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

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| **G.M., Appellant** | ) | |
| **and** | ) | |
| **DEPARTMENT OF HOMELAND SECURITY, FEDERAL AIR MARSHALL SERVICE, NEWARK FIELD OFFICE, West Orange, NJ, Employer** | ) | **Docket No. 10-1424**<br>**Issued: April 19, 2011** |

*Appearances:*
*Jeffrey P. Zeelander, Esq.,* for the appellant
*Office of Solicitor,* for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge

### ***JURISDICTION***

On April 29, 2010 appellant, through his attorney, filed a timely appeal from the April 19, 2010 merit decision of the Office of Workers' Compensation Programs concerning entitlement to schedule award compensation. Pursuant to the Federal Employees' Compensation Act[1] 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 met his burden of proof to establish more than a four percent permanent impairment of his left upper extremity, for which he received a schedule award.

On appeal, appellant's attorney suggests that to the extent that the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009)

[1] 5 U.S.C. § 8101 *et seq.*

directs a physician to disregard aspects of impairment to a rateable body part, the Board must find that as a matter of law that this is improper in the determination of impairment ratings in cases under the Act.[2] He contends that the Office's procedure manual requires that in evaluating a claim for a schedule award, the medical examiner should state that all impairments (including preexisting, nonemployment related and subsequently developed impairments) must be considered in calculating the award.[3]

## ***FACTUAL HISTORY***

On February 28, 2008 appellant, then a 37-year-old federal air marshal, filed a traumatic injury claim alleging that, on February 27, 2008 during a body sparing drill, he made contact with his opponents arm causing appellant's arm to move in an unintended way. He alleged that, as a result, he suffered a blunt force impact to the inner elbow/upper forearm area causing weakness in his arm, swelling, bruising and constant flexing of the bicep muscle. On March 26, 2008 the Office accepted appellant's claim of sprain of elbow and forearm, other specified sites, left. On April 1, 2008 appellant underwent an exploration and repair of biceps rupture using an interference fit screw. On October 9, 2008 the Office expanded his claim to accept it for biceps tendon rupture, left.

On February 2, 2009 appellant filed a claim for a schedule award. In a January 8, 2009 report, Dr. Emmanuel E. Jacob, appellant's treating Board-certified physiatrist, evaluated appellant's impairment under the fifth edition of the A.M.A., *Guides* (2001) and determined that he had 19 percent upper extremity impairment.

By letter dated May 11, 2009, the Office informed appellant that it was now applying the sixth edition of the A.M.A., *Guides* and asked that he obtain an evaluation from his physician that applied the new A.M.A., *Guides*. Accordingly, Dr. Jacob revised his January 8, 2009 report, applied the sixth edition of the A.M.A., *Guides* and determined that appellant had seven percent impairment to his upper extremity. He noted that appellant's diagnoses were sprain of the left elbow and forearm and biceps tendon rupture with surgical repair. Dr. Jacob assigned appellant's accepted injury of left elbow and forearm sprain was assigned a class 1 with midrange default value of one percent Class of Diagnosis (CDX) upper extremity impairment pursuant to Table 15-4.[4] He found a grade modifier 1 based on Functional History (GMFH) (Table 15-7, p. 406), a grade modifier 1 based on Physical Examination (GMPE) (Table 15-8, p. 408) and a grade modifier 0 based on Clinical Studies (GMCS) (Table 15-9, p. 410). Dr. Jacob then applied the grade modifiers and determined that appellant had a net adjustment of minus one[5] which adjusted one to the left of mid range grade C resulting in a grade B impairment which equaled one percent upper extremity impairment (Table 15-4, p. 398). He then noted that

[2] 5 U.S.C. §§ 8101-8193.

[3] *See* Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.809.4.b(1) (September 2009).

[4] A.M.A., *Guides* 398, Table 15-4.

[5] GMFH of one minus CDX of one equals zero. GMPE of one minus CDX of one equals zero. GMCS of zero minus CDX of one equals minus one. Adding these figures yields a sum net adjustment of minus one.

appellant had an accepted injury of left biceps tendon rupture with surgical repair which he assigned class 1 with midrange default value of five percent CDX upper extremity impairment pursuant to Table 15-4, p. 399. Dr. Jacob applied the grade modifiers 1 for GMFH (Table 15-7, p. 406), one for GMPE (Table 15-8, p. 408) and two for GMCS (Table 15-9, p. 410). He then calculated that this resulted in a net adjustment of plus one.[6] Dr. Jacob then calculated that this would result in a grade D impairment which was equivalent to six percent upper extremity impairment (Table 15-4, p. 399). He then added these figures together (one percent plus six percent) and determined that appellant had seven percent impairment of the left upper extremity pursuant to the sixth edition of the A.M.A., *Guides*.

On July 9, 2009 the Office asked the Office medical adviser to make a determination with regard to appellant's impairment for schedule award purposes. In a response of the same date, the medical adviser utilized the findings in the report of Dr. Jacobs but determined that appellant had four percent impairment of the left upper extremity. Dr. Jacobs noted that appellant's claim was accepted for sprain of the left elbow and rupture of the left biceps tendon, for which surgery was performed. The Office medical adviser agreed with Dr. Jacob that the CDX of class 1 with a mid default value (for tendon rupture) was five (Table 15-4, p. 399). He found that appellant was entitled to a GMFH of 1 (Table 15-7, p. 406) for some weakness of the left arm, some stiffness and pain on repeated use. The Office medical adviser found that appellant was entitled to a GMPE of 1 for muscle strength in the left arm and left hand 4/5, ½ inch atrophy in left arm, mild loss of pronation and supination and full flexion of elbow (Table 15-8, p. 408). He found that appellant had a grade 0 for GMCS as no clinical studies were in the file (Table 15-9, p. 410). Adding these figures together the Office medical adviser noted that appellant was entitled to a net modifier adjustment of minus one, which would move the default value one space to the left, thereby equaling a four percent impairment of the left upper extremity.[7] The medical adviser also noted that Dr. Jacobs graded separately for sprain of the left arm and the elbow for an additional impairment of one percent. The Office medical adviser noted that this was not correct, that the sixth edition of the A.M.A., *Guides* state that only the major diagnosis is to be put into the diagnostic grid and then modified using the various grade modifiers. Accordingly, the medical adviser found that appellant had four percent impairment of the left upper extremity (5 - 1 = 4).

In an August 14, 2009 addendum, Dr. Jacobs stated that he reviewed the report of the Office medical adviser and disagreed with his calculations. He stated that there were two separate accepted work-related injuries on February 27, 2008, a sprain of the elbow and forearm, which is a soft tissue injury and a left biceps tendon rupture, which is a muscle injury. Dr. Jacobs stated that these diagnoses were for two separate parts of the body and constituted two separate work injures and should be rated separately.

In a September 3, 2009 report, the Office medical adviser stated that the sixth edition of the A.M.A., *Guides*, clearly state that the major clinical diagnosis in the injured region must be

[6] GMFH of one minus CDX of one equals zero. GMPE of one minus CDX one equals zero. GMCS of two minus CDX one equals one. Adding these figures yields a sum net adjustment of plus one.

[7] A.M.A., *Guides* 399, Table 15-4 (GMFH – CDX = 1 – 1 = 0), (GMPE – CDX = 1 – 1 = 0), (GMCS – CDX = 0 – 1 = -1).

selected and placed in the proper diagnostic grid to a class CDX and that you get the default value from this class. He believed that Dr. Jacob misinterpreted the instructions. The Office medical adviser noted that the sprain of the elbow is a minor diagnosis and it occurred as part of a major injury which caused the tendon rupture in the left elbow. He stated that the sprain, since it is relatively minor, would fall into class 0 on Table 15-2, p. 391 even if one was to combine two diagnoses from the injured extremity. The medical adviser concluded that this would add nothing to the four percent he got using the main diagnosis. He concluded that he still believed that his initial rating of four percent impairment to the left upper extremity was correct.

By decision dated April 19, 2010, the Office issued a schedule award for a four percent impairment of the left upper extremity. In making this determination, it found that the weight of the evidence was represented by the Office medical adviser as he is considered an expert in interpreting the A.M.A., *Guides* and provided a clear explanation and rationale to support that he use the A.M.A., *Guides* correctly.

## ***LEGAL PRECEDENT***

The schedule award provisions of the Act provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a mater which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[8]

For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[9] Initial schedule award decisions issued on or after May 1, 2009 will be based on the sixth edition of the A.M.A., *Guides,* even if the amount of the award was calculated prior to that date. A claimant who has received a schedule award under a previous edition may make a claim for an increased award, which should be calculated according to the sixth edition.[10]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[11] Under the sixth edition, the evaluator identifies the impairment class for the

[8] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[9] FECA Bulletin No. 09-03 (issued March 15, 2009); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[10] *Id. See also T.B.*, Docket No. 09-1903 (issued April 15, 2010) (the Board held that, in a claim for an increased schedule award due to worsening of an accepted impairment, the Office medical adviser must utilize the edition of the A.M.A., *Guides* in effect at the time the Office issues a decision on the augmented schedule award).

[11] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

diagnosed condition CDX, which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

After obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for a rationalized opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*.[13]

## ***ANALYSIS***

The Office accepted appellant's claim for sprain of the left elbow and forearm and also for left biceps tendon rupture. Under the sixth edition of the A.M.A., *Guides*, if there are multiple diagnoses within a specific region, then the most impairing diagnosis is rated, because it is probably this will incorporate the functional losses of the less impairing diagnoses.[14] In the instant case, appellant's physician, Dr. Jacob, rated appellant as evincing a 1 percent impairment to his left upper extremity based on the sprain of this left elbow and forearm and 6 percent based on biceps tendon rupture with surgical repair. The Office medical adviser indicated that this was improper; he stated that these two diagnoses could not be combined. The Board finds that the A.M.A., *Guides* require a physician to pick one diagnosis for the region.[15] On appeal, appellant's attorney contends that this procedure is improper and that to the extent that the sixth edition of the A.M.A., *Guides* indicates that different diagnoses cannot be combined, it is inconsistent with the Office's procedures. The Office has explicitly adopted the standards of the sixth edition of the A.M.A., *Guides* effective May 1, 2009 for evaluating permanent impairment.[16] The Board has concurred in this adoption. Moreover, with regard to evaluating impairment in the upper extremities, these conditions play a role in determining grade modifiers with the various adjustment grids, including those for functional history, physical examination and clinical studies, which in turn can alter the default impairment values found in Table 15-4.[17]

The Board finds that there is a conflict between the Office medical adviser and Dr. Jacobs with regard to the extent of permanent impairment attributable to appellant's biceps tendon rupture with surgical repair. Both physicians agree that the default value is five pursuant to Table 15-4. Both also agree that appellant has a grade modifier of 1 for GMFH and 1 for GMPE. However, Dr. Jacob opined that appellant was entitled to a grade modifier of 2 for GMCS whereas the Office medical adviser determined that appellant was entitled to a grade modifier of zero. This difference is significant in that using Dr. Jacob's conclusion of a grade modifier of 2, the impairment rating would be one to the left of the default grade or an impairment rating of 4.

[12] A.M.A., *Guides* (6th ed. 2009), page 494-531.

[13] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (January 2010).

[14] A.M.A., *Guides* 529, 16.3f.; *see also H.P.*, Docket No. 10-962 (issued November 10, 2010).

[15] *See H.P.*, *supra* note 14.

[16] *See supra* note 9.

[17] *See* A.M.A., *Guides* 509-20.

Utilizing the Office medical adviser's conclusion that appellant was entitled to a GMCS of 0, the rating is one to the right of the default rating and would result in an impairment of 6. Therefore, there is an unresolved conflict between appellant's treating physician, Dr. Jacob, and the Office medical adviser with regard to the proper impairment rating based on the rupture of appellant's biceps tendon. An Office medical adviser may create a conflict in medical opinion but generally may not resolve the conflict.[18] Section 8123(a) provides that if there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[19] This case will be remanded to the Office to refer appellant for an impartial medical examination regarding the extent of the impairment to appellant's left upper extremity.

## ***CONCLUSION***

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

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated April 19, 2010 is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: April 19, 2011
Washington, DC

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

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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

[18] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating the Medical Evidence*, Chapter 2.810.7(g) (April 1993).

[19] 5 U.S.C. § 8123(a); *Alfred R. Anderson*, 54 ECAB 179 (2002).