United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	**Docket No. 10-2093**
	)	**Issued: June 9, 2011**
DEPARTMENT OF THE ARMY, PUBLIC WORKS DEPARTMENT, NAVAL AIR STATION, Marietta, GA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On August 13, 2010 appellant filed a timely appeal of a July 13, 2010 Office of Workers' Compensation Programs' merit decision denying an additional schedule award. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

ISSUE

The issue is whether appellant has more than nine percent permanent impairment of his right upper extremity and four percent impairment of his left upper extremity for which he has received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board on appeal.[2] On September 20, 2000 appellant, then a 45-year-old maintenance mechanic, sustained a deep cut to his right forearm when a piece of plate glass broke and fell on his arm. The Office accepted his claim for laceration of the right forearm on February 9, 2001. Dr. James C. McIntosh, Jr., a Board-certified orthopedic surgeon, performed a repair of laceration to the brachioradialis tendon in the right forearm. He noted that appellant had a transverse laceration which went through the musculotendinous junction of his brachioradialis. Dr. McIntosh stated that he intended to bring the brachioradialis into an elongated position, but was unable to do so due to fibrosis proximally and tendon adherence distally.

Appellant filed an occupational disease claim on February 4, 2002 alleging that he developed carpal tunnel syndrome due to his employment duties. On September 5, 2001 he under went nerve conduction velocity (NCV) studies which were consistent with mild-to-moderate left carpal tunnel syndrome and mild right carpal tunnel syndrome. The Office accepted carpal tunnel syndrome under a separate claim and aggravation of carpal tunnel syndrome on April 5, 2002.[3] Appellant filed a second claim for carpal tunnel syndrome on December 24, 2003.

By decision dated November 15, 2007, the Office granted appellant a schedule award for nine percent impairment of the right upper extremity and four percent impairment of the left upper extremity. Appellant appealed this decision to the Board and on November 4, 2008,[4] the Board found that there was an unresolved conflict of medical opinion evidence between appellant's attending physician, Dr. Scott Gillogly, a Board-certified orthopedic surgeon, and the Office medical adviser regarding the nature and extent of appellant's permanent impairment. Dr. Gillogly completed reports on February 7, 2005, August 4 and 9, 2006 and opined that appellant had 19 percent impairment of his right upper extremity due to sensory impairments of the median nerve impacting his thumb, middle and ring finger as well as motor deficits of the brachioradialis tendon resulting in a loss of grip strength. The district medical adviser reviewed Dr. Gillogly's reports on behalf of the Office and opined that appellant was not entitled to an impairment rating due to motor impairment of his brachioradialis. He disagreed with both the use of grip strength to determine a motor impairment and with Dr. Gillogly's finding that appellant had continuing symptoms in his brachioradialis following the surgical repair. The Board remanded the case for the Office to refer appellant to an impartial medical examiner and properly determine his permanent impairment for schedule award purposes. The facts and circumstances of the case as set forth in the Board's prior decision are adopted herein by reference.

[2] In an order remanding case dated March 10, 2006, the Board found that the Office's decisions regarding appellant's wage-earning capacity and overpayment were not sufficiently detailed and remanded for appropriate decisions. Docket No. 05-1391 (issued March 10, 2006).

[3] The Office doubled appellant's claims File No. xxxxxx264 and File No. xxxxxx454.

[4] Docket No. 08-658 (issued November 4, 2008).

In a letter dated December 16, 2008, the Office referred appellant for evaluation by Dr. Todd Zeigler, a Board-certified orthopedic surgeon, acting as the impartial medical examiner. In his February 11, 2009 report, Dr. Zeigler reviewed appellant's history of injury and the statement of accepted facts. He found that gross strength testing did not reveal a marked lack of strength in the hand, but that appellant had some subjective decreased sensation in the fingertips. Dr. Zeigler stated that appellant's brachioradialis was palpable and "does fire with attempts at elbow flexion … and neutral pronation and supination." He stated that appellant had atrophy, but no gross difference in flexion strength between the right and left arms. Dr. Zeigler diagnosed bilateral carpal tunnel syndrome with resulting impairment and surgical repair of the brachioradialis tendon with no objective evidence of residual significant problems with the tendon or the superficial radial nerve. He stated, "I do not see objective evidence of justification for a rating related to the brachioradialis tendon or any superficial radial nerve issues [of] wrist strength issues. I would recommend the [four percent] impairment for the left upper extremity and the [nine percent] impairment of the right upper extremity."

By decision dated March 5, 2009, the Office denied appellant's claim for an additional schedule award finding that Dr. Zeigler's report established that appellant did not have additional impairment due to his brachioradialis injury. Appellant requested an oral hearing on March 27, 2009. The Branch of Hearings and Review found on June 11, 2009 that the case was not in posture for a hearing and remanded for the Office to secure a supplemental report from Dr. Zeigler describing how he reached the impairment ratings given.

On July 14, 2009 the Office requested a supplemental report from Dr. Zeigler applying the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, to his findings and providing a complete impairment rating. Dr. Zeigler did not respond. In a letter dated April 22, 2010, the Office referred appellant for an additional impartial medical examination with Dr. Matthew Jaffee, a Board-certified orthopedic surgeon, who completed a report on June 18, 2010 listing appellant's history of injury and medical treatment. Dr. Zeigler noted that appellant had not had carpal tunnel release surgery and that he experienced numbness over the dorsum of the right hand as well as grip weakness and loss of extension strength in the right hand. He found mild muscle atrophy on the right and mild-to-moderate weakness of the finger and thumb extension, wrist extension and mild grip strength weakness. Dr. Zeigler diagnosed carpal tunnel syndrome. He diagnosed mild-to-moderate bilateral carpal tunnel syndrome and a complex laceration of the right forearm including soft tissue, tendon and superficial nerve. Dr. Zeigler found that appellant retained residual deficits of his forearm including palpable scar tissue, a defect in muscle, muscle atrophy, decreased sensory perception over superficial radial aspect of the hand and weakness to finger and wrist extension. He then calculated appellant's impairment stating:

> "According to AMA guidelines …, using diagnosis based impairment grids, … demonstrates a wrist laceration or ruptured muscle tendon with residual loss of function and normal motion to represent a class I injury.[5] Within specific grade of the injury, with class [A] being mild and class E being severe, I find this patient to be a class C…. [T]his correlates to a [five percent] permanent partial disability

[5] A.M.A., *Guides* 395, Table 15-3.

> of the upper extremity with respect to his laceration. This number must [be] added to his permanent partial disability for bilateral carpal tunnel syndrome, treated nonsurgically…. [P]atient has findings of decreased sensation which puts him into a modifier 2 category.[6] Symptoms within this category are mild giving him an impairment rating of [four percent] of the upper extremity for carpal tunnel syndrome on each side. This gives a final permanent partial disability of [nine percent] of the right upper extremity secondary to his laceration and carpal tunnel syndrome using diagnosis based impairment."

The Office referred this report to the district medical adviser on June 29, 2010. In a report dated July 8, 2010, the district medical adviser found that in accordance with the sixth edition of the A.M.A., *Guides* and Dr. Jaffee's report appellant had nine percent impairment of the right upper extremity based on a class C or five percent laceration of the brachioradialis tendon[7] and four percent impairment of the upper extremities bilaterally due to residual sensory loss from carpal tunnel syndrome grade 2A.[8]

By decision dated July 13, 2010, the Office denied appellant's claim for an additional schedule award finding that the weight of the medical opinion evidence rested with the reports of Dr. Jaffee and the district medical adviser which concluded that appellant had no more than nine percent impairment of his right upper extremity and four percent impairment of his left upper extremity for which he had received schedule awards.

LEGAL PRECEDENT

The schedule award provision of the Act[9] and its implementing regulations[10] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions of the body. The Act, 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 discretion of the Office. 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 Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[11]

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[6] *Id*. at 449, Table 15-23.

[7] *Id.* at 395, Table 15-3.

[8] *Supra* note 6.

[9] 5 U.S.C. §§ 8101-8193, 8107.

[10] 20 C.F.R. § 10.404.

[11] For new decisions issued after May 1, 2009 the Office began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides* (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (January 2010); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

In addressing upper extremity impairments, the sixth edition of the A.M.A., *Guides* requires identification of 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). The net adjustment formula is GMFH - CDX + GMPE - CDX + GMCS - CDX.[12]

ANALYSIS

In the prior decision, the Board found that there was a conflict of medical evidence which required referral of appellant to an impartial medical examiner to determine the extent of his permanent impairment. The Office referred appellant to Dr. Zeigler to resolve the conflict. Dr. Zeigler agreed with the impairment rating provided by the previous Office medical adviser, but did not provide a detailed impairment rating. The Branch of Hearings and Review found that this report was not sufficient and requested that the Office obtain a supplemental report from Dr. Zeigler, who did not respond to the Office's request. The Office's procedure manual provides that if the selected impartial medical examiner failed to provide an adequate clear response after a specific request for clarification, the Office may then seek a second impartial medical examiners opinion.[13]

The Office referred appellant to Dr. Jaffee to determine the extent of his permanent impairment for schedule award purposes. Dr. Jaffee based his report on a proper factual background and provided physical findings in support of his determination that appellant had nine percent impairment of the right upper extremity and four percent impairment of the left. In situations were 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.[14] The Board finds that Dr. Jaffee's report was sufficiently detailed and well reasoned to resolve the conflict of medical opinion evidence and establish appellant's permanent impairment for schedule award purposes.

Both Dr. Jaffee and the district medical adviser found that appellant had a wrist laceration with residual loss. The default grade for this condition is C with five percent impairment. Dr. Jaffee found that appellant had a grade 2 modifier for functional history based findings of decreased sensory perception.[15] He indicated that appellant had a grade modifier 1 for muscle atrophy[16] and no grade modifier for clinical studies. When the above formula is applied appellant has a net adjustment of 0 and a grade C or five percent impairment of his upper extremity. This impairment rating correlates with the A.M.A., *Guides* and was confirmed by the district medical adviser.

[12] A.M.A., *Guides* 411.

[13] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.6.b (May 2003).

[14] *Nathan L. Harrell,* 41 ECAB 401, 407 (1990).

[15] A.M.A., *Guides* 406, Table 15-7.

[16] *Id*. at 408, Table 15-8.

In regards to appellant's diagnosed condition of carpal tunnel syndrome, Dr. Jaffee found that appellant had decreased sensation due to this condition a grade modifier 2 in physical findings under the A.M.A., *Guides*.[17] Appellant had documentation of a neuropathy syndrome, the September 5, 2001 NCV studies which demonstrated conduction delay or grade modifier 1. Dr. Jaffee concluded that appellant's symptoms were mild on the functional scale, a grade modifier 1 and that therefore appellant had four percent impairment of each upper extremity due to his accepted condition of carpal tunnel syndrome. The district medical adviser agreed with these findings and conclusions and the Board finds that this impairment rating comports with the A.M.A., *Guides*.

As Dr. Jaffee, the impartial medical examiner, properly applied the A.M.A., *Guides* to appellant's findings on physical examination and electrodiagnostic testing, the Board finds that his report is entitled to the weight of the medical evidence and establishes appellant's permanent impairment for schedule award purposes.

CONCLUSION

The Board finds that appellant has no more than nine percent impairment of his right upper extremity and four percent impairment of his left upper extremity for which he has received schedule awards.

[17] *Supra* note 6.

ORDER

IT IS HEREBY ORDERED THAT the July 13, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 9, 2011
Washington, DC

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

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board