United States Department of Labor
Employees' Compensation Appeals Board

STEPHEN R. DUTY, Appellant	)	
and	)	**Docket No. 04-808**
	)	**Issued: July 21, 2004**
DEPARTMENT OF THE AIR FORCE, OKLAHOMA CITY AIR LOGISTICS CENTER, TINKER AIR FORCE BASE, OK, Employer	)	

Appearances:
James R. Linehan, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
MICHAEL E. GROOM, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On February 6, 2004 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit schedule award decision dated January 7, 2004, finding that he had no more than an additional one percent impairment of the left upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award.

ISSUE

The issue on appeal is whether appellant sustained more than a nine percent permanent impairment of the left upper extremity.

FACTUAL HISTORY

This is the third appeal in this case. The Board, by decision dated October 16, 2002, found that there existed a conflict of medical opinion between an Office referral physician, Dr. Richard A. Ruffin, a Board-certified orthopedic surgeon, and Dr. John W. Ellis, appellant's treating physician, regarding the percentage of impairment to appellant's upper extremities.[1] The Board set aside the July 24, 2001 and February 25, 2002 Office schedule awards granting five percent impairment to each upper extremity and remanded the case to the Office for referral of appellant to an impartial medical specialist. In an August 12, 2003 decision, the Board set aside Office decisions dated April 13 and February 21, 2003 and April 16, 2002 which granted an additional three percent impairment of the left upper extremity and remanded the case for further development.[2] The Board found, that the Office improperly selected Dr. Robert Unsell to serve as an impartial medical specialist as the physician was not a Board-certified specialist. The law and the facts of the case are set forth in the Board's prior decisions and are incorporated herein by reference.

On remand the Office referred appellant to Dr. Bernie McCaskill, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on the extent of the permanent impairment of appellant's left upper extremity.

In a report dated November 25, 2003, Dr. McCaskill provided a description of the factual and medical history and reported his findings on examination. He indicated that appellant had full active range of motion of the cervical spine and of both upper extremities. The physician also indicated that measurements taken with a goniometer, demonstrated full active extension of each elbow, 120 degrees of active elbow flexion bilaterally, 90 degrees of active forearm pronation bilaterally and 80 degrees of active forearm supination bilaterally. Regarding the wrists, Dr. McCaskill noted that appellant had 60 degrees of active flexion of each wrist, 70 degrees of active extension of each wrist, 20 degrees of active radial deviation of each wrist and 40 degrees of active ulnar deviation of each wrist. He noted no obvious swelling, atrophy or deformity in either upper extremity, some local tenderness over the lateral epicondyle of each elbow and that radial pulses were full and intact bilaterally. Dr. McCaskill advised that appellant had elbow flexion and extensor weakness which appeared to be related to pain resulting from lateral epicondylitis of each elbow. He indicated that appellant had one grade of elbow flexor weakness and forearm supination weakness bilaterally which also appeared to be related to pain resulting from the lateral epicondylitis of each elbow. Dr. McCaskill noted that appellant was sensitive to percussion over his left transverse carpal ligament but not over his right transverse carpal ligament and that there were otherwise no abnormal neurological findings noted in either upper extremity.

Dr. McCaskill diagnosed bilateral epicondylitis of each elbow, bilateral elbow flexion and supination weakness secondary to lateral epicondylitis of each elbow, and bilateral carpal tunnel entrapment of each median nerve, noting they were all chronic. He explained that the

[1] Docket No. 02-1361 (issued October 16, 2002).

[2] Docket No. 03-1500 (issued August 12, 2003).

only abnormal physical findings related to the accepted diagnoses were those of slight loss of active elbow flexion bilaterally and bilateral elbow flexion and supination weakness which appeared to be related to pain from lateral epicondylitis rather than resultant from neurological, dysfunction and sensitivity to percussion over his left transverse carpal ligament. Dr. McCaskill explained that appellant did not otherwise have objective evidence of neurological dysfunction in that he had no physical findings consistent with specific peripheral nerve entrapment. He specifically noted that appellant did not have any weakness of opposition of either thumb as might be present with advanced changes related to carpal tunnel entrapment of either median nerve. Dr. McCaskill further noted that appellant did not have limitation of active motion of both wrist and demonstrated normal sensation in both hands.

Dr. McCaskill opined that appellant's impairment was related to bilateral elbow flexion and bilateral forearm supination weakness secondary to lateral epicondylitis. He indicated that the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (5th ed. 2001) (A.M.A., *Guides*) did not provide a specific impairment for such a weakness of nonneurological origin given the lack of other significant abnormal physical findings. However, Dr. McCaskill opined that appellant's weakness was legitimate, significant and related to the accepted condition of lateral epicondylitis, and assigned an impairment pursuant to Table 16.15 of the A.M.A., *Guides.*[3] He determined that a motor deficit for dysfunction was related to appellant's weakness based on his diagnosis of a radial nerve lesion sparing of the triceps. Dr. McCaskill noted that under Table 16-15 the maximum impairment related to motor deficit for this dysfunction was equivalent to 35 percent. He explained that, because appellant had one grade of weakness bilaterally, his impairment related to weakness would best be described as .20 x 35 or a 7 percent impairment to each extremity.[4] He further advised that appellant had a two percent impairment to each upper extremity resultant from loss of active flexion of each elbow as indicated in Figure 16.34 of the A.M.A., *Guides.*[5] The physician concluded that appellant had a total impairment to each upper extremity of nine percent and a total impairment to the whole body of five percent resulting from each upper extremity injury and a total permanent physical impairment to the whole body of ten percent.

On December 19, 2003 an Office medical adviser reviewed Dr. McCaskill's November 25, 2003 report, and concurred with Dr. McCaskill's findings that appellant had a nine percent impairment of both upper extremities. Regarding the left upper extremity, he referred to Table 16.15 of the A.M.A., *Guides*[6] and utilized the 35 percent figure of Dr. McCaskill, as this was the maximum impairment related to motor deficits. The Office medical adviser also referred to Table 16-11 and noted that a Grade 4 was in the 1 to 25 percent range and he multiplied .20 x 35 finding a 7 percent impairment to the left upper extremity.[7] He further advised that appellant had loss of flexion which equaled a two percent impairment to the

[3] A.M.A., *Guides,* 492, Table 16.15.

[4] *Id.* at 484 Table 16-11.

[5] *Id.* at 472, Figure 16-34.

[6] *Id.* at 492, Table 16.15.

[7] *Id.* at 484, Table 16-11.

left upper extremity as indicated in Figure 16.34 of the A.M.A., *Guides*.[8] Accordingly, the Office medical adviser concluded that appellant had a nine percent impairment of the left upper extremity. Additionally, the Office medical adviser noted that appellant had previously received schedule awards and advised that these should be subtracted from the current rating.

By decision dated January 7, 2004, the Office determined that appellant was entitled to an additional schedule award of one percent to the left upper extremity. The Office noted that appellant had already received schedule awards totaling eight percent for the left upper extremity.[9]

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[10] and its implementing regulation[11] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of specified members or functions of the body. However, the Act does not specify the manner in which the percentage loss shall be determined. For consistent results and to ensure equal justice under the law to all appellants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[12] Neither the Act nor its implementing federal regulations provides for a schedule award for impairment to the back or to the body as a whole. Furthermore, the back is specifically excluded from the definition of "organ" under the Act.[13]

ANALYSIS

On appeal, appellant alleged that there was a discrepancy between his physician and the Office physician and he believed he was entitled to a greater schedule award. However, appellant is not a physician as defined under the Act,[14] therefore, his argument concerning whether he is entitled to an additional award is not relevant as they do not carry any weight. The

[8] *Id.* at 472, Figure 16-34.

[9] The Board notes that the record before the Board does not contain a schedule award with regard to the right upper extremity. As this matter is in an interlocutory position, it is not before the Board in the present appeal. *See* 20 C.F.R. § 501.2(c).

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] FECA Bulletin No. 01-05 (issued January 29, 2001); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

[13] *Terry E. Mills*, 47 ECAB 309 (1996).

[14] *See* 5 U.S.C. § 8101(2); *Sheila G. Peckenschneider*, 49 ECAB 430, 432 (1998); *Arnold A. Alley*, 44 ECAB 920-21 (1993).

Board notes that appellant was not entitled to any schedule award based on impairment pertaining solely to his back or for whole person impairment.[15]

In the instant case, the Office based its nine percent left upper extremity schedule award on the opinion of the impartial medical specialist, Dr. McCaskill. He noted appellant's history of injury and treatment, examined appellant, took measurements, and reviewed the A.M.A., *Guides.* In accordance with the A.M.A. *Guides,* he advised that appellant was entitled to a nine percent impairment of the right and left lower extremities and explained his findings under the A.M.A., *Guides.* The physician referenced page 492, Table 16-15[16] regarding appellant's dysfunction for peripheral nerve injury which provides a maximum impairment to motor deficit for dysfunction of 35 percent. He utilized a finding of 20 percent for appellant's weakness according to Table 16-11 and properly calculated a 7 percent impairment for each extremity.[17] He added a two percent impairment for each extremity pursuant to Figure 16-34[18] for a total impairment to each upper extremity of nine percent. In a December 24, 2003 report, the Office medical adviser agreed with Dr. McCaskill's application of the A.M.A., *Guides*.[19] The Office medical adviser noted that appellant had previously received schedule awards for his upper extremities, which should be subtracted from the total. In the January 7, 2004 schedule award decision, the Office noted that appellant had previously received awards for eight percent impairment of his left upper extremity and granted him an additional award of one percent.

In situations where 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.[20] The Board finds that the opinion of Dr. McCaskill is entitled to special weight. Dr. McCaskill reviewed appellant's medical records and provided detailed physical and objective findings on examination. He discussed the diagnostic testing, explained his clinical findings, referred to the fifth edition of the A.M.A., *Guides* and provided medical rationale to support his conclusion that appellant was entitled to no more than a nine percent impairment of the left upper extremity. The Board finds that the weight of the medical opinion evidence is represented by the well-rationalized opinion of Dr. McCaskill which is based on a complete and accurate factual and medical background.

Appellant has not provided any medical reports, based on objective findings, which establish that he is entitled to more than a nine percent permanent impairment of the left lower extremity for which he received a schedule award. Therefore, appellant has failed to establish his entitlement to an increased schedule award.

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[15] *See* footnote 6.

[16] A.M.A., *Guides* 492, Table 16-15.

[17] *Id.* at 484, Table 16-11.

[18] *Id.* at 472, Figure 16-34.

[19] The fifth edition of the A.M.A., *Guides* became effective February 1, 2001. FECA Bulletin No. 01-05 (issued January 29, 2001) provides that any initial schedule award decision issued on or after February 1, 2001 will be based on the fifth edition of the A.M.A., *Guides*, even if the amount of the award was calculated prior to that date.

[20] *Guiseppe Aversa*, 55 ECAB ___ (Docket No. 03-2042, issued December 12, 2003).

CONCLUSION

The Board finds that appellant has not established that he sustained more than a nine percent permanent impairment of the left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 7, 2004 is hereby affirmed.

Issued: July 21, 2004
Washington, DC

Colleen Duffy Kiko
Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member