United States Department of Labor
Employees' Compensation Appeals Board

R.S., Appellant	)	
and	)	**Docket No. 10-255**
	)	**Issued: November 29, 2010**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, 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:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 3, 2009 appellant filed a timely appeal from an August 6, 2009 schedule award decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination in this case.

ISSUE

The issue is whether appellant has more than a three percent impairment of the left upper extremity for which she received a schedule award and whether she has any ratable impairment of the right upper extremity or either lower extremity.

On appeal, appellant's attorney asserts that a conflict in medical opinion exists between her attending physician and the Office medical adviser.

FACTUAL HISTORY

On May 16, 2003 appellant, then a 51-year-old nurse case manager, was struck by a van while crossing the street to attend a meeting at the employing establishment nursing home. She stopped work. The Office accepted her claim for a concussion without loss of consciousness, left shoulder adhesive capsulitis, left shoulder disorder of the bursa and tendons, other derangements of the left shoulder, cervical strain, cervical herniated disc and lumbar strain. Appellant was placed on the periodic compensation rolls. On March 8, 2006 Dr. Todd Schwartz, a Board-certified osteopath practicing orthopedic surgery, performed left shoulder arthroscopy with subacromial decompression and debridement of a tear of the posterosuperior labrum.[1] Appellant was referred for vocational rehabilitation and elected to retire effective June 20, 2007.[2]

On August 25, 2008 appellant filed a schedule award claim and submitted a May 29, 2008 report from Dr. Nicholas Diamond, an osteopath, who reviewed the history of injury, medical records and noted appellant's complaint of neck, upper and lower extremity pain with numbness and weakness. Dr. Diamond advised that she could no longer perform activities of daily living including household chores and had difficulty with self-care. On physical examination, he noted tenderness and decreased range of motion in the cervical spine, both shoulders and lumbar spine. Dr. Diamond provided results of grip and pinch key testing and advised that manual muscle strength of the upper and lower extremities tested at 4+/5, bilateral upper extremity sensory examination was normal and that she had thigh atrophy on the left. He diagnosed: left L3-4 herniated nucleus pulposus; L4-5 disc bulging with spondylosis; bulging discs at C3 through C7; post-traumatic shoulder impingement syndrome with posterior and superior labral tear; status post left shoulder arthroscopy with posterosuperior labral debridement and subacromial decompression; post-traumatic left C5-6 radiculopathy; post-traumatic left ulnar nerve (cubital tunnel) syndrome at the elbow; post-traumatic left L5 radiculopathy; post-traumatic cephalgia; post-traumatic left acromioclavicular joint arthritis; and post-traumatic right shoulder subacromial/subdeltoid bursitis and clavicular osteolysis.

Under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[3] appellant had 32 percent left arm impairment. This was comprised of 2 percent impairment for loss of left shoulder range of motion, 10 percent impairment due to resection arthroplasty, 20 percent impairment due to grip strength deficit and 3 percent pain-related impairment. Dr. Diamond found four percent right arm impairment due to one percent loss of shoulder flexion and three percent pain-related impairment. He rated left leg impairment of six percent based on three percent left thigh atrophy and three percent impairment due to pain. The impairment to the right leg was rated as three percent due to a pain.

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[1] In February 2007, a third-party claim was settled.

[2] In a November 29, 2007 decision, the Office found that appellant had the wage-earning capacity of a nurse consultant. By decision dated December 7, 2007, an Office hearing representative found that an overpayment in compensation in the amount of $11,065.18 had been created because proper deductions were not made for appellant's health insurance. Appellant was found not at fault, but not entitled to waiver because her income exceeded her expenses by $610.00 a month. The overpayment was repaid in full.

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

On September 6, 2008 Dr. Arnold T. Berman, an Office medical adviser Board-certified in orthopedic surgery, reviewed the medical record. He disagreed with the impairment ratings of Dr. Diamond as the surgical report did not indicate that appellant underwent a resection arthroplasty of the left clavicle and would not be entitled to an impairment rating on that basis.[4] Dr. Berman noted that under the A.M.A., *Guides* strength loss cannot be rated in the presence of decreased motion. Further, no right upper extremity condition had been accepted by the Office and there was not work-related etiology to explain the finding of left thigh atrophy. Dr. Diamond did not provide any explanation regarding the three percent pain-related impairments attributed to each extremity under Chapter 18. Dr. Berman advised that under Figure 16-40 of the fifth edition of the A.M.A., *Guides*, appellant had one percent impairment for 160 degrees of flexion; under Figure 16-43, one percent impairment for 150 degrees of abduction; and under Table 16-46, one percent impairment for 75 degrees of internal rotation. This totaled three percent impairment of the left arm.

In a March 3, 2009 decision, the Office granted appellant a schedule award for three percent impairment of the left upper extremity to run from May 29 to August 2, 2008.

Appellant, through her attorney, timely requested a hearing that was held on June 10, 2009. She testified that in 1990 she injured her left knee and had surgery while working at Temple University. Appellant described the May 16, 2003 employment injury, subsequent medical care and her current condition. It was argued that the report of Dr. Diamond should represent the weight of medical opinion.[5]

In an August 6, 2009 decision, an Office hearing representative affirmed the March 3, 2009 schedule award.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[6] 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

[4] The Board notes that Dr. Berman misidentified Dr. Diamond as Dr. Rodriguez in his report. A close reading of the report, however, clearly indicates that Dr. Berman was referring to Dr. Diamond's report.

[5] On July 20, 2009 counsel stated that she was forwarding a July 10, 2009 report from Dr. Diamond; however, the report is not presently of record.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id*. at § 10.404(a).

to calculate schedule awards.[9] For decisions issued after May 1, 2009, the sixth edition will be used.[10]

Office procedures provide that, 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.[11]

ANALYSIS

The Board finds that appellant has no more than three percent impairment of her left arm, for which she received a schedule award.

Regarding the left upper extremity, Dr. Diamond rated 10 percent impairment for left shoulder resection arthroplasty; however, Table 16-27 of the fifth edition of the A.M.A., *Guides* provides that the distal clavicle must be resected for such an impairment rating.[12] Appellant's March 8, 2006 operative report noted that subacromial decompression and debridement of a tear of the posterior labrum were performed, not a distal clavicle resection. Dr. Diamond did not sufficiently address how such surgical procedure warranted the impairment rating he assigned under Table 16-27. He rated 20 percent impairment for grip strength deficit; but the A.M.A., *Guides* do not encourage the use of grip strength for impairment ratings because strength measurements are functional tests influenced by subjective factors that are difficult to control and the A.M.A., *Guides* is based on anatomic impairment. The A.M.A., *Guides* do not assign a large role to loss of grip strength measurements. Only in rare cases should grip strength be used and only when it represents an impairing factor that has not been otherwise considered adequately.[13] Dr. Diamond did not adequately explain the 20 percent grip strength rating in light of the provisions of section 16.8 in strength evaluation. Without sufficient explanation or rationale, this impairment rating is of diminished probative value.[14]

On September 6, 2008 Dr. Berman reviewed Dr. Diamond's report and rated impairment to the left arm based on loss of range of motion deficits. There was one percent impairment for 160 degrees of left shoulder flexion under Figure 16-40,[15] one percent impairment for 150

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

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

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

[12] A.M.A., *Guides*, *supra* note 3 at 506.

[13] *Mary L. Henninger*, 52 ECAB 408 (2001).

[14] *James R. Taylor*, 56 ECAB 537 (2005).

[15] A.M.A., *Guides*, *supra* note 3 at 476.

degrees of adduction under Figure 16-43[16] and one percent impairment due to 75 degrees of internal rotation under Figure 16-46.[17] This totaled three percent impairment of the left arm.

The Board notes that appellant has no accepted right upper extremity condition; however, her claim was accepted for a cervical strain and cervical herniated disc. Although the A.M.A., *Guides* include guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under the Act for injury to the spine.[18] 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. 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 originates in the spine.[19] Dr. Diamond assigned 10 percent impairment due to loss of right shoulder flexion; but he did not address how this loss of range of motion was caused by appellant's accepted cervical condition. He did not provide an analysis under section 16.5 of the A.M.A., *Guides*[20] or explain how such loss was contributed to by cervical radiculopathy. The medical evidence of record is not sufficient to support impairment to appellant's right arm due to the injury accepted in this claim.

Dr. Diamond rated left leg impairment due to left thigh atrophy, appellant has no accepted lower extremity condition. Appellant claim was accepted for a lumbar strain and, as noted, she may be entitled to a schedule award for permanent impairment to a lower extremity even though the cause of the impairment originates in the spine.[21] Section 17.2 of the A.M.A., *Guides* provides that anatomic changes, including atrophy are properly assessed in physical examination, supported by clinical studies.[22] Dr. Diamond provided gastrocnemius and quadriceps circumferential measurements. He did not explain how the accepted lumbar strain or lumbar radiculopathy would contribute to left thigh atrophy.[23] Appellant has not established this impairment of her left leg with probative medical opinion.[24]

Dr. Diamond also assessed pain to all four extremities under Chapter 18. The Board notes that the fifth edition of the A.M.A., *Guides* allows for an impairment percentage to be

[16] *Id*. at 477.

[17] *Id*. at 479.

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

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

[20] A.M.A., *Guides*, *supra* note 3 at 480.

[21] *Thomas J. Engelhart*, *supra* note 19.

[22] A.M.A., *Guides*, *supra* note 3 at 525.

[23] The record reflects that appellant has a history of a preexisting left knee condition; but Dr. Diamond did not provide any history of such condition or explanation of how the accepted injury caused or contributed to any preexisting impairment to the left leg.

[24] *See K.H.*, 61 ECAB ____ (Docket No. 09-341, issued December 30, 2009).

increased by up to three percent for pain if an individual appears to have a pain-related impairment that has increased the burden on his or her condition slightly.[25] A formal pain assessment is to be performed in accordance with Chapter 18.[26] Dr. Diamond did not provide a formal pain assessment as described by Chapter 18; rather, he merely cited to page 574 in support of his ratings. This reduces the probative value of his impairment estimate such that appellant has not established pain as a basis for rating impairment to any extremity. There is no well-rationalized medical evidence to establish more than three percent left upper extremity impairment based on the range of motion findings of the Office medical adviser under the fifth edition of the A.M.A., *Guides*.

CONCLUSION

The Board finds that appellant has not established more than three percent left arm impairment.

ORDER

IT IS HEREBY ORDERED THAT the August 6, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 29, 2010
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[25] *T.H.*, 58 ECAB 335 (2007).

[26] A.M.A., *Guides*, *supra* note 3 at 573.