United States Department of Labor
Employees' Compensation Appeals Board

R.T., Appellant	)	
and	)	**Docket No. 07-2164**
	)	**Issued: June 6, 2008**
DEPARTMENT OF TRANSPORTATION, FEDERAL AVIATION ADMINISTRATION, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 21, 2007 appellant, through counsel, filed a timely appeal from an August 6, 2007 decision of the Office of Workers' Compensation Programs denying an increased schedule award for his right upper extremity. 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 has more than a 20 percent impairment of the right upper extremity, for which he received a schedule award. On appeal, his counsel contends that there is an unresolved conflict in the medical opinion evidence.

FACTUAL HISTORY

On January 21, 1998 appellant, then a 46-year-old maintenance mechanic, filed a traumatic injury claim alleging that he dislocated his right shoulder, bruised his right leg and shin and bruised the left side of his face on that date when a dumpster he was loading fell over. The

Office accepted the claim for fractured right shoulder humerus, left shoulder overuse syndrome and right leg tibia sprain and authorized right shoulder arthroscopy, which was performed on February 24, 1999. Appellant stopped work on January 21, 1998 and was placed on the periodic rolls for temporary total disability. The Office subsequently expanded his claim to include the condition of right brachial plexopathy.[1]

On July 17, 2003 Dr. Nicholas P. Diamond, an examining Board-certified osteopathic physician specializing in pain management, diagnosed multiple levels cervical spinal stenosis/spondylosis with C5-6 degeneration, status post C5-6 anterior cervical discectomy and fusion, post-traumatic glenoid shoulder labral tear, status post arthroscopy and "derivative aggravation of left shoulder superimposed over old pathology due to overuse of compensatory situation." A physical examination revealed periscapular tenderness and pain with range of motion. Range of motion for the right shoulder included 90 degrees of forward elevation, 90 degrees of abduction, 55 degrees of cross-over adduction and 90 degrees of external rotation. Using a Jamar Hand Dynameter, Dr. Diamond found that appellant had 20 kilograms of force strength for the right hand at Level 3. For the right upper extremity, he found that appellant had a 20 percent impairment under Tables 16-32 and 16-34 on page 509 of the fifth edition American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] for grip strength deficit; a six percent impairment under Figure 16-40, page 476 for right shoulder flexion, a four percent impairment under Figure 16-43, page 477 for decreased abduction and a three percent impairment under Figure 18-1 on page 574 for pain. Dr. Diamond concluded that appellant had an 31 percent impairment of his right upper extremity using the Combined Values Chart. He combined the 6 and 4 percent values to equal 10 percent, then adding the 20 percent to equal 28 percent and then adding the 3 percent value. Dr. Diamond indicated that appellant reached maximum medical improvement on July 17, 2003.

On October 27, 2003 appellant filed a claim for a schedule award.

On November 6, 2003 the Office medical adviser concluded that appellant had a 22 percent impairment of the right upper extremity and a 5 percent impairment of the left upper extremity. Using the A.M.A., *Guides* (5th ed. 2001), the Office medical adviser found that appellant had a 6 percent impairment for 90 degrees elevation, 4 percent impairment for 90 abduction, a 10 percent impairment for decreased grip and 3 percent impairment for pain.

By decision dated August 31, 2004, the Office granted a schedule award for a 22 percent impairment of the right upper extremity. The award ran from July 17, 2003 to November 8, 2004 for 68.64 weeks.

On September 7, 2004 appellant's counsel requested a hearing before an Office hearing representative.

[1] On August 4, 2000 the Office of Personnel Management approved appellant's application for a disability retirement. On April 30, 2003 appellant elected to receive retirement benefits from the Office of Personnel Management effective May 31, 2003.

[2] Hereinafter A.M.A., *Guides*.

In an October 15, 2004 addendum report, Dr. Diamond noted that his agreement with the Office medical adviser regarding the range of motion determination. However, he disagreed with the Office medical adviser on the grip strength deficit. In support of his opinion, Dr. Diamond stated:

> "I have used the formula as per Table 16-32 and 16-34 on page 509. According to Table 16-32 on page 509 it is noted that a 51[-]year-old male grip strength in the dominant side should be 45.9; 45.9 minus 20 divided by 45.9 would then equate to a 20 [percent] upper extremity impairment secondary to grip strength deficit."

By decision dated May 31, 2005, the Office hearing representative found that Dr. Diamond's supplemental report was sufficient to warrant further development. She set aside the October 15, 2004 decision and remanded the case for further development.

On September 15, 2005 the Office medical adviser opined: "[t]here is some rationale for Dr. Diamond's use of the 'Normal Grip Strength' tables for different age groups." The Office medical adviser stated that he believed "the 10 percent grip strength on the r[igh]t is accurate."

By decision dated September 29, 2005, the Office denied appellant's request for an additional schedule award.

By letter dated October 4, 2005, appellant's counsel requested an oral hearing before an Office hearing representative, which was held on February 8, 2006.

In a decision dated March 28, 2006, the Office hearing representative affirmed the denial of appellant's request for an increased schedule award. The Office hearing representative found that the Office medical adviser's opinion constituted the weight of the evidence. He also rejected appellant's contention that the Office erred in failing to include his cervical surgery when calculating the upper extremity impairment as the surgery was neither employment related nor authorized by the Office.

Appellant disagreed with the March 28, 2006 decision and filed an appeal with the Board. On June 27, 2007 the Board set aside and remanded the case as the record on appeal was incomplete.[3]

By decision dated August 6, 2007, the Office denied appellant's request for an increased schedule award for his right upper extremity.[4]

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[3] Docket No. 06-2091 (issued June 27, 2007).

[4] The Board notes the Office the record contains no final decision by the Office on appellant's left upper extremity impairment.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[5] and section 10.404 of the implementing federal regulations,[6] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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*[7] has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[8]

Proceedings under the Act are not adversary in nature, nor is the Office a disinterested arbiter.[9] While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[10] Accordingly, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[11]

ANALYSIS

The Office accepted that appellant sustained fractured right shoulder humerus, left shoulder overuse syndrome and right leg tibia sprain and right brachial plexopathy. He received a schedule award for a 22 percent impairment of his right upper extremity.

On November 6, 2003 an Office medical adviser calculated that appellant had a 22 percent impairment of his right upper extremity. The Office granted a schedule award based on the impairment rating of the Office medical adviser. The Board finds, however, that this rating is of diminished probative value because it was not derived in accordance with the A.M.A., *Guides*.[12]

The Office medical adviser determined that appellant was entitled to a 10 percent impairment rating for right grip strength deficit, but did not reference the applicable tables he

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.,* 53 ECAB 331 (2002).

[8] 20 C.F.R. § 10.404.

[9] *Rebecca O. Bolte*, 57 ECAB 687 (2006).

[10] *William B. Webb*, 56 ECAB 156 (2004); *Russell F. Polhemus*, 32 ECAB 1066 (1981).

[11] *Peter C. Belking*, 56 ECAB 580 (2005); *see Robert F. Hart*, 36 ECAB 186 (1984).

[12] *See Carl J. Cleary*, 57 ECAB 563 (2006); *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding that an opinion which is not based upon the standards adopted by the Office and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's impairment).

was utilized in his rating.[13] The A.M.A., *Guides* provides that a strength evaluation under these tables should only be included in the calculation of an upper extremity impairment if such a deficit has not been considered adequately by other impairment rating methods.[14] The Office medical adviser provided no explanation of why the identified strength impairment in this case could not be adequately considered by the other impairment rating methods for the upper extremity. Therefore, he has not properly assessed appellant's strength deficits under the A.M.A., *Guides*. For this reason, it was not appropriate to base the granting of appellant's schedule award on the opinion of the Office medical adviser.

The record also contains a July 17, 2003 report in which Dr. Diamond, an examining physician, determined that appellant had a 31 percent impairment of his right upper extremity and a 4 percent impairment of his left upper extremity. However, his impairment rating is of diminished probative value because it was not derived in accordance with the A.M.A., *Guides*. Dr. Diamond found that appellant had 20 percent impairment under Tables 16-32 and 16-34 of the A.M.A., *Guides* for right grip strength deficit. However, he did not provide any explanation of why the identified strength impairment could not be adequately considered by the other impairment rating methods.

As noted above, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[15] Appellant's impairment has not been adequately evaluated in accordance with the relevant standards of the A.M.A., *Guides*. The case will be remanded to the Office for further development of the medical evidence. After such further development as the Office deems necessary, it should issue an appropriate decision regarding appellant's claim.

CONCLUSION

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

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[13] *See* A.M.A., *Guides* 509, Tables 16-32 and 16-34.

[14] The A.M.A., *Guides* provides that an example of an impairment that would not be adequately considered by other rating methods would be loss of strength caused by a severe muscle tear that healed leaving a palpable muscle defect. If the rating physician determines that loss of strength should be rated separately in an extremity that presents other impairments, the impairment due to loss of strength could be combined with the other impairments, only if based on unrelated etiologic or pathomechanical causes. Otherwise, the impairment ratings based on objective anatomic findings take precedence. (Emphasis in the original.) The A.M.A., *Guides* further provides that decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximum force. A.M.A., *Guides* 508, section 16.8a. *See also* FECA Bulletin No. 01-05 (issued January 29, 2001) regarding the limited use of grip strength to measure weakness.

[15] *See supra* notes 9 and 10 and accompanying text.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 6, 2007 is set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: June 6, 2008
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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