United States Department of Labor
Employees' Compensation Appeals Board

L.M., Appellant	)	
and	)	**Docket No. 10-2279**
	)	**Issued: August 5, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 10, 2010 appellant, through his attorney, filed a timely appeal of a June 2, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

ISSUE

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

On appeal, counsel argued that the supplemental report from the impartial medical examiner was insufficient and that case required additional development of the medical evidence.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board on appeal. On July 3, 2003 appellant, then a 43-year-old general worker, filed a traumatic injury claim alleging that he injured his hand and arm when he was hit by a truck trunk. OWCP accepted her claim for contusion, left hand crush injury of the left fingers; injury to the nerve roots, spinal plexuses and nerves of the left shoulder and arm; median nerve lesions; ulnar nerve lesion, tendon injury; and crush injury of the left forearm. On November 17, 2003 appellant's attending physician, Dr. Arthur Vasen, a Board-certified orthopedic surgeon, performed a left nerve tenosynovectomy in the forearm and left ulnar nerve decompression in the forearm with neurolysis in the forearm. Dr. Michael Coyle, a Board-certified orthopedic surgeon, performed a neurolysis of the median and ulnar nerves in the left forearm, fasciotomy of muscle herniation flexor digitorum superficialis ring finger and muscle belly left forearm, extensor tenolysis and tenosynovectomy of forearm flexor tendons, flexor carpi radialis, flexor carpi ulnaris, flexor follicis longus, flexor digitorum superficialis, index, middle, ring and little fingers and flexor digitorum profundus index, middle, ring and little fingers on December 16, 2005. By decision dated August 23, 2006, OWCP terminated appellant's compensation benefits effective August 6, 2006.

Due to a conflict of medical opinion evidence, OWCP referred appellant to Dr. Ian Fries, a Board-certified orthopedic surgeon, for an impartial medical examination. Based on Dr. Fries' report OWCP issued a decision dated January 22, 2008, granting appellant a schedule award for three percent impairment of his left upper extremity. By decision dated August 7, 2008, the hearing representative affirmed the January 22, 2008 decision. Appellant appealed this decision and by decision dated September 30, 2009,[2] the Board found that Dr. Fries was properly selected as the impartial medical examiner, however, the Board found that Dr. Fries did not adequately explain the basis for his schedule award determination in his September 14, 2007 report. Dr. Fries awarded appellant two percent impairment due to his left wrist surgical scar and the Board found that FECA provides for schedule awards for scars only for serious disfigurement of the face, head or neck[3] so that appellant was not entitled to an impairment rating for his wrist scar. He also awarded appellant three percent impairment due to pain in accordance with Chapter 18 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[4] (A.M.A., *Guides*) but did not explain his reasoning for this award and finally, he did not provide any impairment rating for the confirmed finding of total loss of sensation in the volar and dorsal aspects of appellant's ring finger. The Board remanded the case for OWCP to request a supplemental report from Dr. Fries addressing any objective impairment based on a new evaluation of appellant's physical impairment due to loss of range of motion, loss of strength and sensory deficit and pain. The facts and circumstances of the case as set out in the Board's prior decision are adopted herein by reference.

[2] Docket No. 09-421 (issued September 30, 2009).

[3] 5 U.S.C. § 8107(c)(21).

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

In a letter dated November 20, 2009, OWCP requested that Dr. Fries provide a supplemental report in accordance with the sixth edition of the A.M.A., *Guides*.[5] It stated, "Also, if you think a reexam[ination] is needed, please let us know that too." Dr. Fries submitted a report dated December 24, 2009, reviewed the defects in his prior report as found by the Board and stated that at the beginning of his September 12, 2007 examination he elicited a complete list of appellant's complaints which initially included only index, middle and little finger numbness when those fingers were locked. Appellant also reported partial numbness which also involved the thumb. Dr. Fries stated that throughout the examination appellant progressively expanded the extent of his sensory deficits. He concluded that appellant's expanding claim was a discrepancy, as any abnormal sensory pattern would be well established and static from the injury sustained four years previously. Dr. Fries concluded based on examination and objective findings that appellant's sensory deficit claims were greatly exaggerated. He noted that appellant had no supportive objective findings of substantial loss of sensation in all his left fingers which would include anhydrosis, atrophy, fingernail abnormalities, loss rugae and stigmata of injury. Dr. Fries stated that patients with true substantial sensory deficits frequently have scars from cuts and burns that were not felt in the impacted area. He further noted that appellant claimed the inability to distinguish a single from a double touch of the left thumb, index, middle and little fingers. Dr. Fries stated, "Two touch test is a sham test, because there is no physiological basis for a claim of sensing a single touch, but not two touches in succession." He stated that appellant's physical examination and medical records including a magnetic resonance imaging (MRI) scan did not support nerve root, plexus or shoulder and upper arm nerve injuries and that the medical evidence also failed to support a crush injury of the left forearm, tendon injury or median nerve lesions. Dr. Fries did not assign an impairment rating for impact to any scheduled member due to these accepted conditions as he found no impact due to these conditions.

Dr. Fries applied the A.M.A., *Guides*, (6th ed. 2009) to the confirmed physical findings and stated, "Referring to the Digit Regional Grid, Table 15-2, Page 391, 'pain in digit,' [appellant's] little finger is assessed as class 1, with a range from zero to one percent impairment of the digit." He stated that appellant's functional history was consistent with a grade modifier two.[6] Dr. Fries found that as appellant's physical examination was discrepant a grade modifier could not be assessed.[7] He stated that appellant's clinical studies did not document objective finger pathology and resulted in a grade modifier of zero.[8] Applying the adjustment formula, Dr. Fries concluded that appellant's digital impairment remained at the default value of C or one percent of the digit or one percent of the upper extremity.

[5] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6a (January 2010); *id*., Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[6] A.M.A., *Guides*, 406, Table 15-7.

[7] *Id*. at 411, 2a.

[8] *Id*. at 410, Table 15-9.

Dr. Fries found that appellant had an ulnar nerve lesion as the result of surgical scarring resulting in mild sensory deficit or class 1 impairment of zero to two percent.[9] He noted that appellant's functional history was consistent with grade modifier two[10] and that his physical examination was discrepant so that a grade modifier could not be assessed.[11] Dr. Fries stated that electrodiagnostic studies documented an ulnar conduction delay in the forearm for clinical studies grade modifier of one.[12] Applying the net adjustment formula, he concluded that appellant had one percent impairment of the upper extremity due to ulnar nerve dysfunction. Dr. Fries combined these impairments to reach two percent impairment of the left upper extremity.

Dr. Fries did not provide an additional pain impairment rating noting that the sixth edition of the A.M.A., *Guides* included pain within the general impairment ratings and limited the amount of impairment awarded for subjective factors.[13]

Dr. Andrew Merola, district medical director, reviewed Dr. Fries' December 24, 2009 report on January 10, 2010. He summarized and agreed with Dr. Fries conclusion of two percent impairment and maximum medical improvement on September 14, 2007.

By decision dated January 20, 2010, OWCP determined that Dr. Fries' December 24, 2009 report constituted the weight of the medical evidence and established that appellant had no more than three percent impairment of his left upper extremity for which he had previously received a schedule award. Counsel requested an oral hearing on January 11, 2010. He appeared at the oral hearing on April 19, 2010 and argued that Dr. Fries should have performed a new examination and new electrodiagnostic testing.

On June 2, 2010 the Branch of Hearings and Review affirmed OWCP's January 20, 2010 decision finding that Dr. Fries' December 24, 2009 report was entitled to the weight of the medical evidence and established that appellant had no more than three percent impairment of his left upper extremity for which he received a schedule award.[14]

[9] *Id*. at 442, Table 15-21.

[10] *Id*. at 406, Table 15-7.

[11] *Id*. at 411, 2a.

[12] *Id*. at 410, Table 15-9.

[13] *Id*. at 40.

[14] Counsel requested reconsideration of the June 2, 2010 hearing representative's decision from OWCP on June 15, 2010 and appealed this decision to the Board on September 10, 2010. OWCP issued a decision on September 17, 2010. The Board and OWCP may not simultaneously have jurisdiction over the same case. *See* 20 C.F.R. § 501.2(c)(3). Because OWCP must review its prior decision in order to determine whether appellant submitted additional new and relevant evidence, OWCP may not issue a decision regarding the same issue on appeal before the Board. It therefore did not have the authority to issue its September 17, 2010 decision and this decision is therefore null and void. *Arlonia B. Taylor*, 44 ECAB 591, 597 (1993).

LEGAL PRECEDENT

The schedule award provision of FECA[15] and its implementing regulations[16] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[17]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). The net adjustment formula is (GMFH -- CDX) + (GMPE -- CDX) + (GMCS -- CDX).[18]

ANALYSIS

The Board previously found that Dr. Fries was properly selected as the impartial medical examiner and remanded the case for OWCP to secure a supplemental report from Dr. Fries addressing the extent of appellant's permanent impairment for schedule award purposes. OWCP requested a supplemental report from Dr. Fries and gave him the opportunity to further examine appellant if he felt necessary. Dr. Fries completed a supplemental report on December 24, 2009 and explain his previous findings that appellant's sensory examination was not reliable. He noted that appellant responded inappropriately to double touch testing establishing that his responses were not physiological and that the additional objective findings expected with such high degree of sensory impairment were not present during appellant's physical examination. In regard to appellant's additional conditions such as his injury to nerve roots, spinal plexus and nerves of the shoulder and arm as well as crushing injury of the left forearm or median nerve lesion and effect of late tendon injury, Dr. Fries explained why he did not provide an impairment rating for these conditions. He noted the medical records and appellant's description of complaints did not include these conditions. Dr. Fries also reviewed medical tests previously performed such as MRI scan and electrodiagnostic testing and concluded that impairment due to these conditions was not supported.

In situations were 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

[15] 5 U.S.C. §§ 8101-8193, 8107.

[16] 20 C.F.R. § 10.404.

[17] *Supra* note 5.

[18] A.M.A., *Guides* 411.

factual background, must be given special weight.[19] The Board finds that Dr. Fries supplemental report is based on a proper factual background, as he considered the statement of accepted facts as well as the Board's prior decision. Dr. Fries also provided clear medical reasoning for his decision to discount appellant's sensory deficit claims, his injury to nerve roots, spinal plexus and nerves of the shoulder and arm as well as crushing injury of the left forearm or median nerve lesion and effect of late tendon injury. He noted that absence of findings in the medical records, described testing him performed as well as test results including electrodiagnostic studies and MRI scan and noted that the specific objective physical findings which would support appellant's claims were not present. Given the lack of physical findings and the medical basis provided by Dr. Fries for his conclusions, he has provided sufficient medical rationale to support his determination. The Board concludes that this report is sufficient to resolve the conflict of medical opinion evidence on the issue of sensory deficit and the lack of impairment resulting from appellant's accepted injury to nerve roots, spinal plexus and nerves of the shoulder and arm as well as crushing injury of the left forearm or median nerve lesion and effect of late tendon injury and must be given special weight.

Dr. Fries then proceeded to apply the standards and procedures of the sixth edition of the A.M.A., *Guides* to his findings on physical examination. He provided a diagnosis of pain in the digit, found this was class 1 impairment with a range from zero to one percent impairment of the digit.[20] Dr. Fries then determined the appropriate grade modifiers for substitution in the appropriate formula noting that appellant had a function history of pain with normal activity or grade modifier 2.[21] He stated that appellant's physical examination was discrepant and that under the A.M.A., *Guides* this element should be eliminated from the calculation.[22] Dr. Fries stated that appellant's clinical studies did not establish relevant findings and resulted in a grade modifier 0.[23] The Board finds that he properly determined that appellant had only one percent impairment of the upper extremity due to finger pain.

In regard to appellant's medical history and electrodiagnostic studies which supported forearm ulnar sensory neuropathy, Dr. Fries found that appellant had mild sensory deficit objectively verified or class 1 impairment of the ulnar nerve below the midforearm with an impairment range from zero to two percent.[24] He again evaluated function history, physical examination and clinical studies to reach modifiers of 2, 0 and 1 respectively. The Board finds that Dr. Fries properly determined that appellant had one percent impairment of the upper extremity due to ulnar nerve impairment.

[19] *Nathan L. Harrell*, 41 ECAB 401, 407 (1990).

[20] A.M.A., *Guides* 391, Table 15-2.

[21] *Id*. at 406, Table 15-7.

[22] *Id*. at 411, 2a.

[23] *Id*. at 410, Table 15-9.

[24] *Id*. at 443, Table 15-21.

As stated above, Dr. Fries provided a detailed and well-reasoned report explaining why and how he determined to include only specific conditions and further properly applied the appropriate provisions of the A.M.A., *Guides* to reach his impairment rating. The Board therefore disagrees with counsel and finds that Dr. Fries reports are sufficient to resolve the conflict of medical opinion evidence and establish that appellant has no more than three percent impairment of his left upper extremity for which he has received a schedule award.

CONCLUSION

The Board finds that appellant has no more than three percent impairment of his upper extremity for which he has received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the June 2, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 5, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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