United States Department of Labor
Employees' Compensation Appeals Board

K.J., Appellant	)	
and	)	**Docket No. 10-192**
	)	**Issued: September 23, 2010**
DEPARTMENT OF THE NAVY, COMMANDER IN CHIEF-ATL FLEET, STS BASES HUMAN RESOURCES OFFICE, Norfolk, VA, Employer	)	

Appearances:
Jeffrey P. Zeelander, 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 October 26, 2009 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated October 19, 2009. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant met her burden of proof to establish that she sustained more than a three percent permanent impairment of her right upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On December 27, 2005 appellant, then a 61-year-old telecommunications technician, sustained injury when a telephone cord wrapped around the heel of her shoe causing her to trip and fall. She stopped work on December 27, 2005. On February 27, 2006 the Office accepted

appellant's claim for a right arm proximal humerus fracture. Appellant received wage-loss compensation benefits. On February 20, 2009 she filed a Form CA-7 claim for a schedule award.

In a March 26, 2009 report, Dr. Daisy A. Rodriguez, Board-certified in internal medicine and a treating physician, reviewed appellant's history of injury and treatment. She examined appellant and provided findings for range of motion. For the right wrist, Dr. Rodriguez noted full flexion, 30 degrees of extension, full radial and ulnar deviation. For the right elbow, she found full flexion, extension, pronation and supination. Dr. Rodriguez noted that the right shoulder had 100 degrees of flexion, 15 degrees of extension, 100 degrees of abduction, full adduction, internal rotation of 80 degrees and external rotation of 80 degrees. She noted that strength was not reported due to right shoulder reduced range of motion and shoulder and upper arm pain. Dr. Rodriguez advised that otherwise strength was "5/5," the deep tendon reflexes were "2/4" throughout, equal and symmetrical.

In a June 27, 2009 report, Dr. Rodriguez, referred to the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* hereinafter (A.M.A., *Guides*) (6th ed. 2008) and noted that appellant had a pain disability questionnaire (PDQ) score of 114 that she equated to severe disability and a grade modifier of three. She referred to Appendix 3-1, page 43 and Table 17-A, page 599 of the A.M.A., *Guides.* Dr. Rodriguez noted that appellant's *Quick*DASH score was 77.[1] She selected a grade modifier of three for severe problems according to Table 15-7.

In a July 5, 2009 report, Dr. Rodriguez provided an impairment rating of 17 percent. She referred to Table 15-8, Table 15-9, Table 15-34, Table 15-35 and Table 15-37.[2] Dr. Rodriguez rated appellant's range of motion of the shoulder finding 100 degrees of flexion for three percent impairment, 15 degrees of extension for two percent impairment and 100 degrees of abduction for three percent impairment. She added these values for a total of eight percent and noted a grade adjustment of two. Dr. Rodriguez concluded that appellant had nine percent upper extremity impairment due to lost range of motion. For post-traumatic osteoarthrosis, she referred to Table 15-5, Table 15-8 and Table 15-9.[3] Dr. Rodriguez indicated that appellant was class one in the shoulder regional grid. She advised that the *Quick*DASH functional assessment tool represented a Grade 3 modifier (grade modifier for functional history -- GMFH). Dr. Rodriguez also found a Grade 1 modifier based on appellant's physical examination findings (grade modifier for physical examination -- GMPE). She also found a Grade 1 modifier based on clinical studies (grade modifier for clinical studies -- GMCS). Dr. Rodriguez noted that, to determine the final impairment under the sixth edition, she applied the net adjustment formula (NAF): GMFH (3) minus CDX (1) plus GMPE (1) minus CDX (1) plus GMCS (1) minus CDX. Based on the formula, she determined that the net adjustment modifier was two. Dr. Rodriguez advised that the plus two net adjustment modifier allowed for adjustment from Grade C, the

[1] The *Quick*DASH method is a method utilized to determine disabilities of the arms, shoulders and hands using an activities-of-daily-living questionnaire. A.M.A., *Guides* 482.

[2] *Id*. at 408, 410, 475, 477.

[3] *Id*. at 402, 408, 410.

default, to Grade 1E, which represented nine percent impairment of the upper extremity. She concluded that the 9 percent for the post-traumatic osteoarthritis and the 9 percent for the range of motion, when combined, correlated to an impairment of 17 percent to the right upper extremity.

In a report dated August 17, 2009, Dr Morley Slutsky, an Office medical adviser, reviewed the medical evidence for rating impairment under the A.M.A., *Guides*. He determined that appellant had an impairment of three percent of the right arm. Dr. Rodriguez noted that appellant's most impairing diagnosis was post-traumatic degenerative joint disease (DJD) of the shoulder secondary to the humeral fracture. Dr. Slutsly noted that Dr. Rodriguez erroneously utilized the grade modifier for functional history which was "clearly outside of the parameters accepted by the [A.M.A.,] *Guides*." He noted that Dr. Rodriguez rated appellant for loss of shoulder motion and combined it with the impairment for post-traumatic DJD, which was not allowed under the A.M.A., *Guides.* The medical adviser explained that in most cases, only the diagnosis-based impairment was allowed.[4] Dr. Slutsky stated that the range of motion measurements documented by Dr. Rodriguez were not correctly performed and could not be used. He referred to Table 15-5, page 401-05, finding the most impairing diagnoses was post-traumatic DJD, for which appellant was diagnosed as a Class 1 with a default Grade C equal to five percent arm impairment. Dr. Slutsky noted that she had some marginal cortical erosions along the patellofemoral humeral head compatible with degenerative change. The medical adviser disagreed with the Grade 3 modifier, of Dr. Rodriguez. He explained that he did not use a functional history grade modifier as appellant's symptoms did not reflect such a score and she did not require help with self-care activities. Dr. Slutsky referenced section 15.3a, at page 406 to note that, if the grade for functional history differed by two or more grades than that for physical examination or clinical studies, then the score must be excluded as it was not valid. He agreed with Dr. Rodriguez that the physical examination grade modifier was one. The medical adviser noted that Dr. Rodriguez did not document performing three measurements per joint motion as required by section 15.7, "[r]ange of [m]otion [i]mpairment" at page 459. Three sets of measurements were required per joint motion, the measurements were averaged and each of the three measurements should be within 10 degrees of the calculated average. The measurements for the affected average are then compared with that, of the opposite extremity, (if it is normal) to determine the percentage of relative deficit of the affected extremity and then applied to the appropriate tables. Dr. Rodriguez referred to Table 15-9, page 410 and utilized the clinical studies grade modifier. Dr. Slutsky used a grade modifier of one in agreement with Dr. Rodriguez as appellant had a healed humeral fracture with mild pathology and noted a final grade of B which yielded three percent impairment to the right arm.

On October 13, 2009 the Office requested that the Office medical adviser address the date of maximum medical improvement. On October 14, 2009 Dr. Slutsky stated that maximum medical improvement was March 26, 2009, the date that Dr. Rodriguez examined appellant.

In an October 19, 2009 decision, the Office granted appellant a schedule award for a three percent impairment of the right arm.[5]

[4] *Id*. at 481.

[5] An earlier decision dated April 8, 2009 denying her schedule award was vacated.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[6] and its implementing 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 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. For decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* has been adopted as the appropriate standard for evaluating schedule losses.[8]

ANALYSIS

Appellant's claim was accepted by the Office for a proximal humerus fracture on the right. On February 20, 2009 appellant filed a claim for a schedule award. The Board finds that the medical evidence of record establishes no more than three percent impairment to her right arm.

Appellant provided several reports from Dr. Rodriguez. On her March 26, 2009 Dr. Rodriguez addressed range of motion findings and on June 27, 2009 noted pain and functional measurements. In a July 5, 2009 report, she advised that appellant had 9 percent impairment for her post-traumatic osteoarthrosis and 9 percent impairment for loss of range of motion, or a total combined impairment of 17 percent to the right arm. The Board notes that under the sixth edition of the A.M.A., *Guides*, impairments to the upper extremities are covered by Chapter 15 section 15-2, entitled Diagnosis-Based Impairment.[9] This section is the method of choice for calculating impairment to the upper extremities. Range of motion may be used for rating impairment in the following two situations:

> "1. For amputation ratings, deficits of motion for the remaining portion of the limb, may be combined with the amputation impairment.
>
> "2. In very rare cases, severe injuries may result in passive range of motion losses qualifying for [C]lass 3 or 4 impairment. If the active range of motion impairment percentage is greater than the percentage impairment derived from the diagnosis-based class, then the impairment is rated by range of motion as a stand[-]alone rating. This range of motion for the impairment may only be used if the active range of motion is within 10 degrees of the passive range of motion measured. The active range of motion measurement is what determines the final impairment rating. Examples include complex flexor or extension tendon or

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *See* FECA Bulletin No. 09-03 (issued March 15, 2009). A.M.A., *Guides* (6th ed. 2008).

[9] Section 15.2, A.M.A., *Guides* 387.

multiple tendon laceration injuries, severe crush injuries, residual compartment syndrome, or other conditions having significant functional loss."[10]

In this case, Dr. Rodriguez did not explain how appellant's injury fell into either of these categories. Therefore, her loss of range of motion estimate cannot be utilized as a stand-alone rating.

With regard to the diagnosis-based impairment rating for post-traumatic osteoarthrosis, the Board notes that Table 15-5 does not list post-traumatic osteoarthrosis. To the extent this diagnosis is consistent with post-traumatic DJD, the diagnosis identified by the Office medical adviser, Dr. Rodriguez did not explain the details of her calculation or her use of grade modifiers. For example, for a functional history grade modifier, she selected a grade modifier of three for a severe problem based in part on a *Quick*DASH score. The A.M.A., *Guides* provide that when a grade for functional history differs by two or more grades from that described by physical examination or clinical studies, it should be assumed to be unreliable and should be excluded from the grading process.[11] Under Table 15-6, a functional history grade modifier of three corresponds to a severe problem; pain and symptoms with less than normal activity and the individual require assistance to perform self-care activities.[12] The record does not establish that appellant's functional history reveals severe problems due to residuals of her accepted injury or that she requires assistance to perform self-care activities. The Board has held that an attending physician's report is of diminished probative value where the A.M.A., *Guides* are not properly followed.[13]

The Office medical adviser evaluated impairment by identifying the impairing diagnosis as right shoulder DJD. The Board notes that the initial step in the evaluation process is to identify the impairment class by using the corresponding diagnosis-based regional grid. Dr. Slutsky utilized the shoulder regional grid, Table 15-5 and identified a Class 1 impairment based on residual consisting of marginal cortical erosion along the posterolateral humeral head compatible with degenerative change.[14] Once the impairment class was determined based on the diagnosis, the grade was initially assigned the default value, C. Under Table 15-5, the default Grade C, for a Class 1 impairment represents five percent upper extremity impairment.[15]

After determining the impairment class and default grade, the Office medical adviser addressed the applicable grade adjustments for so-called nonkey factors or modifiers. These include adjustments for functional history GMFH, physical examination GMPE and clinical

[10] A.M.A., *Guides* 461.

[11] *Id*. at 406-07.

[12] *Id*. at 406.

[13] *J.G.*, 61 ECAB ___ (Docket No. 09-1128, issued December 7, 2009).

[14] A.M.A., *Guides* 405.

[15] The grades range from A to E, with A representing zero percent upper extremity impairment, B and C representing one percent and D and E representing two percent upper extremity impairment. A.M.A., *Guides* 402, Table 15-5.

studies GMCS. The grade modifiers are used in the NAF to calculate a net adjustment.[16] The final impairment grade is determined by adjusting the grade up or down from the default value C by the calculated net adjustment. The Office medical adviser explained that there was a zero functional history grade GMFH because appellant's symptoms did not represent the grade modifier of three (severe problem) by Dr. Rodriguez. Regarding a physical examination grade modifier, GMPE, he assigned a grade modifier one (mild problem) for appellant's right shoulder crepitus.[17] Applying the net adjustment formula (GMFH-CDX = -1) + (GMPE-CDX = 0) + (GMCS-CDX = 0) resulted in a grade modifier of minus one, which resulted in a grade adjustment from C to B. The corresponding upper extremity impairment for a Class 1, grade B for post-traumatic DJD is three percent.[18]

The Board finds that the Office medical adviser properly applied the A.M.A., *Guides* to rate impairment to appellant's right shoulder as three percent under the formula of the sixth edition. The rating of Dr. Slutsky is in accordance with the protocols pertaining to upper extremity impairment determinations and represents the weight of medical opinion.

On appeal, counsel contends that the Office medical adviser used that method which yielded the smallest portion of impairment instead of rating appellant for all aspects of impairment. As noted, Dr. Slutsky clearly explained his rating under the sixth edition of the A.M.A., *Guides*.

CONCLUSION

The Board finds that appellant has three percent impairment of the right upper extremity.

[16] Net Adjustment = (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX). A.M.A., *Guides* 411, Section 15.3d.

[17] A.M.A., *Guides* 408, Table 15-8. The Office medical adviser properly indicated that Dr. Rodriguez' range of motion measurements could not be used as a grade modifier as her report did not document performing measurements in conformance with the A.M.A., *Guides*. The A.M.A., *Guides* require three measurements that should all fall within 10 degrees of the calculated average. *See* A.M.A., *Guides* 464. Dr. Rodriguez' reports did not note three range of motion measurements.

[18] A.M.A., *Guides* 405, Table 15-5.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 19, 2009 is affirmed.

Issued: September 23, 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