United States Department of Labor
Employees' Compensation Appeals Board

T.C., Appellant	)	
and	)	**Docket No. 08-2112**
	)	**Issued: June 12, 2009**
DEPARTMENT OF THE NAVY, NAVAL AIR SYSTEMS COMMAND, Cherry Point, NC, Employer	)	

Appearances:
Appellant, 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 July 28, 2008 appellant filed a timely appeal from a July 15, 2008 schedule award decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the schedule award claim.[1]

ISSUE

The issue is whether appellant has established more than five percent right upper extremity impairment, for which he received a schedule award.

[1] Subsequent to appellant's appeal, the Office issued a December 12, 2008 schedule award decision concerning appellant's left upper extremity. The Board has no jurisdiction to review this decision as it was issued after the filing of this appeal. *See* 20 C.F.R. §§ 501.2(c) and 501.3.

FACTUAL HISTORY

On May 25, 2006 appellant, then a 50-year-old pneudraulic systems mechanic, filed an occupational disease claim attributing numbness and pain in his right hand, elbow and arm to his federal employment. The Office accepted his claim for right elbow epicondylitis, bilateral carpal tunnel syndrome and bilateral lesion of the ulnar nerve. On January 22, 2007 appellant underwent a right carpal tunnel release and right ulnar nerve transfer. The Office paid compensation and he returned to work.

On December 1, 2008 appellant filed a schedule award claim. He submitted medical reports pertaining to his right upper extremity.[2] In a February 4, 2008 report, Dr. Brian J. Battersby, a Board-certified orthopedic surgeon, opined that appellant reached maximum medical improvement on January 17, 2008 for the right upper extremity. He also opined that appellant had a 12 percent impairment of the right upper extremity for carpal tunnel syndrome and ulnar nerve deficit under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

In a February 19, 2008 report, Dr. G. Pujadas, an Office medical adviser, reviewed the medical record. He opined that appellant reached maximum medical improvement on January 17, 2008 for his right upper extremity. Based on Dr. Battersby's November 8, 2007 treatment report, the medical adviser determined that appellant had zero permanent impairment to the right upper extremity under scenario three on page 495 of the A.M.A., *Guides*.

The Office found a conflict in medical opinion arose between Dr. Battersby and the Office medical adviser regarding the extent of permanent impairment. It referred appellant, together with the case record and a statement of accepted facts and a list of questions, to Dr. Noel Rogers, a Board-certified orthopedic surgeon, selected as the impartial medical specialist.

In a June 27, 2008 report, Dr. Rogers reviewed appellant's history and noted findings on examination. He advised that appellant had a full range of motion without pain in the shoulders and good "2+" strength in the deltoids. Dr. Rogers reported grip felt weak on examination, but noted extension of the fingers revealed good strength and biceps and triceps were "2+" bilaterally. Examination of the intrinsics *via* the first dorsal interosseous showed good strength bilaterally. Grip strength, using actual measurement, was 20 pounds on both the left and right side. Tenderness was noted on both wrists over the scars and on the ulnar notches bilaterally. Sensations of the thumbs, index and long fingers were "2+," but the right ring and little finger showed decreased sensation. Tinel's sign was negative on the right side with a positive Tinel's at the ulnar nerves bilaterally. Median nerve pressure revealed tenderness bilaterally. In addressing permanent impairment, Dr. Rogers prefaced his impairment rating by noting that the A.M.A., *Guides* had "no tables that specifically rate carpal tunnel syndrome, so we will have to go to the nerves." Utilizing Tables 13-23 and 13-24 on pages 346 and 348 of the A.M.A., *Guides*, respectively he found the median nerve fell into a Class 1 classification for both motor and sensory function and, therefore, had zero percent impairment. Dr. Rogers found that the

[2] As previously noted, appellant received a separate schedule award for his left upper extremity. *Id.*

[3] A.M.A., *Guides* (5th ed. 2001).

ulnar nerve had a Class 4 or 26 percent rating for sensation and a Class 1 or 0 percent motor deficit. He noted that appellant's ring and little fingers were impaired on the right and, under Table 16-1 page 438 of the A.M.A., *Guides*, 26 percent impairment rating for sensation for the ring and little finger would result in 3 percent ring finger impairment and 3 percent little finger impairment, for a total 6 percent right hand impairment. Utilizing Table 16-2 on page 439 of the A.M.A., *Guides*, Dr. Rogers found that six percent right hand impairment converted to five percent right arm impairment.

The Office referred Dr. Rogers' June 27, 2008 report to a second Office medical adviser for review. On July 9, 2008 the Office medical adviser found appellant reached maximum medical improvement on January 17, 2008. He concurred with Dr. Rogers' rating of five percent impairment of the right upper extremity based on a mild degree of ulnar sensory loss.

By decision dated July 15, 2008, the Office granted appellant a schedule award for five percent permanent impairment of the right upper extremity. The award covered the period April 12 through July 30, 2008 for a total 15.6 weeks of compensation. In a July 11, 2008 memorandum, the Office noted that appellant was being paid leave buy back during the period February 29 through April 11, 2008 and, in order to avoid overlapping payments, the schedule award would start on April 12, 2008 as opposed to the date of maximum medical improvement, January 17, 2008. It further noted the change was not disadvantageous to appellant.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing 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. The Act, however, 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 to 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 implementing regulations as the appropriate standard for evaluating schedule losses.[6]

Section 8123(a) of the Act 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.[7] When 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.[8]

[4] 5 U.S.C. §§ 8101-8193.

[5] 20 C.F.R. § 10.404.

[6] *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[7] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

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

ANALYSIS

The Office properly determined that a conflict in medical evidence arose between the opinions of Dr. Battersby, appellant's attending physician, who found 12 percent right upper extremity impairment, and Dr. Pujadas, an Office medical adviser, who found no impairment to his right upper extremity. It referred appellant to Dr. Rogers for an impartial evaluation.

Dr. Rogers found appellant had five percent permanent impairment of the right arm based on ulnar sensory loss of a mild degree. He utilized Tables 13-23 and 13-24 on pages 346 and 348 of the A.M.A., *Guides*, which related to appellant's pain or sensory deficit and loss of muscle power and motor function resulting from peripheral nerve disorders, respectively. For the median nerve, Dr. Rogers indicated that appellant had a Class 1 or zero percent impairment for both sensory and motor function. For the ulnar nerve, he found appellant had a Class 1 or zero percent motor deficit. From Table 13-23, Dr. Rogers opined that appellant had a Class 4 or 26 percent sensory deficit of the ulnar nerve.[9] He then converted the 26 percent sensory deficit rating, under conversion tables in the A.M.A., *Guides*, to find 5 percent impairment of the arm. This is an error, however, as Dr. Rogers did not properly use the rating procedure set forth in Table 13-23 for determining sensory impairment resulting from a peripheral nerve disorder. Table 13-23 notes that, for the upper extremities, the examiner should find the value for maximum loss of function of the specific nerve or root due to pain or loss of sensation using Figures 16-48 and 16-49 in Chapter 16 and multiply the percentage associated with the identified nerve by the percentage associated with the decreased sensation from Table 13-23.[10] In this case, Dr. Rogers noted only that appellant had 26 percent ulnar nerve sensory impairment under Class 4 but he failed to follow the procedure set forth at Table 13-23 by identifying the maximum loss of function of the ulnar nerve under Table 16-14 in Chapter 16 which would then be multiplied by the 26 percent sensory impairment that he identified under Class 4. Moreover, while he rated 26 percent impairment (Class 4) value for the affected digits, he did not fully explain how he arrived at this rating under Class 4 for which provides a range of 26 to 60 percent. The Office medical adviser concurred with Dr. Rogers' flawed impairment rating. The Board further notes that Dr. Rogers noted that the A.M.A., *Guides* do not have specific provisions for rating carpal tunnel syndrome. However, the Board notes that page 495 of Chapter 16 of the A.M.A., *Guides* sets forth a scheme for rating carpal tunnel syndrome.[11] Because Dr. Rogers did not properly assess appellant's permanent impairment of the right arm pursuant to the A.M.A., *Guides*, his opinion does not resolve the conflict in medical opinion.

When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in his original report.[12] The Board will set aside the Office's July 15, 2008 decision and

[9] A Class 4 sensory deficit under Table 13-23 has a range of 26 to 60 percent sensory impairment for decreased sensation with or without pain, interfering activity. A.M.A., *Guides*, Table 13-23, at 346.

[10] *See id.*

[11] A.M.A., *Guides* 495. *See T.A.*, 59 ECAB ___ (Docket No. 07-1836, issued November 20, 2007).

[12] *L.R. (E.R.)*, 58 ECAB ___ (Docket No. 06-1942, issued February 20, 2007).

remand the case for the Office to obtain a supplemental opinion from Dr. Rogers that will resolve medical conflict. Following this and such further development as may be required, the Office shall issue an appropriate final decision on appellant's entitlement to a schedule award for the right arm.[13]

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the July 15, 2008 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: June 12, 2009
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

[13] On appeal, appellant questions why his schedule award did not commence on his date of injury. The Board notes that it is well established that the period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the employment injury. *J.C.*, 58 ECAB ___ (Docket No. 06-1018, issued January 10, 2007).