United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 10-973**
	)	**Issued: January 11, 2011**
SOCIAL SECURITY ADMINISTRATION, Baltimore, MD, Employer	)	

Appearances:
J. Steven Huffines, 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
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On February 23, 2010 appellant filed a timely appeal from a January 26, 2010 merit decision of the Office of Workers' Compensation Programs denying an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than a 27 percent impairment of her left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board. By decision dated November 17, 2008, the Board remanded the case for clarification from the impartial medical specialist, Dr. John C. Gordon, regarding his rating of 60 percent left arm impairment.[1] The Office selected Dr. Gordon

[1] Docket No. 08-969 (issued November 17, 2008). Dr. Gordon was the second impartial medical specialist.

to resolve a conflict in medical opinion between Dr. Robert W. Macht who opined that appellant had 60 percent left arm impairment under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[2] and an Office medical adviser who rated 25 percent left arm impairment. The Board remanded the case for further development of the medical evidence. The facts and history as set forth in the prior decision are incorporated by reference.

On December 5, 2008 the Office requested that Dr. Gordon clarify the 60 percent left arm impairment rating under the A.M.A., *Guides*. In a February 9, 2009 report, Dr. Gordon listed appellant's loss of range of motion measurements and reiterated his rating under the A.M.A., *Guides*. On February 24, 2009 Dr. Morley Slutsky, an Office medical adviser, observed that Dr. Gordon did not document the actual goniometric measurements that were used to calculate the left wrist impairment which was required under the A.M.A., *Guides*. The Office found that Dr. Gordon's reports were not sufficient to resolve the conflict and referred appellant to Dr. Constantine Misoul, a Board-certified orthopedist, for a new impartial medical examination.

In a March 3, 2009 report, Dr. Misoul opined that appellant had 49 percent permanent impairment of the left arm. On March 21, 2009 Dr. Slutsky advised that additional information concerning some of Dr. Misoul's calculations were needed. On March 24, 2009 the Office requested Dr. Misoul document the anatomical basis for the loss of range of motion findings related to the accepted conditions and explain how the impairment was calculated. Dr. Misoul did not respond to the Office's request for clarification.

In an April 21, 2009 report, Dr. Slutsky rated impairment based on measurements contained in Dr. Misoul's March 3, 2009 report. He noted that Dr. Misoul did not correctly calculate the loss of supination, did not document left wrist measurements and did not properly substantiate the 49 percent rating. Dr. Slutsky discounted the range of motion loss in appellant's thumb and fingers and opined that appellant had 27 percent left arm impairment based on pain and lost range of motion loss in the left wrist.

By decision dated April 23, 2009, the Office granted appellant a schedule award for 27 percent permanent impairment of the left arm. Since appellant was previously paid 25 percent impairment, an additional 2 percent impairment was awarded.

Appellant requested an oral hearing, which was held August 5, 2009. In a September 28, 2009 decision, an Office hearing representative set aside the April 23, 2009 decision and directed that appellant be referred to a new impartial medical specialist.

The Office referred appellant to Dr. William Smulyan, a Board-certified orthopedic surgeon, for an impartial medical evaluation. Dr. Smulyan, however, was an associate of Dr. Larry Becker, who previously rated appellant's impairment. The Office disqualified Dr. Smulyan from serving as an impartial medical examiner.

The Office referred appellant to Dr. Zia Zakai, a Board-certified orthopedic specialist, for an impartial evaluation. In a January 5, 2010 report, Dr. Zakai noted the history of injury and

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

appellant's treatment. Under the sixth edition of the A.M.A., *Guides*, Dr. Zakai opined that appellant had 30 percent left arm impairment. She noted normal range of motion of the shoulder, 15 degrees lack of extension at the elbow and no evidence of any forearm musculature atrophy. Dr. Zakai indicated there was definite lack of cooperation on appellant's behalf during the examination. Appellant kept her fingers closed even against resistance, but after gradual persuasion, she relaxed her finger and was able to extend fully at the MP and PIP joints of the finger and flex fully at the PIP, DIP and MP joints of the finger. Thumb range of motion was normal. Grip strength was initially reported as one kilogram but subsequent attempts did not register any grip on diameter. Dr. Zakai reported flexion and extension were 10 degrees, radial deviation was 0 degree, ulnar deviation was 10 degrees, supination was 80 degrees and pronation was 70 degrees. She stated maximum medical improvement was attained in December 2005. For wrist range of motion, Dr. Zakai indicated Table 15-32, page 473 was used with a grade modifier of 2 for radial and ulnar deviation. She indicated that appellant had four percent impairment for loss of radial deviation and four percent impairment for loss of ulnar deviation. Table 15-33, page 474 was used for elbow/forearm range of motion with a grade modifier of 3 for flexion and extension. Dr. Zakai stated this resulted in nine percent impairment for loss of flexion and nine percent impairment for loss of extension. This resulted in 26 percent impairment due to wrist range of motion loss. Under Table 15-33, page 474, Dr. Zakai found one percent impairment due to loss of pronation for which grade modifier of 1 was used. She also attributed three percent impairment due to persistent pain and weakness. The total impairment was 30 percent. Dr. Zakai found no impairment was given due to finger and thumb involvement as appellant voluntarily refused to open her fingers, but passively, after persuasion, had full range of motion at the finger and thumb. She stated that appellant's position of the fingers during examination was due to her lack of cooperation.

In a January 21, 2010 report, Dr. Craig Uejo, an Office medical adviser, reviewed Dr. Zakai's report. He noted section 15.7e of the A.M.A., *Guides* discussed wrist motion impairment but section 15.7a described reasons when to not consider motion findings as reliable for rating purposes. Dr. Uejo noted that section 15.7a permitted the examiner to disallow the rating for loss of active range of motion if there was no pathoanatomic or physiological correlate and there was suboptimal effort or symptom magnification. Since Dr. Zakai reported a lack of cooperation on examination, appellant's abnormal range of motion findings were unreliable for rating purposes. The most objective and reliable basis for an impairment rating would be the diagnostic-based impairment for a triangular fibrocartilage complex (TFCC) tear under section 15.2, page 387 and section 15.2c, page 390 of the A.M.A., *Guides.* Under Table 15-3, page 396, the medical adviser attributed eight percent arm impairment for the TFCC tear in a Class 1 rating. Under Table 15-7, page 506, he assigned a grade modifier of 2 for functional history adjustment as appellant had pain symptoms with normal activity with or without medication to control symptoms. Under Table 15-9, the medical adviser assigned a grade modifier of 1 for clinical studies adjustment as the clinical studies confirm the diagnosis of a mild pathology. He then concluded that appellant had 10 percent left upper extremity impairment for the TFCC tear pursuant to the diagnostic-based impairment methodology.

By decision dated January 26, 2010, the Office denied appellant's claim for an additional schedule award. Determinative weight was accorded to the Office medical adviser's opinion.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] provides for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. The Act, 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 mater which rests in the sound discretion of the Office. 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. The A.M.A., *Guides* has been adopted by the Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[4]

Schedule award decisions issued between February 1, 2001 and April 30, 2009 utilize the fifth edition of the A.M.A., *Guides*.[5] Effective May 1, 2009, the Office adopted the sixth edition of the A.M.A., *Guides*,[6] published in 2008, as the appropriate edition for all awards issued after that date.[7] The Board has held that, as of May 1, 2009, a request for an additional schedule award based on new medical evidence should be calculated according to the sixth edition of the A.M.A., *Guides* even if the prior award was calculated under a previous edition.[8]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[9] Under the sixth edition, the evaluator identifies 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).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - DCX) + (GMCS - CDX).

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.[11] When there exists 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

[3] 5 U.S.C. §§ 8101-8193.

[4] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[5] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[6] FECA Bulletin No. 09-03 (issued March 15, 2009).

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 9, 2010).

[8] *M.F.*, Docket No. 09-1901 (issued July 1, 2010); *T.B.*, Docket No. 09-1903 (issued April 15, 2010).

[9] A.M.A., *Guides* (6th ed. 2008), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[10] A.M.A., *Guides* 494-531 (6th ed. 2008).

[11] 5 U.S.C. § 8123(a).

sufficiently well rationalized and based upon a proper factual background, must be given special weight.[12]

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides.*[13] The Board has held that, to properly resolve a conflict in medical opinion, it is the impartial medical specialist who should provide a reasoned opinion as to a permanent impairment to a scheduled member of the body in accordance with the A.M.A., *Guides.* An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.[14]

ANALYSIS

The Office accepted appellant's claim for dislocation of the left wrist and sprain and authorized arthroscopy with debridement of torn triangular fibrocartilage complex (TFCC). On March 7, 2006 appellant was granted a schedule award for 25 percent left arm impairment. The Board previously remanded the case for a supplemental report from the second impartial medical specialist, Dr. Gordon. The Office found that Dr. Gordon failed to properly apply the A.M.A., *Guides* in his supplemental report and, thus, referred appellant to Dr. Misoul for a third impartial medical examination. When Dr. Misoul failed to clarify his report, Dr. Slutsky, the Office medical adviser, found that Dr. Misoul's findings warranted 27 percent impairment of the left arm under the fifth edition of the A.M.A., *Guides*, appellant received a schedule award for an additional two percent impairment on April 23, 2009. An Office hearing representative subsequently found it was improper for the Office medical adviser to use Dr. Misoul's findings when the requested clarification from Dr. Misoul was not received. Appellant was thus referred to Dr. Smulyan for a fourth impartial medical examination. The Office, however, found that Dr. Smulyan could not be considered an impartial medical specialist as he was an associate of Dr. Larry Becker, who was previously associated with this case. The Office then referred appellant to Dr. Zakai for an impartial medical examination.[15]

In his January 6, 2010 report, Dr. Zakai opined that, while there was a lack of cooperation on appellant's behalf during the examination, she was able to get passive findings. She opined appellant had 30 percent left upper extremity impairment under the sixth edition of the A.M.A., *Guides*. Dr. Uejo, the Office medical adviser who reviewed Dr. Zakai's report, advised the

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

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[14] *See Richard R. LeMay*, 56 ECAB 341 (2005); *Thomas J. Fragale*, 55 ECAB 619 (2004).

[15] When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a medical conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, it has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report. When the impartial medical specialist's statement of clarification or elaboration is not forthcoming, or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative or lacks rationale, the Office must submit the case to a another impartial specialist for an opinion on the issue in question. *I.H.*, 60 ECAB ___ (Docket No. 08-1352, issued December 24, 2008).

impairment rating could only be based upon a diagnostic-based baseline rating to the left wrist for the TFCC tear as appellant's lack of cooperation in her physical examination rendered her abnormal motion findings unreliable for rating purposes. Under a diagnostic-based methodology, he opined appellant had 10 percent upper extremity impairment. The Office found that the weight of the medical evidence rested with Dr. Uejo.

Appellant's attorney contends that the Office medical adviser overstepped his role in reviewing an impartial medical specialist's findings. The Board agrees. An Office medical adviser may review a report to verify the correct application of the A.M.A., *Guides* and confirm the percentage of permanent impairment,[16] but it is the impartial medical specialist who must resolve a conflict in medical opinion.[17] It is well established that when a referee examination is arranged to resolve a conflict in medical opinion, the medical adviser is not to attempt clarification or expansion of the impartial medical specialist's opinion.[18] The Office medical adviser stated that, since Dr. Zakai reported that appellant demonstrated lack of cooperation in her physical examination, her abnormal range of motion findings were considered unreliable for rating purposes. The Office medical adviser substituted his judgment for that of the impartial medical specialist in determining appellant's permanent impairment. It is the role of the medical adviser to verify a correct application of the A.M.A., *Guides*, but it is for the impartial medical specialist to resolve the conflict. The Office issued the January 26, 2010 decision denying an additional schedule award beyond the 27 percent schedule award previously paid based on Dr. Uejo's report.

Appellant's attorney argues that Dr. Zakai's report is insufficient to resolve the medical conflict regarding the extent of appellant's permanent impairment. He contends that there is no support for Dr. Zakai's finding that appellant had full range of motion of her hand, fingers and thumb. With regard to appellant's hand, Dr. Zakai indicated in her report that there was definite lack of cooperation on her behalf as she kept her fingers closed against resistance. However, she indicated that after gradual persuasion, appellant was able to relax her finger and extend fully at the MP and PIP joints of the finger, flex fully at the PIP, DIP and MP joints of the finger and had normal range of motion of the thumb. Dr. Zakai's clinical examination included an examination of appellant's hand, fingers and thumb. Dr. Zakai's 30 percent impairment rating, however, was based on range of motion findings for radial deviation, ulnar deviation, forearm supination and pronation, and elbow flexion and extension and pain.

Under the sixth edition of the A.M.A., *Guides*, impairments to the upper extremities are generally covered by section 15-2, entitled diagnosis-based impairment.[19] This section is the method of choice for calculating impairment to the upper extremities. Range of motion is used

[16] *I.H., supra* note 15; Federal (FECA Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(c) (April 1993).

[17] *I.H., supra* note 15; *Richard R. LeMay*, *supra* note 14.

[18] *I.H., supra* note 15; Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.5(c) (October 1995).

[19] A.M.A., *Guides* 387, section 15.2.

primarily as a physical examination adjustment factor.[20] Range of motion may be used as a stand alone rating for impairment in the following two situations:

> "1. For amputation ratings, deficits of motion for the remaining portion of the limb, may be combined with the amputation impairment.
>
> "2. In very rare cases, severe injuries may result in passive range of motion losses qualifying for [C]lass 3 or 4 impairment. If the active range of motion impairment percentage is greater than the percentage impairment derived from the diagnosis-based class, then the impairment is rated by range of motion as a stand-alone rating. This range of motion for the impairment may only be used if the active range of motion is within 10 degrees of the passive range of motion measured. The active range of motion measurement is what determines the final impairment rating. Examples include complex flexor or extension tendon or multiple tendon laceration injuries, severe crush injuries, residual compartment syndrome, or other conditions having significant functional loss."[21]

In this case, Dr. Zakai did not explain how appellant's injury fell into either of these categories. Therefore, a supplemental report should be requested from Dr. Zakai. If Dr. Zakai is unwilling or unable to explain the basis of her impairment rating pursuant to the A.M.A., *Guides,* the case should be referred to another impartial medical specialist. Following this and such further development of the record as may be necessary, the Office shall issue an appropriate decision on the extent of impairment to appellant's left arm.

As to the Office's use of the sixth edition of the A.M.A., *Guides*, the Board notes that the method used in rating impairment for purposes of a schedule award is a matter which rests in the sound discretion of the Director. In *Harry D. Butler*,[22] the Board addressed the Office's use of the A.M.A., *Guides* to evaluate impairment since the first edition single volume published in 1971. The Director has adopted the subsequent editions of the A.M.A., *Guides* and stated the date specific when use of each edition should be made applicable to claims under the Act. Counsel has not established that the Director abused the discretion delegated under section 8107 or the implementing federal regulations to make the sixth edition of the A.M.A., *Guides* applicable to all claimants as of May 1, 2009. The fact that the sixth edition revises the evaluation methods used in previous editions does not establish an abuse of discretion. As noted in FECA Bulletin No. 09-03, the American Medical Association periodically revises the A.M.A., *Guides* to incorporate current scientific clinical knowledge and judgment and to establish standardized methodologies for calculating permanent impairment.

[20] *Id*.

[21] A.M.A., *Guides* 461.

[22] 43 ECAB 859 (1992).

CONCLUSION

The Board finds that this case is not in posture for decision. The medical evidence requires further development.

ORDER

IT IS HEREBY ORDERED THAT the January 26, 2010 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: January 11, 2011
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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