# United States Department of Labor
# Employees' Compensation Appeals Board

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| **R.H., Appellant** | ) | |
| **and** | ) | **Docket No. 15-0031** |
| | ) | **Issued: July 24, 2015** |
| **DEPARTMENT OF THE NAVY, PORTSMOUTH NAVAL SHIPYARD, Portsmouth, NH, Employer** | ) | |

*Appearances:*
*James G. Noucas, Jr., Esq.,* for the appellant
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

### ***JURISDICTION***

On October 7, 2014 appellant, through counsel, filed a timely appeal from a June 18, 2014 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 the case.

### ***ISSUE***

The issue is whether appellant established that he has more than five percent impairment of the right upper extremity for which he received a schedule award.

On appeal counsel asserts that, as the opinion of the referee physician is insufficient, vague, and not responsive, the case must be remanded for appointment of a new and impartial referee.

[1] 5 U.S.C. §§ 8101-8193.

## ***FACTUAL HISTORY***

On March 23, 2009 appellant, then a 57-year-old battery ship alteration installation manager, filed an occupational disease claim alleging that employment duties caused right carpal tunnel syndrome and ulnar neuropathy at the right elbow. A March 17, 2009 right upper extremity electrodiagnostic study showed severe median mononeuropathy across the wrist and electrophysiologic evidence of focal ulnar neuropathy across the elbow.

OWCP accepted right carpal tunnel and cubital tunnel syndromes. On August 25, 2009 Dr. Sacha D. Matthews, Board-certified in orthopedic and hand surgery, performed right carpal tunnel release and right subcutaneous ulnar nerve transposition. Appellant received appropriate compensation after surgery. On November 9, 2009 he returned to full-time work and missed intermittent periods thereafter for medical treatment and therapy.

On April 11, 2011 appellant filed a Form CA-7 for a schedule award. In an April 26, 2011 report, Dr. Matthews indicated that appellant reached maximum medical improvement on February 14, 2011. He stated that appellant had some persistent impairment consisting of paresthesias/numbness of the little finger. Dr. Matthews advised that he did not perform impairment evaluations. Appellant retired in June 2011.

By letter dated July 26, 2011, OWCP informed appellant of the type of medical evidence needed to support a schedule award claim, including an impairment determination completed in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] (hereinafter A.M.A., *Guides*).

In a February 4, 2011 report, Dr. John Dolan, a Board-certified neurologist, performed right upper extremity electrodiagnostic testing that demonstrated persistent compressive demyelination of the median nerve across the carpal tunnel space with evidence of axon loss of the ulnar nerve. He diagnosed carpal tunnel syndrome and ulnar neuropathy.

In an August 9, 2011 report, Dr. Frank A. Graf, a Board-certified orthopedist, noted the accepted conditions and appellant's medical history and job duties. He reviewed medical records and provided examination findings. Dr. Graf referenced Table 15-23, Entrapment/Compression Neuropathy Impairment, of the sixth edition of the A.M.A., *Guides*. After applying grade modifiers and the net adjustment formula, he concluded that appellant had five percent right arm impairment for carpal tunnel syndrome. Dr. Graf next determined that appellant had a class 2 ulnar nerve impairment under Table 15-21, Peripheral Nerve Impairment, with a default value of 17 percent. He applied grade modifiers and the net adjustment formula and concluded that appellant had 23 percent impairment for ulnar nerve injury. Using the Combined Values Chart, Dr. Graf concluded that appellant had a total 27 percent right arm impairment.

On December 21, 2011 Dr. Christopher R. Brigham, an OWCP medical adviser who is Board-certified in family and occupational medicine, reviewed Dr. Graf's report. He disagreed with Dr. Graf's finding of impairment pursuant to the sixth edition of the A.M.A., *Guides*, stating, in accordance with Table 15-23, appellant had two percent right upper extremity

[2] A.M.A., *Guides* (6th ed. 2008).

impairment due to peripheral neuropathy at the carpal tunnel and eight percent arm impairment due to peripheral neuropathy at the cubital tunnel. Dr. Brigham noted that, as appellant had more than one entrapment syndrome, the nerve qualifying for the larger impairment, the ulnar nerve at the elbow, was given the full impairment of 8 percent, but that the median nerve impairment with a lesser impairment of 2 percent was to be rated at 50 percent, which yielded 1 percent impairment due to carpal tunnel syndrome. He found that appellant had nine percent total right arm impairment.

OWCP determined that a conflict had been created between Dr. Graf and Dr. Brigham regarding the degree of appellant's right upper extremity impairment, and referred him to Dr. David N. Markellos, a Board-certified orthopedic surgeon, for an impartial evaluation. In a June 12, 2012 report, Dr. Markellos noted that appellant was left hand dominant. He reviewed the medical record and reported appellant's complaint of persistent symptoms following surgery. Physical examination demonstrated a mildly tender elbow incision and a mildly positive ulnar nerve Tinel's sign on the right with no visible asymmetry or atrophy and decreased sensation to light and sharp touch on the ulnar aspect of the right hand and slightly diminished right gross grip strength measured by three tests of the Jamar dynamometer. There was full range of motion of the elbow, wrist, and all digits. Dr. Markellos diagnosed history of right nondominant carpal tunnel syndrome and cubital tunnel syndrome, status postsurgical repair in August 2009; no significant objective clinical findings that would indicate persistent right carpal tunnel syndrome; and clinical evidence of mild residual ulnar neuropathy (cubital tunnel syndrome). He advised that maximum medical improvement was reached on February 14, 2011 and adopted Dr. Brigham's application of the A.M.A., *Guides*, concluding that appellant had a nine percent right upper extremity impairment.

In reports dated August 30 and September 15, 2012, Dr. Morley Slutsky, Board-certified in occupational medicine and an OWCP medical adviser, reviewed the record. Regarding carpal tunnel syndrome, he disagreed with the conclusions of Drs. Graf, Brigham and Markellos, stating that none of the physicians provided an analysis of the electrodiagnostic criteria and that Dr. Markellos assigned two percent impairment for carpal tunnel syndrome without performing calculations demonstrating how he arrived at his numbers. Dr. Slutsky indicated that for test findings, he used a March 17, 2009 preoperative electrodiagnostic study. He found that, in accordance with Table 15-23, appellant had a grade modifier of 2 for test findings, a modifier 1 for history, and a 0 modifier for physical examination findings. Dr. Slutsky averaged this, which yielded right arm impairment of two percent. He rated appellant's *Quick*DASH score as moderate which raised the right upper extremity impairment due to compression at the wrist to three percent. For cubital tunnel syndrome, ulnar nerve entrapment, Dr. Slutsky again noted that Dr. Markellos did not explain how he arrived at his eight percent rating. He indicated that under Table 15-23, appellant had a grade modifier of 1 for history, and a grade modifier of 2 for physical findings, with a default value of five. Dr. Slutsky again averaged this, which yielded a right arm impairment of two percent which, when raised by appellant's moderate *Quick*DASH score, yielded three percent right arm impairment due to compression at the elbow. He noted that, when there are multiple simultaneous nerve entrapments, the larger one is given full value and the second largest rating is given 50 percent of its value, and these are combined. As each impairment yielded a three percent value and Dr. Slutsky used one at full value or three percent and second at 1.5 percent, which he rounded up to two percent. Dr. Slutsky concluded that appellant had five percent right upper arm.

By decision dated November 27, 2012, appellant was granted a schedule award for five percent impairment of the right upper extremity, for a total of 15.6 weeks, to run from February 15 to June 4, 2011. OWCP found that the weight of the medical evidence rested with the impairment calculation of Dr. Slutsky, an OWCP medical adviser.

Appellant, through counsel, requested a review of the written record.[3] On March 29, 2013 an OWCP hearing representative set aside the November 27, 2012 decision and remanded the case to OWCP to clarify questions raised in Dr. Slutsky's report regarding dysfunction of the ulnar nerve and assignment of the cubital tunnel impairment that required clarification from Dr. Markellos, the referee physician. On remand OWCP was to obtain a supplemental report from Dr. Markellos.

On April 30, 2013 OWCP asked Dr. Markellos to provide a supplemental report regarding his impairment calculations. In a September 4, 2013 report, Dr. Markellos noted his review of Dr. Slutsky's report concerning appellant's right upper extremity impairment. He stated:

> "Although I have 35 years of orthopedic experience, the limitations of my report are due to my experience being limited to the 4th edition of the [A.M.A., *Guides*,] used in Maine and limited exposure to the 6th edition of the [A.M.A., *Guides*] in our practice. My review of Dr. Slutsky's report finds it to be detailed, complete, and accurate."

On June 18, 2014 OWCP found that appellant was not entitled to a right arm impairment rating greater than five percent, for which he received a schedule award on November 27, 2012.

## ***LEGAL PRECEDENT***

The schedule award provision of FECA[4] and its implementing federal regulations,[5] 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.[6] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

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

[3] Appellant initially requested a hearing but changed his request to written record review.

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id*. at § 10.404(a).

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

and Health (ICF).[8] Impairment due to carpal tunnel and cubital tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[9] In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[10] The A.M.A., *Guides* specifically indicate that if multiple simultaneous neuropathies occur in the same limb, both impairments may be rated and the nerve qualifying for the larger impairment is given the full impairment while the nerve qualifying for the smaller impairment is rated at 50 percent.[11] The A.M.A., *Guides* further indicate that Table 15-23 is to be used for rating focal nerve compromise,[12] and Appendix 15-B provides further guidance regarding electrodiagnostic evaluation of entrapment syndromes.[13]

Section 8123(a) of FECA 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.[14] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination, and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[15] 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.[16]

OWCP procedures further provide that, while an OWCP medical adviser may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility and not that of OWCP medical adviser. The medical adviser should not resolve the conflict of medical opinion or attempt to clarify or expand the opinion of the

[8] *Supra* note 2 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[9] *Id*. at 449.

[10] *Id*. at 448-50.

[11] *Id*. at 448.

[12] *Id*.

[13] *Id*. at 487-90.

[14] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

[15] 20 C.F.R. § 10.321.

[16] *V.G.*, 59 ECAB 635 (2008).

medical referee. If clarification is necessary, a supplemental report should be obtained from the referee specialist.[17]

## ***ANALYSIS***

OWCP accepted appellant's occupational disease claim for right carpal and cubital tunnel syndromes. On April 11, 2011 appellant filed a schedule award claim. OWCP found that a conflict in medical evidence was created between the opinions of Dr. Graf, an attending orthopedist who found 27 percent right arm impairment, and Dr. Brigham, an OWCP medical adviser who found 9 percent impairment. OWCP then referred appellant to Dr. Markellos, a Board-certified orthopedic surgeon, for an impartial evaluation.

In a June 12, 2012 report, Dr. Markellos provided physical examination findings. He advised that maximum medical improvement was reached on February 14, 2011 and adopted Dr. Brigham's application of the A.M.A., *Guides*, concluding that appellant had nine percent right upper extremity impairment.

Dr. Slutsky, a second OWCP medical adviser, reviewed the medical record.[18] In reports dated August 30 and September 15, 2012, he noted that neither Dr. Graf, Dr. Brigham, nor Dr. Markellos provided an analysis of the electrodiagnostic criteria and that Dr. Markellos assigned two percent impairment for carpal tunnel syndrome without performing calculations which showed how he arrived at his numbers. Dr. Slutsky indicated that for test findings, he used a March 17, 2009 preoperative electrodiagnostic study and found that, in accordance with Table 15-23, appellant had a grade modifier of 2 for test findings, a modifier 1 for history, and a 0 modifier for physical examination findings. He averaged this, which yielded two percent right arm impairment. Dr. Slutsky rated appellant's *Quick*DASH score as moderate which raised the right arm impairment due to compression at the wrist to three percent. Regarding cubital tunnel syndrome, ulnar nerve entrapment, he again noted that Dr. Markellos did not explain how he arrived at his rating of eight percent. Dr. Slutsky indicated that, under Table 15-23, appellant had a grade modifier of 1 for history, and a grade modifier of 2 for physical findings, with a default value of five. He again averaged this, which yielded a right upper extremity impairment of two percent which, when raised by appellant's moderate *Quick*DASH score, yielded a right arm impairment due to compression at the elbow to three percent. Dr. Slutsky noted that when there are multiple simultaneous nerve entrapments, the larger one is given full value and the second largest rating is given 50 percent of its value, and that these are combined. He indicated that in this case each impairment yielded a three percent value and therefore used one at full value or three percent and the second at 1.5 percent, which he rounded up to two percent. Dr. Slutsky concluded that appellant had a total five percent right arm impairment.

[17] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(g)(1,2) (February 2013).

[18] A second OWCP medical adviser was selected because the conflict was between Dr. Graf, an attending orthopedic surgeon, and Dr. Brigham, the first OWCP medical adviser. *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6g. (February 2013).

On November 27, 2012 appellant was granted a schedule award for a five percent impairment of the right arm. Following appellant's request for review of the written record, in a March 29, 2013 decision, an OWCP hearing representative set aside the November 27, 2012 decision and remanded the case to OWCP to clarify questions raised in Dr. Slutsky's report that required clarification from Dr. Markellos, the referee physician. On remand OWCP was to obtain a supplemental report from Dr. Markellos.

In a September 4, 2013 report, Dr. Markellos noted his review of Dr. Slutsky's report concerning appellant's right arm impairment. He indicated that, while his experience was somewhat limited in that Maine used the fourth edition of the A.M.A., *Guides*, he had reviewed Dr. Slutsky's report and found it to be detailed, complete, and accurate.

On June 18, 2014 OWCP found that appellant was not entitled to a right upper extremity impairment rating greater than five percent, for which he received a schedule award on November 27, 2012.

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.[19]

In a June 12, 2012 report, Dr. Markellos adopted Dr. Brigham's application of the A.M.A., *Guides*, concluding that appellant had nine percent right upper extremity impairment. In his September 4, 2013 report, Dr. Markellos, who reviewed Dr. Slutsky's report concerning appellant's right upper extremity impairment, merely stated:

> "Although I have 35 years of orthopedic experience, the limitations of my report are due to my experience being limited to the 4th edition of the [A.M.A., *Guides*,] used in Maine and limited exposure to the 6th edition of the [A.M.A., *Guides*] in our practice. My review of Dr. Slutsky's report finds it to be detailed, complete, and accurate."

The Board finds that Dr. Markellos' reports are not sufficiently rationalized such that his medical opinion is of diminished probative value. In *Frederick Justiniano*,[20] the Board set aside the report of an impartial specialist who stated his agreement with the opinion of an OWCP second opinion physician without offering adequate medical rationale to support his own medical conclusions. The Board finds that in the present appeal, Dr. Markellos relied too extensively on the impairment evaluations of Dr. Brigham and Dr. Slutsky without providing an adequate

[19] *L.R. (E.R.)*, 58 ECAB 369 (2007).

[20] 45 ECAB 491 (1994).

impairment evaluation in which he applied the process under the sixth edition of the A.M.A., *Guides*.[21]

The conflict in medical opinion thus remains unresolved. When an 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 to another impartial specialist for the purpose of obtaining a rationalized medical opinion on the issue.[22]

Upon return of the case record, OWCP should refer appellant to another impartial specialist. The impartial specialist should provide an evaluation in accordance with the sixth edition of the A.M.A., *Guides* regarding appellant's right arm impairment. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision.

## ***CONCLUSION***

The Board finds this case is not in posture for decision as there is an unresolved conflict in medical opinion evidence regarding the degree of appellant's right upper extremity impairment.

[21] *See Charles H. Miller*, Docket No. 93-2000 (issued March 22, 1995) (in a situation where there exists a medical conflict, if the weight of the medical evidence lies anywhere, it must be with the opinion of the specialist chosen to resolve the outstanding conflict).

[22] *Id*.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the June 18, 2014 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for further proceedings consistent with this opinion of the Board.

Issued: July 24, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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