United States Department of Labor
Employees' Compensation Appeals Board

R.Z., Appellant	)	
	)	
and	)	**Docket No. 10-1915**
	)	**Issued: May 19, 2011**
DEPARTMENT OF THE INTERIOR, BLM-NATIONAL INTERAGENCY FIRE CENTER, Boise, ID, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 14, 2010 appellant timely appealed the June 10, 2010 decision of the Office of Workers' Compensation Programs, which denied his request for a hearing. He also timely appealed the Office's March 5, 2010 schedule award decision. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over these issues.

ISSUES

The issues are: (1) whether appellant has greater than five percent impairment of the right upper extremity; and (2) whether the Office properly denied appellant's request for a hearing.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On February 3, 2003 appellant, a 45-year-old electronics technician, was injured in a snowmobile accident. The claim was accepted for multiple contusions, and fractures to the right shoulder, clavicle and ribs. The Office subsequently accepted scapula fracture, brachial plexus lesions, and fractures at T1 to T6 and T7 to T12.

On May 23, 2006 appellant filed a claim for a schedule award. In a November 9, 2004 report, Dr. John G. Kloss, a Board-certified orthopedic surgeon, noted appellant's history of injury and medical treatment. Under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*), he determined that appellant had 19 percent whole person impairment. In letters dated June 20, 2006 and May 14, 2007, the Office acknowledged appellant's request for a schedule award and advised him that he would be eligible once he reached maximum medical improvement. It requested a new report from his physician based on the A.M.A., *Guides.*

In a March 17, 2008 report, Dr. Kloss noted appellant's history and examined him. He determined that appellant had decreased numbness on the ulnar side of the hand which was consistent with chronic right brachial plexopathy abnormal motor function. Dr. Kloss found that appellant had decreased light touch in the ulnar distribution more than the median distribution; extension of the shoulder of only 30 degrees on the right versus 60 degrees on the left and adduction of the shoulder of only 20 degrees on the right versus 60 degrees on the left. He diagnosed chronic right brachial plexopathy of the right upper extremity. Dr. Kloss explained that appellant had 42 percent impairment of the right arm or 25 percent of the whole person.

In a November 17, 2008 report, an Office medical adviser determined that additional information was needed from Dr. Kloss. He advised that the values for range of motion including extension and adduction were needed as well as neuromuscular findings on examination to assess brachial plexus deficits.

On November 19, 2008 the Office requested additional information from Dr. Kloss. In a January 24, 2009 response, Dr. Kloss noted that appellant had shoulder extension of 30 degrees which was equivalent to a one percent impairment of the upper extremity and shoulder adduction of 20 degrees which was equal to one percent of the upper extremity. Regarding a brachial plexus injury, he explained that his evaluation was unchanged and noted that he had referred to the appropriate tables under the A.M.A., *Guides.* Dr. Kloss also explained that there was no reason to reappraise permanent impairment with respect to appellant's neuromuscular status.

In a February 26, 2009 report, the Office medical adviser noted that a detailed reevaluation of the neuromuscular findings in 2008 was not performed. He recommended a second opinion examination to address appellant's right upper extremity impairments.

On July 13, 2009 the Office referred appellant for a second opinion, along with a statement of accepted facts, a set of questions and the medical record to Dr. Paul C. Collins, a Board-certified orthopedic surgeon.

In a September 14, 2009 report, Dr. Collins reviewed appellant's history of injury. On examination, appellant had a flexible cervical spine with no significant limitation. Regarding the shoulders, Dr. Collins determined that appellant had loss of muscle function and formation in his right deltoid area, 116 degrees of forward flexion on the right and 156 degrees on the left, 86 degrees of abduction on the right and 96 degrees on the left, internal rotation of 44 degrees on the right and 58 degrees on the left and external rotation of 68 degrees bilaterally. He noted grip strength on the right of 20 kilograms versus 46 kilograms on the left. Dr. Collins found decreased sensation in his fourth and fifth fingers on the right side relative to the left, which appellant related increased over the last year. He noted that there were no changes in the lumbar spine postsurgery of three years ago. Dr. Collins also advised that regarding lumbar range of motion appellant had forward flexion of 60 degrees and 0 degrees of extension; with side bending of 15 degrees bilaterally; negative straight leg raising and no sensory deficits. He utilized the sixth edition of the A.M.A., *Guides*. Dr. Collins referred to Table 15-21 and explained that it was the best way to proceed with sensory loss in the right upper extremity.[2] He noted that peripheral nerve upper extremity impairment in the axillary nerve, with a mild motor deficit, would correspond to an impairment of 13 percent of the right arm. Dr. Collins explained that there were several ways to determine an impairment rating; however, he advised that the fracture in the scapula appeared to have healed and the limitation was neurological.

On October 6, 2009 the file was referred to the Office medical adviser. In an October 9, 2009 report, the Office medical adviser reviewed the report of Dr. Collins. He concurred with Dr. Collins finding of a mild motor loss of the right axillary nerve. The Office medical adviser noted that appellant had sensory loss related to the ulnar nerve for the fourth and fifth fingers and explained that this was not the type of loss expected with axillary sensory deficits under Figure 15-8.[3] He advised that he was in agreement with only rating the axillary motor nerve deficit utilizing the "Peripheral Nerve Impairment" grid Table 15-21.[4] The Office medical adviser noted that Dr. Collins found that appellant's scapular fracture had healed with no residual problems with the exception of the right axillary nerve motor deficit. He disagreed with the assignment of 13 percent as Dr. Collins did not perform the required net adjustment calculations. The Office medical adviser also explained that the maximum impairment for mild motor losses of the axillary nerve was 9 percent, not 13 percent.[5] He found that Dr. Collins' findings were consistent with a functional history grade modifier of one noting that there was no indication that appellant required modification to perform self-care activities unassisted. The grade modifier for clinical studies was also one based on evidence of mild chronic neuropathic motor changes. The Office medical adviser advised that appellant fell into a class 1 for mild axillary motor deficit and the default grade of C would translate to five percent upper extremity impairment. He explained that the net adjustment calculated to zero with no movement from the default grade of C and opined that the final impairment grade was C or a final right upper extremity impairment of five percent.

[2] A.M.A., *Guides* 436 (6th ed. 2008).

[3] *Id.* at 432.

[4] *Id.* at 436.

[5] *Id.*

In an October 27, 2009 decision, the Office granted a schedule award for five percent permanent impairment of the right arm. The award ran from September 14, 2009 to January 1, 2010.

On November 5, 2009 appellant requested a hearing and asserted that he was entitled to a greater award.

In a February 1, 2010 decision, an Office hearing representative found that the case was not in posture for decision. She found that the Office medical adviser did not address whether Dr. Collins' opinion that the sensory loss impairment was the most advantageous determination was correct, given that Dr. Collins had erroneously determined that appellant had 13 percent using that section of the A.M.A., *Guides*. The hearing representative also found that he did not address whether the range of motion deficits in the right shoulder should be considered and whether that would have resulted in a greater impairment rating than the five percent awarded. She directed the Office to refer the file to the Office medical adviser and obtain an opinion as to whether the five percent awarded was the most advantageous application of the A.M.A., *Guides* and whether appellant had any greater permanent impairment of the right upper extremity.

On February 10, 2010 the Office requested that the Office medical adviser provide an updated opinion.

In a February 16, 2010 report, the Office medical adviser explained that right shoulder range of motion could not be used as a rating method or as a grade modifier for the right axillary nerve rating. He noted that shoulder range of motion was not preferred to a diagnosis-based impairment rating. Furthermore, the Office medical adviser advised that the A.M.A., *Guides*, specifically discouraged the use of range of motion as a rating method and that it was used as a grade modifier. He explained that the A.M.A., *Guides* had a diagnosis-based rating for the axillary nerve, and thus the range of motion method was not applicable. The Office medical adviser referred to section 15.7, number 12 of the A.M.A., *Guides* and noted that it indicated "[o]nly if no other approach is available to rating, calculate impairment based on range of motion."[6] He found that the shoulder range of motion measurements were not valid as Dr. Collins only provided one range of motion measurement per shoulder motion, which was inconsistent with the requirements of section 15.7 and thus could not be utilized.[7] The Office medical adviser explained that, even if the measurements were valid, they would not result in greater impairment as range of motion measurements were stand alone ratings which could not be combined with any other impairment rating. He further noted that the five percent upper extremity was the same number applicable to the axillary nerve and thus the final impairment would not be greater than five percent *via* either method. Additionally, the Office medical adviser indicated that the range of motion measurements could not be used as a grade modifier for the axillary nerve condition because section 15.4e of the A.M.A., *Guides* precluded the use of physical findings as grade modifiers in net adjustment calculations when peripheral nerves were

[6] *Id.* at 481.

[7] *Id.* at 472.

rated.[8] He reiterated his opinion that appellant had five percent impairment of the right upper extremity.

In a March 5, 2010 decision, the Office affirmed the October 27, 2009 decision, which found that appellant was entitled to an impairment of five percent of the right upper extremity.

On May 18, 2010 appellant requested a hearing.

In a June 10, 2010 decision, the Office found that appellant was not entitled to a hearing for the reason that his request was not made within 30 days of the issuance of its March 5, 2010 decision. It exercised its discretion and determined that it would not grant a hearing for the reason that the issue in the case could equally well be addressed by requesting reconsideration and submitting new evidence not previously considered pertaining to his claim for a schedule award.

LEGAL PRECEDENT -- ISSUE 1

Section 8107 of the Act sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[9] It, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[10] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides.*[11]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under the Act for injury to the spine.[12] 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. Therefore, 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 originated in the spine.[13] A schedule award is not payable for an impairment of the

[8] *Id.* at 430.

[9] For a total loss of use of an arm, an employee shall receive 312 weeks of compensation. 5 U.S.C. § 8107(c)(1) (2006).

[10] 20 C.F.R. § 10.404.

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

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

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

whole body.[14] It is well established that, in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[15]

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).[16] Under the sixth edition of the A.M.A., *Guides*, for upper extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS).[17] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[18]

ANALYSIS -- ISSUE 1

Appellant submitted reports from his treating physician, Dr. John Kloss, a Board-certified orthopedic surgeon, who rated impairment of 42 percent of the right upper extremity. However, he did not fully explain his rating or utilize the appropriate edition of the A.M.A., *Guides.* As noted, the sixth edition of the A.M.A., *Guides* became effective as of May 1, 2009.[19] The opinion of Dr. Kloss is of diminished probative value as it was not based on a correct application of the appropriate A.M.A., *Guide*s.[20] As his report did not comport with the A.M.A., *Guides*, it is insufficient to establish any greater impairment that which the Office awarded appellant.

The Board notes that, in a September 14, 2009 report, the second opinion physician, Dr. Collins set forth findings and referred to the appropriate edition of the A.M.A., *Guides.* While Dr. Collins rated impairment of 13 percent of the right arm, he did not fully explain how he arrived at this conclusion under Table 15-21. For example, he stated that appellant had a mild motor deficit for the axillary nerve yet he selected percentage, 13 percent, that reflected a moderate motor deficit. As Dr. Collins' report did not comport with the A.M.A., *Guides*, it is also of limited probative value.

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."[21] The

[14] *N.M.*, 58 ECAB 273 (2007).

[15] *Peter C. Belkind*, 56 ECAB 580 (2005).

[16] A.M.A., *Guides* (6th ed. 2008), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[17] *Id*. at 385-419.

[18] *Id*. at 411.

[19] *See supra* note 11.

[20] 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 permanent impairment. *I.F.*, Docket No. 08-2321 (issued May 21, 2009).

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

initial step in the evaluation process is to identify the impairment class by using the corresponding diagnosis-based regional grid. The Office medical adviser, in a February 16, 2010 report, reviewed Dr. Collins' findings and utilized the "Peripheral Nerve Impairment" grid, Table 15-21, A.M.A., *Guides* 436, and identified a class 1 impairment based on "mild axillary motor deficit." He noted that the default category would warrant a grade of C. Under Table 15-21, the default grade, C, for a class 1 diagnosis to the axillary nerve for mild motor deficit represents five percent upper extremity impairment.[22]

After determining the impairment class and default grade, the next step in the process is to determine if there are any applicable grade adjustments for so-called "nonkey" factors or modifiers. These include adjustments for GMFH, GMPE and GMCS. The grade modifiers are used in the net adjustment formula to calculate a net adjustment.[23] 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 determined that the A.M.A., *Guides* precluded the use of grade modifiers for axillary nerve conditions. He referred to section 15.4e of the A.M.A., *Guides* precluded the use of physical findings as grade modifiers in net adjustment calculations when peripheral nerves were rated.[24] The Office medical adviser explained in his October 9, 2009 report that the clinical studies and functional history grade modifiers were both one. Thus, the net adjustment formula did not change from the default grade of C.[25] In his February 16, 2010 report, the Office medical adviser also explained why other modes of rating appellant's impairment were either not applicable under the A.M.A., *Guides* or would result in no greater impairment.

The Board finds that the Office medical adviser's impairment rating conforms to the A.M.A., *Guides*, and thus, represents the weight of the medical evidence regarding the extent of appellant's right upper extremity impairment. Appellant has not submitted any credible medical evidence indicating he has greater than five percent impairment of the right upper extremity.

On appeal, appellant asserted that he wanted to know what happened to the rest of his award. As stated, the Office medical adviser provided the only impairment rating that conformed to the A.M.A., *Guides.* Appellant also questioned the report of the second opinion physician and alleged that it was quick and painful. However, he did not provide any evidence to support that the examination was improper. As noted, appellant has not submitted any medical evidence to establish greater than five percent impairment of the right arm under the sixth edition of the A.M.A., *Guides*.

[22] The grades range from A to E, with A representing zero (0) percent upper extremity impairment, B and C representing one (2) and (5) percent, and D and E representing (7) and (9) percent upper extremity impairment. Table 15-21, A.M.A., *Guides* 436.

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

[24] A.M.A., *Guides* 430.

[25] *See supra* note 18 and accompanying text.

LEGAL PRECEDENT -- ISSUE 2

Section 8124 of the Act provides that a claimant is entitled to a hearing before an Office representative when a request is made within 30 days after issuance of an Office final decision.[26]

Section 10.615 of Title 20 of the Code of Federal Regulations provide: "A hearing is a review of an adverse decision by a hearing representative. Initially, the claimant can choose between two formats: An oral hearing or a review of the written record."[27]

Section 10.616(a) of Title 20 of the Code of Federal Regulations further provide: "A claimant injured on or after July 4, 1966, who had received a final adverse decision by the district Office may obtain a hearing by writing to the address specified in the decision. The hearing request must be sent within 30 days (as determined by postmark or other carrier's date marking) of the date of the decision for which a hearing is sought."[28]

The Office's regulations provide that a request received more than 30 days after the Office's decision is subject to the Office's discretion[29] and the Board has held that the Office must exercise this discretion when a hearing request is untimely.[30]

ANALYSIS -- ISSUE 2

Appellant requested a hearing on May 19, 2010. The Board notes that the request for a hearing was more than 30 days after the Office issued its March 5, 2010 decision. Appellant was not entitled to a hearing as a matter of right.

The Office properly exercised its discretion in denying a hearing upon appellant's untimely request by determining that the issue could be equally well addressed by requesting reconsideration and submitting new evidence. The Board notes that the Office issued its denial of the hearing request on June 10, 2010. Appellant therefore had until March 5, 2011 to request reconsideration before the Office under 5 U.S.C. § 8128 or appeal the merits of the Office's March 5, 2010 decision to the Board.

The only limitation on the Office's authority is reasonableness. Abuse of discretion is generally shown through proof of manifest error, a clearly unreasonable exercise of judgment or actions taken which are contrary to logic and deductions from known facts.[31] There is no

[26] 5 U.S.C. § 8124(b)(1).

[27] 20 C.F.R. § 10.615.

[28] 20 C.F.R. § 10.616(a).

[29] *Id.* at § 10.616(b).

[30] *Samuel R. Johnson*, 51 ECAB 612 (2000).

[31] The only limitation on the Office's authority is reasonableness. Abuse of discretion is generally shown through proof of manifest error, a clearly unreasonable exercise of judgment or actions taken which are contrary to logic and deductions from known facts. *See Daniel J. Perea*, 42 ECAB 214 (1990). There is no evidence of record that the Office abused its discretion in denying appellant's request for a hearing under these circumstances.

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CONCLUSION

Appellant has not established that he has greater than five percent impairment of the right upper extremity. The Board also finds that the Office properly denied his request for a hearing.

ORDER

IT IS HEREBY ORDERED THAT the June 10 and March 5, 2010 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: May 19, 2011
Washington, DC

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

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

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