workers' Compensation Programs dated September 10, 1997 is hereby set aside and this case is remanded to the Office for further proceedings consistent with this opinion.

Dated, Washington, D.C.
October 5, 1999

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member