United States Department of Labor
Employees' Compensation Appeals Board

H.S., Appellant	)	
and	)	**Docket No. 11-628**
	)	**Issued: December 23, 2011**
U.S. POSTAL SERVICE, GULF WINDS STATION, St. Petersburg, FL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 11, 2011 appellant filed a timely appeal from an August 27, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP) denying his claim for an increased schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than a 25 percent permanent impairment of the left arm or a 21 percent permanent impairment of the right arm for which he received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board. By decision dated September 23, 2009, the Board set aside December 12, 2007 and July 3, 2008 decisions denying appellant's claim for

[1] 5 U.S.C. § 8101 *et seq.*

an increased schedule award.[2] The Board found that the impartial medical examiner, Dr. Howard Schuele, a Board-certified orthopedic surgeon, failed to provide an adequate finding regarding the extent of appellant's permanent impairment of the upper extremities. The Board remanded the case for OWCP to obtain an opinion sufficient to resolve the issue of the extent of his permanent impairment of the upper extremities and remanded the conflict in opinion. The facts and circumstances of the case as set forth in the Board's prior decision are hereby incorporated by reference.

On April 21, 2010 OWCP referred appellant to Dr. Gilberto Vega, a Board-certified orthopedic surgeon, for an impartial medical examination.[3] In a report dated May 27, 2010, Dr. Vega found a positive Tinel's sign on the left for carpal and cubital tunnel syndrome. He diagnosed probable bilateral carpal tunnel based on positive electromyogram (EMG) and nerve conduction studies (NCS), left cubital tunnel syndrome, bilateral degenerative joint disease of the carpometacarpal joints of the thumbs, cervical spondylosis without radiculopathy, a biceps tendon rupture by history without objective findings and shoulder pain of undetermined etiology. Dr. Vega obtained x-rays of the shoulders showing a preserved glunohumeral joint with mild acromioclavicular narrowing. He recommended additional diagnostic studies, including a magnetic resonance imaging (MRI) scan study of the shoulders to determine whether appellant had a rotator cuff problem, a functional capacity evaluation and a repeat EMG and NCS. Dr. Vega utilized the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent* Impairment (6th ed. 2009) (A.M.A., *Guides*) and determined that appellant had a five percent bilateral upper extremity impairment due to arthritis of the thumbs, a four percent left upper extremity impairment due to carpal and cubital tunnel syndrome and a two percent right upper extremity impairment due to carpal tunnel syndrome.

By letter dated June 8, 2010, OWCP authorized Dr. Vega's request for further diagnostic studies. An EMG/NCS performed on July 8, 2010 revealed mild to moderate bilateral carpal tunnel syndrome and mild cubital tunnel syndrome, both worse on the left side. Appellant also

[2] Docket No. 08-2550 (issued September 23, 2009). OWCP accepted that appellant sustained bilateral shoulder arthritis, a left arm and shoulder sprain, a biceps tendon rupture and left ulnar neuropathy under file number xxxxxx265. It further accepted that he sustained bilateral carpal tunnel syndrome and an aggravation of bilateral osteoarthritis of the base of the thumbs under file number xxxxxx357. OWCP granted appellant a schedule award for a 12 percent right upper extremity impairment and a 16 percent left upper extremity impairment. It combined both file numbers under master file number xxxxxx357. On March 7, 2007 it found that appellant had a 21 percent permanent impairment of the right upper extremity and a 25 percent permanent impairment of the left upper extremity.

[3] On October 13, 2009 OWCP referred appellant to Dr. Charles Finn, a Board-certified orthopedic surgeon, for an impartial medical examination. On November 11, 2009 Dr. Finn concluded that appellant had a five percent impairment of each upper extremity due to carpal and cubital tunnel syndrome. In response to OWCP's request for clarification, on December 23, 2009 Dr. Finn indicated that his five percent impairment rating was based on Table 17 on page 49 of the A.M.A., *Guides*. An OWCP medical adviser reviewed Dr. Finn's report and found that it was "completely erroneous" and asserted that he should provide clarification. OWCP requested further clarification from Dr. Finn on February 1, 2010. On February 23, 2010 Dr. Finn found that appellant had a three percent impairment for arthritis, a five percent impairment for carpal tunnel and cubital tunnel and a five percent impairment for ulnar neuropathy. On April 8, 2010 OWCP's medical adviser recommended a new examination after finding Dr. Finn's opinion not adequately explained.

underwent a functional capacity evaluation but was unable to have an MRI scan study due to his pacemaker.[4]

In an addendum dated July 14, 2010, Dr. Vega determined that diagnostic studies revealed cubital tunnel syndrome greater on the left and bilateral carpal tunnel syndrome. He asserted that as appellant could not undergo an MRI scan study of the shoulders due to his pacemaker, he was "unable to submit a disability rating for his right and left shoulder." Dr. Vega noted that x-rays of the shoulders revealed minimal findings and the functional capacity evaluator found inconsistencies. He stated, "Therefore, I will restrict to submit a disability rating strictly on the bilateral thumb carpometacarpal degenerative arthritic changes, the bilateral carpal tunnel syndrome and the left cubital tunnel syndrome only."

On August 5, 2010 an OWCP medical adviser reviewed Dr. Vega's reports and opined that he inaccurately determined the impairment of the thumb using instability rather than arthritis. He concurred with Dr. Vega's finding regarding the bilateral carpal tunnel syndrome but noted that cubital tunnel syndrome was not an accepted condition.

By letter dated August 13, 2010, OWCP requested that Dr. Vega review OWCP's medical adviser's August 5, 2010 report and provide a clarifying opinion. In an August 17, 2010 response, Dr. Vega applied the sixth edition of the A.M.A., *Guides* and found a two percent impairment due to carpal tunnel syndrome for each upper extremity but no impairment due to cubital tunnel syndrome as it was not an accepted condition. He concluded that appellant had an eight percent whole person impairment.

On August 20, 2010 an OWCP medical adviser concurred with Dr. Vega's finding that appellant had a two percent impairment of each upper extremity due to carpal tunnel syndrome and a five percent impairment of each upper extremity due to his thumb impairment. He further included Dr. Vega's prior finding of a three percent impairment due to a left ulnar lesion, or cubital tunnel syndrome. The medical adviser determined that appellant had a total left upper extremity impairment of 10 percent and a right upper extremity impairment of 7 percent.

By decision dated August 27, 2010, OWCP found that appellant did not have more than the previously awarded 25 percent left upper extremity impairment or the 21 percent right upper extremity impairment and thus denied his claim for an increased schedule award.

On appeal appellant argues that he is entitled to a greater schedule award and that his ulnar neuropathy was discounted due to his age.

[4] A functional capacity evaluation dated July 6, 2010 showed "inconsistent effort" and "inappropriate pain behaviors."

LEGAL PRECEDENT

The schedule award provision of FECA,[5] and its implementing federal regulations,[6] 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. However, FECA 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

The sixth edition requires identifying 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).[9] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

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.[10]

In situations where OWCP secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or elaboration, it has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original opinion. If the specialist is unwilling or unable to clarify and elaborate on his or her opinion, the case should be referred to another appropriate impartial medical specialist.[11]

ANALYSIS

OWCP accepted that appellant sustained bilateral shoulder arthritis, a sprain of the left arm and shoulder, a biceps tendon rupture, left ulnar neuropathy, bilateral carpal tunnel syndrome and an aggravation of bilateral osteoarthritis of the thumbs. It granted him schedule awards for a 21 percent permanent impairment of the right upper extremity and a 25 percent

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*. at § 10.404(a).

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[9] A.M.A., *Guides* 494-531.

[10] *Barry Neutuch*, 54 ECAB 313 (2003); *David W. Pickett*, 54 ECAB 272 (2002).

[11] *See Phillip H. Conte*, 56 ECAB 213 (2004); *Guiseppe Aversa*, 55 ECAB 164 (2003).

permanent impairment of the left upper extremity. On prior appeal, the Board set aside OWCP's denial of appellant's claim for an increased schedule award after finding that the opinion of the impartial medical examiner, Dr. Schuele, did not provide a sufficiently independent finding regarding the extent of the upper extremity impairment. It remanded the case for resolution of the continued conflict in opinion.

OWCP referred appellant to Dr. Vega for an impartial medical examination.[12] 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.[13] On May 27, 2010 Dr. Vega diagnosed bilateral carpal tunnel syndrome, left cubital tunnel syndrome, bilateral degenerative joint disease of the thumbs, cervical spondylosis without radiculopathy, a biceps tendon rupture by history and shoulder pain of unknown origin. He requested that OWCP authorize additional diagnostic testing, including an MRI scan of the shoulders and electrodiagnostic testing. On July 14, 2010 Dr. Vega reviewed diagnostic studies showing bilateral cubital and carpal tunnel syndrome. He noted that it was not possible to obtain an MRI scan of appellant's shoulders due to his pacemaker. Dr. Vega advised that he was unable to provide a disability rating for the shoulders as he could not obtain an MRI scan study, and as x-rays revealed minimal findings and a functional capacity evaluation showed inconsistencies. He did not, however, specifically find that appellant did not have an impairment of the shoulders but instead related that he would not "submit a disability rating for his right and left shoulder" primarily because appellant was unable to undergo the MRI scan. Under the sixth edition of the A.M.A., *Guides*, however, it is possible to evaluate a shoulder impairment using range of motion rather than the diagnosis-based method.[14] The prior impartial medical examiner, Dr. Schuele, found that appellant had a 14 percent impairment of each shoulder due to loss of range of motion.

As discussed, where OWCP secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or elaboration, it has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original opinion. If the specialist is unwilling or unable to clarify and elaborate on his or her opinion, the case should be referred to another appropriate impartial medical specialist.[15] Accordingly, the Board will remand the case to OWCP. On remand, OWCP requested Dr. Vega to provide a rating based on range of motion,

[12] OWCP originally referred appellant to Dr. Finn for an impartial medical examination; however, he was unable to adequately respond to its request for clarification; thus, it properly referred appellant for another impartial medical examination. *Id*.

[13] *Darlene R. Kennedy*, 57 ECAB 414 (2006).

[14] A.M.A., *Guides* 403. Table 15-5 of the sixth edition of the A.M.A., *Guides* provides a method of rating shoulder impairments using the diagnosis-based method. The diagnoses in Table 15-5 are marked with an asterisk that indicates that, if motion loss is present, the shoulder impairment may alternatively be assessed using loss of range of motion. The impairment due to loss of range of motion stands alone and is not combined with a diagnosis-based impairment. *Id*. at 475.

[15] *See supra* note 11.

on the extent of permanent impairment to both shoulders and the total impairment of his upper extremities.[16] Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the August 27, 2010 merit decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: December 23, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[16] OWCP previously sought clarification from Dr. Vega on August 13, 2010.