United States Department of Labor
Employees' Compensation Appeals Board

C.K., Appellant	)	
and	)	**Docket No. 09-2371**
	)	**Issued: August 18, 2010**
DEPARTMENT OF JUSTICE, BUREAU OF ALCOHOL, TOBACCO & FIREARMS, Fairview Heights, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 23, 2009 appellant filed a timely appeal from a July 22, 2009 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 claim.

ISSUE

The issue is whether appellant has greater than a total 48 percent impairment to his left arm for which he received a schedule award.

FACTUAL HISTORY

On June 22, 2000 appellant, then a 37-year-old special agent, filed a traumatic injury claim alleging that on June 2, 2000 he dislocated his left shoulder while performing pull-ups for his physical certification. The Office accepted the claim for left shoulder labral tear and authorized left shoulder arthroscopy with anterior shoulder reconstruction, which was performed on July 26, 2000 and placed him on the periodic rolls. Appellant returned to full-time regular

duty on December 2, 2001. Subsequently, the Office accepted a recurrence of disability beginning February 10, 2003 and authorized additional shoulder surgery, which took place on April 22, 2003. Appellant returned to limited duty on October 9, 2003.

On April 25, 2006 the Office accepted appellant's claim for a recurrence of disability beginning March 23, 2006 and again authorized left arthroscopic surgery, which was performed on May 15, 2006. It expanded the acceptance of his claim to include hemorrhage of the gastrointestinal tract and injury to the left axillary nerve.[1]

On December 3, 2001 appellant filed a claim for a schedule award.

By decision dated April 9, 2002, the Office issued a schedule award for 27 percent permanent impairment of the left upper extremity. The period of the award ran from March 19, 2002 to October 29, 2003. On September 1, 2005 the Office granted appellant a schedule award for an additional 21 percent impairment of the left upper extremity. The period of the award ran from November 8, 2004 to February 9, 2006. The total of both awards was 48 percent left arm impairment.

On May 29 and July 19, 2007 appellant filed a claim for an increased schedule award.

In a report dated September 4, 2007, Dr. Jack C. Tippet, a second opinion Board-certified orthopedic surgeon, found that appellant had reached maximum medical improvement by May 1, 2007. Using the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) he determined that appellant had 16 percent impairment for 10 degrees flexion, 1 percent impairment for 41 degrees extension, 5 percent impairment for 72 degrees abduction, 1 percent impairment for 20 degrees adduction, 0 percent impairment for 80 degrees internal rotation and 1 percent impairment for 20 degrees external rotation using Figure 16-40, Figure 16-43 and Figure 16-46 at pages 476, 477 and 479, respectively. This provided 24 percent permanent impairment based on range of motion.

Dr. Tippet found that appellant had strength of 2/5 as appellant was unable to hold arm in abduction against gravity and thus had 40 percent of normal or a 60 percent loss of strength. Using the Combined Values Chart for range of motion and muscle weakness, he concluded that appellant had 65 percent left upper extremity impairment.

In an October 29, 2007 report, Dr. Daniel D. Zimmerman, an Office medical adviser, reviewed Dr. Tippet's rating and noted that the impairment for strength using Table 16-35 was not calculated correctly.

On November 6, 2007 Dr. Tippet agreed with Dr. Zimmerman that his calculation for shoulder weakness was incorrect and revised his rating to reflect 40 percent left upper extremity impairment.

On November 9, 2007 Dr. Zimmerman again reviewed both of Dr. Tippet's reports and determined that appellant had 42 percent left upper extremity impairment. The reports by

[1] By decision dated July 30, 2007, the Office denied appellant's claim for a schedule award for his upper gastrointestinal tract as it was not covered under the Federal Employees' Compensation Act.

Drs. Tippet and Zimmerman agreed that appellant sustained 42 percent left upper extremity impairment.

By decision dated February 12, 2008, the Office denied appellant's claim for an additional schedule award as he had previously been awarded a total of 48 percent permanent impairment.

On February 16, 2008 appellant requested an oral hearing before an Office hearing representation. A telephonic hearing was held on June 11, 2008.

On March 5, 2008 Dr. Naseem A. Shekhani, an examining Board-certified physiatrist and family practitioner, concluded that appellant had 57 percent impairment of his left upper extremity. Using the fifth edition of the A.M.A., *Guides* and using Figure 16-43, Figure 16-46 and Table 16-15, page 492, he found 11 percent impairment for 20 degrees flexion, 2 percent impairment for 15 degrees extension, 10 percent impairment for 10 degrees abduction, 1 percent impairment for 10 degrees adduction, 2 percent impairment for 10 degrees external rotation and "internal rotation XX% for 10 degrees.[2]" This totaled 31 percent permanent impairment for range of motion.

Dr. Shekhani identified the affected nerve as the axillary nerve which had a maximum impairment of 5 percent for sensory loss and 35 percent for motor loss. He classified the sensory deficit at 80 percent impairment thereby reducing the maximum impairment for sensory deficit to 4 percent (.80 x 5 percent) and 28 percent for motor deficit (.80 x 35 percent).

Using the Combined Values Chart, page 604, Dr. Shekhani combined the 4 percent with 28 percent to reach 31 percent impairment for the axillary nerve. He also found seven percent sensory deficit alone for the ulnar nerve below the forearm, also from Table 16-15, page 492. Combining the 31 percent for the axillary nerve and 7 percent for the ulnar nerve, Dr. Shekhani found 37 percent for sensory deficit. Combining the 37 percent with the 31 percent loss of range of motion, he found the total permanent impairment of left upper extremity at 57 percent.

On May 12, 2008 Dr. Raymond F. Cohen, an attending osteopath, concluded that appellant had a total 69 percent impairment of the left arm, using the fifth edition of the A.M.A., *Guides*. He concluded that appellant had a Grade 3 muscle function with 26 percent deficit and a Grade 3 sensory deficit of 26 percent, relying on Table 16-10. Dr. Cohen combined these for a total 38 percent combined motor and sensory impairment of the axillary nerve.

As to appellant's loss of range of motion, Dr. Cohen used Figure 16-40, Figure 16-43 and Figure 16-46 to find 16 percent impairment for 10 degrees flexion, 4 percent impairment for 20 degrees extension, 7 percent impairment for 20 degrees abduction, 2 percent impairment for 30 degrees adduction, 4 percent impairment for 50 degrees external rotation and 2 percent impairment for 50 degrees internal rotation, resulting in a total 35 percent impairment. Using the Combined Values Chart, Dr. Cohen combined 38 percent with 35 percent for a total left upper extremity impairment of 69 percent.

[2] Based on the measurement of 10 degrees for internal rotation, this calculation should be five percent, according to Figure 16.46, page 479. Using 5 percent would agree with Dr. Shekhani's calculation of 31 percent.

On July 13, 2008 Dr. Zimmerman reviewed the impairment ratings by Drs. Cohen and Shekhani. He opined that neither physician's ratings could be used to determine permanent impairment under the A.M.A., *Guides*.

The Office medical adviser corrected Dr. Cohen's rating on motor and sensory deficit due to the axillary nerve condition. Dr. Cohen's report found that appellant had 26 percent sensory and motor deficits of the axillary nerve. Dr. Zimmerman multiplied 26 percent times the maximum 5 percent for sensory deficit to equal 1 percent (.26 x 5 percent) and multiplied 26 percent times the maximum 35 percent for weakness to equal 9 percent (.26 x 35 percent). This totaled 10 percent for the axillary nerve impairment.

Using the Combined Values Chart, the Office medical adviser combined the 10 percent nerve deficit with the 35 percent range of motion deficit to total 42 percent impairment. As this did not exceed the prior 48 percent schedule award, the medical evidence did not warrant an additional schedule award.

With respect to Dr. Shekhani, the Office medical adviser disagreed with his finding of 80 percent impairment for weakness. The definition in the A.M.A., *Guides* under Table 16-11, page 484, to find 80 percent impairment is "evidence of slight contractibility; no joint movement." The range of motion measurements reported by Dr. Shekhani did not comport with that description.

By decision dated August 12, 2008, the Office denied appellant's claim for an increased schedule award finding that the reports of Drs. Cohen and Shekhani to be insufficient. It relied on the Office medical adviser's rating.

On August 21, 2008 appellant requested an oral hearing before an Office hearing representative, which was held on December 18, 2008.

On January 9, 2009 the Office received a November 6, 2008 report by Dr. David T. Volarich, an examining osteopath, and a December 6, 2008 report from Dr. John S. Daniels, an attending Board-certified internist and appellant's primary care physician. Dr. Daniels concluded that based on appellant's third surgery he should be entitled to a schedule award greater than 47 percent. He reviewed the medical evidence and stated that there was no question that the weakness in appellant's left upper extremity had progressed.

Dr. Volarich found that appellant had a total of 58 percent left arm impairment using the fifth edition of the A.M.A., *Guides*. Using Figure 16-40, Figure 16-43 and Figure 16-46 to find 11 percent impairment for 20 degrees flexion, 2 percent impairment for 15 degrees extension, 7 percent impairment for 20 degrees abduction, 1 percent impairment for 25 degrees adduction, 1 percent impairment for 15 degrees external rotation and 2 percent impairment for 60 degrees internal rotation. Adding these impairments together results in a total 24 percent left upper extremity impairment due to motion loss.

With respect to sensory loss for ulnar neuropathy in the forearm and hand, Dr. Volarich used Table 16-10, page 482. He classified Grade 3 sensory deficit based on distorted tactile sensation of 50 percent. Dr. Volarich applied this grading to Table 16-15, page 492 with reference to the ulnar below forearm nerve loss and multiplied 7 percent by 50 percent to find a

total ulnar nerve sensory deficit of 3.5 percent, which was rounded up to 4 percent. Appellant was also found to have 75 percent sensory deficit due to peripheral nerve impairment. Applying this rating to the maximum sensory loss of the axillary nerve, appellant was found to have 4 percent (.75 x 5 percent) impairment due to axillary nerve palsy.

As to the left upper extremity motor loss, Dr. Volarich used Table 16-11, page 484 where he found a Grade 2 bordering on Grade 1 motor deficit impairment with 75 percent motor deficit, finding no active joint motion. Using Table 16-15, page 492 he multiplied 35 percent for axillary nerve by 75 percent (.75 x 35 percent) to find a total motor loss impairment due to axillary nerve of 26 percent.

Dr. Volarich stated that these measurements did not adequately address the remaining losses to appellant's arm. He used Table 16-34, page 509 to measure the impairment due to atrophy and disuse of the left upper extremity. Dr. Volarich concluded that appellant's index of 58 percent placed him in the mid-category, which represented 20 percent impairment. Adding 24 percent for motor deficit, 32 percent for peripheral nerve involvement and 20 percent for weakness, he found that appellant had 58 percent total left upper extremity impairment.

Dr. Cohen reviewed Dr. Volarich's report and agreed that his rating was more appropriate than Dr. Cohen's previous rating of 69 percent.

On February 23, 2009 the Office hearing representative found the reports by Drs. Cohen, Daniels and Volarich required further review by the Office medical adviser. The Office hearing representative set aside the August 12, 2008 decision and remanded the case to the Office.

On March 10 and May 13, 2009 Dr. Zimmerman reviewed the reports submitted by Drs. Daniels, Cohen and Volarich. By notes dated March 10, 2009, the Office medical adviser reviewed the report of Dr. Volarich. He discounted Dr. Volarich's report by noting that the Office had not accepted an axillary nerve lesion or any ulnar nerve entrapment. The medical adviser stated that, if there was such an entrapment, it had not been treated by any physician and could not be considered to be at maximum medical improvement. Even including the questionable findings of axillary nerve condition of Dr. Volarich's report, Dr. Zimmerman found, using the Combined Values Chart, that 26 percent plus 24 percent plus 4 percent still yielded only 46 percent -- less than the 48 percent already awarded.

On May 13, 2009 Dr. Zimmerman acknowledged that the Office had accepted an axillary nerve condition. He noted, however, that the previous calculations had included the nerve impairment ratings and the award still did not exceed the 48 percent already awarded. Dr. Zimmerman reiterated his opinion that the medical evidence did not establish that appellant had greater than 48 percent impairment of the left upper extremity, for which he received schedule awards.

On June 21, 2009 Dr. Zimmerman was again asked by the Office to review appellant's medical records using the sixth edition of the A.M.A., *Guides*. As of May 1, 2009, the sixth edition was to be utilized to calculate all schedule awards. Dr. Zimmerman noted that the sixth edition was diagnosis based and only one diagnosis was appropriate. He calculated an impairment rating for each accepted condition. Using Table 15-5, page 404 the impairment value for a labral tear could be no more than 5 percent. Using Table 15-5, page 403, appellant's

dislocated shoulder would be Class 3 and the maximum impairment rating is 46 percent. Using the Table 15-21, page 436, the Office medical adviser found the axillary nerve impairment Class 3 and the maximum impairment was 35 percent. Dr. Zimmerman applied Table 15-34, page 475, to find that appellant's range of motion deficits totaled 25 percent left upper extremity as measured by Dr. Volarich. He stated that, in using the sixth edition of the A.M.A., *Guides*, the highest impairment rating was 46 percent and thus does not establish that appellant had more than the 48 percent left upper extremity impairment previously received.

By decision dated July 22, 2009, the Office denied appellant's claim for an additional schedule award.

LEGAL PRECEDENT

The schedule award provision of the Act[3] and its implementing regulations[4] 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 to all claimants, good administrative practice necessitates 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 the implementing regulations as the appropriate standard for evaluating schedule losses.[5] Effective May 1, 2009, the Office adopted the sixth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[6]

After obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the Office medical adviser providing rationale for the percentage of impairment specified.[7]

ANALYSIS

The Board finds that this case is not in posture for decision.

Office procedures provide that, effective May 1, 2009, all schedule awards are to be calculated under the sixth edition of the A.M.A., *Guides*. The Bulletin clarifies that "Any recalculations of previous awards which result from hearings or reconsideration decisions issued on or after May 1, 2009, should be based on the [sixth] edition of the A.M.A., *Guides*." The

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.*

[6] FECA Bulletin No. 09-03 (issued March 15, 2009); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[7] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

Bulletin notes, "a claimant who has received a schedule award calculated under a previous edition and who claims an increased award, will receive a calculation according to the [sixth] edition for any decision issued on or after May 1, 2009."

The Office properly forwarded the case to Dr. Zimmerman to evaluate appellant's claim under the sixth edition. The sixth edition has changed its focus to be more "diagnosis based with these diagnoses being evidence-based when possible."[8] Under Chapter 15, *The Upper Extremities*, the A.M.A., *Guides* states: "Most impairment values for the upper extremity are calculated using the diagnosis-based impairments [(DBI)]."[9] Under section 15.2, the A.M.A., *Guides* explain that "Most impairments are based on the DBI, in which an impairment class is determined by the diagnosis and specific criteria; this is then adjusted by 'non-key' factors (grade modifiers) that may include functional history (FH), physical examination (PE) and clinical studies (CS)…. Alternative approaches are also provided for basing impairment on peripheral nerve deficits, CRPS, amputation and range of motion.... Range of motion ratings cannot be combined with other approaches, with the exception of amputation. Complex regional pain syndrome ratings cannot be combined with other approaches."[10]

Consistent with the sixth edition, Dr. Zimmerman noted that each accepted condition should be evaluated under the DBI method to determine which would allow for the most clinically accurate impairment rating. He cited under section 15.2, "In most cases only one diagnosis will be appropriate."[11] Dr. Zimmerman further referenced that under section 15.3c, "In the shoulder, it is not uncommon for rotator cuff tears, SLAP or other labral lesions and biceps tendon pathology to all be present simultaneously. The evaluator is expected to choose the most significant diagnosis and to rate only that diagnosis using the DBI method that has been described."[12] If CS confirm more than one of those diagnoses, the grade can be modified accordingly.[13]

Using the DBI method, Dr. Zimmerman rated each of appellant's accepted conditions: dislocation of the shoulder, a labral tear and injury to the axillary nerve. For dislocation of the shoulder, the Office medical adviser referred to Table 15-5 on page 405[14] and based on appellant's condition as reported by his physicians classified it as Class 3 where the range of the impairment was from 34 to 46 percent. Although he noted that, as appellant had surgical treatment the range would fall in the middle, he believed it could be as high as 46 percent.

As for the labral tear, again using Table 15-5 on page 404, Dr. Zimmerman noted the maximum rating was five percent.

[8] A.M.A., *Guides*, page 2

[9] *Id*. at 385.

[10] *Id.*

[11] *Id.*

[12] *Id.* at 409.

[13] *Id.*

[14] Although the report lists page 403, it is clear from the A.M.A., *Guides* that it should be page 405.

The axillary nerve injury was evaluated using Table 15-21 on page 436. Due to the seriousness of this injury, Dr. Zimmerman rated it a Class 3, for which the impairment rating ranged from 26 to 35 percent. Because of the limitation on appellant's activities of daily living,[15] the Office medical adviser found that the impairment rating could reach the maximum impairment rating of 35 percent.

The A.M.A., *Guides* also provide for an impairment rating for loss of range of motion. Under section 17.7, however, the sixth edition states: "This section is to be used as a **stand-alone** rating when other grids refer you to this section or when no other diagnosis-based sections of this chapter are applicable for impairment rating of a condition." (Emphasis in the original). Using the range of motion values reported by Dr. Volarich, the Office medical adviser found under Table 15-34 that flexion of 20 degrees equals nine percent impairment; extension of 15 degrees equals two percent impairment; abduction of 20 degrees equals six percent impairment; adduction of 25 degrees equals two percent impairment; internal rotation of 60 degrees equals two percent impairment; and external rotation of 15 degrees equals four percent impairment. This totaled a 25 percent permanent impairment rating for range of motion.

Considering the four different methods for rating impairment, the Office medical adviser determined the highest rating was 46 percent for dislocation of the shoulder. As this was less than the previous schedule award of 48 percent, the Office, by decision dated July 22, 2009, denied appellant's claim for an increased schedule award.

The Board finds, however, that the case is not in posture for decision. Regarding nerve injuries, the A.M.A., *Guides* state: "Peripheral nerve impairment may be combined with DBIs at the upper extremity level as long as the DBI does not encompass the nerve impairment."[16] The A.M.A., *Guides* continue, however, "Characteristic deformities and manifestations resulting from peripheral nerve lesions, such as restricted motion, atrophy and vacomotor, trophic and reflex changes, have been taken into consideration in the estimated impairment values shown in this section. Therefore, when impairment results strictly from a peripheral nerve lesion, no other rating method is applied to this section to avoid duplication or unwarranted increase in the impairment estimation."[17]

The Office medical adviser did not specifically address whether the axillary nerve impairment rating may be combined with the DBI impairment rating of 34 to 46 percent or whether the A.M.A., *Guides* preclude such combination. Under section 2.7 of the A.M.A., *Guides*, an explanation of how the impairment rating was calculated is a crucial part of the sixth edition.[18] It is unclear in this case whether appellant's severe motor limitations results from the axillary nerve impairment would be fully compensated as the DBI rating. "Discussion of how the [A.M.A.,] *Guides'* criteria were applied to medical information that generated the specific

[15] *See* A.M.A., *Guides* page 482-86.

[16] *Id.* at 419.

[17] *Id.* at 423.

[18] *Id.* at 28.

rating is required for an impairment rating to be consistent with the [A.M.A.,] *Guides*."[19] As there was no discussion by the Office medical adviser as to whether these impairment ratings may be combined, the case will be remanded for further clarification.

CONCLUSION

The Board will set aside the Office decision and remand the case for further development consistent with the findings herein.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 22, 2009 is set aside and remanded for further development.

Issued: August 18, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[19] *Id.*