

syndrome and paid benefits. Appellant underwent left carpal tunnel release on August 3, 2000 and a right carpal tunnel release on October 19, 2000. She returned to full-time limited-duty work on January 29, 2001.

On April 27, 2001 appellant requested a schedule award. In a May 15, 2001 report, Dr. Patrick J. Hughes, a Board-certified neurologist and OWCP referral physician, opined that while there were no objective findings that the bilateral carpal tunnel condition was active, appellant still had symptoms that did not clear up completely after surgery. He also opined that she was able to work full time with restrictions. In a May 22, 2001 report, Dr. Hughes opined that under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*), appellant had 10 percent impairment to each arm. Following OWCP's June 4, 2000 request for clarification, he opined in a June 6, 2001 report that, because she had 12 percent impairment, she had a disability. Dr. Hughes explained that, since appellant had impairment and disability, objective findings were not needed to show that her condition was active.

In a July 9, 2001 report, Dr. Richard DiStefano, a Board-certified orthopedic surgeon, noted the history of injury, presented findings and diagnosed status post right and left carpal tunnel releases. He opined under the fifth edition of the A.M.A., *Guides*, that appellant had 18.5 percent impairment of her left hand and 7.5 percent impairment of her right hand. No physical findings were provided.

OWCP found a conflict of medical opinion between Dr. Hughes and Dr. DiStefano regarding appellant's diagnosis and whether she had permanent impairment. It referred appellant to Dr. Daniel Elstein, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve the conflict in medical opinion. In a November 10, 2001 report, Dr. Elstein reviewed her medical record and discussed his findings on examination. He provided an impression of bilateral carpal tunnel syndrome with mild loss of flexion involving the right index, middle and ring fingers. Because of the mild limitation of motion of both wrists, Dr. Elstein found appellant had 7.5 percent impairment to each upper extremity. He added another 25 percent "loading" for mild restriction to the right hand fingers or a total of 10 percent impairment to the right upper extremity.

The claim was dormant until a June 24, 2007 letter in which appellant inquired about the status of her case. In a July 30, 2007 report, OWCP's medical adviser opined that she had no ratable permanent impairment under the fifth edition of the A.M.A., *Guides*. He indicated that the evidence showed no objective findings in either hand, only subjective complaints. The medical adviser noted that Dr. DiStefano had not provided findings to explain his rating, that Dr. Elstein did not relate the loss of flexion in the finger to carpal tunnel syndrome and that an earlier examination had indicated no objective findings.

On June 19, 2008 OWCP requested clarification from Dr. Elstein of his findings. As Dr. Elstein was no longer in practice, OWCP referred appellant to Dr. Richard Byrne, a Board-certified orthopedic surgeon, for an impartial medical examination. In a December 29, 2008 report, Dr. Byrne reviewed appellant's medical records and listed findings on examination. He opined that maximum medical improvement was reached October 19, 2001. Dr. Byrne opined that, under the fifth edition of the A.M.A., *Guides*, appellant had 5 percent left upper

extremity impairment based on loss of motion and 12.5 percent right upper extremity impairment based on 40 percent impairment to the right middle finger, which was equivalent to 7 percent upper extremity impairment and 5.5 percent impairment based on loss of motion.

In an April 4, 2009 report, OWCP's medical adviser agreed that maximum medical improvement was reached October 19, 2001. Using Dr. Byrne's examination findings, he opined that, under the fifth edition of the A.M.A., *Guides*, appellant had 12.5 percent impairment of the right upper extremity and 5 percent of the left upper extremity.

In a May 11, 2009 letter, OWCP requested that Dr. Byrne provide an impairment rating under the sixth edition of the A.M.A., *Guides*, which became effective May 1, 2009. On May 15, 2009 Dr. Byrne opined that he was unable to perform an impairment rating under the sixth edition of the A.M.A., *Guides*.

OWCP referred appellant to Dr. Farouq Al-Khalidi, a Board-certified orthopedic surgeon, for an impartial medical examination. In an August 11, 2009 report, Dr. Al-Khalidi, reviewed appellant's medical records and noted his findings on examination. He found negative Tinel's sign and Phalen's test over both wrists, no sensory deficits, no weakness and only mild discomfort with making a tight fist of the right index and long finger. Dr. Al-Khalidi diagnosed status post open decompression of carpal tunnel, both wrists and mild degenerative arthritic changes of the distal interphalangeal (DIP) joints of the right little and ring fingers, unrelated to the accepted condition. He opined that appellant reached maximum medical improvement and, that, under the sixth edition of the A.M.A., *Guides*, she exhibited no objective evidence of permanent impairment of either hand.

In an October 14, 2009 report, OWCP's medical adviser reviewed Dr. Al-Khalidi's findings on examination and requested a copy of a May 9, 2000 electromyogram/nerve conduction (EMG/NCV) test to determine impairment for carpal tunnel syndrome under Table 15-23, page 449. He stated that, if the EMG/NCV test was not available, then there was no impairment under the sixth edition of the A.M.A., *Guides* as there was no clinical evidence of median nerve dysfunction on Dr. Al-Khalidi's evaluation and no other basis for an impairment rating in either upper extremity related to appellant's bilateral carpal tunnel syndrome. The medical adviser noted that, while Dr. Al-Khalidi found mild degenerative arthritic changes of the DIP joints of the right little and ring fingers, these were not work-related conditions and would not be addressed. He indicated that the date of maximum medical improvement was August 11, 2009.

On December 2, 2009 OWCP's medical adviser reviewed the preoperative May 9, 2000 EMG/NCV test and stated that it exhibited evidence of sensory conduction block under Appendix 15-B, page 487 of the A.M.A., *Guides* and, thus, meet the criteria for rating both extremities under Table 15-23, page 339 for carpal tunnel syndrome. Based on Dr. Al-Khalidi's findings on examination, he found the average modifiers for history was zero, for physical findings was zero and for physical findings was one. The medical adviser indicated that the default upper extremity impairment was two percent and that Dr. Al-Khalidi did not provide a Disabilities, Arms, Shoulder and Hand (*QuickDASH*) score or identify any functional deficit. He stated that the functional status would be negligible and there would be an adjustment to the left for a final impairment of one percent for each upper extremity.

On December 14, 2009 OWCP requested that Dr. Al-Khalidi provide appellant with the *QuickDASH* questionnaire (or similar functional questionnaire) and then score and apply Table 15-23 for the final impairment assignment. Dr. Al-Khalidi did not respond to OWCP's request.

On November 25, 2009 appellant retired.

In a May 16, 2011 report, another OWCP medical adviser reviewed appellant's medical record and statement of accepted facts along with Dr. Al-Khalidi's August 1, 2009 report. He noted that Dr. Al-Khalidi found negative Tinel's sign and Phalen's test over both wrists, no sensory deficits, no weakness and only mild discomfort with making a tight fist of the right index and long finger. Using Dr. Al-Khalidi's findings on examination, the medical adviser opined, under Table 15-23, page 449 of the A.M.A., *Guides* that these findings resulted in a grade modifier of 0, which corresponded to no impairment for both upper extremities. Maximum medical improvement was noted to be August 11, 2009.

By decision dated June 28, 2011, OWCP denied appellant's schedule award claim. It found that she had not met the requirements for entitlement to a schedule award as her condition had not reached a fixed and permanent state.

On July 22, 2011 appellant, through her attorney, requested a review of the written record by an OWCP hearing representative. By decision dated November 14, 2011, OWCP's hearing representative affirmed the June 28, 2011 decision. The hearing representative accorded special weight to Dr. Al-Khalidi's August 1, 2009 impartial report and found that the second medical adviser correctly utilized Dr. Al-Khalidi's August 1, 2009 findings on examination under the sixth edition of the A.M.A., *Guides* to find appellant did not sustain a ratable permanent impairment.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations² 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. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.³ For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates 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 implementing

² 20 C.F.R. § 10.404; *see* 5 U.S.C. § 8107.

³ *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

regulations as the appropriate standard for evaluating schedule losses.⁴ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁵

Section 8123(a) provides that, if there is a 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.⁶ It is well established that, when a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.⁷

When OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in the original report.⁸ However, when the impartial medical specialist is unable to clarify or elaborate on the original report or if a supplemental report is also vague, speculative or lacking in rationale, OWCP must submit the case record to a second impartial specialist for the purpose of obtaining a rationalized medical opinion on the issues.⁹

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the medical adviser providing rationale for the percentage of impairment specified.¹⁰ Although the medical adviser may review an opinion of an impartial medical examiner, the resolution of the conflict is solely the responsibility of the impartial medical examiner.¹¹

ANALYSIS

The Board finds that the case is not in posture for decision due to an unresolved conflict in medical opinion.

⁴ *Ronald R. Kraynak*, 53 ECAB 130 (2001).

⁵ 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).

⁶ *Veronica Williams*, 56 ECAB 367, 370 (2005).

⁷ *Regina T. Pellicchia*, 53 ECAB 155 (2001).

⁸ *Raymond A. Fondots*, 53 ECAB 637 (2002); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

⁹ *Nancy Keenan*, 56 ECAB 687 (2005); *Roger W. Griffith*, 51 ECAB 491 (2000).

¹⁰ *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

¹¹ *K.P.*, Docket No. 11-1012 (issued January 13, 2012).

A conflict in medical opinion existed between Dr. Hughes and Dr. DiStefano regarding appellant's diagnosis and whether a permanent impairment existed. OWCP properly referred appellant to Dr. Elstein for an impartial evaluation to resolve the conflict. While Dr. Elstein performed that examination and rendered a report, OWCP determined that his opinion required clarification. As he was no longer in practice, OWCP properly referred appellant to Dr. Byrne for an impartial evaluation. When OWCP asked that Dr. Byrne provide a rating under the sixth edition of the A.M.A., *Guides*, he declined. OWCP properly referred appellant to Dr. Al-Khalidi to resolve the medical conflict. Dr. Al-Khalidi examined appellant and issued a report on August 11, 2009.

On appeal, counsel argues that there was unreasonable delay in developing the schedule award issue and appellant should not be penalized for such delay. He argues that that schedule award should have been based upon Dr. Elstein's November 10, 2001 opinion, which OWCP's medical adviser reviewed. As noted above, all schedule award decisions issued beginning May 1, 2009 are based on the sixth edition of the A.M.A., *Guides*. While OWCP did not act on Dr. Elstein's report for almost six years, the Board notes that OWCP requested clarification from Dr. Elstein which he was unable to provide. As such, Dr. Elstein's report was insufficient to resolve the medical conflict. OWCP could not accord determinative weight to Dr. Byrne's December 29, 2008 opinion as further clarification, an impairment rating conforming with the sixth edition of the A.M.A., *Guides*, was needed which Dr. Byrne did not provide. Thus, it properly sought from Dr. Al-Khalidi an impairment rating under the sixth edition of the A.M.A., *Guides*.¹²

Counsel asserts that Dr. Al-Khalidi's August 11, 2009 report cannot be accorded special weight as an impartial medical examiner he failed to provide any explanation or discussion as to the percentage of an impairment rating. The Board agrees. In this case, two medical advisers reviewed Dr. Al-Khalidi's August 11, 2009 report. Although OWCP's medical adviser may review an opinion of an impartial medical examiner, the resolution of the conflict remains solely the responsibility of the impartial medical examiner.¹³ The first medical adviser found there was no clinical evidence of median nerve dysfunction on Dr. Al-Khalidi's evaluation and thus no impairment under the sixth edition of the A.M.A., *Guides*. He also found that the preoperative May 9, 2000 EMG/NCV test met the criteria for rating both upper extremities under Table 15-23, page 339 but noted that Dr. Al-Khalidi did not provide a *QuickDASH* score or identify any functional deficit. Based on this, OWCP properly requested a supplemental report from Dr. Al-Khalidi. When no response was received from Dr. Al-Khalidi, the conflict in medical evidence remained unresolved as to the issue of appellant's permanent impairment. OWCP should have referred appellant to another impartial medical specialist for a rationalized medical opinion on the matter.¹⁴ Instead, another medical adviser reviewed Dr. Al-Khalidi's report and found no permanent impairment under the sixth edition of the A.M.A., *Guides*. As OWCP had

¹² See *supra* note 5. See *J.S.*, Docket No. 10-1938 (issued June 21, 2011) (where the Board noted that the applicable date of the sixth edition of the A.M.A., *Guides*, is as of the schedule award decision reached; it is not determined by either the date of maximum medical improvement or when the claim for such award was filed).

¹³ *K.P.*, Docket No. 11-1012 (issued January 13, 2012).

¹⁴ See *Guiseppe Aversa*, 55 ECAB 164 (2003).

previously determined that clarification was needed from Dr. Al-Khalidi to resolve the medical conflict, it improperly relied upon the second medical adviser's review of Dr. Al-Khalidi's report to denying her schedule award claim. The conflict in medical opinion regarding permanent impairment remained unresolved.¹⁵

The case will be remanded to OWCP for referral of appellant to an impartial medical examination pursuant to 5 U.S.C. § 8123(a). Following this and any necessary further development of the medical evidence, OWCP shall issue an appropriate decision regarding her schedule award claim.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the November 14, 2011 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: August 15, 2012
Washington, DC

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

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

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

¹⁵ See *Richard R. LeMay*, 56 ECAB 341 (2005).