United States Department of Labor
Employees' Compensation Appeals Board

K.R., Appellant	)	
and	)	**Docket No. 16-0542**
	)	**Issued: December 21, 2016**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS CANTEEN SERVICES, Chicago, IL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 1, 2016 appellant, through counsel, filed a timely appeal from a December 2, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met his burden of proof in establishing greater than six percent permanent impairment of the right upper extremity, for which he received schedule awards.

FACTUAL HISTORY

OWCP accepted that on July 30, 2008 appellant, then a 28-year-old retail clerk, sustained a closed metacarpal neck fracture of his right fifth finger when two cases of a canned nutrition drink fell on his right hand. The fracture healed in an angulated position.

On November 11, 2008 Dr. John Sonnenberg, an attending Board-certified orthopedic surgeon, performed a corrective osteotomy of the right fifth finger and metacarpal neck fracture. OWCP approved the procedure. Appellant received compensation for work absences related to his surgical recovery.

On May 26, 2009 OWCP obtained a second opinion from Dr. David H. Trotter, a Board-certified orthopedic surgeon, who found limited motion in the right fifth finger. Dr. Trotter opined that appellant could perform full-time modified duty. Following a program of occupational therapy, appellant returned to modified duty in June 2009.

On September 15, 2009 Dr. Daniel P. Mass, an attending orthopedic surgeon, performed an open reduction and internal wire fixation of the right fifth finger, with tenolysis of the extensor tendons and excision of a neuroma. On February 2, 2010 he performed an osteotomy of the right fifth metacarpal with open reduction and internal fixation, tenolysis of the extensor tendon and a tendon wrap. OWCP authorized the procedures. Appellant participated in occupational therapy from September 2009 to July 2010. He received wage-loss compensation from September 15, 2009 through October 9, 2010 on the supplemental rolls.

In an April 30, 2010 report, Dr. Jacqueline Bernard, an attending Board-certified neurologist, noted appellant's complaints of right hand pain and tremor. On examination, she found increased tone in the right arm with a possible volitional component. Dr. Bernard diagnosed a dystonic hand tremor with possible ulnar neuropathy. A May 7, 2010 electromyogram (EMG) and nerve conduction velocity (NCV) study of the right upper extremity showed mild right ulnar neuropathy across the elbow, correlating the clinical finding of tremors in the right hand and arm.

In an August 2, 2010 report, Dr. Mass diagnosed cubital tunnel syndrome, directly related to wearing a sling after the initial trauma and two surgical procedures.

OWCP found a conflict of medical opinion between Dr. Trotter and Dr. Mass, regarding the nature and extent of appellant's injury-related residuals. To resolve the conflict, OWCP selected Dr. Michael I. Vender, a Board-certified orthopedic surgeon, as impartial medical examiner. Dr. Vender submitted an October 4, 2010 report reviewing the medical record. On examination, he noted that appellant presented "with visibly gross shaking and tremoring of the upper extremity" and complained of paresthesias in his right hand. Dr. Vender observed a

"visibly thickened longitudinal scar on the ulnar aspect of the hand," slight malrotation of the metacarpal, a loss of 20 degrees metacarpophalangeal flexion, and a loss of 10 degrees proximal interphalangeal extension. X-rays demonstrated plate and screw fixation of the metacarpal of the right fifth finger. Dr. Vender obtained updated EMG and NCV studies on October 1, 2010, which showed mild bilateral median neuropathy at both wrists and borderline right ulnar neuropathy across the elbow. He opined that appellant's tremor was functional or behavioral. Dr. Vender opined that appellant could return to full-time work with lifting limited to 25 pounds.

On September 30, 2010 appellant claimed a schedule award (Form CA-7). OWCP advised appellant to provide an impairment rating in compliance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, the A.M.A., *Guides*).

On January 7, 2011 Dr. Mass found that appellant had reached maximum medical improvement (MMI). He opined that appellant's right hand was "essentially unusable" due to severe tremor and chronic pain syndrome.

OWCP referred the medical record to an OWCP medical adviser to obtain an impairment rating. In a May 18, 2011 report, the medical adviser opined that according to Table 15-31 of the A.M.A., *Guides*,[3] a loss of 20 degrees metacarpophalangeal flexion and 10 degrees proximal interphalangeal extension as observed by Dr. Mass equaled 38 percent impairment of the digit. According to Table 15-12,[4] this equaled three percent permanent impairment of the right arm.

By decision dated June 20, 2011, OWCP granted appellant a schedule award for three percent permanent impairment of the right arm. In a June 24, 2011 letter, appellant requested an oral hearing, which was held before an OWCP hearing representative on April 11, 2012. At the hearing, he described the onset of the right hand tremor after the third surgery. Appellant submitted additional evidence.

An August 30, 2011 magnetic resonance imaging (MRI) scan showed deformity of the right fifth metacarpal with ulnar angulation and fixation devices within the metacarpal bone. A September 9, 2011 EMG and NCV study report showed severe right ulnar nerve entrapment at the elbow with signs of local demyelination.[5]

On February 10, 2012 OWCP expanded the claim to accept acquired deformity of the right fifth finger, injury to digital nerve, late effect of tendon injury, and right arm pain.

[3] Table 15-31, page 470 of the sixth edition of the A.M.A., *Guides* is entitled "Finger Range of Motion."

[4] Table 15-12, page 421 of the sixth edition of the A.M.A., *Guides* is entitled "Important Values Calculated From Digit Impairment."

[5] Appellant also submitted an October 6, 2011 report from Dr. Jacob Salomon, an attending general surgeon. Dr. Salomon diagnosed "post-traumatic stress disorder with permanent tremors of the right hand and wrist and severe ulnar nerve damage." He opined that appellant's right hand was totally unusable and that he was presently disabled for work. In an undated report received by OWCP on January 4, 2012, Dr. Stylianos Angelakos, an attending family practitioner, noted that appellant could not flex the fingers of his right hand, and had a "persistent uncontrollable tremor" of the entire right arm. He opined that the tremor was causally related to the June 30, 2008 injury.

By decision dated May 23, 2012, an OWCP hearing representative affirmed the June 20, 2011 schedule award.

In an August 10, 2012 report, Dr. Anatoly Rozman, an attending Board-certified physiatrist, noted appellant's history and opined that he had reached MMI. He noted that the September 9, 2011 electrodiagnostic testing was "strongly positive for ulnar neuropathy." Appellant presented with weakness and contracture of the right arm. On right arm examination, Dr. Rozman found severe weakness in wrist flexion, distal interphalangeal flexion, proximal interphalangeal flexion, and metacarpophalangeal flexion, upper end contracture of the distal interphalangeal joint at 15 degrees, and flexion at 25 degrees. The proximal interphalangeal joint of the right fifth finger had extension at 1 degree and flexion at 35 degrees. Metacarpophalangeal extension was limited to 12 degrees. Dr. Rozman observed marked decreased sensation in the ulnar nerve distribution, in the digits as well as the distal forearm. Skin changes indicated complex regional pain syndrome. Appellant had a significant dystonic tremor of the right hand, related to ulnar neuropathy.

Referring to Table 15-2[6] of the A.M.A., *Guides*, Dr. Rozman found a class 1 diagnosis-based impairment Class of Diagnosis (CDX) for an extensor tendon rupture with residual loss of function, equaling six percent permanent impairment of the right fifth finger. He found a grade modifier for Functional History (GMFH) of 2 according to Table 15-7,[7] for moderate problems. According to Table 15-8,[8] appellant had a grade modifier of 2 for findings on Physical Examination (GMPE), and a modifier of 2 for Clinical Studies (GMCS) according to Table 15-9.[9] Applying the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (2-1) + (2-1) + (2-1), the "adjustment modifier will be 2+, which moved his impairment rating to 8 percent of the digit."

Under Table 15-31, Dr. Rozman found 25 percent permanent impairment of the digit due to limitation of distal interphalangeal joint flexion to 25 degrees, equaling 2 percent impairment of the right arm. He found 40 percent digit or 1 percent arm impairment due to limitation of proximal interphalangeal joint extension, a 42 percent digit or 4 percent right arm impairment due to proximal interphalangeal joint flexion limited to 35 degrees, 7 percent digit or 1 percent arm impairment for metacarpophalangeal joint extension limited to 12 degrees. Dr. Rozman combined two percent for the distal interphalangeal joint, five percent for the proximal interphalangeal joint, one percent for the metacarpophalangeal joint, to yield six percent upper extremity impairment. He added five percent impairment due to the grade adjustment modifiers for range of motion, equaling six percent upper extremity impairment. Dr. Rozman rated ulnar

[6] Table 15-2, page 391 of the sixth edition of the A.M.A., *Guides* is entitled "Digit Regional Grid: Digit Impairments."

[7] Table 15-7, page 406 of the sixth edition of the A.M.A., *Guides* is entitled "Functional History Adjustment: Upper Extremities."

[8] Table 15-8, page 408 of the sixth edition of the A.M.A., *Guides* is entitled "Physical Examination Adjustment: Upper Extremities."

[9] Table 15-9, page 410 of the sixth edition of the A.M.A., *Guides* is entitled "Clinical Studies Adjustment: Upper Extremities."

neuropathy according to Table 15-21,[10] with a CDX of class 2, equaling 22 percent impairment of the upper extremity. Totaling these impairments, he found 6 percent impairment of the right arm due to decreased digital range of motion, 22 percent for ulnar neuropathy, 1 percent for the extensor tendon injury, totaling 25 percent permanent impairment of the right arm.

On August 24, 2012 appellant claimed an increased schedule award.

On August 29, 2012 OWCP obtained a second opinion from Dr. Ning Sun, a Board-certified neurologist, who opined that appellant's mild ulnar neuropathy was not related to the accepted injury and was not the cause of his right hand tremor. Dr. Sun recommended consultation with a movement disorder specialist.

In an August 30, 2012 report, an OWCP medical adviser reviewed Dr. Rozman's report. He found a class 1 CDX for metacarpal fracture according to Table 15-2, a GMFH of 3 for symptoms with mild activity requiring medication, a grade 2 GMPE for mild deformity. The medical adviser noted that a GMCS was not appropriate for the assessment. Using the net adjustment formula, OWCP's medical adviser found a net adjustment of +2, equaling eight percent impairment of the right fifth finger or one percent impairment of the right upper extremity. He used Table 15-31 to assess 25 percent impairment for distal interphalangeal joint flexion at 25 degrees, and 2 percent digit impairment for distal interphalangeal joint extension at 15 degrees, 42 percent digit impairment for proximal interphalangeal joint flexion at 35 degrees, 7 percent impairment for metacarpal phalangeal joint flexion at -12 degrees. The medical adviser added the values to equal 52 percent impairment of the right fifth finger. Utilizing Table 15-12,[11] he converted the 52 percent digit impairment to 5 percent upper extremity impairment, in addition to the 1 percent for the diagnosis-based impairment, equaling a total 6 percent permanent impairment of the right upper extremity.

By decision dated November 29, 2012, OWCP granted appellant a schedule award for an additional three percent permanent impairment of the right upper extremity, for a total of six percent permanent impairment.

In a March 20, 2013 letter, counsel requested reconsideration. In a February 6, 2013 report, Dr. Rozman opined that OWCP should include ulnar nerve deficits in the impairment rating as the right fifth finger was enervated by the ulnar nerve.

OWCP obtained an updated report from OWCP's medical adviser on May 11, 2013. The medical adviser noted that there was no medical documentation of record that appellant sustained digital nerve damage.

By decision dated June 13, 2013, OWCP denied modification, finding that the medical evidence did not establish a greater percentage of right arm impairment than previously awarded.

[10] Table 15-21, page 436 of the sixth edition of the A.M.A., *Guides* is entitled "Peripheral Nerve Impairment (UEI)."

[11] Table 15-12, page 421 of the sixth edition of the A.M.A., *Guides* is entitled "Impairment Values Calculated from Digit Impairment."

In a June 14, 2013 letter, counsel requested a telephonic hearing. He provided July 5 to September 9, 2013 progress notes from Dr. Rozman discussing appellant's return to part-time modified duty on August 12, 2013, and later work stoppage on September 9, 2013 due to increased pain. Appellant received compensation for the remaining hours of his tour and intermittent work absences.

By decision dated September 26, 2013, OWCP set aside the June 13, 2013 decision and remanded the case to obtain a second opinion regarding whether appellant sustained neurologic impairment to the right upper extremity.

On November 14, 2013 OWCP obtained a second opinion from Dr. Allan Brecher, a Board-certified orthopedic surgeon, regarding the nature and extent of appellant's condition. Dr. Brecher noted a negative Tinel's sign at the right elbow, no active motion of the fingers on the right hand, and a right hand tremor. He opined that the tremor was not an orthopedic problem. Dr. Brecher explained that he could not assess impairment due to loss of motion, as appellant had no active motion of the fingers. He contended that Dr. Rozman misapplied with A.M.A., *Guides* by assessing appellant's voluntarily limited motion as true orthopedic restriction.

On January 16, 2014 OWCP obtained a second opinion from Dr. Ricardo Kohn, a Board-certified neurologist. Dr. Kohn reviewed the medical record and a statement of accepted facts (SOAF). On examination, he found an involuntary tremor of the right hand with constant twitching of the forearm muscles. Dr. Kohn noted that appellant's responses indicated total sensory loss and 0/5 strength throughout the right arm. However, appellant had normal muscle bulk and tone in the right arm. Dr. Kohn diagnosed a closed metacarpal fracture, tremor, monoplegia of upper limb, dominant side, skin sensation disturbance, and ulnar neuropathy. He explained that appellant did not have a true right arm paralysis as there was a two second lag in drop when his arm was raised by the examiner. Also, although appellant responded incorrectly 10 out of 10 times in sensory testing, a "true neurological deficit will have approximately 50 percent of the responses correct." Dr. Brecher characterized appellant's ulnar neuropathy as an incidental finding unrelated to the accepted right fifth metacarpal fracture. He recommended evaluation by a movement disorder clinic for psychogenic tremor.

An OWCP medical adviser reviewed the medical record on February 17, 2014, and opined that there was a lack of objective evidence indicating a continuing right arm permanent impairment. He noted that several physicians asserted that appellant was malingering. The medical adviser found eight percent permanent impairment of the right fifth finger due to the metacarpal fracture according to Table 15-2, equaling one percent permanent impairment of the right arm.

In a March 11, 2014 decision, OWCP denied appellant's claim for an increased schedule award.

On March 17, 2014 counsel requested a telephonic hearing. He submitted additional medical evidence. In March 12 and May 5, 2014 letters, Dr. Rozman opined that Dr. Kohn mischaracterized appellant's symptoms and failed to review the complete medical record. He

contended that, while appellant's condition had not been diagnosed definitively, he had objective ulnar neuropathy and was not malingering.[12]

By decision dated September 4, 2014, an OWCP hearing representative set aside the March 11, 2014 decision, as there was an outstanding conflict of medical opinion between Dr. Kohn and Dr. Rozman, regarding appellant's clinical presentation, whether he had right ulnar neuropathy, and whether he had attained MMI. She remanded the case to OWCP for selection of an impartial medical specialist. The hearing representative instructed that, if the impartial medical specialist determined that appellant had attained MMI, that he or she should provide an impairment rating according to the appropriate portions of the A.M.A., *Guides*.

On July 9, 2014 appellant claimed a recurrence of disability (Form CA-2a) commencing June 1, 2014. He described feeling a "pop" in his right arm while performing his light-duty job, causing increased pain in his right hand. Appellant received wage-loss compensation from June 29 to July 12, 2014 on the supplemental roll.[13]

On December 1, 2014 OWCP obtained an impartial medical evaluation from Dr. Norman V. Kohn, a Board-certified neurologist. Dr. Kohn reviewed the medical record and a SOAF. He related appellant's symptoms of numbness at the surgical incision, right hand and elbow paresthesias, and increased right hand sensitivity. Dr. Kohn did not observe any tremor in the right arm. On examination of the right arm, he found no muscle wasting or atrophy, no skin changes, increased tone, and "waxy flexibility characteristic of volitional motor impairment." Dr. Kohn opined that appellant's symptoms lacked "a consistent character to support a specific underlying physiologic process and no underlying neurologic mechanism has been identified by any examiner." He characterized the "pattern and progression of alleged motor deficits [as] bizarre and not explainable by any organic process." Appellant's pattern of sensory loss was also nonphysiologic. Dr. Kohn determined that appellant had attained MMI. Referring to the A.M.A., *Guides*, Dr. Kohn found a class 1 CDX for metacarpal fracture according to Table 15-2, a GMFH of 1, a GMPE of 2, and a GMCS of 0. This resulted in a net adjustment of +1, raising the default seven percent impairment to eight percent, equaling one percent permanent impairment of the right upper extremity. Dr. Kohn provided a January 12, 2015 addendum, finding that appellant no longer had residuals of the accepted injury, and could perform sedentary work. He emphasized that all of appellant's symptoms were nonphysiologic and entirely unrelated to the accepted metacarpal fracture. An OWCP medical adviser reviewed Dr. Kohn's reports on December 15, 2015 and concurred with his assessment.

By decision dated January 13, 2015, OWCP denied appellant's claim for an increased schedule award, finding that the medical evidence did not establish greater than the six percent right arm impairment for which he received previous schedule awards.

[12] Dr. Rozman referred appellant for pain management with Dr. Krishna Chunduri, a Board-certified anesthesiologist, who diagnosed "[r]ight upper extremity pain and neuralgia" on July 2, 2014.

[13] By decision dated September 19, 2014, OWCP denied appellant's claim for compensation from June 1 to 14, 2014, finding that he failed to submit medical evidence establishing that the accepted injury disabled him for work for that period. On June 26, 2015 an OWCP hearing representative affirmed the September 19, 2014 decision.

In a January 16, 2015 letter, counsel requested a telephonic hearing, held September 16, 2015. At the hearing, he contended that OWCP improperly disregarded Dr. Rozman's opinion. Counsel submitted additional evidence.

In a January 5, 2015 report, Dr. Rozman noted that appellant experienced increased right shoulder pain. He held appellant off work intermittently. Dr. Rozman contended in a January 26, 2015 letter that appellant was forced to exceed his work restrictions. He noted that appellant had attained MMI as of August 10, 2012. Referring generally to the A.M.A., *Guides*, Dr. Rozman opined that appellant had 25 percent permanent impairment of the right upper extremity. He argued that OWCP's medical adviser wrongly excluded ulnar neuropathy from his impairment rating. Dr. Rozman also contended that OWCP should authorize an additional schedule award for the accepted pain condition.

OWCP obtained a second opinion regarding the nature and extent of appellant's condition from Dr. James Elmes, a Board-certified orthopedic surgeon. In an April 10, 2015 report, Dr. Elmes reviewed the medical record and SOAF. He related appellant's complaints of chronic right ulnar hand pain radiating into the forearm and right shoulder. On examination of the right arm, Dr. Elmes observed 4/5 strength in the deltoid, biceps, and triceps, limited right shoulder motion, tenderness to palpation of the lateral epicondyle and posterior olecranon, full passive range of motion throughout the hand, no atrophy, and absent vibratory, light touch, and pinprick sensation. He noted that appellant's right hand tremor diminished or stopped when appellant was distracted. Dr. Elmes diagnosed a resolved fifth metatarsal fracture, other acquired deformity with malunion, injury to the right digital nerve with neuroma and scar tissue, late effect tendon injury with scar tissue and restricted motion, psychogenic motion disorder, psychogenic pain disorder, and depressive disorder. He opined that appellant's pain and motion disorders with central nervous system conditions unrelated to the accepted injury. Dr. Elmes found that appellant had reached MMI and would benefit from a home exercise program. He required work restrictions for the right arm, unrelated to the accepted conditions.

OWCP found a conflict of medical opinion between Dr. Rozman and Dr. Elmes regarding the nature and extent of the accepted conditions and appellant's work capacity. To resolve the conflict, it selected Dr. William A. Heller, a Board-certified orthopedic surgeon, as impartial medical examiner.[14] Dr. Heller submitted a July 24, 2015 report reviewing the SOAF and the medical record. On examination of the right upper extremity, he noted no autonomic dysfunction of the hand, no swelling or edema in the arm, resting tremor of the hand, wrist, and forearm, and limited active range of motion throughout the right upper extremity. Appellant asserted that he had no sensation in any digits, but "did not show any loss of motor function and had no evidence of atrophy of thenar, hypothenar, or interosseous musculature." Dr. Heller diagnosed right fifth metacarpal fracture with post-traumatic stiffness and fracture malunion, resolved. He opined that appellant's right hand weakness, clumsiness, and tremor were unrelated to the metacarpal fracture and had no apparent explanation. Dr. Heller noted "work restrictions with no use of right upper extremity."

[14] The record contains bypass records documenting Dr. Heller's selection.

By decision dated December 2, 2015, an OWCP hearing representative affirmed the finding that appellant had sustained no greater than six percent permanent impairment of the right upper extremity, based on Dr. Norman Kohn's opinion being afforded the special weight of the medical evidence. She found that Dr. Rozman's reports did not document objective clinical findings indicating a greater percentage of impairment than that already awarded.

LEGAL PRECEDENT

The schedule award provisions of FECA[15] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the OWCP. For consistent results and to ensure equal justice, the Board has authorized 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 OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[16] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[17]

No schedule award is payable for a member, function, or organ of the body not specified in FECA or in the regulations.[18] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back,[19] no claimant is entitled to such an award.[20] However, in 1966, amendments to FECA modified the schedule award provision to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. As the schedule award provision of FECA includes the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[21]

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).[22]

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[15] 5 U.S.C. § 8107.

[16] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[17] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[18] *Henry B. Floyd, III*, 52 ECAB 220 (2001).

[19] FECA specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

[20] *Thomas Martinez*, 54 ECAB 623 (2003).

[21] *See Thomas J. Engelhart*, 50 ECAB 319 (1999).

[22] A.M.A., *Guides* (6th ed. 2008), page 3, Section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

In addressing upper extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on functional history, physical examination, and clinical studies.[23] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[24]

Section 8123(a) of FECA provides that when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict.[25] When there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a), to resolve the conflict in the medical evidence.[26] In situations where there are 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 on a proper factual background, must be given special weight.[27]

ANALYSIS

OWCP accepted that appellant sustained a closed metacarpal neck fracture of the right fifth finger, acquired deformity of the right fifth finger, injury to digital nerve, late effect of tendon injury, and right upper extremity pain. Appellant underwent a November 11, 2008 corrective osteotomy with pin fixation, a September 15, 2009 open reduction and internal fixation with tenolysis of the extensor tendons and excision of a neuroma, and a February 2, 2010 open reduction and internal fixation, tenolysis of the extensor tendon and a tendon wrap. OWCP authorized these procedures.

Appellant claimed a schedule award on September 30, 2010. An OWCP medical adviser reviewed the medical evidence and assessed 38 percent permanent impairment of the right fifth finger according to Table 15-12, equaling three percent permanent impairment of the right arm. OWCP issued a June 20, 2011 schedule award for three percent permanent impairment of the right arm. It affirmed the decision on May 23, 2012.

Appellant claimed an increased schedule award on August 24, 2012. He provided an August 10, 2012 report from Dr. Rozman, an attending Board-certified physiatrist, finding 8 percent arm impairment for tendon rupture, 6 percent for limited motion of the joints of the right fifth finger, 22 percent of the right arm for ulnar neuropathy, and 1 percent for the extensor tendon injury, for a combined 25 percent permanent impairment of the right arm. An OWCP medical adviser reviewed Dr. Rozman's report on August 30, 2012 and calculated six percent impairment of the right upper extremity due to the loss of finger motion observed. OWCP then

[23] A.M.A., *Guides* 385-419; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[24] *Id.* at 411.

[25] 5 U.S.C. § 8123(a); *Robert W. Blaine*, 42 ECAB 474 (1991).

[26] *Delphia Y. Jackson*, 55 ECAB 373 (2004).

[27] *Anna M. Delaney*, 53 ECAB 384 (2002).

issued a November 29, 2012 schedule award for an additional three percent permanent impairment of the right arm.

OWCP obtained an impartial medical evaluation on December 1, 2014 from Dr. Norman V. Kohn, a Board-certified neurologist, to resolve a conflict of opinion between Dr. Rozman and Dr. Ricardo Kohn, the Board-certified neurologist and second opinion physician**,** regarding the nature and extent of any neurological injury-related conditions and the percentage of any additional permanent impairment. Dr. Norman Kohn reviewed the medical records and SOAF, and performed a thorough clinical examination. He found that appellant's right hand tremor, right upper extremity paresthesias, and subjective loss of sensation had no physiologic basis. Dr. Kohn calculated a one percent permanent impairment of the right upper extremity, less than the six percent previously awarded. OWCP therefore denied an additional increased schedule award by decision dated January 13, 2015.

Upon reconsideration, counsel argued that OWCP had disregarded Dr. Rozman's neurological findings. OWCP thereafter obtained a second opinion on April 10, 2015 from Dr. Elmes who found a resolved fifth metacarpal fracture and psychogenic neurologic manifestations. It then found a conflict between Dr. Elmes and Dr. Rozman with regard to appellant's work capacity and whether he sustained any consequential neurologic conditions. OWCP selected Dr. Heller, a Board-certified orthopedic surgeon, to resolve that conflict. The Board notes that OWCP did not find a new conflict regarding the percentage of permanent impairment, or request that Dr. Heller address the schedule award issue. Dr. Heller provided a July 24, 2015 report, explaining that the accepted fracture had resolved completely, and that the remainder of appellant's presentation was nonphysiologic.

In opposition to Dr. Kohn's opinion, appellant submitted January 5 and 26, 2015 reports from Dr. Rozman. The Board notes that as Dr. Rozman was on one side of the conflict resolved by Dr. Norman Kohn, Dr. Rozman's additional reports are of insufficient weight to overcome the special weight accorded to Dr. Kohn's opinion or to create a new conflict of medical opinion.[28]

OWCP then issued its December 2, 2015 decision**,** finding that appellant had established no more than six percent permanent impairment of the right upper extremity, for which he received schedule awards. It based its determination on Dr. Kohn's December 1, 2014 report, noting its comprehensive and well-reasoned nature.

The Board finds that the weight of the medical evidence established that he had no greater than a six percent permanent impairment of the right upper extremity. Dr. Kohn reviewed the complete medical record and a SOAF. He opined that appellant had attained MMI. Dr. Kohn performed an extremely thorough clinical examination, during which he observed no objective motor deficit, neurologic abnormality, deformity, or atrophy. There is no other probative medical evidence indicating a greater impairment than the six percent awarded. The Board notes that while OWCP did not directly address Dr. Heller's opinion in its December 2, 2015 decision, his report indicates that appellant had no objective impairment. OWCP therefore properly issued its December 2, 2015 decision denying appellant's claim for an increased schedule award.

[28] *Virginia Davis-Banks*, 44 ECAB 389 (1993); *Dorothy Sidwell*, 41 ECAB 857 (1990).

On appeal, counsel contends that OWCP's December 2, 2015 decision is "wrong because it gives no credence to the claimant's evidence." The Board notes, however, that OWCP thoroughly considered the reports of Dr. Rozman and appellant's other attending physicians.

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 OWCP properly found that appellant sustained no more than six percent permanent impairment of the right upper extremity, for which he received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 2, 2015 is affirmed.

Issued: December 21, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board