United States Department of Labor
Employees' Compensation Appeals Board

J.D., Appellant **and** **DEPARTMENT OF THE ARMY, PROVOST MARSHAL OFFICE, Fort Monmouth, NJ, Employer**	)	**Docket No. 06-700** **Issued: August 2, 2006**

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge

JURISDICTION

On January 30, 2006 appellant filed a timely appeal from the October 4, 2005 merit decision of the Office of Workers' Compensation Programs, which denied an amended schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the schedule award issue.

ISSUE

The issue is whether appellant has more than a 21 percent permanent impairment of his right upper extremity.

FACTUAL HISTORY

On January 28, 2000 appellant, then a 55-year-old lead police officer, sustained an injury in the performance of duty when he slipped on ice in the employing establishment parking lot and fell. The Office accepted his claim for multiple contusions and right shoulder bursitis. Appellant received compensation for temporary total disability on the periodic rolls. The Office authorized right shoulder surgery. On April 27, 2000 he underwent a right shoulder arthroscopy

with extensive debridement, a right shoulder acromioplasty, bursectomy and release of the coracoacromial ligament and a partial excision of the clavicle at the acromioclavicular joint inferior surface. The Office expanded its acceptance of appellant's claim to include a right rotator cuff tear.

On March 7, 2002 the Office issued a schedule award for an 11 percent permanent loss of use of the right shoulder due to loss of shoulder motion. In a decision dated July 28, 2003, an Office hearing representative found that a conflict had arisen between the Office referral physician and appellant's physician, who reported more severe physical findings. To resolve the conflict, the Office referred appellant, together with the case file and a statement of accepted facts, to Dr. Ian Blair Fries, a Board-certified orthopedic surgeon.

On October 6, 2003 Dr. Fries reported that appellant had a 15 percent impairment of the right upper extremity due to loss of shoulder motion, a 5 percent impairment due to a partial acromioclavicular arthroplasty and a 3 percent impairment following an approved postsurgical release for right carpal tunnel syndrome. He combined the first 2 impairments for 19 percent, which he then combined with 3 percent for a total right upper extremity impairment of 23 percent. Dr. Fries also reported a three percent impairment of the left upper extremity due to an approved surgical release for left carpal tunnel syndrome. He reported the following in bold print: "Therefore, the impairment ratings of [appellant] based upon the A.M.A., *Guides* [American Medical Association, *Guides to the Evaluation of Permanent Impairment*] (5th [e]d. [2001]) are; right upper extremity 19 percent and left upper extremity 3 percent." An Office medical adviser reviewed his findings and determined that appellant had a 21 percent permanent impairment of his right upper extremity and a 3 percent permanent impairment of the left.

In a decision dated December 8, 2003, the Office issued an amended schedule award for an additional 10 percent permanent impairment of the right upper extremity for a total impairment of 21 percent.[1] In a decision dated August 2, 2004, an Office hearing representative set aside the December 8, 2003 decision and remanded the case for further development. The hearing representative found that Dr. Fries' report required clarification because he inconsistently reported the total impairment of appellant's right upper extremity.

In a supplemental report dated February 9, 2005, Dr. Fries confirmed a mathematical error in his earlier report. He clarified that the 19 percent impairment for decreased shoulder motion and partial acromioclavicular arthroplasty combines with the 3 percent impairment following postsurgical release of right carpal tunnel syndrome for a 21 percent total impairment of the right upper extremity.

In a decision dated March 9, 2005, the Office denied any additional schedule award for the right upper extremity beyond the 21 percent previously awarded.

Appellant, through his attorney, requested an oral hearing before an Office hearing representative, which was held on July 12, 2005. He testified about the problems he was currently having with his right arm. Appellant's attorney argued that Dr. Fries should have measured motor deficits and loss of grip strength and should have estimated 10 percent for the

[1] The Office mistakenly referred to the right lower extremity.

acromioclavicular arthroplasty. He argued that clarification from Dr. Fries would be appropriate, that there should be some explanation for estimating only five percent for the distal resection.

In a decision dated October 4, 2005, the hearing representative affirmed the denial of an additional schedule award.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[2] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[3]

Section 8123(a) of the Act provides in part: "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."[4] 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.[5]

When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report. When the impartial medical specialist's statement of clarification or elaboration is not forthcoming or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative or lacks rationale, the Office must submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question.[6] Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Act will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[7]

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[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

[4] 5 U.S.C. § 8123(a).

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

[6] *See Nathan L. Harrell*, 41 ECAB 402 (1990).

[7] *Harold Travis*, 30 ECAB 1071 (1979).

ANALYSIS

In his October 6, 2003 report, Dr. Fries, the impartial medical specialist, reported that appellant had a 15 percent impairment of the right upper extremity due to loss of shoulder motion. Using the fifth edition of the A.M.A., *Guides*, he correctly determined the impairment value contributed by each of the six units of motion and he correctly added these values to arrive at the rating for loss of shoulder motion.[8]

When other criteria do not adequately encompass the extent of the impairment, the evaluating physician may consider impairments due to other disorders, such as impairment of the upper extremity following arthroplasty of specific joints.[9] Table 16-27, page 506, of the A.M.A., *Guides* provides a 10 percent estimate of impairment for a total shoulder distal clavicle (isolated) resection arthroplasty. On April 27, 2000 appellant underwent a partial excision of the clavicle at the acromioclavicular joint inferior surface. The Board therefore finds that Dr. Fries provided justification for rating the impairment due to partial resection arthroplasty at five percent.

In the presence of decreased motion, motion impairments are derived separately and combined with the arthroplasty impairment using the Combined Values Chart at page 604 of the A.M.A., *Guides*.[10] The 15 percent impairment due to loss of shoulder motion combines with the 5 percent impairment for a partial resection arthroplasty for a 19 percent impairment of the right upper extremity.

Finally, Dr. Fries estimated a three percent impairment of the right upper extremity due to residuals of carpal tunnel syndrome following surgical release. But he expressed doubt whether appellant had any such residuals:

> "I recommended electrodiagnostic studies of both upper extremities to document his sensory condition and the status of his bilateral carpal tunnel syndromes. A copy of the studies performed by Dr. Sung Paik on September 30, 2003 is attached. He found evidence of median and ulnar diabetic neuropathies in the right and left upper extremities. There were no clear residuals of his alleged carpal tunnel syndromes. [I confirmed this in a telephone conference with Dr. Paik.]"

Nonetheless, Dr. Fries offered an impairment rating for residuals of carpal tunnel syndrome:

> "[Appellant] has bilateral median and ulnar peripheral neuropathies documented on electrodiagnostic studies. Therefore, the three percent per hand is based upon a surmise some of the electrical abnormalities might be due to carpal tunnel

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[8] A.M.A., *Guides* Figure 16-40, page 476; Figure 16-43, page 477; Figure 16-46, page 479. The upper extremity impairment resulting from abnormal shoulder motion is calculated from the pie charges by adding directly the upper extremity impairment values contributed by each motion unit. *Id*. at 474.

[9] *Id*. at 499, 505.

[10] *Id*. at 505.

residuals. I have not awarded the maximum of five percent with clear electrical abnormalities of carpal tunnel syndrome (See page 495, 2.). His peripheral neuropathies are not work related, but are probably diabetic. I have not rated his peripheral neuropathies, nor his early bilateral Dupuytren's disorder. [Appellant's] pain complaints are not outstanding for his pathology and thus he does not qualify for an additional pain rating."

The Board finds that the rating given by Dr. Fries for residuals of carpal tunnel syndrome is not well supported. Where the electrodiagnostic studies show evidence of diabetic peripheral neuropathies with no clear residuals of carpal tunnel syndrome, the physician evaluating impairment should not give an estimate for residuals "based upon a surmise." Appellant is not entitled to a schedule award for residuals of carpal tunnel syndrome.

Nonetheless, appellant is entitled to a schedule award for the full amount of the permanent loss of use of the member, including the loss caused by a preexisting nonemployment-related impairment as well as the increased impairment caused by the employment injury.[11] It does not matter that his median and ulnar neuropathies are diabetic and not work related. So long as the neuropathies preexisted the January 28, 2000 employment injury, appellant's schedule award must include any resulting impairment.

The Board will set aside the Office's October 4, 2005 decision and remand the case for a supplemental report from Dr. Fries. This is not a case in which the impartial medical specialist's statement of clarification or elaboration was not forthcoming or in which the specialist was unable to clarify or elaborate on the original report or in which the specialist's supplemental report was also vague, speculative or lacking in rationale. Dr. Fries should therefore be given an opportunity to supplement his otherwise fine report with a rating for any preexisting peripheral neuropathies applying the procedures and grading schemes set out in Table 16-10, page 482 and Table 16-11, page 484 of the A.M.A., *Guides*. He should also elaborate on appellant's early Dupuytren's contracture: whether it was preexisting, to what is it "incidental" and, if necessary, how best to rate any impairment therefrom under the A.M.A., *Guides*.[12] After such further development of the evidence as may be necessary, the Office shall issue an appropriate final decision on appellant's entitlement to a schedule award.

CONCLUSION

The Board finds that this case is not in posture for decision. Further, development of the medical evidence is warranted.

[11] *Frances Marie Kral*, 24 ECAB 157, 162 (1972).

[12] Both Dr. Fries and the Office hearing representative, in his October 4, 2005 decision, have well explained why a rating for pain, loss of grip or loss of pinch strength is not justified and their comments need not be repeated here.

ORDER

IT IS HEREBY ORDERED THAT the October 4, 2005 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: August 2, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board