United States Department of Labor
Employees' Compensation Appeals Board

C.H., Appellant	)	
and	)	**Docket No. 11-910**
	)	**Issued: November 18, 2011**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS AFFAIRS MEDICAL CENTER, Clarksburg, WV, 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, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 1, 2011 appellant, through her attorney, filed a timely appeal from a January 21, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award case.

ISSUE

The issue is whether appellant has more than a one percent permanent impairment of the left upper extremity, for which she received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On October 23, 2008 appellant, then a 39-year-old practical nurse, filed a traumatic injury claim alleging that she sustained an injury to her left upper arm on October 12, 2008 when she helped restrain a patient. OWCP accepted the claim for a sprain of the shoulder and upper arm.

On May 26, 2009 appellant filed a claim for a schedule award. By letter dated May 29, 2009, OWCP requested that she submit an impairment evaluation from a physician utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). By decision dated June 29, 2009, it denied appellant's claim for a schedule award finding that she had not submitted medical evidence showing that she had a permanent impairment.

On July 20, 2009 appellant, through her attorney, requested a telephone hearing. At the telephone hearing, held on October 26, 2009, counsel related that appellant was scheduled for an impairment evaluation.

In a report dated November 12, 2009, Dr. Richard M. Ward, a Board-certified orthopedic surgeon, discussed appellant's work injury and her complaints of "pain and stiffness in her left shoulder aggravated by using her left arm out in front of her or by trying to raise it above shoulder level." He found that she had reached maximum medical improvement. Dr. Ward measured range of motion of the left shoulder and stated, "With her scapula fixed, [appellant] has a true 90 degrees of left shoulder flexion, 90 degrees of abduction, 30 degrees of internal rotation and 30 degrees of external rotation." He determined that, according to Table 15-34 on page 475 of the sixth edition of the A.M.A., *Guides*, 80 degrees flexion yielded a six percent impairment, 80 degrees abduction yielded a six percent impairment, 30 degrees internal rotation yielded a four percent impairment and 30 degrees external rotation yielded a two percent impairment. Dr. Ward added the impairment ratings due to loss of range of motion to find an 18 percent left upper extremity impairment. He noted that appellant's "history is consistent with a [g]rade 2 modifier."

By decision dated January 4, 2010, the hearing representative set aside the June 29, 2009 decision. He instructed OWCP to refer Dr. Ward's November 12, 2009 impairment evaluation to an OWCP medical adviser for review.

On January 5, 2010 an OWCP medical adviser reviewed the medical evidence of record and noted that a magnetic resonance imaging (MRI) scan study showed "a very tiny amount of fluid in the subacromial subdeltoid bursa" with no rotator cuff tear.[2] He opined that Dr. Ward did not properly determine the impairment using range of motion measurements. The medical adviser noted that section 15.7 on page 464 of the A.M.A., *Guides* requires that the evaluating physician provide three measurements for motion that are averaged. The three measurements must be within 10 degrees of the average. As Dr. Ward did not provide three measurements, the medical adviser found that he inappropriately used range of motion to determine the extent of appellant's impairment. He thus applied the diagnosis-based method to Dr. Ward's clinical findings. The medical adviser identified a class 1 impairment due to bursitis using the

[2] A December 3, 2008 MRI scan study showed possible mild bursitis and no rotator cuff tear.

nonspecific shoulder pain diagnosis from the shoulder regional grid set forth in Table 15-5 on page 401, which yielded a default value of one percent.[3] After determining the impairment class and default grade, the medical adviser considered whether there were any applicable grade adjustments for Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). He found a grade modifier of 2 for functional history as appellant had pain and stiffness of the left arm. The medical adviser found no modifier for physical examination as Dr. Ward did not provide any objective deficits as set forth in Table 15-8 on page 408. He found a grade modifier of 1 for clinical studies based on the MRI scan study finding of "a small amount of fluid consistent with bursitis." Utilizing the net adjustment formula discussed above, the medical adviser found that (GMFH - CDX) + (GMCS - CDX) or (1-1) + (1-1) = 0, yielded a 0 adjustment. He concluded that appellant had a one percent permanent impairment of the left upper extremity.

By decision dated January 11, 2010, OWCP granted appellant a schedule award for a one percent permanent impairment of the left upper extremity. The period of the award ran for 3.12 weeks from November 12 to December 3, 2009.

On January 21, 2010 appellant, through her attorney, requested a telephone hearing. He submitted an impairment evaluation dated March 14, 2010 from Dr. William N. Grant, a Board-certified internist, who related, "I have not seen [appellant] as a patient. I have evaluated the notes of Dr. Ward." Dr. Grant assessed appellant's *Quick*DASH (Disabilities of the Arm, Shoulders and Hand) score as 75 and listed Dr. Ward's range of motion measurements. Referencing Table 15-34 on page 475, he found that 80 degrees flexion yielded a nine percent impairment, 80 degrees abduction yielded a five percent impairment, 30 degrees internal rotation yielded a four percent impairment and 30 degrees external rotation yielded a two percent impairment. Dr. Grant used the Combined Values Chart on page 604 to find a total impairment due to loss of range of motion of 19 percent. He further opined that appellant had a grade modifier of 2 for loss of motion and a grade modifier of 2 for functional history, which he found yielded no modification of her impairment under Table 15-36 on page 477, applicable to functional history adjustments to range of motion impairments.

At the telephone hearing, held on April 13, 2010, appellant's attorney argued that Dr. Grant's opinion conformed to the sixth edition of the A.M.A., *Guides* and established that she had a 19 percent left upper extremity impairment.

By decision dated June 28, 2010, the hearing representative set aside the January 11, 2010 decision. She remanded the case for an OWCP medical adviser to review Dr. Grant's opinion.

On July 9, 2010 an OWCP medical adviser reviewed and summarized the impairment evaluations. He found that the opinions of Dr. Grant and Dr. Ward were not supported by objective, clinical findings and that neither properly applied the sixth edition of the A.M.A., *Guides*. The medical adviser determined that appellant's impairment could not be evaluated

[3] OWCP accepted that appellant sustained a right elbow and forearm sprain rather than epicondylitis. However, the elbow regional grid at Table 15-4 on page 398 sets forth identical impairment values for an elbow sprain/strain as for lateral or medial epicondylitis of the elbow.

using range of motion as neither Dr. Grant nor Dr. Ward provided range of motion findings for her unaffected right shoulder as required by the A.M.A., *Guides*. Further, neither physician indicated that he measured range of motion three times after a warm up and then rounded the measurements. The medical adviser further noted that Dr. Benjamin Moorehead, a Board-certified internist, in a report dated July 10, 2009, found full flexion of the left shoulder.[4] He stated:

> "Given the minimal MRI [scan] findings, there is insufficient pathology to correlate with the severe motion deficits recorded by Drs. Ward and Grant. In terms of consistency and reliability, given the fact that Dr. Moorehead noted pain but 'full motion' to flexion causes one to question the motion values assigned for the shoulder by Drs. Grant and Ward, considering their significant motion loss including flexion. Recall that motion measurements are only as reliable as the effort placed by a patient on the day of their examination; therefore, patients can perform less than they are capable but never more. The range of motion findings, in this case, are deemed unreliable and should not be used as a basis for impairment; therefore, the more applicable method to rate impairment in the DBI [diagnosis-based impairment] method as outlined above."

OWCP's medical adviser applied the diagnosis-based impairment method and found that appellant had a class 1 muscle sprain/strain using the tendinitis diagnosis according to Table 15-5 on page 402, which yielded a default value of one percent. He determined that she had a grade modifier of 3 for functional history based on Dr. Grant's finding of a 75 *Quick*DASH score. The medical adviser, however, citing the A.M.A., *Guides* on page 406, noted that, if functional history differed by two or more grades from the clinical studies or physical examination findings, it "should be assumed to be unreliable." He stated, "In this case, the [f]unctional [h]istory is greater than [two] from the clinical studies; therefore, this must be excluded from the adjustment process." The medical adviser found that appellant had no adjustment due to physical examination findings as the range of motion measurements did not conform to the provisions of the A.M.A., *Guides*. He determined that the grade modifier for clinical studies was one, for a net adjustment of zero and a total left upper extremity impairment of one percent.

By decision dated July 12, 2010, OWCP found that appellant was not entitled to an additional award beyond the previously awarded one percent impairment. On July 20, 2010 appellant's attorney requested a telephone hearing. A telephone hearing was held on November 4, 2010.

In a decision dated January 21, 2011, the hearing representative affirmed the July 12, 2010 decision. She found that an OWCP medical adviser had reviewed the medical evidence that his opinion constituted the weight of the evidence and established that appellant had no more than a one percent left upper extremity impairment.

[4] In a report dated July 10, 2009, Dr. Moorehead found full shoulder flexion and a "painful arc of impingement with abduction."

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations,[6] 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, FECA 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, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

The sixth edition requires identifying 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).[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

The A.M.A., *Guides* at section 15.7 provides:

> "Range of motion should be measured after a 'warm up,' in which the individual moves the joint through its maximum range of motion at least [three] times. The range of motion examination is then performed by recording the active measurements from [three] separate range of motion efforts…. All measurements should fall within 10 [degrees] of the mean of these [three] measurements. The maximum observed measurement is used to determine the range of motion impairment."[10]

ANALYSIS

OWCP accepted that appellant sustained a sprain of the left shoulder and upper arm due to an October 12, 2008 employment injury. In May 2009, appellant filed a claim for a schedule award. In the November 12, 2009 impairment evaluation, Dr. Ward measured range of motion of her left shoulder as 80 degrees flexion, 80 degrees abduction, 30 degrees internal rotation and 30 degrees external rotation.[11] He found that appellant had an 18 percent permanent impairment due to loss of range of motion of the left shoulder. OWCP's medical adviser reviewed

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*. at § 10.404(a).

[8] 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).

[9] A.M.A., *Guides* 494-531.

[10] *Id*. at 464.

[11] Dr. Ward listed 90 degrees of shoulder flexion in his measurements but indicated that appellant had 80 degrees of shoulder flexion when providing his impairment rating.

Dr. Ward's report and found that he did not provide valid range of motion measurements as required by section 15.7a of the A.M.A., *Guides*. As discussed, the A.M.A., *Guides* requires the rating physician to obtain three measurements per joint motion. The measurements are then averaged and each of the three measurements shown must be within 10 degrees of the calculated average. The maximum observed measurement is then used to determine the range of motion impairment.[12] As an OWCP medical adviser found that Dr. Ward's range of motion measurements were not reliable, he applied provisions for determining the diagnostic-based estimate to the clinical findings. He identified the diagnosis as a class 1 impairment due to bursitis, with a default value of one percent under Table 15-5. The medical adviser applied grade modifiers of 2 for functional history and one for clinical studies, which he found yielded a net adjustment of zero or a one percent left upper extremity impairment.

On March 14, 2010 Dr. Grant provided an impairment evaluation based on his review of Dr. Ward's findings. He determined that appellant had a *Quick*DASH score of 75. Dr. Grant utilized Dr. Ward's range of motion measurements which he found yielded a 19 percent permanent impairment of the left upper extremity according to Table 15-34. He found that appellant had no adjustment to the range of motion finding due to grade modifiers of 2 for loss of motion and two for functional history under Table 15-36.

On July 9, 2010 an OWCP medical adviser reviewed the evidence and found that neither Dr. Ward nor Dr. Grant properly applied the provisions of the A.M.A., *Guides*. He asserted that appellant's impairment could not be evaluated using range of motion measurements as the physicians did not measure range of motion three times after a warm up and then utilize the average of the measurements as required by section 15.7 of the A.M.A., *Guides*. The medical adviser further noted that another physician had measured full flexion on July 10, 2009. He consequently used the diagnosis-based impairment method and identified the diagnosis as class 1 tendinitis, which yielded a one percent default value. The medical adviser found a one percent grade modifier for clinical studies and no grade modifier for physical examination as the range of motion measurements were not in accordance with the A.M.A., *Guides.* He further found that appellant had a grade modifier of 3 for functional history based on her *Quick*DASH score of 75. The A.M.A., *Guides*, however, provides that, if the grade modifier for functional history differs by two or more grades from either clinical studies or physical examination findings, it should be deemed unreliable and excluded.[13] The medical adviser applied the grade modifier of 1 for clinical studies, which yielded a net adjustment of zero for a one percent left upper extremity impairment. There is no medical evidence conforming to the A.M.A., *Guides* showing a greater percentage of impairment.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

[12] A.M.A., *Guides* 464.

[13] *Id*. at 406.

CONCLUSION

The Board finds that appellant has no more than a one percent permanent impairment of the left upper extremity, for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the January 21, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 18, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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