United States Department of Labor
Employees' Compensation Appeals Board

E.T., Appellant	)	
and	)	**Docket No. 10-894**
	)	**Issued: February 9, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On February 18, 2010 appellant filed a timely appeal from a January 28, 2010 merit decision of the Office of Workers' Compensation Programs denying his claim for an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has more than five percent impairment of his left arm.

On appeal, his attorney asserts that the opinion of the attending physician should be given weight as the Office medical adviser deemed the opinion of the Office referral physician inadequate. Counsel also argued that the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[1] is inconsistent with Office procedures.

[1] A.M.A., *Guides* (6th ed. 2008); FECA Bulletin No. 09-03 (issued March 15, 2009).

FACTUAL HISTORY

This case has previously been before the Board.[2] By decision dated May 2, 2006, the Board found that appellant was required to make an election of benefits between the 20 percent increase in benefits he received from the Department of Veterans Affairs and compensation benefits he received under the Federal Employees' Compensation Act for his accepted major depression.[3] The Board found that appellant failed to establish that dysphagia or any other corticospinal condition was causally related to the February 6, 2001 employment injury and that a conflict in medical evidence was not resolved regarding whether his erectile dysfunction condition was causally related to the employment injury.[4] In an April 25, 2007 decision, the Board found that appellant did not establish that his erectile dysfunction was causally related to his February 6, 2001 employment injury.[5] The law and facts of the previous Board decisions are incorporated herein by reference.

The accepted conditions in this case are cervical strain, left shoulder strain, herniated disc at C6-7 with discectomy and fusion, and major depressive disorder. By decision dated March 22, 2004, appellant was granted a schedule award for a three percent impairment of the left upper extremity. On October 29, 2004 an additional schedule award for two percent was awarded. On September 3, 2009 he filed an additional schedule award claim and submitted reports from Dr. Daisy A. Rodriguez, an attending Board-certified internist, and a *Quick*DASH assessment.

In a July 28, 2009 report, Dr. Rodriguez reviewed the history of injury. She provided findings on physical examination including left shoulder range of motion (ROM) and diagnosed cervical sprain/strain; trapezius sprain/strain; herniated disc at C6-7 with cord compression, status post surgical excision and fusion; cervical radiculopathy, left acromioclavicular sprain/strain; depression psychosis; erectile dysfunction; laryngeal dysphagia, status-post surgery; and chronic pain. On August 8, 2009 Dr. Rodriguez reiterated the diagnoses. In an impairment rating dated August 25, 2009, she advised that all diagnoses were attributable to the February 6, 2001 employment injury and that, in accordance with the sixth edition of the A.M.A., *Guides*, appellant had a Class 1 left upper extremity impairment under Table 15-5, Shoulder Regional Grid, due to acromioclavicular strain. She then used the grade modifiers, finding that for functional history (GMFH), finding an average of PDQ and *Quick*DASH scores, for an adjustment of 3; that for physical examination (GMPE), with an impingement sign, an adjustment of 1 was appropriate; and that a modifier for clinical studies (GMCS) was not applicable as no studies were available, for a net adjustment of 2 with an assigned grade of E, which, under Table 15-5 yielded a five percent impairment. Dr. Rodriguez then stated that for radiculopathy/peripheral nerve impairment of the left upper extremity, utilizing Table 15-21, Table 15-14, Table 15-7, Table 15-8 and Table 15-9, appellant had a Class 1 left upper extremity

[2] Appellant, then a 42-year-old letter carrier, slipped and fell on ice and snow on February 6, 2001 while in the performance of his federal duties.

[3] 5 U.S.C. §§ 8101-8193.

[4] Docket No. 05-1984 (issued May 2, 2006).

[5] Docket No. 07-80 (issued April 25, 2007).

impairment for ulnar, below midforearm, mild motor deficit. She again used the grade modifier for GMFH, finding that an average of PDQ and *Quick*DASH scores yielded an adjustment of 3; that for GMPE, with mild atrophy, mild motor deficit at 4+/5 strength and reduced sensation to light touch and pin prick, an adjustment of 1; and that GMCS was not applicable. Dr. Rodriguez used the net adjustment formula, finding a net adjustment of 2, with an assigned grade modifier of E, for a nine percent left upper extremity impairment due to radiculopathy/peripheral nerve impairment. She then concluded that appellant had a combined left upper extremity impairment of 14 percent.

In an October 25, 2009 report, Dr. Arnold T. Berman, an Office medical adviser Board-certified in orthopedic surgery, reviewed the medical record, including Dr. Rodriguez's August 25, 2009 impairment rating. He advised that appellant was not entitled to a schedule award for ulnar nerve compression as it was not an accepted condition and agreed with Dr. Rodriguez that appellant had five percent left upper extremity impairment for the acromioclavicular joint condition with August 25, 2009 as the date of maximum medical improvement.

The Office referred appellant to Dr. Robert Franklin Draper, Jr., a Board-certified orthopedic surgeon, for a second opinion evaluation.[6] In a December 22, 2009 report, Dr. Draper reviewed the record, including the statement of accepted facts and appellant's complaint of left upper extremity numbness. Physical examination demonstrated normal muscle strength and decreased sensation at the C6 and C7 dermatomes with decreased light touch sensation involving the left little finger, ulnar side of the left hand, and two-point discrimination of six millimeters. involving the left little finger. Dr. Draper diagnosed degenerative cervical disc disease and advised that Table 15-18 of the sixth edition of the A.M.A., *Guides* was the most appropriate for evaluating appellant, and with mild retained, protective sensation and some pain, he had a two percent left upper extremity impairment associated with the C6-7 discectomy and fusion. He advised that an alternative method of determining the impairment rating was less accurate, explaining that under Table 15-21, appellant was rated at Class I for a five percent impairment but that after using the appropriate modifiers, he had a zero percent upper extremity impairment under this method. Dr. Draper provided a worksheet indicating that appellant had a two percent diagnosis-based impairment of the left upper extremity.

In a January 16, 2010 report, Dr. Berman noted that Dr. Draper did not make an impairment recommendation with regard to appellant's left shoulder. He disagreed with Dr. Draper's conclusion of left upper extremity impairment as it related to the cervical spine, and reiterated his recommendation that appellant had a five percent left upper extremity impairment, based on shoulder derangement.

By decision dated January 28, 2009, the Office denied appellant's claim for additional schedule award and accorded the weight of the medical evidence to Dr. Berman. It noted that appellant had previously received schedule awards for five percent left upper extremity impairment.

[6] Appellant was initially referred to Dr. Kevin F. Hanley, a Board-certified orthopedist, but, due to a scheduling conflict, was referred to Dr. Draper.

LEGAL PRECEDENT

The schedule award provision of the Act, and its implementing federal regulations,[7] 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, the Act 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, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[10] It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[11]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under the Act for injury to the spine.[12] In 1960, amendments to the Act modified the schedule award provisions 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. Therefore, as the schedule award provisions of the Act include 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.[13] A schedule award is not payable for an impairment of the whole body.[14] It is well established that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[15]

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).[16] Under the sixth edition of the A.M.A., *Guides*, 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

[7] 20 C.F.R. § 10.404.

[8] *Id*. at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[10] A.M.A., *Guides*, *supra* note 1.

[11] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[12] *Pamela J. Darling*, 49 ECAB 286 (1998).

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

[14] *N.M.*, 58 ECAB 273 (2007).

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

[16] A.M.A., *Guides*, *supra* note 1 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): *A Contemporary Model of Disablement*."

examination (GMPE) and clinical studies (GMCS).[17] The net adjustment formula is (GMFH-CDX) + (GMPE - CDX) + (GMCS- CDX).[18]

ANALYSIS

The Board finds that this case is not in posture for decision as to the extent of appellant's left upper extremity impairment. The case will be remanded to the Office for further development. The accepted conditions are cervical strain, left shoulder strain, herniated disc at C6-7 with discectomy and fusion on September 19, 2001 and major depressive disorder. The record reflects that appellant received schedule awards for a total of five percent impairment. On September 3, 2009 he filed a claim for an additional schedule award.

On appeal, appellant contends that Dr. Rodriguez's opinion should be accorded the weight of the medical evidence. In an August 25, 2009 impairment evaluation, Dr. Rodriguez stated that appellant had a Class 1 left upper extremity impairment under Table 15-5, Shoulder Regional Grid,[19] of the sixth edition of the A.M.A., *Guides* due to acromioclavicular strain and sprain. She then used the grade modifiers, finding an adjustment of 3 for GMFE, based on an average of PDQ and *Quick*DASH scores; an adjustment of 1 for GMPE for impingement sign; and found that a modifier for GMCS was not applicable as no studies were available, for a total net adjustment of 2 with an assigned grade of E which, under Table 15-5, yielded a five percent upper extremity impairment.[20] Dr. Berman, an Office medical adviser, agreed with this analysis that appellant was entitled to a five percent left upper extremity for a left shoulder injury. As appellant had previously received schedule awards for the left upper extremity totaling five percent, the evidence did not establish that he was entitled to a greater upper extremity award solely based on a left shoulder injury.

Dr. Rodriguez, however, also provided an impairment assessment for radiculopathy/ peripheral nerve impairment of the left upper extremity by utilizing Table 15-21, Table 15-14, Table 15-7, Table 15-8 and Table 15-9.[21] She advised that appellant had a Class 1 left upper extremity impairment for ulnar, below midforearm, mild motor deficit and used the grade modifier for GMFH, again finding that an average of PDQ and *Quick*DASH scores yielded an adjustment of 3; that for GMPE, with mild atrophy, mild motor deficit at 4+/5 strength and reduced sensation to light touch and pin prick yielded an adjustment of 1; and that GMCS was not applicable. Dr. Rodriguez used the net adjustment formula, finding a net adjustment of 2, with an assigned grade modifier of E, for a nine percent left upper extremity impairment due to radiculopathy/peripheral nerve impairment.

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

[18] *Id*. at 411.

[19] *Id*. at 401-05.

[20] The Board notes that Dr. Rodriguez identified the final grade as a five percent WPI or whole person impairment, whereas Table 15-5 clearly advised that a Grade E, Class 1 impairment yields a five percent upper extremity impairment. Thus her designation of WPI is considered a typographical error.

[21] A.M.A., *Guides*, *supra* note 1 at 406-11, 425 and 436-44.

Section 15-4 of the sixth edition of the A.M.A., *Guides*, provides that peripheral nerve impairment may be combined with diagnosis-based impairments at the upper extremity level as long as the diagnosis-based impairment does not encompass the nerve impairment.[22] The A.M.A., *Guides* note that it is important to determine the anatomic distribution and severity of loss of function resulting from sensory deficits or pain and motor deficits and loss of power and that these must be accurately graded to define the potential range of impairments associated with the nerve lesion. Only unequivocal and permanent deficits are given permanent impairment ratings.[23]

Dr. Berman advised that appellant was not entitled to a schedule award for ulnar nerve entrapment because this was not an accepted condition. Dr. Rodriguez, however, diagnosed cervical radiculopathy at C6-8, noting physical findings of mild atrophy, mild motor deficit at 4+/5 strength, and reduced sensation to light touch and pin prick. The Board notes that an accepted condition is a herniated disc at C6-7. The Board finds that her impairment rating with regards to peripheral nerve impairment does not comport with the A.M.A., *Guides* because she granted an adjustment of three for functional history or GMFH for both the shoulder and the peripheral nerve impairments, merely explaining that this was an average of PDQ and *Quick*DASH scores without further clarification. Table 15-7 explains that a Grade 3 modifier indicates severe problems with pain and symptoms with less than normal activity and that assistance is required to perform self-care activities.[24] While Dr. Rodriguez identified the anatomic distribution and severity of loss of function in her GMPE modifier, her duplication of the GMFH modifier for both the shoulder rating and the peripheral nerve rating without further explanation diminishes the probative value of her opinion.

Dr. Draper, the Office referral physician, evaluated appellant's left upper extremity solely for C7 neuropathy, under both Table 15-18 and Table 15-21. He found a two percent impairment under the former and a zero percent impairment under the latter. Table 2-1 states that if the A.M.A., *Guides* provides more than one method to rate a particular impairment or condition, the method producing the higher rating shoulder be used,[25] and thus appellant would be entitled to a two percent impairment for a peripheral nerve injury under Table 15-18. Dr. Draper, however, did not provide any analysis of the left shoulder such as specific examination findings or an impairment analysis under Table 15-5. As appellant has an accepted left shoulder injury, Dr. Draper's opinion is deficient in this regard.

Proceedings under the Act are not adversarial in nature nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. Once it has begun an investigation of a claim, it must pursue the evidence as far as reasonably possible. The Office has an obligation to see that justice is done.[26] The medical evidence of record does not fully comport with the

[22] *Id*. at 419.

[23] *Id*. at section 15.4a at 423.

[24] *Id*. at 406.

[25] *Id*. at 20; *see C.J.*, 60 ECAB ___ (Docket No. 08-2429, issued August 3, 2009).

[26] *A.A.*, 59 ECAB 726 (2008).

A.M.A., *Guides* or provide a complete analysis of appellant's left upper extremity impairment. The case will be remanded to the Office for further development on the extent of impairment of appellant's left upper extremity in accordance with the sixth edition of the A.M.A., *Guides*.

CONCLUSION

The Board finds that this case is not in posture for decision as to the extent of appellant's left upper extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the January 28, 2010 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded to the Office for further proceedings consistent with this opinion of the Board.

Issued: February 9, 2011
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board