# United States Department of Labor
# Employees' Compensation Appeals Board

| | | |
|---|---|---|
| **A.H., Appellant** | ) | |
| **and** | ) | **Docket No. 09-2288** |
| | ) | **Issued: July 12, 2010** |
| **DEPARTMENT OF HOMELAND SECURITY, U.S. SECRET SERVICE, Washington, DC, Employer** | ) | |

*Appearances:*
*Alan J. Shapiro, 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
JAMES A. HAYNES, Alternate Judge

### *JURISDICTION*

On September 14, 2009 appellant, through counsel, filed a timely appeal from an August 14, 2009 merit decision of the Office of Workers' Compensation Programs' hearing representative. 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 established a greater than one percent impairment of the left upper extremity, for which he received a schedule award.

### *FACTUAL HISTORY*

On February 28, 2007 appellant, then a 37-year-old special agent, filed a traumatic injury claim alleging that on February 21, 2007 he hyperextended his left elbow during training. The Office accepted the claim for left elbow ulnar collateral ligament strain. It authorized surgery for

left elbow reconstruction of the medial ligament and ulnar nerve transposition, which occurred on August 18, 2007.

On August 7, 2008 Dr. David M. Gallatin, a treating Board-certified internist, noted that appellant was doing well following his ulnar nerve transition and left elbow ulnar collateral ligament reconstruction surgery. A physical examination revealed a positive Tinel's sign, normal ulnar, median and radial nerve distribution, 2+ palpable radial pulse, 5/5 intrinsic strength and palpable ulnar nerve in subcutaneous transposed position.

On September 24, 2008 appellant filed a claim for a schedule award.

In a January 4, 2009 report, Dr. Lawrence A. Manning, an Office medical adviser, concluded that appellant had one percent left upper extremity impairment. Using Table 16-10, page 482 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (fifth edition), he stated that appellant had a Grade 4 sensory loss due to minor intermittent ulnar nerve symptoms resulting in 10 percent impairment. Next, Dr. Manning multiplied 10 percent by 7 percent ulnar nerve sensory deficit above the midforearm using Table 16-15, page 492, which resulted in a 0.7 percent left upper extremity impairment, which he rounded up to one percent. He found August 7, 2008 to be the date of maximum medical improvement, which he noted was approximately one year post left elbow surgery and was also the date appellant was released from treatment by his physician to return as needed.

In a decision dated January 27, 2009, the Office granted appellant a schedule award for one percent permanent impairment of the left upper extremity. The award ran for 3.12 weeks for the period August 7 to 28, 2008.

On February 18, 2009 appellant's counsel requested a telephonic hearing before an Office hearing representative, which was held on June 1, 2009.

Following the hearing, appellant submitted a July 8, 2009 evaluation performed by Dr. Stuart J. Goodman, a Board-certified neurologist, using the sixth edition of the A.M.A., *Guides*. Dr. Goodman concluded that appellant had five percent left upper extremity impairment using Table 15-21, page 443 of the sixth edition of the A.M.A., *Guides*. He reported plantar responses as flexor. Appellant related experiencing pain and tingling in the left arm involving the small and ring finger and discomfort with position change. Dr. Goodman found appellant had residual sensory deficit and neuritis of the ulnar nerve as a result of his accepted employment injury. A physical examination revealed a positive Tinel's sign and decreased sensation in the ulnar distribution.

By decision dated August 14, 2009, the Office hearing representative affirmed the January 27, 2009 schedule award. He found the weight of the evidence rested with the Office medical adviser's opinion. The Office hearing representative further found that Dr. Goodman's opinion was of diminished probative value as the physician failed to provide measurements or calculations in support of his conclusion.

## ***LEGAL PRECEDENT***

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulations[2] 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 regulation as the appropriate standard for evaluating schedule losses.[3] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[4]

## ***ANALYSIS***

The Office accepted the claim for left elbow ulnar collateral ligament strain and authorized left elbow reconstruction of the medial ligament and ulnar nerve transposition surgery. The January 27, 2009 schedule award was based on the assessment of appellant's left upper extremity by Dr. Manning, an Office medical adviser. The Board finds that this case is not in posture for a decision because the opinion of the Office medical adviser is insufficient to establish appellant's permanent impairment rating.

To determine appellant's impairment rating, Dr. Manning, an Office medical adviser, reviewed the evidence, concluded that appellant had a one percent left upper extremity impairment. He noted that Table 16-15, page 492, provided a maximum upper extremity sensory deficit of the ulnar nerve as seven percent. Applying this percentage to Table 16-10, page 482, Dr. Manning found that appellant's 10 percent sensory deficit yielded a left arm sensory impairment of 0.70 percent due to sensory deficit, which when rounded up yields 1 percent impairment.[5]

The Board had held that, in schedule award cases where an examining physician has provided a description of physical findings but failed to properly apply the A.M.A., *Guides*, a detailed opinion by the Office medical adviser giving an impairment rating based on the reported

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

[3] *Id. See C.J.*, 60 ECAB ___ (Docket No. 08-2429, issued August 3, 2009); *Billy B. Scoles*, 57 ECAB 258 (2005).

[4] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003). As of May 1, 2009, the sixth edition will be used. FECA Bulletin No. 09-03 (issued March 15, 2008). *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[5] The policy of the Office is to round the calculated percentage of impairment to the nearest whole number. *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3b (January 2010). Fractions are rounded up from .50. *See also J.P.*, 60 ECAB ___ (Docket No. 08-832, issued November 13, 2008); *Carl J. Cleary*, 57 ECAB 563 (2006).

findings and the A.M.A., *Guides* may constitute the weight of the medical evidence.[6] The Office procedures state that, when an Office medical adviser explains his opinion, shows values and computation of impairment based on the A.M.A., *Guides* and considers each of the reported findings of impairment, his opinion may constitute the weight of the medical opinion evidence.[7]

The Board finds that the impairment rating provided by the Office medical adviser is not sufficiently rationalized to constitute the weight of medical opinion.[8] When determining the left arm rating, the Office medical adviser provided no explanation for assigning a 10 percent sensory deficit to appellant's ulnar nerve. Without adequate rationale, the Office medical adviser's medical opinion is of diminished probative value.[9] The Board finds that the impairment rating provided by the Office medical adviser is an insufficient basis upon which to base the Office's schedule award.

Following the telephonic hearing, appellant submitted a July 8, 2009 evaluation by Dr. Goodman based on the sixth edition of the A.M.A., *Guides*. Under the sixth edition of the A.M.A., *Guides*, impairments of the upper extremities are covered by Chapter 15. Section 15-2, entitled diagnosis-based impairment, indicates that "Diagnosis-based impairment is the primary method of evaluation of the upper limb."[10] The initial step in the evaluation process is to identify the impairment class by using the corresponding diagnosis-based regional grid. Dr. Goodman concluded that appellant had five percent left upper extremity impairment using Table 15-21, page 443. While he provided physical findings of residual sensory deficit and neuritis of the ulnar nerve, positive Tinel's sign and decreased sensation in the ulnar distribution, he did not identify either the class or grade for appellant's sensory loss. Dr. Goodman did not adequately explain how he arrived at his conclusion. He did not refer to any grade or class for appellant's sensory loss or note whether the sensory impairment was mild or moderate to support his findings. Thus, Dr. Goodman did not adequately explain how he derived the impairment rating for sensory loss within the range of values shown in Table 15-21. As such, the impairment rating made by Dr. Goodman is of diminished probative value.

On remand, the Office should conduct the medical development necessary to determine the permanent impairment of appellant's left upper extremity in accordance with the appropriate edition of the A.M.A., *Guides*.[11] Following such development, the Office shall issue a *de novo* decision on appellant's schedule award.

---

[6] *J.Q.*, 59 ECAB ___ (Docket No. 06-2152, issued March 5, 2008); *Linda Beale*, 57 ECAB 429 (2006).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(h) (April 1993). *See also Tommy R. Martin*, 56 ECAB 273 (2005).

[8] See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (January 2010) (as a matter of course, the Office medical adviser should provide rationale for the percentage of impairment specified ).

[9] *See* A.M.A., *Guides* 482 (5th edition) (method for determining impairment ratings).

[10] *Id.* at 387, Section 15.2 (6th edition).

[11] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Reconsiderations*, Chapter 2.1602.5b (January 2004).

## ***CONCLUSION***

The Board finds that this case is not in posture for a decision because the opinion of the Office medical adviser is insufficient to establish appellant's permanent impairment rating. The case is remanded for further medical development followed by an appropriate decision.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated August 14, 2009 is set aside and the case remanded for further proceedings consistent with the above opinion.

Issued: July 12, 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