United States Department of Labor
Employees' Compensation Appeals Board

R.H., Appellant	)	
and	)	**Docket No. 14-0737**
	)	**Issued: September 4, 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:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 12, 2014 appellant, through counsel, filed a timely appeal from an August 21, 2013 schedule award 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 schedule award.

ISSUE

The issue is whether appellant established more than one percent permanent impairment of the right or left upper extremities for which he received a schedule award.

On appeal counsel asserts that OWCP did not properly develop the medical record as it failed to provide complete and accurate medical histories for reviewing physicians, and improperly allowed a medical adviser to provide a second record review. For these reasons,

[1] 5 U.S.C. §§ 8101-8193.

appellant argues that the reports of the second opinion, referee physician, and OWCP medical advisers should be excluded.

FACTUAL HISTORY

On April 30, 2001 appellant, then a 45-year-old painter/blaster, filed an occupational disease claim alleging that his employment duties caused arm and wrist pain. He began limited duty. OWCP accepted carpal tunnel syndrome, lateral epicondylitis, and bilateral forearm tendinitis of each arm as employment related.

A November 1, 2001 electrodiagnostic study showed right mild median neuropathy at the wrist. The study on the left was at the high end of the reference range. Dr. Randi D. Lebar, a Board-certified orthopedic surgeon, performed a right carpal tunnel release on December 21, 2001.

In a January 24, 2003 report, Dr. John T. Chance, Board-certified in orthopedic surgery and surgery of the hand, noted appellant's complaint of right and left hand pain and a prior history of a right thumb fracture. He diagnosed left ulnar neuropathy (cubital tunnel syndrome), bilateral/lateral epicondylitis, Dupuytren disease (not work related), and right thumb degenerative joint disease, status post remote injury. On June 24, 2003 Dr. Chance advised that appellant's bilateral arm pain and numbness were worse.

On December 29, 2003 appellant filed a schedule award claim. By letter dated January 12, 2004, OWCP informed him of the evidence needed to support a schedule award claim and enclosed a form letter for his physician. The letter advised that an impairment determination should be completed in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] (hereinafter A.M.A., *Guides*). In an August 8, 2005 report, Dr. William Chernin, Board-certified in family medicine, answered all questions on the form letter "permanently disabled."

Nothing further was submitted by appellant until his attorney contacted OWCP in July 2008. In a February 18, 2009 report, Dr. Minh Tran, a Board-certified physiatrist, reviewed the 2001 carpal tunnel surgery and appellant's complaint that shoulder problems began at work around 2002. She indicated that appellant had left shoulder acromioplasty and distal clavicle excision on April 5, 2005. Dr. Tran examined appellant and diagnosed right acromioclavicular (ACL) joint degenerative disease.

In a September 22, 2009 report, Dr. Frank A. Graf, a Board-certified orthopedic surgeon, noted the accepted conditions and appellant's medical history and job duties. After his retirement, appellant worked part time as a janitor from 2004 to 2008. He reported that in late 2000 he began having constant thumb and wrist pain that extended into the forearm, elbows, upper arms and shoulders which continued and now included neck pain. Dr. Graf reviewed medical records and provided findings on examination. Appellant had bilateral upper extremity repetitive motion and vibration syndrome that evolved from work exposure. Dr. Graf noted that appellant had permanent changes in multiple upper extremity anatomical structures including

[2] A.M.A., *Guides* (5th ed. 2000).

bilateral carpal tunnel syndrome, bilateral chronic tendinitis and lateral epicondylitis, bilateral chronic forearm tendinitis, bilateral chronic shoulder pain with symptomatic rotator cuff and ACL joints, bilateral chronic hand pain with symptomatic carpometacarpal (CMC) and carpal to carpal osteoarthritis. He also diagnosed bilateral Dupuytren's nodular fasciitis that was not work related.

Dr. Graf stated that under the sixth edition of the A.M.A., *Guides*,[3] there was no listing for hand/arm vibration syndrome or repetitive motion syndrome, noting that appellant did not have vasomotor, pseudomotor and trophic changes found in complex pain syndrome. He opined that appellant had a condition which had global effects on both arms, and that hand/arm vibration syndrome should be a listed impairment class. To establish an appropriate diagnosis for each injured part of the arm, Dr. Graf assigned an appropriate class of impairment, followed by use of the adjustment grid and grade modifiers including functional history, physical examination and clinical studies with assignment of upper extremity ratings, which he combined under the Combined Values Chart for each diagnosis. He combined the arm impairments following the ratings for each diagnosis, concluding that complex regional pain syndrome was a global diagnosis with class assignments and impairment ratings for global upper extremity symptoms. Dr. Graf indicated that appellant had a bilateral class 2 impairment for thumb arthritis, for five percent arm impairment; a bilateral class 1 impairment for epicondylitis, for seven percent arm impairment; a bilateral class 1 impairment for shoulder ACL joint and rotator cuff injury, for seven percent arm impairment; and that, under Table 15-23, he had a bilateral median nerve syndrome for five percent arm impairment. He stated that using the Combined Values Chart and appellant's *Quick*DASH score, he had a total 39 percent impairment to each upper extremity. Dr. Graf referenced Table 15-1 and opined that appellant's bilateral hand/arm vibration syndrome and repetitive motion disorder was a class 3 or severe problem.

On November 9, 2009 Dr. Barry W. Levine, an OWCP medical adviser Board-certified in internal medicine and pulmonary disease, reviewed Dr. Graf's report. He stated that based on the sixth edition of the A.M.A., *Guides* appellant had an 11 percent right upper extremity impairment and an 18 percent left upper extremity impairment. OWCP requested that Dr. Levine explain the difference between his rating and those of Dr. Graf. In a June 13, 2010 report, he stated that Dr. Graf's impairment ratings were not accurate. Dr. Levine explained his findings and conclusions.

On October 26, 2010 Dr. Graf stated that maximum medical improvement for the right upper extremity was reached six months after the December 21, 2001 carpal tunnel release, or June 21, 2002, and that his conclusion that appellant had 39 percent upper extremity impairment was a total combined for right and left arm impairments.

In December 2010 OWCP referred the record to Dr. Christopher R. Brigham, an OWCP medical adviser Board-certified in family and occupational medicine. In a January 3, 2011 report, Dr. Brigham disagreed with Dr. Graf's impairment analysis, noting that Dr. Graf did not reference any tables or properly apply grade modifiers. He stated that maximum medical improvement was reached on October 26, 2010, the date of Dr. Graf's evaluation. Dr. Brigham

[3] *Id*. (6th ed. 2008).

comprehensively explained his conclusion that appellant had a total 12 percent right upper extremity impairment and 11 percent impairment on the left.

On May 11, 2011 OWCP asked Dr. Graf to provide range of motion measures for appellant's arms. In a May 25, 2011 response, Dr. Graf stated that range of motion was of limited relevance and referred to his 2009 report. OWCP forwarded Dr. Brigham's July 21, 2011 report to Dr. Graf for review. In a July 26, 2011 report, Dr. Graf noted that a critique of another physician's permanent impairment analysis was not the same as an opinion of permanency in a specific patient and that to arrive at such an opinion, a clinical examination was essential to a fair and equitable process. He reiterated that the A.M.A., *Guides* had limitations with regard to appellant, as he discussed in his September 22, 2009 report.

In August 2011 OWCP referred appellant to Dr. Lawrence Leonard, a Board-certified orthopedic surgeon, for a second opinion. In a September 26, 2011 report, Dr. Leonard reviewed the statement of accepted facts and medical record. He noted appellant's report that after retirement from the shipyard, he worked as a cab driver and a janitor; stopped work about three years prior, and at the present time, volunteered as driver driving 900 miles over approximately 24 hours weekly. Appellant complained of bilateral thumb, wrist, elbow, and shoulder pain. Dr. Leonard noted appellant's description of his daily activities that included, in addition to volunteer driving, cooking, yard work, fishing, and walking his dog. He described physical examination findings and diagnosed status post left shoulder acromioplasty and distal clavicle excision in April 2005; status post right carpal tunnel release in December 2001; bilateral Dupuytren's contracture; history of open reduction of fracture, right metacarpal, age 16; and history of multiple joint aches and pains, etiology undetermined. Dr. Leonard determined that maximum medical improvement would be six months postsurgery for the left shoulder and right hand. He found that no impairment rating was necessary for appellant's shoulders and CMC joint arthritis because these conditions were not accepted. There was no impairment due to a preexisting injury. Dr. Leonard advised that, under the A.M.A., *Guides*, utilizing the diagnosis-based impairment methodology, Table 15-4, appellant had one percent impairment of each arm due to bilateral elbow epicondylitis. He found no impairment due to carpal tunnel syndrome, as there were no sensory deficits on physical examination. Dr. Leonard concluded that appellant had one percent impairment of each arm.

In an October 31, 2011 report, Dr. Brigham agreed with Dr. Leonard that appellant had no impairment due to carpal tunnel syndrome. Excluding the ratings for the unaccepted conditions, he agreed that appellant had one percent impairment to each upper extremity.

OWCP found that a conflict in medical opinion arose regarding appellant's upper extremity impairments. In a May 22, 2012 letter to appellant, it identified the conflict as between Dr. Leonard and Dr. Brigham, and referred him to Dr. David N. Markellos, a Board-certified orthopedic surgeon, for an impartial evaluation. In a second May 22, 2012 letter, addressed to Dr. Markellos, OWCP again identified the conflict as between Dr. Leonard and Dr. Brigham.

In May 29, 2012 correspondence appellant's counsel informed OWCP that in the letter addressed to Dr. Markellos, the conflict was identified as between Dr. Leonard and Dr. Brigham. He also maintained that appellant's bilateral shoulder conditions were work related.

In an August 7, 2012 report, Dr. Markellos noted his review of the medical record and appellant's description of his work duties. Appellant complained of bilateral elbow, shoulder and forearm pain over the years. Dr. Markellos further indicated that appellant reported that after he left federal employment he worked in a janitorial job and currently did volunteer driving for the disabled, averaging about 30 hours per week. He was puzzled by the identified conflict between Dr. Leonard and Dr. Brigham as the physicians agreed in their impairment analyses. Dr. Markellos provided upper extremity physical examination findings including normal shoulder range of motion bilaterally. He indicated that there was no evidence of residual carpal tunnel syndrome either by history or clinical examination with negative Tinel's sign and Phalen's test, normal sensation of all digits, and no evidence of atrophy. There was no tenderness at the lateral epicondyles but pain of the dorsal extensors and no evidence at the present time of cubital tunnel syndrome. Dr. Markellos advised that he agreed with the impairment assessment regarding epicondylitis found by Dr. Leonard and confirmed by Dr. Brigham, that appellant had a one percent permanent impairment of each upper extremity due to epicondylitis and no impairment for carpal tunnel syndrome.

In a November 13, 2012 report, Dr. Morley Slutsky, Board-certified in occupational medicine and an OWCP medical adviser, indicated that to complete a review of the record, he needed a copy of a NeuroMetrix study performed prior to the December 21, 2001 right carpal tunnel release, the April 4, 2005 operative report for appellant's left shoulder surgery, and any additional diagnostic tests. At OWCP's request, appellant forwarded the November 1, 2001 NeuroMetrix test; Dr. Lebar's treatment notes from November 9, 2001 to September 7, 2006; November 11, 2004 bilateral shoulder x-rays that demonstrated degenerative changes about the ACL joints; bilateral hand x-rays dated November 11, 2004 that demonstrated degenerative joint disease; a preoperative history and physical dated April 1, 2005 prior to left shoulder surgery; and an April 4, 2005 operative report for left shoulder acromioplasty and distal clavicle excision for left shoulder rotator cuff tendinitis and ACL joint arthritis.

On July 24, 2013 Dr. Slutsky reviewed the record, including Dr. Markellos' report. He stated that maximum medical improvement was reached on September 21, 2011. Dr. Slutsky agreed that, as there was no clinical evidence of carpal tunnel syndrome or cubital tunnel syndrome, appellant had no impairment for these conditions. He noted that the A.M.A., *Guides* provide that range of motion is used primarily as a physical examination adjustment factor and, only if no other approach was available, should an impairment calculation be based on range of motion. Dr. Slutsky advised that appellant's most impairing diagnosis was bilateral/lateral epicondylitis. Under Table 15-4, he determined that appellant had one percent impairment of each arm due to a diagnosis of lateral epicondylitis.

By decision dated August 21, 2013, appellant was granted schedule awards for one percent impairment of the right and left arms. The awards totaled 6.24 weeks, to run from September 21 to November 3, 2011. OWCP credited the opinion of Dr. Markellos who provided a referee impairment evaluation.[4]

[4] In the August 21, 2013 decision, OWCP identified the conflict as between the opinions of Drs. Graf, Brigham and Leonard.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations,[6] 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.[7] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[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, for upper extremity impairments 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 - CDX) + (GMCS - CDX).[11] In determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[12]

Although the diagnosis-based approach is the preferred method of evaluating permanent impairment under the sixth edition of the A.M.A., *Guides*,[13] Table 15-2 through Table 15-5 provide that, if loss of motion is present, the impairment may alternatively be assessed under section 17-7, range of motion impairment.[14] A range of motion impairment stands alone and is not combined with a diagnosis-based impairment.[15]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[16] In

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*. at § 10.404(a).

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

[9] A.M.A., *Guides, supra* note 3 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[10] *Id*. at 385-419.

[11] *Id*. at 411.

[12] *Peter C. Belkind*, 56 ECAB 580 (2005).

[13] A.M.A., *Guides, supra* note 4 at 461, section 15.7.

[14] *Id*. at 391-05.

[15] *Id.* at 405.

[16] *Id*. at 449.

Table 15-23, grade modifiers 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.[17]

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.[18] 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.[19] 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.[20]

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's medical adviser who should not resolve the conflict of medical opinion or attempt to clarify or expand the opinion of the medical referee. If clarification is necessary, a supplemental report should be obtained from the referee specialist.[21]

ANALYSIS

The accepted conditions in this case are bilateral carpal tunnel syndrome, bilateral/lateral epicondylitis and bilateral forearm tendinitis.

The Board notes that Dr. Brigham considered appellant's impairment rating on two occasions. OWCP procedures indicate that only after a case has been referred for a referee examination, is it necessary to route the file to a new OWCP medical adviser for schedule award calculation review.[22] In this case, OWCP referred appellant's file to Dr. Brigham in December 2010 and October 2011, prior to its determination in May 2012 that a conflict in medical evidence arose. There was no error in referring the record to Dr. Brigham on two occasions. The Board also notes that, although Dr. Slutsky submitted two reports dated

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

[18] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

[19] 20 C.F.R. § 10.321.

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

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

[22] *Id*.

November 13, 2012 and July 24, 2013, he merely requested OWCP to obtain additional test reports. In the second report, he reviewed the record including the additional evidence.

As to appellant's arguments regarding the statement of accepted facts, OWCP procedures provide that the statement of accepted facts should include accepted conditions.[23] There is no mandate that it include preexisting or subsequently acquired conditions. OWCP has not accepted that appellant sustained an employment-related shoulder condition. However, as discussed below, preexisting impairment to a scheduled member is to be included in an impairment analysis.[24]

Regarding the identified conflict in medical opinion, the Board notes that OWCP stated that it arose between Dr. Leonard, who provided a second opinion evaluation for OWCP, and Dr. Brigham, an OWCP medical adviser. The Board has held a conflict in medical evidence is created between the medical opinion of an employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, not between two OWCP physicians.[25] Since the conflict in this case was between two OWCP physicians, Dr. Markellos cannot serve as a referee physician. His opinion cannot be accorded the special weight accorded an impartial examiner.[26] Dr. Markellos' opinion, however, can still be considered for its own intrinsic value.[27] His impairment conclusion, as supported by that of Dr. Leonard and Drs. Brigham and Slutsky, OWCP medical advisers, constitutes the weight of the medical evidence that appellant has one percent impairment of each arm due to epicondylitis and no impairment of either arm due to carpal tunnel syndrome. Both Dr. Leonard and Dr. Markellos performed thorough physical examinations. Dr. Leonard advised that, in accordance with the A.M.A., *Guides*, utilizing the diagnosis-based impairment methodology, under Table 15-4, appellant had one percent impairment of each upper extremity due to bilateral elbow epicondylitis. He found no impairment due to carpal tunnel syndrome, noting that there were no sensory deficits on his examination. Dr. Leonard concluded that appellant had one percent impairment of each arm. Dr. Markellos agreed with this conclusion regarding appellant's upper extremity impairments, as did Dr. Brigham in his October 27, 2011 report and Dr. Slutsky on July 24, 2013.

While Dr. Graf performed an impairment evaluation, he did not appropriately follow the process outlined in the A.M.A., *Guides*. Rather he did not reference tables other than Table 15-1, Definition of Impairment Classes. As Dr. Graf did not properly follow the procedures outlined in the A.M.A., *Guides*, his opinion is of diminished probative value.[28] The Board

[23] *Id*. at Chapter 2.809.5 (February 2013).

[24] *Peter C. Belkind*, *supra* note 12.

[25] 5 U.S.C. § 8123(a); 20 C.F.R. § 10.321.

[26] *See, e.g., Delphia Y. Jackson*, 55 ECAB 373 (2004) (where the Board found that OWCP improperly found a conflict under 5 U.S.C. § 8123 between two physicians, neither of whom was appellant's physician; the physician selected to resolve the assumed conflict was not considered an impartial medical specialist and his report was not entitled to special weight).

[27] *See Cleopatria McDougal Saddler*, 47 ECAB 480 (1996).

[28] *R.A.*, Docket No. 09-2134 (issued August 3, 2010).

therefore concludes that the medical evidence of record establishes that appellant has one percent impairment of each upper extremity due to epicondylitis and no impairment of either upper extremity due to carpal tunnel syndrome.

CONCLUSION

The Board finds appellant has failed to establish more than one percent permanent impairment of the right or left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the August 21, 2013 decision of the Office of Workers' Compensation Programs is affirmed.[29]

Issued: September 4, 2015
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[29] Michael E. Groom, Alternate Judge, participated in the preparation of this decision but was no longer a member of the Board effective December 27, 2014.