United States Department of Labor
Employees' Compensation Appeals Board

J.M., Appellant	)	
and	)	**Docket No. 11-1681**
	)	**Issued: May 10, 2012**
U.S. POSTAL SERVICE, PROCESSING & DELIVERY CENTER, San Francisco, CA, Employer	)	

Appearances:
Capp. P. Taylor, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

On July 2, 2011 appellant, through his attorney, filed a timely appeal from a February 2, 2011 schedule award decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than 15 percent impairment to his right arm or more than 3 percent impairment to his left arm, for which he received schedule awards.

Appellant, through his attorney, contends that the schedule award ratings were in error because the statement of accepted facts did not list right carpal tunnel syndrome as an accepted condition and therefore it was not rated. He also argued that the evaluation by OWCP's medical adviser was deficient.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On March 17, 2003 appellant, then a 44-year-old mail processor, filed an occupational disease claim alleging an upper extremity and neck condition as a result of keying and doing repetitive work. OWCP accepted brachial neuritis/radiculitis, right rotator cuff syndrome, left carpal tunnel syndrome, cervical radiculopathy and left shoulder rotator cuff syndrome. In another claim, it accepted right carpal tunnel syndrome. The cases were combined into the present master file.[2] On July 27, 2005 appellant underwent an arthroscopic subacromial decompression; arthroscopic debridement of superior synovitis in the rotator interval and anterior shoulder and open acromioclavicular (AC) joint resection.

On September 18, 2009 appellant filed a claim for a schedule award. Dr. Jules P. Steinmitz, a Board-certified physiatrist, evaluated appellant under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2009) (A.M.A., *Guides*) and determined that appellant had a 29 percent right upper extremity impairment and a left upper extremity impairment of 34 percent. He noted accepted conditions of bilateral carpal tunnel; bilateral shoulder impingement; AC joint arthrosis right shoulder; and chronic cervical strain. Dr. Steinmitz evaluated appellant's left wrist as class 3 due to severe sensory loss and combined with motor deficit. He opined that the default impairment is 27 percent of the left upper extremity and that the net adjustment factor is zero and that the final impairment for appellant's left wrist is 27 percent of the left upper extremity. With regard to the right wrist, Dr. Steinmitz found that appellant had a category 2 impairment based on moderate sensory and motor loss with a default impairment of 17 percent and a net adjustment factor of zero, and that therefore the final impairment was 17 percent of the right upper extremity.[3] With regard to his evaluation of the right shoulder, he stated that, due to the accepted condition of AC joint arthroplasty with impingement, this is a class 1 diagnosis with an impairment default at one percent. Dr. Steinmitz noted that the right shoulder has a plus 2 modifying factor based upon physical examination and clinical studies and that functional history was not applicable. He calculated 0+1+1=2, and concluded that the final impairment is 12 percent of the upper extremity impairment on the right according to the A.M.A., *Guides.* In evaluating the left shoulder, Dr. Steinmitz used the range of motion model in the A.M.A., *Guides*,[4] and determined that as flexion is 170 degrees, this equaled a three percent impairment of the upper extremity; as extension is 30 degrees, this equaled a one percent impairment of the upper extremity; and as abduction is 160 degrees, this equaled a three percent impairment of the upper extremity. He stated that remaining motions were not with normal limits and therefore the final impairment was seven percent of the right upper extremity. In summary, Dr. Steinmitz concluded that the combined right upper extremity impairment was 29 percent and the left upper extremity impairment was 34 percent.

[2] OWCP File No. xxxxxx412. OWCP accepted that appellant, then a 36-year-old letter sorter machine operator, sustained right carpal tunnel syndrome due to factors of his federal employment.

[3] A.M.A., *Guides* 438, Table 15-21.

[4] *Id.* at 475, Table 15-34.

On May 11, 2010 OWCP referred appellant's claim to OWCP's medical adviser for determination of an impairment rating for schedule award purposes. The medical adviser stated that he did not see a report of the physical examination accompanying Dr. Steinmitz's rating and that it did not appear to be correct. He recommended a second opinion evaluation.

On June 17, 2010 OWCP referred appellant to Dr. Alan B. Kimelman, a Board-certified physiatrist, for a second opinion. In making the referral, it noted in the statement of accepted facts that the accepted conditions were cervical radiculopathy, bilateral shoulder impingement syndrome/strain; and left carpal tunnel. The statement of accepted facts noted that appellant had another case that was accepted for right carpal tunnel syndrome. In a July 15, 2010 report, Dr. Kimelman found that for the left upper extremity appellant had a 32 percent impairment and that, for the right upper extremity, appellant had 36 percent impairment. For the right upper extremity, he noted that appellant had a class 2 impairment based on range of motion of 22 percent pursuant to the A.M.A., *Guides*.[5] Dr. Kimelman noted grade modifiers which yielded 23 percent impairment for range of motion limitation. With regard to the combined impairment for peripheral nerves of the right upper extremity, he noted impairment for the right shoulder based on class 1 which equaled an impairment of three percent to which he added modifiers of 2 to yield an impairment of five percent.[6] Dr. Kimelman diagnosed an impairment for right brachial plexus motor deficit by noting a class 1 rating based on mild motor deficit which would merit 9 percent rating, which he adjusted upwards with grade modifiers to equal 13 percent impairment.[7] He combined the 13 percent impairment for right brachial plexus motor deficit and the 5 percent for the right shoulder and determined that appellant had an impairment of the combined peripheral nerves of 17 percent. Combining the 17 percent impairment rating for combined peripheral nerves with the 23 percent impairment for range of motion yielded an impairment rating of the right upper extremity of 36 percent. With regard to the left upper extremity, Dr. Kimelman noted an impairment based on range of motion based on class 2 due to residual loss which yielded 17 percent impairment which he adjusted upward with grade modifiers to yield an 18 percent impairment based on range of motion.[8] He also noted an impairment based on peripheral nerves of 17 percent. In reaching this conclusion, Dr. Kimelman noted impairment based on the left shoulder due to a class 1 ranking which yielded three percent impairment which he adjusted upward based on grade modifiers to yield five percent impairment.[9] With regard to the left brachial plexus sensory deficit, he reached his calculations based on class 1 impairment which would yield a three percent impairment,[10] which he adjusted upward to five percent based on grade modifiers. With regard to left brachial plexus motor deficit, Dr. Kimelman noted a class 1 impairment which would be 9 percent,[11] which he adjusted upward with grade modifiers

[5] *Id.*

[6] *Id.* at 402, Table 15-5.

[7] *Id.* at 434, Table 15-20.

[8] *Id.* at 475, Table 15-34; 406.

[9] *Id.* at 402, Table 15.5.

[10] *Id.* at 434, Table 15-20

[11] *Id.*

to equal 13 percent. He then added one percent impairment for diagnosis-based impairment for the left wrist.[12] Combining the 17 percent impairment for peripheral nerves with the 18 percent for range of motion, Dr. Kimelman concluded that appellant had 32 percent impairment of the left upper extremity. In making his calculations, he did not rate appellant for right carpal tunnel syndrome, as he noted that this condition was not accepted by OWCP.

On November 7, 2010 OWCP's medical adviser reviewed the report of the second opinion physician. He determined that the total impairment of the right upper extremity equaled 15 percent and the left upper extremity equaled 3 percent. The medical adviser noted that the diagnosis-based estimate for left shoulder impingement syndrome based on class 1 was 10 percent. He increased this by 2 percent based on grade modifiers to equal an impairment of 12 percent. The medical adviser noted a diagnosis-based estimate for left shoulder impingement syndrome class 1 was one percent, which he adjusted upward with grade modifiers to equal an impairment of two percent.[13] He noted an impairment for right carpal tunnel syndrome of three percent.[14] The medical adviser found the combined rating for impairment to the right upper extremity was 15 percent. With regard to the left upper extremity, he noted diagnosis-based estimate for left shoulder impingement syndrome based on class 1 default position of one percent modified upward with grade modifiers to equal an impairment of two percent.[15] The medical adviser added an impairment rating due to left carpal tunnel syndrome of one percent.[16] Combining these figures, he determined that appellant had an impairment rating to his left upper extremity of three percent. The medical adviser differed from Dr. Kimelman in that he did not believe an impairment rating for left brachial plexus deficit was merited. He also disagreed with Dr. Kimelman's ratings with regard to range of motion.

On February 2, 2011 OWCP issued a schedule award for 15 percent right upper extremity impairment and 3 percent left upper extremity impairment.

LEGAL PRECEDENT

An employee seeking compensation under FECA has the burden of establishing the essential elements of his claim, including that he sustained an injury in the performance of duty as alleged and that an employment injury contributed to the permanent impairment for which schedule award compensation is alleged.[17]

The medical evidence required to establish a causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a

[12] *Id.* at 395, Table 15.3.

[13] *Id.* at 402, Table 15-5.

[14] *Id*. at 449, 15-23.

[15] *Id.* at 402, Table 15-5.

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

[17] *See S.S.*, Docket No. 10-1536 (issued March 18, 2011) (the Board found that appellant was not entitled to a schedule award as he did not establish that he sustained a permanent impairment causally related to his work injury).

physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[18]

The schedule award provision of FECA[19] and its implementing regulations[20] 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[21] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[22]

ANALYSIS

OWCP accepted appellant's claim for brachial neuritis/radiculitis, right rotator cuff syndrome, left carpal tunnel syndrome, cervical radiculopathy and left shoulder rotator cuff syndrome. Furthermore, it accepted appellant's claim for right carpal tunnel syndrome in an earlier case.

OWCP's medical adviser noted that Dr. Steinmitz, appellant's treating physician, did not base his findings on a recent medical evaluation. OWCP referred appellant for a second opinion with Dr. Kimelman.[23] Dr. Kimelman rated appellant with left upper extremity impairment of 32 percent and a right upper extremity impairment of 36 percent. The medical adviser reviewed Dr. Kimelman's opinion, and determined that appellant had 15 percent impairment of the right upper extremity and 3 percent impairment of the left upper extremity. It issued its schedule award decision based on the opinion of the medical adviser.

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

OWCP determined that appellant was entitled to 15 percent impairment to his right upper extremity. In evaluating appellant under the diagnosis-based impairment criteria, Dr. Kimelman used Table 15-5 of the A.M.A., *Guides,* and found that as appellant had a class 1 impairment, the default impairment rating was three percent. This rating is for residual loss, functional with normal motion. The medical adviser utilized the default impairment rating for status post distal clavicle resection or AC separation type 3, which is a default rating of 10 percent. Both

[18] *Victor J. Woodhams*, 41 ECAB 345, 351-52 (1989).

[19] 5 U.S.C. § 8107.

[20] 20 C.F.R. § 10.404.

[21] *Id.*

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

[23] *See generally*, 20 C.F.R. § 10.320.

Dr. Kimelman and the medical adviser adjusted the grade modifiers upward by 2. However, with regard to right carpal tunnel syndrome, Dr. Kimelman erroneously believed that he was not to make a rating. The case should be remanded to Dr. Kimelman to allow him the opportunity to determine a rating based on right carpal tunnel syndrome.

OWCP determined that appellant had three percent impairment to his left upper extremity. With regard to the diagnosis-based impairment of the left shoulder, using Table 15-5 of the A.M.A., *Guides*,[24] Dr. Kimelman indicated that appellant had five percent impairment whereas OWCP's medical adviser found three percent impairment. The difference between the two physicians is on the default position that starts the calculation, as both agree that grade modifiers will increase the rating by two percent. Pursuant to Table 15-5 of the A.M.A., *Guides*,[25] Dr. Kimelman used the default position of 3, which is described as residuals loss, functional with normal motion. The medical adviser used the default position of 1, which is described as history of painful injury, residual symptoms without consistent objective findings. The medical adviser did not explain why he used this as the default position, which is different from the second opinion physician who conducted an examination. Therefore, further clarification is required from the medical adviser on this matter. With regard to left carpal tunnel syndrome, Dr. Kimelman found zero percent impairment rating. However, the medical adviser found that appellant had one percent upper extremity impairment for left carpal tunnel syndrome. He noted that, pursuant to A.M.A., *Guides* Table 15-23, the test findings are grade modifier 1, history is modifier 1 and physical findings are modifier 0, which is an average grade modifier of 67 or 1. Then, using the functional scale value 1, mild as a modifier, he set the upper extremity impairment as one percent. OWCP properly evaluated appellant's impairment with regard to left carpal tunnel syndrome. With regard to left brachial plexus deficit, Dr. Kimelman found a right brachial plexus sensory deficit of five percent utilizing Table 15-20 of the A.M.A., *Guides*.[26] He found a right brachial plexus motor deficit of 13 percent. Utilizing the same table, Dr. Kimelman found 5 percent impairment for left brachial plexus sensory deficit and 13 percent impairment for left brachial plexus motor deficit. The medical adviser objected to these findings. He noted that Dr. Kimelman noted that the deficits were difficult to discern and the objective testings were normal or showed no specific deficit. The medical adviser stated that it did not seem reasonable to use this as a rating factor. Furthermore, the medical adviser objected to Dr. Kimelman's use of range of motion rating for the shoulders as he noted limited pain. The Board notes that the diagnosis-based approach is the preferred method of evaluating permanent impairment under the sixth edition of the A.M.A., *Guides*.[27] However, if the medical adviser had questions with regard to the rating, he should have asked Dr. Kimelman for a clarification.

While appellant bears the burden of establishing his entitlement to FECA benefits, OWCP shares responsibility in the development of the evidence to see that justice is done.[28]

[24] *Id.* at 407.

[25] *Id.* at 403.

[26] *Id.* at 434.

[27] *Id.* at 461, section 15.7.

[28] *C.M.*, Docket No. 11-1234 (issued January 11, 2012).

Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[29] Accordingly, this case will be remanded for clarification from Dr. Kimelman. After OWCP has developed the case record to the extent it deems necessary, a *de novo* decision shall be issued.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the February 2, 2011 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded for further proceedings consistent with this decision of the Board.

Issued: May 10, 2012
Washington, DC

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

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

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

[29] *Richard F. Williams*, 55 ECAB 343, 346 (2004).