United States Department of Labor
Employees' Compensation Appeals Board

E.S., Appellant	)	
and	)	**Docket No. 12-916**
	)	**Issued: September 3, 2013**
DEPARTMENT OF THE ARMY, U.S. ARMY MATERIEL COMMAND, Fort Monmouth, NJ, 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
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On March 20, 2012 appellant, through his attorney, filed a timely appeal from the December 14, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has more than a seven percent permanent impairment of his right arm, for which he received a schedule award.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

OWCP accepted that on May 30, 2008 appellant, a 55-year-old supply systems analyst, sustained a closed fracture of his right radius head due to a fall at work. Appellant returned to his regular work without restrictions on May 31, 2008.[2]

In a July 17, 2008 report, Dr. Chalnick stated that appellant was status post nondisplaced fracture of his right radius head and that his right arm was splinted for nearly four weeks after the May 30, 2008 accident. He indicated that appellant's right arm had full pronation, but lacked about 10 degrees of extension and a few degrees of supination and flexion.

An August 7, 2008 examination by Dr. Chalnick revealed that appellant had a positive Phalen's sign and a negative Tinel's sign in his right arm consistent with "potential carpal tunnel syndrome." Appellant had no atrophy or weakness in his right arm and had 5/5 grip strength. On November 3, 2008 Dr. Scott C. Woska, an attending Board-certified physiatrist, indicated that recent electrodiagnostic testing showed that appellant had mild median neuropathy at his right wrist consistent with carpal tunnel syndrome. He stated that appellant appeared to have full range of motion of his right elbow without instability or crepitus.[3]

In a December 3, 2008 report, Dr. David Weiss, an attending osteopath, determined that appellant had 54 percent permanent impairment of his right arm under the standards of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). He reported physical examination findings, including the results of range of motion and grip strength testing, and noted that the May 30, 2008 work injury was the competent producing factor for the observed findings. Dr. Weiss indicated that appellant's overall right arm impairment was comprised of the combination of several ratings (using the Combined Values Chart), including a 6 percent rating for 4/5 motor strength in the right biceps, a 10 percent rating for 4/5 motor strength in the right triceps, a 20 percent rating for right lateral pinch deficit and a 31 percent rating for grade 2 sensory deficit in the right median nerve. He found that maximum medical improvement was reached on December 3, 2008.

On March 6, 2009 Dr. Henry J. Magliato, a Board-certified orthopedic surgeon and an OWCP medical adviser, noted that there was a marked difference in the findings observed by Dr. Chalnick and Dr. Weiss. He noted that the objective medical evidence showed that appellant had a lesser permanent impairment of his right arm than that found by Dr. Weiss. Dr. Magliato recommended that appellant be referred to an impartial medical specialist.

OWCP determined that there was a conflict in the medical evidence between Dr. Weiss and Dr. Magliato regarding the extent of appellant's right arm impairment. In June 2009, it

[2] In a May 6, 2008 report, Dr. David L. Chalnick, an attending Board-certified orthopedic surgeon, noted that appellant reported that on May 2, 2008 he felt a ripping sensation in his right elbow while pushing a couch at home. He indicated that the findings on physical examination were consistent with a right distal biceps tendon tear. On May 27, 2008 Dr. Chalnick stated that the findings of recent magnetic resonance imaging (MRI) testing confirmed that appellant sustained a right distal biceps tendon tear.

[3] In July 2009, OWCP accepted, under a different claim file, that appellant sustained work-related bilateral carpal tunnel syndrome and bilateral trigger finger.

referred appellant to Dr. Elliot C. Semet, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on the extent of the permanent impairment of his right arm.

In an August 3, 2009 report, Dr. Semet diagnosed status post radial head fracture of the right elbow with bilateral carpal tunnel syndrome, status post biceps tendon tear, status post volar ganglion removal (1999 surgery) and status post chronic post-traumatic medial and lateral epicondylitis. He indicated that appellant's impairment rating, based upon the fifth edition of the A.M.A., *Guides*, was consistent with Dr. Weiss' use of the A.M.A., *Guides*. Dr. Semet stated that the difference between his and Dr. Weiss' rating would be that "the motor strength deficit of the biceps is not taken into account and therefore his value of six percent is not included." There was no injury to appellant's right triceps tendon when his right radial head was injured and his epicondylitis would not affect his biceps strength. Dr. Semet noted that appellant had a Class 2 to 3 sensory deficit which, at most, would be a 25 percent sensory impairment. He stated:

> "In regards to the median nerve, below the mid forearm, attributing his motor deficit to be part of his decreased lateral pinch strength. This would give him 25 percent of 39 or approximately 10 percent. This would give him a total combined right upper extremity impairment of 24 percent as reviewed from the Combined Value Chart on page 604.
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> "On examination of his right upper extremity on this particular day, I would give the patient an impairment of 24 percent. However, noting that [sic] continued compression neuropathy of his median nerve, I would expect this impairment rating to continue to affect this patient and, in fact, he may become more impaired if his median neuropathy is not addressed."

In a March 12, 2010 letter, OWCP requested that Dr. Semet provide a supplemental report which rated impairment based on the standards of the sixth edition of the A.M.A., *Guides*.

On June 15, 2010 OWCP received a copy of Dr. Semet's August 3, 2009 report which contained an addendum by Dr. Semet stating:

> "I have reviewed my previous reports regarding Dr. David Weiss's Regional Independent Medical Evaluation, as well as Dr. David Chalnick's notes. I have reviewed the notes and now have the sixth edition of the [A.M.A., *Guides*] for the evaluation of permanent impairment. There is no change in my evaluation. The numbers were within a range and are unchanged by the [A.M.A., *Guides*] of the [sixth edition]. I found no significant difference in my overall evaluation and my opinions remain the same. It is of note that the other doctor's evaluation came from the [fifth edition] and you now want me to do it from the [sixth edition]. In any event, there is no change in the evaluation of my percentage."

In a July 14, 2010 note, Dr. Andrew A. Merola, a Board-certified orthopedic surgeon and an OWCP medical adviser, indicated that Dr. Semet reported no change in his percentage calculations. He stated, "Unfortunately, he does not summarize how he arrives at those calculations so we cannot appropriately determine the schedule loss of use."

In an August 31, 2010 letter, OWCP requested that Dr. Semet provide additional details regarding his derivation of an impairment rating under the sixth edition of the A.M.A., *Guides*, including the measurements he took and the tables he applied. It provided Dr. Semet 14 days from the date of the letter to provide such clarification. Dr. Semet did not respond to OWCP's letter within the time allotted.

OWCP determined that there continued to be a conflict in the medical evidence regarding the extent of appellant's right arm impairment and referred him to Dr. Robert Dennis, a Board-certified orthopedic surgeon, for an impartial medical examination.

The record includes an MEO23 iFECS report noting that appellant's impartial medical appointment was scheduled with Dr. Dennis on May 24, 2011. The record also contains a series of screen captures showing the selection of Dr. Dennis through the computerized rotation process of the Physicians Directory System (PDS).[4]

In a May 24, 2011 report, Dr. Dennis detailed appellant's medical history, including providing a description of the May 30, 2008 work injury. He noted that appellant reported having carpal tunnel release surgery in April 2011 and that the trigger finger of the third finger of his right hand had been medically corrected. Dr. Dennis stated that on May 2, 2008 appellant had a right distal biceps tendon tear while pushing a couch and that surgery for this was not performed due to his age and occupation. He reported findings on examination, including the findings of range of motion testing for the right elbow. Appellant had 125 degrees of flexion, 15 degrees of extension, 65 degrees of pronation and 65 degrees of supination. Dr. Dennis stated that, by MRI scan testing, clinical examination and history, appellant's preexisting right distal biceps tendon tear was responsible for the weakness of his biceps muscle function and that this condition contributed to his limited range of elbow motion. Grip strength was normal, the length of both arms was equal, the right elbow showed no effusion or crepitus and there were no clinical findings of deformity about the right elbow. Dr. Dennis stated that he examined appellant for carpal tunnel findings and noted that "there were none." Phalen's test and Finklestein's test were negative, there was no tenderness over the Canal of Guyon and there were no specific areas of neurological hypesthesia or paresthesias in any of the fingers. Dr. Dennis also noted that he did not observe any trigger finger findings. He stated, "The only functional loss that was identifiable to the nondisplaced radial head fracture 'is the range of motion loss.'" Dr. Dennis explained how he arrived at an impairment rating for appellant's right arm under the sixth edition of the A.M.A., *Guides*. He noted that appellant's main diagnosis-based condition was the right distal head fracture which was a class 1 condition under Table 15-4 (Elbow Regional Grid) on page 399, but determined that his right arm impairment should be calculated under the range of motion method. Dr. Dennis referenced Table 15-33 on page 474,[5] noting that appellant's 125 degrees of flexion equaled three percent impairment, his 15 degrees of extension equaled two percent impairment, his 65 degrees of pronation equaled one percent impairment and his 65 degrees of supination equaled one percent impairment. These figures were added to total seven percent right arm impairment. Dr. Dennis then found that appellant had a functional grade modifier of

[4] *See infra* notes 21, 22.

[5] Dr. Dennis mentioned Figure 15-13 on page 462, but it is clear from the resultant impairment ratings for limited elbow motion that the impairment calculations were derived from Table 15-33.

one and a physical examination grade modifier of one and determined, by applying Table 15-35 and Table 15-36 on page 477 that there was no need to adjust the total impairment found due to limited right elbow motion. Therefore, appellant had a total right arm impairment of seven percent.[6]

In a June 15, 2011 report, Dr. Magliato stated that he agreed with Dr. Dennis' assessment that appellant had seven percent permanent impairment of his right arm under the standards of the sixth edition of the A.M.A., *Guides.*

In a June 27, 2011 award of compensation, OWCP granted appellant a schedule award for seven percent permanent impairment of his right arm. The award ran for 21.84 weeks from December 3, 2008 to May 4, 2009 and was based on the opinion of Dr. Dennis.

Appellant requested a telephonic hearing with an OWCP hearing representative regarding his schedule award claim. During the October 13, 2011 hearing, counsel argued that Dr. Dennis did not properly take into account appellant's preexisting right arm condition of right biceps tendon tear or his accepted condition of right carpal tunnel syndrome in calculating his right arm impairment.

In a December 14, 2011 decision, an OWCP hearing representative affirmed OWCP's June 27, 2011 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[7] and its implementing regulations[8] 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 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 regulations as the appropriate standard for evaluating schedule losses.[9] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[10] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[11]

[6] Dr. Dennis determined that appellant reached maximum medical improvement on December 3, 2008.

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999).

[9] *Id*.

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

[11] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3(a)(3) (January 2010). This portion of OWCP procedure provides that the impairment rating of a given scheduled member should include "any preexisting permanent impairment of the same member or function."

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the elbow, reference is made to Table 15-4 (Elbow Regional Grid) beginning on page 398.[12] Table 15-4 also provides that, if loss of elbow motion is present, impairment may alternatively be assessed using section 15.7 (range of motion impairment). Such a range of motion impairment stands alone and is not combined with a diagnosis-based impairment.[13]

Section 8123(a) of FECA provides in pertinent part: "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."[14] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[15] In situations where 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.[16]

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 his original report. However, when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative, or lacking in rationale, OWCP must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[17]

It is well established that OWCP procedures provide that an impartial medical specialist must be selected from a rotational list of qualified Board-certified specialists, including those certified by the American Medical Association and American Osteopathic Association.[18] The physician selected as the impartial specialist must be one wholly free to make an independent evaluation and judgment. To achieve this end, OWCP has developed procedures for the selection of the impartial medical specialist designed to provide adequate safeguards against the appearance that the selected physician's opinion was biased or prejudiced.[19] The procedures

[12] *See* A.M.A., *Guides* 398-400 (6th ed. 2009).

[13] *Id.* at 400.

[14] 5 U.S.C. § 8123(a).

[15] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

[16] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[17] *Harold Travis*, 30 ECAB 1071, 1078 (1979).

[18] *See A.R.*, Docket No. 09-1566 (issued June 2, 2010); *LaDonna M. Andrews*, 55 ECAB 301 (2004).

[19] *See Raymond J. Brown*, 52 ECAB 192 (2001).

contemplate that impartial medical specialists will be selected from Board-certified specialists in the appropriate geographical area on a strict rotating basis in order to negate any appearance that preferential treatment exists between a particular physician and OWCP.[20] OWCP's procedures provide that the selection of referee physicians (impartial medical specialists) is made through a strict rotational system using appropriate medical directories. The procedure manual provides that the PDS should be used for this purpose wherever possible.[21] The PDS is a set of stand-alone software programs designed to support the scheduling of second opinion and referee examinations. The PDS database of physicians is obtained from the American Board of Medical Specialties which contains the names of physicians who are Board-certified in certain specialties.[22]

ANALYSIS

OWCP accepted that on May 30, 2008 appellant sustained a closed fracture of his right radius head due to a fall at work. In July 2009, it accepted, under a different claim file, that appellant sustained work-related bilateral carpal tunnel syndrome and bilateral trigger finger. On June 27, 2011 OWCP granted appellant a schedule award for seven percent permanent impairment of his right arm. The award was based on the May 24, 2011 report of Dr. Dennis, a Board-certified orthopedic surgeon who served as an impartial medical specialist.

The Board finds that OWCP properly determined that there was a conflict in the medical evidence regarding the extent of appellant's right arm impairment between Dr. Weiss, an attending osteopath, and Dr. Magliato, a Board-certified orthopedic surgeon serving as an OWCP medical adviser.[23] OWCP properly referred appellant to Dr. Dennis for an impartial medical examination and opinion on this matter.

On appeal, counsel argued that appellant should not have been referred to Dr. Dennis but rather should have been issued a schedule award based on the opinion of Dr. Semet, a Board-certified orthopedic surgeon who served as the first impartial medical specialist. Dr. Semet found that appellant had 24 percent of his right arm. The Board notes, however, that OWCP provided Dr. Semet two opportunities to clarify the rationale for his impairment under the appropriate standards of the A.M.A., *Guides,* but that he failed to provide such clarification. Therefore, OWCP properly referred appellant to Dr. Dennis to resolve the continuing conflict in the medical opinion evidence.[24]

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[20] *B.P.*, Docket No. 08-1457 (issued February 2, 2009).

[21] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4b (May 2003). The Board notes that, as of July 2011, the Medical Management Application in the Integrated Federal Employees' Compensation System (iFECS) replaced the prior PDS selection procedure for an impartial medical specialist. *Id.* at Chapter 3.500.5 (July 2011).

[22] *Id.* at Chapter 3.500.7 (September 1995, May 2003).

[23] Dr. Weiss determined in a December 3, 2008 report that appellant had a 54 percent permanent impairment of his right arm. In contrast, Dr. Magliato found on March 6, 2009 that appellant had a lesser impairment of his right arm.

[24] *See supra* note 17.

On appeal, counsel also argued that there was insufficient documentation to show that OWCP followed its procedures in selecting Dr. Dennis as the impartial medical specialist. However, the Board finds that the selection process was documented by a series of screen captures showing the selection of Dr. Dennis through the computerized rotation process of the PDS. This evidence reflects that the medical scheduler properly applied OWCP medical management software to make the impartial medical selection.[25]

The Board finds that the weight of the medical evidence regarding appellant's right arm impairment rests with the well-rationalized opinion of Dr. Dennis, the impartial medical specialist, who properly found that appellant had a seven percent permanent impairment of his right arm.

In his May 24, 2011 report, Dr. Dennis noted that appellant's main diagnosis-based condition was the right distal head fracture under Table 15-4 on page 399, but explained that his right arm impairment should be calculated under the range of motion method.[26] He properly found that, under Table 15-33 on page 474, appellant's 125 degrees of flexion equaled three percent impairment, his 15 degrees of extension equaled two percent impairment, his 65 degrees of pronation equaled one percent impairment and his 65 degrees of supination equaled one percent impairment. These figures were added up to a total right arm impairment of seven percent and Dr. Dennis then correctly found, by applying Table 15-35 and Table 15-36 on page 477, that there was no need to adjust the total impairment found due to limited right elbow motion. Therefore, appellant had a total right arm impairment of seven percent.[27]

Before OWCP and on appeal, counsel argued that Dr. Dennis did not properly take into account appellant's preexisting right arm condition of right biceps tendon tear or his accepted condition of right carpal tunnel syndrome in calculating his right arm impairment. The Board notes that Dr. Dennis adequately considered these conditions in arriving at his impairment rating. He noted that appellant did not show any signs of the work-related right carpal tunnel syndrome and right trigger finger. Dr. Dennis recognized the existence of appellant's preexisting right biceps tendon rupture and specifically stated that any deficits caused by this condition were included in the impairment ratings for limited elbow motion.

For these reasons, appellant did not show that he has more than a seven percent permanent impairment of his right arm. He 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.

[25] *See W.H.*, Docket No. 12-1599 (issued January 17, 2013); *P.G.*, Docket No. 11-76 (issued January 17, 2012). The evidence does not show that any physician was bypassed prior to the selection of Dr. Dennis.

[26] *See supra* note 13. The Board notes that the maximum rating for a distal head fracture is five percent. *See* A.M.A., *Guides* 399, Table 15-4.

[27] Moreover, Dr. Magliato indicated on June 15, 2011 that he agreed with Dr. Dennis' assessment that appellant had a seven percent permanent impairment of his right arm under the standards of the sixth edition of the A.M.A., *Guides.*

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he has more than a seven percent permanent impairment of his right arm, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the December 14, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 3, 2013
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board