United States Department of Labor
Employees' Compensation Appeals Board

J.G., Appellant **and** **U.S. POSTAL SERVICE, PHILADELPHIA BULK MAIL CENTER, Philadelphia, PA, Employer**	)	**Docket No. 09-2259** **Issued: September 27, 2010**

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
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 10, 2009 appellant, through counsel, filed a timely appeal of the June 11, 2009 schedule award decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award case.

ISSUE

The issue is whether appellant has more than 24 percent impairment of the left upper extremity, for which he received a schedule award.

On appeal, appellant's attorney contends that the Office engaged in doctor shopping to limit his schedule award benefits and that it should have given weight to the medical opinion of Dr. Walter W. Dearolf, a Board-certified orthopedic surgeon and impartial medical specialist, which supported an attending physician's impairment rating. He also contends that the Office did not sufficiently explain why a qualified physician was bypassed under the Physicians Directory System (PDS). Counsel argues that the medical report of Dr. Andrew J. Collier, Jr., a

Board-certified orthopedic surgeon and impartial medical specialist, is insufficient to constitute the weight of the medical opinion evidence because he was not properly selected and failed to conduct a thorough physical and neurological examination. Lastly, he argues that the Office erred in having an Office medical adviser review the reports of more than one impartial medical specialist.

FACTUAL HISTORY

The Office accepted that on July 9, 2001 appellant, then a 34-year-old tractor trailer operator, sustained a cervical sprain, left shoulder strain, herniated disc at C6-7 and aggravation of left carpal tunnel syndrome, left ulnar neuropathy and degenerative cervical disc disease when his truck fell into a pothole. It authorized cervical discectomy and fusion which appellant underwent on June 10, 2002.

On November 23, 2004 appellant filed a claim for a schedule award. In an August 10, 2004 medical report, Dr. David O. Weiss, an attending Board-certified orthopedic surgeon, found that appellant had 50 percent impairment of the left upper extremity based on Table 15-15, 16-15, 16-34 and 18-1 at pages 424, 509 and 574 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

On January 8, 2005 an Office medical adviser reviewed Dr. Weiss' August 10, 2004 findings and determined that appellant had 24 percent impairment of the left upper extremity (A.M.A., *Guides* 424, 534, Table 15-15, 15-16, 18-1). He reached maximum medical improvement on August 10, 2004.

By decision dated January 27, 2005, the Office granted appellant a schedule award for 24 percent impairment of the left upper extremity for the period January 23, 2005 to July 1, 2006. On February 1, 2005 appellant, through counsel, requested an oral hearing before an Office hearing representative.

In a September 29, 2005 decision, an Office hearing representative set aside the January 27, 2005 decision and remanded the case to the Office for an appropriate impartial medical examiner to resolve a conflict in the medical opinion evidence between Dr. Weiss and the Office medical adviser regarding the extent of appellant's left upper extremity impairment.

By letter dated November 17, 2005, the Office referred appellant, together with a statement of accepted facts and the medical record, to Dr. Edward J. Resnick, a Board-certified orthopedic surgeon, for an impartial medical examination. In a November 22, 2005 report, Dr. Resnick estimated that appellant sustained 15 percent impairment of the whole person.

By letter December 13, 2005, the Office advised Dr. Resnick that the Federal Employees' Compensation Act[1] does not provide for whole person impairment. It requested that he submit a supplemental report which included an impairment evaluation of appellant's left upper extremity, citing references to the fifth edition of the A.M.A., *Guides*. In a December 20, 2005 report,

[1] 5 U.S.C. §§ 8101-8193.

Dr. Resnick estimated that appellant had nine percent impairment of the left upper extremity and 25 percent impairment of the cervical spine.

On January 20, 2006 Dr. Morley Slutsky, an Office medical adviser, reviewed Dr. Resnick's November 22 and December 20, 2005 findings. He requested that Dr. Resnick submit a supplemental report that fully documented the calculation of his impairment ratings based on the A.M.A. *Guides*. Dr. Slutsky stated that, if he was unable to provide such documentation, then the Office should refer appellant to another impartial medical specialist for a permanent impairment evaluation.

By letter dated January 31, 2006, the Office referred appellant, together with a statement of accepted facts and the medical record, to Dr. Dearolf, a Board-certified orthopedic surgeon, for an impartial medical examination. In a February 21, 2006 report, Dr. Dearolf advised that appellant had 50 percent impairment of the left upper extremity based on sensory, motor and pinch[2] deficits and pain (A.M.A., *Guides* 424, 439, 492, 509, Table 15-15, 15-16, 15-17, 16-3, 16-15, 16-34).

On March 12, 2006 Dr. Slutsky reviewed Dr. Dearolf's February 21, 2006 findings. He requested that Dr. Dearolf submit documentation explaining how he reached his pinch strength impairment rating as he only stated that it revealed diminished strength on the left when compared to the right. Dr. Dearolf did not document the actual pinch strength measurements or calculations which led to his impairment rating.

By letter dated March 15, 2006, the Office advised Dr. Dearolf to submit a supplemental report providing the documentation requested by Dr. Slutsky. In a June 2, 2006 report, Dr. Dearolf stated that he utilized Table 16-34 at page 509 of the A.M.A., *Guides* to calculate his pinch strength impairment rating.

On July 12, 2006 Dr. Slutsky reviewed Dr. Dearolf's March 15, 2006 finding and stated that, he failed to properly utilize the A.M.A., *Guides* in rating pinch strength impairment. He did not document pinch strength measurements in accordance with section 16.8b at page 508 of the A.M.A., *Guides*. Dr. Slutsky stated that he did not know how Dr. Dearolf found diminished pinch strength on the left when compared to the right. He stated that it appeared that Dr. Dearolf clinically measured the loss of pinch strength which does not produce valid measurements for impairment rating purposes. Dr. Slutsky recommended that the Office refer appellant to another physician who was trained and experienced in providing impairment ratings based on the A.M.A., *Guides*.

By letter dated September 14, 2006, the Office referred appellant, together with a statement of accepted facts and the medical record, to Dr. Menachem M. Meller, a Board-certified orthopedic surgeon, for an impartial medical examination. In an October 9, 2006 report, Dr. Meller advised that, while appellant did not have any impairment to the left upper extremity, he had five percent whole person impairment of the cervical spine (A.M.A., *Guides* 392, Table 15-5).

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[2] Dr. Dearolf found that appellant had 30 percent impairment due to decreased pinch strength of the left hand.

On November 9, 2006 Dr. Slutsky reviewed Dr. Meller's October 9, 2006 findings and agreed with his opinion that appellant did not have any left upper extremity impairment. He stated that Dr. Meller's impairment rating for the cervical spine was not allowed by the Office.

By decision dated December 7, 2006, the Office found the medical evidence insufficient to establish that appellant had more than 24 percent impairment of the left upper extremity.[3] On December 12, 2006 appellant, through counsel, requested an oral hearing.

In a July 17, 2007 decision, an Office hearing representative set aside the December 7, 2006 decision. She found that the statement of accepted facts reviewed by Dr. Meller was incomplete as it did not include the acceptance of appellant's claim for left carpal tunnel syndrome for which the Office authorized decompression surgery. The hearing representative remanded the case to the Office to amend the statement of accepted facts to include the stated employment-related left hand condition and authorized surgery for Dr. Meller's review. She instructed the Office to obtain a supplemental report from him providing whether his opinion had changed regarding appellant's left upper extremity impairment.

In an October 11, 2007 report, Dr. Meller stated that he could not provide an impairment rating for the authorized left carpal tunnel and left ulnar decompression surgery as it had not yet been performed. Thus, he stated that appellant had not reached maximum medical improvement. Dr. Meller advised that, if he did not undergo the surgery, then he had 22 percent impairment of the left upper extremity due to motor deficits which represented three percent whole person impairment (A.M.A., *Guides* 484, 489, 492, 604, Table 16-11, 16-15, 16-13, Combined Values Chart). He further advised that appellant had five percent whole person impairment of the cervical spine. Dr. Meller concluded that he had an 18 percent impairment of the whole person.

On October 17, 2007 Dr. Slutsky reviewed Dr. Meller's October 11, 2007 findings and requested clarification regarding his motor deficit impairment rating.

By letter dated October 22, 2007, the Office requested that Dr. Meller submit a supplemental report which addressed Dr. Slutsky's concerns. In a November 2, 2007 report, Dr. Meller stated that appellant had no motor or sensory deficits in the median or ulnar nerves, but found that he had at most, 44 percent impairment of the left upper extremity which remained below the 51 percent deficit (A.M.A., *Guides* 484, 492, Table 16-11, 16-15).

On January 7, 2008 Dr. Slutsky reviewed Dr. Meller's November 2, 2007 findings and found that appellant had five percent impairment of the left upper extremity due to the employment-related left carpal tunnel syndrome.[4] He disagreed with Dr. Meller's 44 percent impairment rating, stating that, he failed to provide sufficient medical rationale based on the A.M.A., *Guides* to support his impairment rating. Dr. Slutsky stated that Dr. Meller's physical examination of the upper extremity was normal. It did not reveal any sensory or motor deficits

[3] The Board notes that, at the time of the Office's December 7, 2006 decision, the Office had already paid appellant compensation for the entire period of his schedule award for 24 percent impairment of the left upper extremity.

[4] Dr. Slutsky found that appellant had five percent impairment of the right upper extremity based on a normal clinical examination.

related to the median or ulnar nerves. An electromyogram/nerve conduction velocity study was abnormal (A.M.A., *Guides* 495).

By decision dated January 10, 2008, the Office found that the medical evidence was insufficient to establish that appellant had more than 24 percent impairment of the left upper extremity. On January 15, 2008 appellant, through counsel, requested an oral hearing.

In a July 25, 2008 decision, an Office hearing representative set aside the January 10, 2008 decision and remanded the case to the Office for referral of appellant to another impartial medical specialist. She found that Dr. Meller's reports were not entitled to special weight accorded to an impartial medical specialist as he failed to properly utilize the A.M.A. *Guides*.

By letter dated July 31, 2008, the Office referred appellant, together with a statement of accepted facts and the medical record, to Dr. Collier for an impartial medical examination. In an August 20, 2008 report, Dr. Collier obtained a history of appellant's July 9, 2001 employment injuries and medical treatment. He described a full physical and neurological examination related to the cervical spine which included 60 degrees of flexion, 45 degrees of extension, 60 degrees of right rotation, 50 degrees of left rotation and 30 degrees each of right and left tilting. Dr. Collier found decreased sensation in the C6 and C7 distribution and over the radial forearm and ulnar forearm and hand. A Tinel's sign was positive for the elbow and wrist over the ulnar nerve and carpal tunnel. On examination of the left elbow, Dr. Collier found 0 to 140 degrees of range of motion. Pronation and supination were 90 degrees each. Dr. Collier stated that the left shoulder was nontender and had full range of motion with flexion and abduction of 180 degrees each, internal rotation of L1 and external rotation of 45 degrees. Appellant had good abductor strength and a negative impingement sign. Dr. Collier opined that he sustained cervical spine strain/sprain and aggravation of underlying degenerative disc disease and possible small herniation at C6-7 with resultant radiculopathy into the left upper extremity as a result of the July 9, 2001 employment-related incident. Appellant was status post anterior cervical spine discectomy and fusion at C5-6 and C6-7. He had no signs of radiculopathy. Appellant had ulnar neuropathy in the left upper extremity which caused some symptoms in the left hand. Dr. Collier stated that he had minor carpal tunnel syndrome that may have been related to his accepted employment-related injuries. He advised that appellant reached maximum medical improvement in 2004.

Regarding the cervical spine, Dr. Collier determined that 60 degrees of flexion constituted a zero percent impairment, 45 degrees of extension constituted a one percent impairment (A.M.A., *Guides* 418, Table 15-12) and 30 degrees of right and left lateral bending each represented a one percent impairment (A.M.A., *Guides* 420, Table 15-13). He found that 60 degrees of right rotation constituted a one percent impairment and 50 degrees of left rotation constituted a one to two percent impairment (A.M.A., *Guides* 421, Table 15-14). Dr. Collier stated that there was no evidence of any weakness, muscle loss or atrophy in either upper extremity which represented a zero percent impairment. He determined that sensory disturbance at C6 and C7 represented a four percent impairment and a three percent impairment, respectively (A.M.A., *Guides* 424, Table 15-17). Dr. Collier rated an additional three percent impairment for pain (A.M.A., *Guides* 574, Table 18-1). He concluded that appellant sustained 15 percent impairment of the cervical spine and left upper extremity which represented nine percent impairment of the whole person.

On September 6, 2008 Dr. Slutsky reviewed Dr. Collier's August 20, 2008 findings. He found that Dr. Collier failed to properly utilize the A.M.A., *Guides* in rating appellant's permanent impairment. Dr. Slutsky requested an explanation for the calculation of his sensory findings and how they were applied to tables in the A.M.A., *Guides*. He noted that an impairment rating for the cervical spine could not be included in appellant's final impairment rating as it was not allowed by the Office.

By letter dated September 8, 2008, the Office requested that Dr. Collier submit a supplemental report addressing the issues raised by Dr. Slutsky. In a September 24, 2008 report, Dr. Collier stated that his final impairment rating did not include cervical spine impairment. He further stated that appellant's sensory deficit in the C6 and C7 distributions was examined by light touch and protected sensibility. Two-point discrimination was not used. Dr. Collier determined that appellant had Grade 4 sensory deficit at C6, for which 25 percent was allowed, resulting in an eight percent impairment which represented two percent impairment. He also determined that appellant had Grade 4 sensory deficit at C7, for which 25 percent was allowed, resulting in a five percent impairment which represented one percent upper extremity impairment (A.M.A., *Guides* 424, Table 15-15, 15-17). Dr. Collier determined that appellant had three percent impairment for pain (A.M.A., *Guides* 574, Table 18-1). He concluded that appellant had a total six percent impairment of the left upper extremity or four percent impairment of the whole person.

On October 14, 2008 Dr. Slutsky reviewed Dr. Collier's September 24, 2008 findings and determined that appellant had three percent impairment of the left upper extremity. He rated sensory loss of the C6 nerve by multiplying eight percent times 25 percent to equal two percent. For sensory loss of the C7 nerve, Dr. Slutsky multiplied five percent times 25 percent to equal 1.25 percent, rounded to 1 percent (A.M.A., *Guides* 424, Table 15-15, 15-17) These impairment ratings were combined to find a total sensory loss of three percent (A.M.A., *Guides* 604, Combined Values Chart).[5] Dr. Slutsky advised that appellant was not entitled to an additional three percent impairment for pain as sensory nerve pain was rated under Chapter 15 (A.M.A., *Guides* 571, section 18-3b).

In an October 20, 2008 decision, the Office found the medical evidence insufficient to establish that appellant had more than 24 percent impairment of the left upper extremity. By letter dated October 22, 2008, appellant, through counsel, requested an oral hearing.

By decision dated May 14, 2009, an Office hearing representative set aside the October 20, 2008 decision and remanded the case to the Office for proper selection of an impartial medical specialist. She found that Dr. Collier was not properly selected under the PDS.

In a June 11, 2009 decision, an Office hearing representative set aside the May 14, 2009 decision, finding that Dr. Collier was properly selected. He affirmed the October 20, 2008

[5] The Board notes that it appears that Dr. Slutsky inadvertently stated that appellant's two percent sensory impairment of the C6 nerve root and one percent sensory impairment of the C7 nerve root of the left upper extremity were based on Table 15-18 at page 424 of the A.M.A., *Guides* rather than Table 15-17 at page 424 of the A.M.A., *Guides* as his findings correlate to the same sensory nerve root impairments listed under Table 15-17.

decision, finding that appellant had no more than 24 percent impairment of the left upper extremity based on Dr. Collier's impartial medical opinion which was supported by Dr. Slutsky.

LEGAL PRECEDENT

The schedule award provision of the Act[6] and its implementing regulations[7] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[8] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[9]

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.[10] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[11] In situations where 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.[12]

It is well established that Office procedures provide that an impartial medical specialist must be selected from a rotational list of qualified Board-certified specialists, including those certified by the American Medical Association and American Osteopathic Association.[13] The physician selected as the impartial specialist must be one wholly free to make an independent evaluation and judgment. To achieve this end, the Office has developed procedures for the selection of the impartial medical specialist designed to provide adequate safeguards against the

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[6] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[7] 20 C.F.R. § 10.404.

[8] 5 U.S.C. § 8107(c)(19).

[9] 20 C.F.R. § 10.404.

[10] 5 U.S.C. § 8123(a).

[11] 20 C.F.R. § 10.321.

[12] *Gloria J. Godfrey*, 52 ECAB 486 (2001); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[13] *See A.R.,* 61 ECAB ___ (Docket No. 09-1566, issued June 2, 2010); *LaDonna M. Andrews*, 55 ECAB 301 (2004).

appearance that the selected physician's opinion was biased or prejudiced.[14] These procedures contemplate selection on a strict rotating basis in order to negate any appearance that preferential treatment exists between a physician and the Office.[15] Moreover, the reasons for the selection made must be documented in the case record.[16]

In some instances, an Office medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A. *Guides*. In this instance, a detailed opinion by the Office medical adviser which gives a percentage based on reported findings and the A.M.A., *Guides* may constitute the weight of the medical evidence.[17]

ANALYSIS

The Office accepted appellant's claim for cervical sprain, left shoulder strain, herniated disc at C6-7 and aggravation of left carpal tunnel syndrome, left ulnar neuropathy and degenerative cervical disc disease. It authorized appellant's June 10, 2002 cervical discectomy and fusion. Due to a conflict between appellant's physician, Dr. Weiss, who found that appellant had 50 percent impairment of the left upper extremity, and an Office medical adviser, who found that appellant had 24 percent impairment of the left upper extremity, the Office referred appellant to Dr. Resnick, as the impartial medical specialist to resolve a conflict in medical opinion. When Dr. Resnick failed to clarify his report, however, the Office referred appellant to Dr. Dearolf for a second impartial medical examination.[18] When Dr. Dearolf also failed to clarify his reports the Office referred appellant to Dr. Meller for a third impartial medical examination.[19] The Office found that Dr. Meller failed to properly apply the A.M.A., *Guides* and, thus, referred appellant to Dr. Collier for a fourth impartial medical examination.

On appeal, counsel contends that the Office did not properly select Dr. Collier as the impartial medical specialist under the PDS as it failed to provide sufficient explanation for bypassing a qualified physician. The record regarding Dr. Collier's selection as the impartial medical specialist reflects that two physicians were bypassed prior to scheduling the examination with Dr. Collier. Dr. E. Michael Okin, a Board-certified orthopedic surgeon, was bypassed due to a conflict. Dr. John P. Salvo, a Board-certified orthopedic surgeon, was bypassed as too busy to examine appellant. The Board finds that there is no evidence that the Office did not select

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[14] *See A.R., supra* note 13; *Raymond J. Brown*, 52 ECAB 192 (2001).

[15] *Id. See also Miguel A. Muniz*, 54 ECAB 217 (2002).

[16] *See D.F.,* 61 ECAB ___ (Docket No. 09-1463, issued August 12, 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4(b) (May 2003). A claimant may ask to participate in the selection of the impartial medical specialist under certain conditions; however, no request was made in this case.

[17] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(h) (April 1993).

[18] *See Talmadge Miller*, 47 ECAB 673 (1996).

[19] *Id.*

Dr. Collier from the PDS or that it failed to comply with its rotational procedures. Appellant did not provide any probative evidence to demonstrate bias on the part of the doctor. The Board has held that 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 proving otherwise. Mere allegations are insufficient to establish bias.[20] Accordingly, the evidence does not establish an error in the selection of Dr. Collier as an impartial medical examiner.

In an August 20, 2004 report Dr. Collier found, based on the 5th edition of the A.M.A. *Guides*, that appellant sustained 15 percent impairment of the cervical spine and left upper extremity. Dr. Collier's report was reviewed by Dr. Slutsky, an Office medical adviser, as appropriate under Office procedures.[21] The Office medical adviser found that Dr. Collier had not properly utilized the A.M.A., *Guides* in determining appellant's impairment and he was asked by the Office to provide a supplemental report to clarify and explain the basis for his impairment rating. On September 24, 2008 Dr. Collier found that appellant had six percent impairment of the left upper extremity which represented four percent impairment of the whole person.

The Board has carefully reviewed Dr. Collier's report and finds that he properly utilized the A.M.A., *Guides* in rating the cervical sensory loss. Dr. Collier found that appellant had Grade 4 sensory loss each at C6 and C7 (A.M.A., *Guides* 424, Table 15-15). He determined that appellant had the maximal 25 percent impairment due to sensory loss at C6 which constituted eight percent impairment and resulted in two percent sensory loss impairment (A.M.A., *Guides* 424, Table 15-15, 15-17). Similarly, Dr. Collier found that he had the maximal 25 percent impairment due to sensory loss at C7 which constituted five percent impairment and resulted in one percent sensory loss impairment (A.M.A., *Guides* 424, Table 15-15, 15-17). In an October 14, 2008 report, the Office medical adviser agreed that appellant had three percent impairment of the left upper extremity, relying on Dr. Collier's finding of two percent impairment at C6 and one percent impairment at C7 due to sensory deficit. (A.M.A., *Guides* 424, 604, Table 15-15, 15-17, Combined Values Chart).

Dr. Collier also referenced Table 18-1 to support his finding of an additional three percent impairment for pain. (A.M.A., *Guides* 574, Table 18-1). As the Office medical adviser correctly pointed out, however, pain is not to be rated separately when the rating can be adequately rated under the other Chapters of the A.M.A. *Guides*.[22] The A.M.A., *Guides* provide: "The impairment ratings in the body organ system chapters make allowance for any accompanying pain."[23] Dr. Collier did not adequately explain why the rating under Chapter 15 on upper extremity impairment did not adequately incorporate pain.

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[20] *See L.W.*, 59 ECAB ___ (Docket No. 07-1346, issued April 23, 2008).

[21] *Supra* note 17.

[22] A.M.A., *Guides* 571; *see D.N.*, 59 ECAB ___ (Docket No. 07-1940, issued June 17, 2008); *Mark A. Holloway*, 55 ECAB 321 (2004).

[23] A.M.A., *Guides* 20.

The Office's procedures state that an Office medical adviser must review the report to verify correct application of the A.M.A., *Guides* and confirm the percentage of permanent impairment as well as specify his reasons for assigning a certain percentage of loss of use to the measurements or factors provided by the examining physician.[24] In this case, Dr. Slutsky properly stated that impairment for pain may not be combined with impairment for sensory pain that was adequately rated under Chapter 15.[25] As the Office medical adviser utilized Dr. Collier's objective clinical findings to compare them with impairment criteria listed in the A.M.A., *Guides*, the Board finds that appellant is entitled to only three percent permanent impairment of the left upper extremity.[26]

On appeal, appellant contended that the Office engaged in doctor shopping and that it should have given weight to Dr. Dearolf's opinion that he had 50 percent impairment of the left upper extremity. If the specialist is unwilling or unable to clarify or elaborate on his or her opinion as requested, the case should be referred to another appropriate impartial medical specialist.[27] Unless this procedure is carried out by the Office, the intent of section 8123(a)[28] will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[29] In this case, the Board notes that, Dr. Slutsky reviewed Dr. Dearolf's initial report and properly found that he incorrectly utilized the A.M.A., *Guides* in reaching his 50 percent impairment of the left upper extremity, which was based on, among other things, pinch strength impairment. After reviewing Dr. Dearolf's supplemental report which stated that he utilized Table 16-34 at page 509 of the A.M.A, *Guides* to rate pinch strength impairment, Dr. Slutsky requested that the Office refer appellant to another impartial medical specialist for evaluation of his permanent impairment. He properly noted that Dr. Dearolf incorrectly utilized the A.M.A., *Guides* in reaching his pinch strength impairment rating as he did not provide any measurements to support his rating in accordance with section 16.8b at page 508.[30] Further, Dr. Slutsky stated that the method he used to reach his pinch strength impairment rating was unclear, noting that his apparent clinical measurement of pinch strength loss did not provide valid measurements for impairment rating purposes. As he properly found that Dr. Dearolf utilized the A.M.A., *Guides* but failed to provide the clarifying evidence requested by the Office, the Board finds that there is no evidence establishing that the Office acted unreasonably in referring appellant to another impartial medical specialist for the evaluation of his permanent impairment.

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[24] *R.S.,* Docket No. 09-1331 (issued April 5, 2010); Federal (FECA) Procedure Manual, *supra* note 17 at Chapter 2.810.7(c) (April 1993).

[25] *Supra* note 22.

[26] If the clinical findings are fully described, any knowledgeable observer may check the findings with the A.M.A., *Guides* criteria. A.M.A., *Guides* 17. *See also I.H.*, 60 ECAB ___ (Docket No. 08-1352, issued December 24, 2008).

[27] *Guiseppe Aversa*, 55 ECAB 164 (2003).

[28] 5 U.S.C. § 8123(a).

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

[30] A.M.A., *Guides* 508, section 16.8b.

Regarding appellant's contention that the Office erred in having Dr. Slutsky review the reports of more than one impartial medical specialist, the Board notes that section 3.500(c)(1) of the Office's procedures only prohibits an Office medical adviser from reviewing a report of an impartial medical specialist if the medical adviser created the conflict.[31] Dr. Resnick, a second opinion specialist, was on one side of the original conflict with Dr. Weiss, appellant's attending physician, on the other.

CONCLUSION

The Board finds that appellant has failed to establish that he has more than 24 percent impairment of the left upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the June 11, 2009 and October 20, 2008 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: September 27, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[31] Federal (FECA) Procedure Manual, *supra* note 16 at Chapter 3.500.5(c)(1) (March 1994).