United States Department of Labor
Employees' Compensation Appeals Board

P.F., Appellant	)	
and	)	**Docket No. 06-1160**
	)	**Issued: August 25, 2006**
DEPARTMENT OF THE ARMY, MADIGAN ARMY MEDICAL CENTER, FORT LEWIS, WA, Employer	)	

Appearances:
P.F., pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On April 19, 2006 appellant filed a timely appeal from decisions of the Office of Workers' Compensation Programs dated February 10 and March 28, 2006, which found that she was not entitled to a schedule award. Pursuant to 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 any permanent impairment caused by her accepted conditions that would entitle her to a schedule award. On appeal, appellant alleges that Dr. Daniel A. Brzusek, an osteopath, was not her attending physician but an Office referral physician and alleged bias on the part of Dr. David S. Smith, a Board-certified orthopedic surgeon, who provided a second opinion evaluation for the Office. She also contends that Dr. Donald D. Hubbard, also Board-certified in orthopedic surgery, who acted as referee examiner was improperly selected.

FACTUAL HISTORY

On October 21, 2004 appellant, then a 47-year-old secretary, filed a Form CA-2, occupational disease claim, alleging that factors of employment caused a left ulnar problem. She did not stop work and later transferred to a research assistant position.[1] On January 20, 2005 the Office accepted that she sustained an employment-related left medial and lateral epicondylitis. By letter dated April 15, 2005, the Office informed her of the evidence she would need to provide to support a claim for a schedule award. On May 2, 2005 she filed a schedule award claim and submitted an April 11, 2005 report from Dr. Robert Wallach, an osteopath, who opined that electromyographic studies were normal and that she had reached maximum medical improvement.

In an April 17, 2005 report, Dr. Brzusek, who practices rehabilitation medicine, provided examination findings for appellant's left upper extremity, noting severe tenderness in the medial and lateral epicondyle. Range of motion was normal and grip strength was decreased. He diagnosed repetitive stress injury of the left upper extremity and medial and lateral epicondylitis. He advised that, pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (hereinafter),[2] tendinitis was to be evaluated in accordance with section 16.7d and that under Tables 16-31 and 16-34, she was entitled to a 54 percent strength loss, which equaled a 20 percent left upper extremity impairment.

In a July 19, 2005 report, an Office medical adviser disagreed with Dr. Brzusek's determination that tendinitis should be based on loss of grip strength in this case as there had been no tendon rupture or surgical release as required at section 16.7d of the A.M.A., *Guides*. He recommended a second opinion evaluation. On September 16, 2005 the Office referred appellant to Dr. Smith. In an October 17, 2005 report, he reviewed the record. Examination of the left upper extremity demonstrated areas of tenderness and full range of motion. He found no evidence of medial or lateral epicondylitis, opining that appellant had generalized pain of the left forearm and hand without clear etiology and concluded that she was at maximum medical improvement. He agreed with the Office medical adviser that it was inappropriate to evaluate appellant's left upper extremity using grip strength and concluded that she had no impairment on an objective basis.

The Office determined that a conflict in medical evidence existed between the opinions of Dr. Brzusek and Dr. Smith regarding whether appellant had a permanent impairment of the left upper extremity. By letter dated January 10, 2006, appellant was referred to Dr. Hubbard for a referee evaluation to provide an impairment rating in accordance with the A.M.A., *Guides*.[3]

In a January 24, 2006 report, Dr. Hubbard noted appellant's history of thoracic outlet syndrome with surgery in 2000 and his review of the statement of accepted facts and medical record. He reported appellant's complaints of left arm weakness from her elbow into her fingers;

[1] The research assistant position did not have the heavy typing requirement of her previous secretarial position.

[2] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[3] Both Dr. Smith and Dr. Hubbard were provided with a statement of accepted facts, a set of questions and the medical record.

difficulty holding onto objects without pain or stiffness; limited elbow, forearm and hand movement; forearm muscle tightness, pain and swelling; weakness of forearm function and strength; tenderness at the elbow which would awaken her at night; and numbness in the hand and forearm when the elbow was bent. Examination findings included full shoulder and elbow range of motion and tenderness to palpation of the thenar eminence of the dorsal surface of the forearm extending from the wrist to the lateral and medial epicondyle but not over the flexor or extensor musculature of the forearm. Palpation of these structures caused a numbness sensation of the third and fourth fingers with no tenderness of the wrist or hand and no evidence of inflammation in the left upper extremity. Dr. Hubbard advised that appellant's left upper extremity motor strength was influenced by pain and was, therefore, invalid but that true provocative tests for lateral and medial epicondylitis were normal. He also advised that grip strength on the left was influenced by pain, noting that dynamometer testing showed significant variations and that a fibromyalgia screen was negative. His diagnostic conclusion was that appellant's medial and lateral epicondylitis were caused by overuse at work and had objectively resolved. He noted that her history of left upper extremity chronic pain and other neuromusculoskeletal symptoms and complaints was of undetermined etiology. He found no objective evidence of recurrent thoracic outlet syndrome, brachial plexopathy, peripheral entrapment of nerve, peripheral neuropathy or residual classic medial or lateral epicondylitis. Dr. Hubbard advised that an impairment rating under section 16.7d of the A.M.A., *Guides* was not appropriate as appellant failed to meet the two required criteria. He noted that appellant's symptoms well exceeded those typically found with medial and lateral epicondylitis and that some of her symptoms and subjective findings were reminiscent of residual neurogenic thoracic outlet syndrome without objective confirmation. He concluded that maximum medical improvement had been reached in April 2005, when she transferred to an occupation that did not require repetitive use of the left upper extremity.

By decision dated February 10, 2006, the Office found that appellant was not entitled to a schedule award for her accepted left upper extremity condition. On February 13, 2006 she requested reconsideration, alleging that Dr. Smith was biased and that the appointment scheduler for the Office, Barbara McDonald, had a personal connection with Dr. Hubbard's office and that she was told that Drs. Hubbard and Brzusek were once partners.[4] Appellant also resubmitted Dr. Wallach's April 11, 2005 report. In a March 28, 2006 decision, the Office found that appellant was not entitled to a schedule award. The Office noted that the medical report submitted did not contain an impairment rating and that Ms. McDonald did not schedule medical appointments. The Office further noted that upon calling Dr. Hubbard's office, the claims examiner was told that he and Dr. Brzusek had never been partners.[5]

[4] Appellant also noted that she formerly worked for the Office and Ms. McDonald had been her supervisor.

[5] While the Office characterized the decision as a nonmerit denial of appellant's reconsideration request, the language of the decisions shows that the merits of her arguments were weighed.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[6] and section 10.404 of the implementing federal regulation,[7] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for all claimants, 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 Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[8]

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[9] Office procedures provide that to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred ("date of maximum medical improvement"), describes the impairment in sufficient detail to include, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other pertinent description of the impairment and the percentage of impairment should be computed in accordance with the fifth edition of the A.M.A., *Guides*. The procedures further provide that after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for opinion concerning the nature and percentage of impairment and the Office medical adviser should provide rationale for the percentage of impairment specified.[10]

Section 16.7d of the A.M.A., *Guides* provides:

> "Several syndromes involving the upper extremity are variously attributed to tendinitis, fasciitis or epicondylitis. The most common of these are the stubborn conditions of the origins of the flexor and extensor muscles of the forearm where they attach to the medial and lateral epicondyles of the humerus. Although these conditions may be persistent for some time, they are not given a permanent impairment rating unless there is some other factor that must be considered. If an individual has had a tendon rupture or has undergone surgical release of the flexor or extensor origins or medial or lateral epicondylitis or has had excision of the epicondyle, there may be some permanent weakness of grip as a result of the

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *See Joseph Lawrence, Jr., supra* note 2; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[9] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(b-d) (August 2002).

tendon rupture or the surgery. In this case, impairment can be given on the basis of weakness of grip strength according to [s]ection 16.8b."[11]

In situations where there are 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 on a proper factual background, must be given special weight.[12]

ANALYSIS

The Board finds that appellant has no permanent impairment of the left upper extremity which would entitle her to a schedule award. Regarding her contention that Dr. Brzusek was an Office referral physician, a facsimile cover sheet in the record indicates that Dr. Brzusek's April 17, 2005 report was faxed directly to appellant and not to the Office. While it was addressed to an Office claims examiner[13] it was sent to the employing establishment. There is no indication in the record that the claims examiners or anyone else in the Office scheduled appellant's appointment with Dr. Brzusek such that he would be considered an Office referral physician.

Appellant generally alleged that Dr. Smith, who provided a second opinion evaluation for the Office and Dr. Hubbard, who provided an impartial evaluation, were biased. However, she submitted no evidence to support her assertions.[14] Mere allegations of bias are not sufficient to establish the fact.[15] Regarding the selection of Dr. Hubbard, an impartial medical specialist properly selected under the Office's rotational procedures will be presumed unbiased and the party seeking disqualification bears the substantial burden of providing otherwise.[16] The Office has developed specific procedures for selecting impartial medical specialists designed to provide adequate safeguards against any possible appearance that the selected physician's opinion was biased or prejudiced.[17] While appellant alleged that Drs. Hubbard and Brzusek were partners, she submitted no evidence to establish this as fact and the Office was informed by Dr. Hubbard's office that the two physicians had never been associated in practice. There is no evidence of

[11] A.M.A., *Guides*, *supra* note 2 at 507.

[12] *Manuel Gill*, 52 ECAB 282 (2001).

[13] Jed Fife had sent appellant the April 15, 2005 development letter.

[14] *See Atanacio G. Sambrano*, 51 ECAB 557 (2000).

[15] *See James F. Weikel*, 54 ECAB 660 (2003).

[16] *Willie M. Miller*, 53 ECAB 697 (2002).

[17] *See Miguel A. Muniz*, 54 ECAB 217 (2002). Office procedures provide that the selection of referee physicians is made by a strict rotational system using appropriate medical directories and specifically states that the Physicians' Directory System (PDS) should be used for this purpose. The procedures explain that the PDS is a set of stand-alone software programs designed to support the scheduling of second opinion and referee examinations and states that the database of physicians for referee examinations is obtained from the MARQUIS Directory of Medical Specialists. Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.7(a) (March 1994); *see Albert Cremato*, 50 ECAB 550 (1999).

record that the Office did not follow proper procedures in selecting Dr. Hubbard to serve as the referee physician.[18] Appellant, therefore, has not established that the opinions of either Dr. Smith or Dr. Hubbard were biased and the record supports that appellant was properly referred to Dr. Hubbard who was properly selected utilizing proper Office procedures.

Appellant also has not established entitlement to a schedule award for her accepted medial and lateral epicondylitis. The Office properly determined that a conflict in the medical evidence was created between the opinions of appellant's physician Dr. Brzusek and Dr. Smith, who provided a second opinion evaluation for the Office. The conflict arose as to whether appellant had a permanent impairment caused by her accepted left upper extremity medial and lateral epicondylitis. The Office then properly referred appellant to Dr. Hubbard, Board-certified in orthopedic surgery, for an impartial evaluation.[19] The Board finds Dr. Hubbard's report is sufficiently well rationalized such that it can be accorded special weight.[20]

In a comprehensive January 24, 2006 report, the physician found that it would not be appropriate to rate appellant's impairment under section 16.7d of the A.M.A., *Guides* as she did not meet either of the required criteria, *i.e.*, she had not had a tendon rupture or undergone surgical release.[21] Dr. Hubbard noted his review of the statement of accepted facts and medical record including appellant's history of thoracic outlet syndrome with surgery and her complaints of left upper extremity pain and weakness. Examination findings demonstrated full range of motion and the physician advised that appellant's left upper extremity motor strength was influenced by pain and was, therefore, invalid but that true provocative tests for lateral and medial epicondylitis were normal. He also advised that grip strength on the left was influenced by pain, noting that dynamometer testing showed significant variations. His diagnostic conclusion was that appellant's medial and lateral epicondylitis was caused by overuse at work and had objectively resolved. Dr. Hubbard noted that her history of left upper extremity chronic pain and other neuromusculoskeletal symptoms and complaints was of undetermined etiology and without objective evidence of recurrent thoracic outlet syndrome, brachial plexopathy, peripheral entrapment of nerve, peripheral neuropathy or residual classic medial or lateral epicondylitis but that some of her symptoms and subjective findings were reminiscent of residual neurogenic thoracic outlet syndrome without objective confirmation. Since Dr. Hubbard provided examination findings and properly provided analysis under the A.M.A., *Guides*, his opinion constitutes the weight of the evidence.[22] The Board finds that the Office properly denied appellant's claim for a schedule award as her accepted condition had resolved.

[18] *Id.*

[19] *Manuel Gill, supra* note 12.

[20] *Id.*

[21] A.M.A., *Guides*, *supra* note 2 at 507.

[22] *See Sharyn D. Bannick*, 54 ECAB 537 (2003).

CONCLUSION

The Board finds that appellant has failed to establish that she is entitled to a schedule award for her accepted medial and lateral epicondylitis.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated March 28 and February 10, 2006 be affirmed.

Issued: August 25, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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