United States Department of Labor
Employees' Compensation Appeals Board

S.C., Appellant	)	
and	)	**Docket No. 11-506**
	)	**Issued: October 5, 2011**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Wilmington, DE, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 24, 2010 appellant filed a timely appeal from the December 23, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP) concerning a schedule award. 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 case.

ISSUE

The issue is whether appellant met her burden of proof to establish that she has more than a five percent permanent impairment of her left arm, for which she received a schedule award.

FACTUAL HISTORY

On August 28, 2007 appellant, then a 59-year-old information receptionist, filed an occupational claim alleging that she sustained injury to her left elbow due to her repetitive job duties. OWCP accepted that she sustained work-related medial epicondylitis of her left elbow.

[1] 20 C.F.R. § 8101 *et seq.*

On January 29, 2009 appellant underwent open debridement/repair of the flexor tendon of the medial epicondyle of her left elbow. The procedure was authorized by OWCP. Appellant did not return to work after her surgery and she retired from the employing establishment.

In an October 19, 2009 report, Dr. Robert A. Smith, a Board-certified orthopedic surgeon who served as an OWCP referral physician, advised that electromyogram (EMG) testing from September 13, 2007 slowed no evidence of any ulnar neuropathy at the left elbow. The only finding was a mild left median neuropathy or carpal tunnel syndrome. Dr. Smith asserted that EMG testing that showed evidence of ulnar neuropathy at the left elbow constituted a false positive result. On physical examination, appellant reported tenderness along the scar on the medial aspect of her left elbow.

On April 19, 2010 appellant filed a claim for permanent impairment. She previously received a schedule award for a five percent permanent impairment of her left arm in connection with another claim accepted for a left shoulder strain.[2]

In an April 23, 2010 letter, OWCP requested that appellant submit additional factual and medical evidence in support of her claim. Appellant submitted a May 5, 2010 report in which Dr. Peter F. Townsend, an attending Board-certified orthopedic surgeon, indicated that she had reached maximum medical improvement.

In a May 24, 2010 decision, OWCP denied appellant's claim on the grounds that she did not submit probative medical evidence showing that she was entitled to additional schedule award compensation.

Appellant, through counsel, requested reconsideration of OWCP's May 24, 2010 decision. She submitted a September 27, 2010 report of Dr. Richard I. Zamarin, an attending Board-certified orthopedic surgeon, who determined that she had an 11 percent permanent impairment under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009). Dr. Zamarin stated that, with regard to appellant's left shoulder, Table 15-5 (Shoulder Regional Grid) on page 401, dictated that she be placed under class 1, muscle tendon shoulder pain, which gave a one percent left upper extremity impairment. Grade modifiers were derived for functional history (grade three due to a *Quick*DASH score of 80), physical examination (grade zero) and clinical studies (grade one). The diagnosis class (class 1) was subtracted from each modifier under the net adjustment formula so 3-1 + 0-1 + 1-1 = 1. Dr. Zamarin indicated that going back to Table 15-5 on page 401 and moving one space to the right still gave a one percent upper extremity impairment. He further stated:

> "The impairment rating for the medial epicondyle was calculated by first going to Table 15-4, [p]age 399, Elbow Regional Grid: Upper Extremity Impairments. Under epicondylitis lateral and medial status post surgical release of flexor/extensor origins, residual symptoms, is a Default Value of five percent [u]pper [e]xtremity. Then using again the modifiers on [p]age 406, Table 15-7, she has a [g]rade 3 [m]odifier with a *Quick*DASH score of 80. Then going to [p]age 408, she has a [g]rade 3 [m]odifier due to her significant findings of

[2] Appellant previously underwent left rotator cuff surgery which was not work related.

tenderness on physical exam[ination]. Then going to [p]age 410, Table 15-9, Clinical Studies Adjustment: upper extremities, I placed her under a [g]rade 1 [m]odifier due to the clinical studies confirming diagnosis, mild pathology. The net adjustment is calculated by subtracting the class from each modifier so 3-1 + 3-1 + 1-1 = 4. The maximum that you can go to the right would be two so a five percent upper extremity impairment is then moved up to a seven percent upper extremity impairment with regard to the medial epicondylitis.

"Then the upper extremity impairment calculated for the ulnar nerve entrapment at the elbow was performed by using Table 15-23, on page 449, Entrapment/ Compression Neuropathy Impairment. The appropriate [g]rade [m]odifier for test findings for the ulnar nerve was normal, which is a [g]rade zero [m]odifier. For the history it was two because there were significant intermittent symptoms, and for the physical findings it was [g]rade one because of her normal physical exam[ination]. These three are added, which equals a three and then divided by three, which gives it a one. [Appellant] therefore falls under [g]rade [m]odifier one, which gives a two percent upper extremity impairment. Because of the *Quick*DASH score of 80, it moves up to a three percent upper extremity impairment.

"One then goes to the Combined Values Chart, on [p]age 604, to combine the upper extremity impairments. A three percent impairment is combined with a one percent impairment, which gives a four percent upper extremity impairment. A 4 percent upper extremity impairment is then combined with a 7 percent upper extremity impairment, which gives an 11 percent upper extremity impairment."

The relevant evidence of record, including the September 27, 2010 report of Dr. Zamarin, was reviewed by Dr. Arnold T. Berman, a Board-certified orthopedic surgeon serving as an OWCP medical adviser. In a December 21, 2010 report, Dr. Berman determined that, based on the standards of the sixth edition of the A.M.A., *Guides*, appellant had a five percent permanent impairment of her left arm. He stated that, under Table 15-4 (Elbow Regional Grid) on page 399, appellant's diagnosis category was a class 1 left medial epicondylitis, status post surgical debridement and release with residual symptoms. The default value of this category was five percent (grade C). Dr. Berman further stated:

"According to the [operation] note of January 29, 2009 which showed no ulnar nerve compression or [electromyogram] and a second operation was not recommended by Dr. Smith in his [second opinion] of October 19, 2009. There is full range of motion of the left elbow and grip strength is normal.

"Grid Adjustment and [g]rade [m]odifiers: [p]age 406, functional history, Table 15-7 is grade modifier one (normal [range of motion], mild), page 410, Table 15-9 clinical studies adjustment upper extremities, grade modifier one, clinical studies confirm diagnosis; [n]et [a]djustment is zero, page 411, [n]et [a]djustment [f]ormula is applied.

"In summary, the [schedule award] reconsideration of the left upper extremity is [g]rade C, [c]lass 1, Table 15-4, which is equal to a five percent left upper

extremity impairment. The date of [maximum medical improvement] is October 19, 2009, the date of Dr. Smith's evaluation."

In a December 23, 2010 decision, OWCP determined that appellant had not met her burden of proof to establish that she has more than a five percent permanent impairment of her left arm, for which she received a schedule award.

LEGAL PRECEDENT

The schedule award provision of FECA[3] and its implementing regulations[4] 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 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[5] For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.[6] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[7]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the elbow, reference is made to Table 15-5 (Elbow Regional Grid) beginning on page 398. With respect to the shoulder, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401. After the Class of Diagnosis (CDX) is determined from the Elbow or Shoulder Regional Grid (including identification of a default grade value), the Net Adjustment Formula is applied using the grade modifier for Functional History (GMFH), grade modifier for Physical Examination (GMPE) and grade modifier for Clinical Studies (GMCS). The Net Adjustment Formula is (GMFH-CDX) + (GMPE-CDX) +

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] *Id*.

[6] *See* FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5th ed. 2001) is used.

[7] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b (June 1993). This portion of OWCP procedure provides that the impairment rating of a given scheduled member should include "any preexisting permanent impairment of the same member or function."

(GMCS-CDX).[8] Under Table 15-23 on page 449 a scheme is provided for evaluating impairment due to entrapment/compression neuropathy, including entrapment of the ulnar nerve.[9] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[10]

Section 8123(a) of FECA provides in pertinent part: "If there is 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."[11] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[12]

ANALYSIS

Appellant received a schedule award for a five percent permanent impairment of her left arm. OWCP determined that appellant was not entitled to additional schedule award based on a December 21, 2010 report of Dr. Berman, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, who found that appellant did not have additional permanent impairment under the standards of the sixth edition of the A.M.A., *Guides*. In a September 27, 2010 report, Dr. Zamarin, an attending Board-certified orthopedic surgeon, found that appellant had an 11 percent permanent impairment of her left arm under the standards of the sixth edition of the A.M.A., *Guides*. The Board finds that there is a conflict in medical opinion between Dr. Berman and Dr. Zamarin regarding the extent of appellant's left arm impairment.

In his December 21, 2010 report, Dr. Berman determined that appellant had five percent impairment due to her left medial epicondylitis, status post surgical debridement and release with residual symptoms. In contrast, Dr. Zamarin determined that appellant had seven percent impairment by applying a similar diagnosis-based analysis of appellant's left elbow condition. However, Dr, Zamarin derived a greater impairment rating because he felt that appellant's left elbow condition collectively warranted higher grade modifier scores for functional history, physical examination and clinical studies.

Dr. Zamarin also found that, based on the findings on examination and diagnostic testing, appellant was entitled to three percent impairment for entrapment of her left ulnar nerve. In contrast, Dr. Berman indicated that, based on his own interpretation of the findings on examination and diagnostic testing, appellant was not entitled to such a rating. Dr. Zamarin determined that appellant was entitled to a one percent impairment rating due to a diagnosis-

[8] *See* A.M.A., *Guides* (6th ed. 2009) 405-11. Table 15-5 also provides that, if motion loss is present for a claimant who has undergone a shoulder arthroplasty, impairment may alternatively be assessed using section 15.7 (range of motion impairment). Such a range of motion impairment stands alone and is not combined with a diagnosis impairment. *Id.* at 405, 475-78.

[9] *Id.* at 449.

[10] *Id.* at 23-28.

[11] 5 U.S.C. § 8123(a).

[12] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

based assessment of her left shoulder condition. He indicated that this was a preexisting impairment and therefore should be included in the assessment of appellant's left arm impairment.[13] In contrast, Dr. Berman did not include an impairment rating for appellant's left shoulder because he did not feel that this constituted an employment-related impairment.

Consequently, the case must be referred to an impartial medical specialist to resolve the conflict in the medical opinion evidence. On remand OWCP should refer appellant, along with the case file and the statement of accepted facts, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion on this matter. After such further development as OWCP deems necessary, OWCP should issue an appropriate decision regarding appellant's claim.

CONCLUSION

The Board finds that, due to a conflict in the medical opinion evidence, the case is not in posture for decision regarding whether appellant has more than a five percent permanent impairment of her left arm.

ORDER

IT IS HEREBY ORDERED THAT the December 23, 2010 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: October 5, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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

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

[13] *See supra* note 7.