United States Department of Labor
Employees' Compensation Appeals Board

L.R., Appellant	)	
	)	**Docket No. 11-1397**
and	)	**Issued: January 6, 2012**
U.S. POSTAL SERVICE, POST OFFICE, New Castle, 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:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 25, 2011 appellant, through her attorney, filed a timely appeal from the May 20, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) concerning a schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) 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 two percent permanent impairment of her left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On February 4, 2009 appellant, a 34-year-old letter carrier, filed a traumatic injury claim alleging that she sustained injuries to her left arm, shoulder, elbow and wrist on January 29, 2009

[1] 5 U.S.C. §§ 8101-8193.

when she slipped and fell on ice while carrying mail. She stopped working on the date of injury and was paid appropriate compensation for lost wages.[2] OWCP accepted appellant's claim for contusions, sprains and strains of the left shoulder, wrist and arm.[3]

In a January 21, 2010 report, Dr. Daisy Rodriguez, a Board-certified internist, provided a history of the January 29, 2009 injury and treatment and examination findings. Range of motion examination of the left shoulder revealed the following results: abduction was limited to 170 degrees; forward flexion was limited to 90 degrees; extension was 40 degrees; and internal rotation was limited to 70 degrees with pain. With abduction to 90 degrees and 0 degrees, there was a positive impingement sign. There was no crepitus or effusion noted and no tenderness in the biceps or in the biceps groove. There was tenderness at the brachial plexus as it courses just above the clavicle and below the clavicle towards the left axilla, tenderness of the supraspinatus tendon and the muscle as it courses above the left scapular ridge and tenderness within the acromioclavicular, supraspinatus area. Left elbow extension was limited to -3 degrees to 4 degrees. There was tenderness within the ulnar groove and compression on this area reproduced tingling in appellant's left hand. Deep tendon reflexes were 2/4 throughout, equal and symmetric. Sensation was grossly intact throughout to light touch. There was a positive Tinel's sign in the left ulnar groove of the left elbow. Grip strength was 30 pounds on the left, which was approximately half of the normal grip strength for a woman of appellant's age Dr. Rodriguez diagnosed left shoulder contusion, sprain and subluxation, left wrist contusion and sprain, left rotator cuff impingement syndrome, left shoulder brachial plexopathy, ulnar neuropathy of the left elbow and chronic pain resulting from her work-related injury. She opined that appellant was suffering significantly from her left shoulder pain, with a sensation of "subluxation" and cramping of the muscles around the shoulder, as well as left elbow tingling and numbness from the wrist down to the left hand.

Applying the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) to her findings, Dr. Rodriguez concluded that appellant had a five percent upper extremity impairment. She 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, soft tissue/contusion. Applying the adjustment grid and grade modifiers, page 406, Table 15-7, adjustments for functional history (grade 2 due to a *Quick*DASH score of 90), physical examination (grade modifier 1, page 408, Table15-8); and page 410, Table 15-9, adjustment for clinical studies (grade modifier 1), Dr. Rodriguez concluded that appellant had a two percent left upper extremity impairment for soft tissue contusion. Applying the same analysis, she concluded that appellant had an additional two percent left upper extremity

[2] This is the second time this case has been before the Board. In a decision dated September 13, 2010, the Board reversed OWCP's June 17, 2009 decision reducing appellant's compensation benefits on the grounds that she refused to cooperate with vocational rehabilitation. Docket No. 10-485 (issued September 13, 2010).

[3] On January 13, 2011 appellant filed a traumatic injury claim alleging that she sustained a left shoulder injury while lifting her mailbag. (File No. xxxxxx135). On August 20, 2008 she filed a traumatic injury claim for a left shoulder sprain (File No. xxxxxx220). Appellant filed five other traumatic injury claims, which were handled as "short form closures:" File No. xxxxxx641 (March 28, 2006 -- alleging contusion of the right hand); File No. xxxxxx027 (September 9, 2006 -- alleging dizziness); File No. xxxxxx584 (October 27, 2006 -- left knee sprain); File No. xxxxxx7l4 (May 2, 2007 -- right ankle sprain); and File No. xxxxxx269 July 10, 2007 -- alleging dehydration).

impairment for her diagnosed shoulder sprain/strain. Referencing Table 15-3, page 395 for a rating of her left wrist impairment, Dr. Rodriguez placed appellant under class 1 (muscle/tendon: sprain/strain). Applying the adjustment grid and grade modifiers, page 406, Table 15-7, adjustments for functional history (grade 2 due to a *Quick*DASH score of 90) and physical examination (grade modifier 0, page 408, Table15-8), Dr. Rodriguez concluded that appellant had a one percent left upper extremity impairment for her left wrist condition, resulting in a total left upper extremity impairment of five percent.

On November 9, 2010 appellant submitted a request for a schedule award.

OWCP referred appellant to Dr. Kevin Hanley, a Board-certified orthopedic surgeon, for an examination and an opinion as to whether she had a permanent impairment of her left upper extremity and, if so, the degree of the impairment. In an October 10, 2010 report, Dr. Hanley determined that, based on the standards of the sixth edition of the A.M.A., *Guides*, appellant had a two percent permanent impairment of her left upper extremity. On examination of the shoulder, abnormal findings included some tenderness around the rotator cuff and minimal loss of motion. Dr. Hanley stated that appellant had "low-grade, subjective residuals with minimal objective findings." Pursuant to page 401 of the sixth edition of the A.M.A., *Guides*, he concluded that the most appropriate diagnosis was "crush injury." Dr. Hanley placed appellant in class 1, with a grade modifier of 1 for functional history (mild problems); grade modifier 1 for physical examination (minimal findings); and grade modifier 1 for clinical studies, resulting in a net adjustment of 2. His examination of the wrist revealed no abnormal findings. Therefore, Dr. Hanley provided a zero percent impairment in regard to the left wrist. He opined that appellant had reached maximum medical improvement (MMI).

The evidence of record was reviewed by an OWCP medical adviser. In a February 1, 2011 report, the medical adviser determined that, based on the standards of the sixth edition of the A.M.A., *Guides*, appellant had a two percent impairment of her left upper extremity. He stated that, under Table 15-5 (Shoulder Region Grid) on page 401, her diagnosis category was a class 1 shoulder contusion or crush injury with healed minor soft tissue or skin injury. The default value of this category was two percent (grade C) (residual symptoms and consistent objective findings at MMI). The medical adviser applied the adjustment grid and grade modifiers as follows: page 406, Table 15-7 (functional history adjustment) grade modifier 1, mild problems; page 408, Table 15-8 (physical examination adjustment) grade modifier 0; and page 410, Table 15-9 (clinical studies adjustment) grade modifier 0. Based on these results, he determined that appellant had a grade C, two percent impairment.

The medical adviser noted that the reports of Dr. Rodriguez and Dr. Hanley were in conflict with one another. He stated that Dr. Rodriguez inappropriately provided an impairment rating for a wrist condition and for a soft tissue sprain and strain of appellant's shoulder, in addition to a rating for shoulder contusion or crush injury, noting that the sixth edition of the A.M.A., *Guides* emphasizes the use of one single diagnostic category wherever possible. The medical adviser opined that, because Dr. Rodriguez incorrectly used the A.M.A., *Guides*, her

recommendations could not be accepted. He opined that the date of MMI was January 29, 2009, the date of Dr. Rodriguez' examination.[4]

In a May 20, 2011 decision, OWCP granted appellant a schedule award for a two percent impairment of her left upper extremity, based on the reports of Dr. Hanley and the OWCP medical adviser. The period of the award was from July 17 through August 6, 2009. OWCP determined that the date of MMI was January 29, 2009.

On appeal, counsel argued that the district medical adviser failed to provide rationale explaining the basis of his impairment rating. Further, he argued that there exists a conflict of medical opinion requiring further development of the medical evidence.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing 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 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.[7] 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.[8] 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.[9]

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 shoulder, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401. With respect to the wrist, reference is made to Table 15-3 (Wrist Regional Grid) beginning on page 396. After the Class of Diagnosis (CDX) is determined from the Wrist or Shoulder Regional Grid (including identification of a default grade

[4] The Board notes that the date of Dr. Rodriguez report to which the DMA referred was not January 29, 2009, but rather January 21, 2010.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999).

[7] *Id.*

[8] *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.

[9] *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 manual provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

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) + (GMCS - CDX).[10] 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.[11]

Section 8123(a) of FECA provides in pertinent part that, 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.[12] 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.[13]

ANALYSIS

Appellant's treating physician, Dr. Rodriguez, opined that appellant had a five percent permanent impairment of her left upper extremity. Dr. Hanley, the second opinion physician and an OWCP medical adviser concluded that appellant had only a two percent left upper extremity impairment based upon the sixth edition of the A.M.A., *Guides*. The Board finds that there is a conflict in medical opinion between Dr. Rodriguez and Dr. Hanley regarding the extent of appellant's left upper extremity impairment.

In his October 10, 2010 report, Dr. Hanley determined that appellant had a two percent permanent impairment of her left upper extremity. Noting minimal objective findings in the shoulder and no abnormal findings in the wrist, he concluded that the most appropriate diagnosis for the shoulder was "crush injury" and placed her in class 1, with grade modifiers of 1 for functional history, physical examination and clinical studies, resulting in a net adjustment of 2. Accordingly, Dr. Hanley concluded that appellant had a two percent permanent impairment of her left shoulder and a zero percent impairment of her left wrist.

In contrast, Dr. Rodriguez determined that appellant had five percent impairment by providing an analysis of appellant's wrist condition and a soft tissue sprain and strain of her shoulder, in addition to an impairment rating for the shoulder contusion. She opined that appellant was suffering significantly from her left shoulder pain, with a sensation of "subluxation" and cramping of the muscles around the shoulder, as well as left elbow tingling and numbness from the wrist down to the left hand. Applying the adjustment grid, grade

[10] *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.

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

[12] 5 U.S.C. § 8123(a).

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

modifiers and adjustments for functional history, physical examination and clinical studies, Dr. Rodriguez concluded that appellant had a two percent left upper extremity impairment for soft tissue contusion, a two percent impairment for shoulder sprain/strain and a one percent impairment for her left wrist condition, resulting in a total five percent left upper extremity impairment.

The district medical adviser agreed with Dr. Hanley's impairment rating. Noting that the sixth edition of the A.M.A., *Guides* emphasizes the use of one single diagnostic category wherever possible, the medical adviser stated that Dr. Rodriguez inappropriately provided an impairment rating for wrist and soft tissue sprain and strain conditions of appellant's shoulder, in addition to a rating for shoulder contusion or crush injury. The Board notes that, in performing an impairment rating of an upper extremity, the sixth edition of the A.M.A., *Guides* provides for the selection of the most applicable diagnosis in each region, application of the adjustment grid and grade modifiers and identification of the appropriate impairment rating by use of the regional grid. Thereafter, upper extremity percentages are to be combined using the Combined Values Chart.[14] Therefore, based on his examination findings, Dr. Rodriguez appropriately provided an impairment rating for appellant's wrist condition, which was in conflict with Dr. Henley's rating.[15] An OWCP medical adviser may review a report to verify the correct application of the A.M.A., *Guides* and confirm the percentage of permanent impairment.[16] It is the impartial medical specialist, however, who must resolve a conflict in medical opinion.[17]

The Board finds that there is a conflict in medical opinion between appellant's treating physician, Dr. Rodriguez and OWCP's medical adviser and second opinion physician, Dr. Henley. Consequently, the case must be referred to an impartial medical specialist to resolve the conflict in the medical opinion evidence.

In its May 20, 2011 decision, OWCP found that the date of MMI to be January 29, 2009. This is the date appellant filed her OWCP claim. The determination of whether MMI has been reached is based on the probative medical evidence of record and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by OWCP. The Board will set aside the selection of January 29, 2009 as the date of MMI as an inadvertent error. 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 it deems necessary, OWCP should issue an appropriate decision regarding appellant's claim.

[14] *See* A.M.A., *Guides*, *supra* note 10 at 389.

[15] The Board notes that Dr. Rodriguez provided impairment ratings of appellant's left shoulder based on two separate diagnoses. The sixth edition of the A.M.A., *Guides* provides for the selection of a single diagnosis that is most applicable for the region being assessed. (*Id.* at 389)

[16] *I.H.*, Docket No. 08-1352 (issued December 24, 2008). Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(c) (April 1993).

[17] *I.H., supra* note *id*.; *Richard R. LeMay*, 56 ECAB 341 (2005).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the May 20, 2011 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: Junuary 6, 2012
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