United States Department of Labor
Employees' Compensation Appeals Board

K.F., Appellant	)	
and	)	**Docket No. 11-966**
	)	**Issued: November 17, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Faxon, OK, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 10, 2011 appellant, through his representative, filed a timely appeal from the September 17, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP), which increased his schedule award. Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than a 13 percent impairment of his right arm and a 10 percent impairment of his left arm, for which he received schedule awards.

FACTUAL HISTORY

On February 7, 2003 appellant, a 53-year-old rural letter carrier, filed an occupational disease claim for compensation benefits alleging that his bilateral carpal tunnel syndrome was a

[1] 5 U.S.C. § 8101 *et seq.*

result of casing mail and driving his route. OWCP accepted his claim for bilateral carpal tunnel syndrome and left ulnar nerve lesion.

Appellant received a schedule award for an 11 percent impairment of his right upper extremity. An OWCP hearing representative set aside the award, however, because the findings on examination differed significantly between appellant's evaluating family physician, Dr. John W. Ellis, and the second-opinion physician, Dr. Michael Shawn Smith, a physiatrist. The hearing representative declared a conflict and remanded the case for further development of the evidence. OWCP referred appellant, together with the medical record and a statement of accepted facts, to Dr. Joel Frazier, a Board-certified orthopedic surgeon, to resolve the conflict and evaluate appellant's impairment under the recently adopted sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[2]

Dr. Frazier described his findings on physical examination and the results of a current electrodiagnostic study. He diagnosed bilateral carpal, cubital and ulnar tunnel syndrome; failed right carpal tunnel release and left carpal tunnel and ulnar nerve release at the elbow with persistent neuropathy, denervation and atrophy of both hands; and left flexor tenosynovitis with locking trigger finger. Dr. Frazier found that appellant was not permanent and stationary and had not reached maximum medical improvement.

OWCP denied appellant's schedule award claim.

Appellant's attending osteopathic surgeon, Dr. J.D. Duncan, found maximum medical improvement. He used the fifth edition of the A.M.A., *Guides* to find a 45 percent impairment of the right upper extremity due to carpal tunnel syndrome, a 39 percent impairment of the left upper extremity due to carpal tunnel syndrome and a 7 percent impairment of the left upper extremity due to left ulnar sensory deficits.

On May 5, 2010 Dr. Frazier reevaluated appellant's impairment and found an 18 percent impairment of the right upper extremity and a 15 percent impairment of the left upper extremity based on range of motion and entrapment compression. He used the sixth edition of the A.M.A., *Guides*. An OWCP medical adviser noted, however, that Dr. Frazier did not describe the abnormality adequately enough to permit review and did not specify which nerves were involved in the compression neuropathies.

OWCP determined a second impartial medical specialist was warranted because Dr. Frazier's most recent report was still insufficient to resolve matters. It referred appellant, together with the medical record and a statement of accepted facts, to Dr. Andrew Olshen, a Board-certified physiatrist.

Dr. Olshen reviewed appellant's medical record and related his history. He described his findings on physical examination and diagnosed right carpal tunnel syndrome, left carpal tunnel syndrome and left ulnar neuropathy characterized by axonal loss. Dr. Olshen found that appellant, who was more than a year post his most recent surgery, had reached maximum medical improvement.

[2] A.M.A., *Guides* (6th ed. 2009).

Using Table 15-23, page 449 of the sixth edition of the A.M.A., *Guides*, Dr. Olshen determined that appellant's left ulnar neuropathy was grade 3 or severe: Test findings showed axon loss, history showed constant symptoms, and physical findings showed atrophy. The default impairment value for a grade 3 or severe neuropathy was eight percent, but Dr. Olshen modified the default value to seven percent because appellant's functional *Quick*DASH score of 23 was mild.

Dr. Olshen found that appellant's left carpal tunnel neuropathy was grade 2 or moderate: test findings showed a motor conduction block, history showed constant symptoms and physical findings showed decreased sensation. The default impairment value for a grade 2 neuropathy was five percent. Dr. Olshen did not modify the default value. Because the nerve qualifying for the larger impairment is given the full impairment, while the nerve qualifying for the smaller impairment is rated at half the impairment listed, Dr. Olshen determined that appellant had a 10 percent impairment of the left upper extremity (7 percent plus half of 5 percent).

Finally, Dr. Olshen found that appellant's right carpal tunnel neuropathy was grade 3 or severe: as with the left ulnar nerve, test findings showed axon loss, history showed constant symptoms and physical findings showed atrophy. The default impairment value for a grade 3 or severe neuropathy was eight percent; appellant's *Quick*DASH score was 43, or moderate. Dr. Olshen increased the default value to a final impairment rating of nine percent.

An OWCP medical adviser accepted Dr. Olshen's ratings. He explained that because appellant previously received an 11 percent award for loss of right wrist motion (4 percent) and right median nerve loss (7 percent), the previous median nerve loss should be subtracted from the current nerve loss, entitling appellant to an additional 2 percent.

On September 17, 2010 OWCP issued a schedule award for a 10 percent impairment of appellant's left upper extremity and a 13 percent impairment of his right (less the previously paid 11 percent for an additional impairment of 2 percent).

On appeal, appellant argues that his claim should have been settled under the fifth edition of the A.M.A., *Guides*, as two evaluations were performed before the rules were changed. He also believes there was no good medical reason not to accept Dr. Frazier's May 5, 2010 medical opinion on the impairment of his left upper extremity. Appellant noted that those who gave him a higher rating spent more time with him. He asks the Board to review whether OWCP handled his claim properly and did not shop around for a lower rating.

LEGAL PRECEDENT

Section 8107 of FECA authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body.[3] Such loss or loss of use is known as

[3] 5 U.S.C. § 8107.

permanent impairment. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[4]

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.[5] 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.[6]

When OWCP secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, OWCP 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, OWCP must submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question.[7] Unless this procedure is carried out by OWCP, the intent of section 8123(a) of FECA will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[8]

ANALYSIS

A conflict in medical opinion arose when appellant's physician, Dr. Ellis, and OWCP's referral physician, Dr. Smith, reported significantly different findings on examination. This led to a significant discrepancy in appellant's impairment rating. To resolve this conflict, OWCP properly referred appellant to Dr. Frazier for an impartial or referee medical evaluation.

Dr. Frazier, however, found that it was premature to evaluate appellant's permanent impairment because he had not yet reached maximum medical improvement.[9] Because Dr. Ellis and Dr. Smith agreed that appellant had reached maximum medical improvement, Dr. Frazier's

[4] 20 C.F.R. § 10.404. As of May 1, 2009, any decision regarding a schedule award must be based on the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

[5] 5 U.S.C. § 8123(a).

[6] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

[7] *See Nathan L. Harrell*, 41 ECAB 402 (1990).

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

[9] Impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized. *See Orlando Vivens*, 42 ECAB 303 (1991) (a schedule award is not payable until maximum improvement -- meaning that the physical condition of the injured member of the body has stabilized and will not improve further -- has been reached).

opinion created a second conflict, one that warranted referral to a second impartial medical specialist.

Dr. Duncan, the attending osteopathic surgeon, reinforced the conflict by joining Dr. Ellis in finding maximum medical improvement. His opinion on appellant's impairment, however, was entitled to little weight because he based it on the outdated fifth edition of the A.M.A., *Guides*. Dr. Frazier returned with a rating under the sixth edition, but his opinion was also entitled to little weight. He incorrectly combined impairment for loss of motion with impairment due to entrapment or compression neuropathy. The A.M.A., *Guides* explains that diagnosis-based impairment is the method of choice for calculating impairment, while range of motion is used principally as an adjustment factor. When other grids refer the evaluator to the range of motion section, or when no other diagnosis-based system is applicable, range of motion impairment serves as a stand-alone rating, one that cannot be combined with a diagnosis-based estimate, such as impairment due to entrapment or compression neuropathy.[10] By giving a rating, Dr. Frazier implied that appellant had reached maximum medical improvement, but he did not make an explicit finding, and he did not explain any change of opinion. Because Dr. Frazier's second report did not resolve the extent of appellant's permanent impairment and because a conflict still existed on the issue of maximum medical improvement, OWCP properly referred appellant to a second impartial medical specialist, Dr. Olshen.[11]

OWCP provided Dr. Olshen with a copy of appellant's medical record and a statement of accepted facts so he could base his opinion on a proper medical and factual history. Dr. Olshen found that appellant had reached maximum medical improvement, as he was more than a year post his most recent surgery.[12] He described his findings on examination and applied the sixth edition of A.M.A., *Guides*. The Board therefore finds that his findings are entitled to special weight in resolving the extent of appellant's impairment.

Dr. Olshen correctly used Table 15-23, on page 449 of the A.M.A., *Guides*, to rate impairment due to entrapment or compression neuropathies. Test findings, history and physical findings confirmed a severe left ulnar neuropathy with a default impairment value of eight percent. Dr. Olshen correctly modified the default value to seven percent to reflect appellant's *Quick*DASH score, which showed only a mild functional loss.

For the left median neuropathy, Dr. Olshen followed the same procedure but misapplied the *Quick*DASH score. Appellant's left wrist condition was moderate; the default impairment rating was five percent. His *Quick*DASH score again showed only a mild functional loss; therefore, the default value should be modified to four percent. Dr. Olshen incorrectly left the default value unchanged at five percent, which would have the effect of inflating the final impairment rating by one percent.

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

[11] *See April Ann Erickson*, 28 ECAB 336 (1977).

[12] The A.M.A., *Guides* provide that postoperatively, a sufficient amount of time for optimal physiologic recovery and rehabilitation should have elapsed before an individual is considered to be at maximum medical improvement and to qualify for a permanent impairment rating. Lesions at the wrist may take six to nine months for maximal recovery of nerve function, and more proximal focal axon loss lesions may take one to two years. *Id*. at 447.

In cases of multiple, concurrent focal nerve compromise syndromes in the same upper extremity, such as an ulnar and median neuropathy, the nerve qualifying for the larger impairment is given the full impairment. The nerve qualifying for the smaller impairment is given half the impairment listed in Table 15-23. The impairments are then combined.[13] Following this procedure, appellant's larger (ulnar) impairment remains seven percent. His smaller (median) impairment is given half its value, or two percent. These combine for a final left upper extremity impairment rating of nine percent.[14] The Board will modify OWCP's September 17, 2010 decision to reflect this proper application of the A.M.A., *Guides*.

Dr. Olshen made a similar error when he rated appellant's right median neuropathy. The neuropathy was severe, with a default impairment value of eight percent. The *Quick*DASH score of 43 showed a moderate functional loss, which lowers the default value to seven percent. Dr. Olshen incorrectly raised the default value to nine percent. Because appellant previously received a schedule award for an 11 percent total impairment of his right upper extremity, he is not entitled to additional compensation for that extremity. The Board will modify OWCP's September 17, 2010 decision to reflect a 7 percent total impairment of the right upper extremity.

Appellant argues that OWCP should have settled his claim under the fifth edition, but there was such a discrepancy in the first two ratings he received under the fifth edition that the issue remained unresolved. Neither Dr. Ellis nor Dr. Smith established his entitlement under the fifth edition. When OWCP referred the matter to Dr. Frazier for resolution of the conflict, the fifth edition was out of use. As of May 1, 2009, any decision regarding a schedule award had to be based on the new sixth edition. Dr. Frazier applied the sixth edition in his May 5, 2010 report, but as the Board noted earlier, he incorrectly combined range of motion with a diagnosis-based estimate, and he did not explain why appellant was now at maximum medical improvement. Further, Dr. Frazier found only a six percent impairment of the left upper extremity due to entrapment or compression neuropathy, which was less than the impairment found by Dr. Olshen. His rating, therefore, would not have been advantageous for appellant.

The Board has carefully reviewed this claim and finds no evidence that OWCP referred him to Dr. Frazier to "shop around" for a lower rating. FECA requires an impartial or referee medical specialist to resolve medical conflicts. OWCP properly referred appellant to Dr. Olshen because a second impartial medical specialist is necessary when the first is unable to resolve the matter satisfactorily.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has a seven percent impairment of his right arm and a nine percent impairment of his left arm. Dr. Olshen's opinion is entitled to special weight, although

[13] *Id*. at 448.

[14] *Id*. at 604 (Combined Values Chart).

his use of the *Quick*DASH scores to modify default impairment values must be corrected to comply with the A.M.A., *Guides*.

ORDER

IT IS HEREBY ORDERED THAT the September 17, 2010 decision of the Office of Workers' Compensation Programs is affirmed as modified.

Issued: November 17, 2011
Washington, DC

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

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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