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

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| **R.M., Appellant** | ) | |
| **and** | ) | **Docket No. 13-1697** |
| | ) | **Issued: April 14, 2014** |
| **DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, Oklahoma City, OK, 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
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

### ***JURISDICTION***

On July 8, 2013 appellant filed a timely appeal from the June 26, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 his burden of proof to establish that he has more than 16 percent permanent impairment of his right arm, for which he received a schedule award.

### ***FACTUAL HISTORY***

OWCP accepted that on June 25, 2009 appellant, then a 50-year-old plumber, sustained injury due to his right arm when pushed backwards while holding a piece of sheet metal that had buckled. It initially accepted that he sustained a neck sprain, lumbar sprain, recurrent dislocation

[1] 5 U.S.C. §§ 8101-8193.

of his right shoulder and sprains of his right upper arm, elbow, lower arm, wrist and shoulder. OWCP subsequently accepted that appellant sustained cervical disc displacement at C4, aggravation of cervical degenerative disc disease and right carpal tunnel syndrome due to the June 25, 2009 work incident. Appellant underwent a cervical discectomy and fusion at C5-6 and C6-7 on February 24, 2010. On June 16, 2010 he had neurolysis of his right median nerve, tenolysis of the flexor tendons of his right wrist and placement of his right neural sleeve. On August 18, 2010 appellant underwent a synovectomy, subacromial decompression, distal clavicle excision and bursectomy of his right shoulder. The procedures were authorized by OWCP and he received disability compensation on the periodic rolls.

In an October 23, 2010 report, Dr. Christopher Jordan, a Board-certified orthopedic surgeon serving as an OWCP referral physician, discussed appellant's neck, right shoulder and right median nerve conditions. He found no evidence of right elbow pathology or low back problems. Dr. Jordan stated that appellant was not at a permanent or stationery status and could not return to work as a plumber but could perform sedentary work with restrictions.

In a November 3, 2010 form report, Dr. John W. Ellis, an attending Board-certified family practitioner, advised that appellant could work with restrictions, including lifting, pushing and pulling no more than 10 pounds. On December 8, 2010 appellant returned to modified work for the employing establishment. On July 21, 2011 he filed a claim for a schedule award due to his June 25, 2009 injury.

In a July 11, 2011 report, Dr. Ellis determined that appellant had 36 percent permanent impairment of his right arm and 15 percent permanent impairment of his left leg under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. He noted that appellant reported pain radiating from his neck down into his right hand and from his back down into his left foot. Dr. Ellis based his impairment rating in part on peripheral nerve deficits involving the C5, C6, C7, L5 and S1 nerve distributions.

On August 1, 2011 Dr. Ronald Blum, a Board-certified internist serving as an OWCP medical adviser, determined that the impairment rating of Dr. Ellis was not in accordance with the medical findings of record. He recommended that appellant be referred to a second opinion physician for an examination and opinion on the extent of his permanent impairment.

In an August 24, 2011 report, Dr. Shawn Smith, a Board-certified physical medicine and rehabilitation physician serving as an OWCP referral physician, found that, under the sixth edition of the A.M.A., *Guides*, appellant had 12 percent permanent impairment of his right arm due to his right shoulder surgery and 5 percent permanent impairment of his right arm due to carpal tunnel syndrome for a total right arm impairment of 17 percent. He did not find any spinal peripheral nerve impairment for appellant's arms or the legs.

On September 6, 2011 Dr. Blum agreed with Dr. Smith's rating that appellant had 12 percent permanent impairment of his right arm due to his right shoulder surgery and 5 percent permanent impairment of his right arm due to carpal tunnel syndrome. He found, however, that Dr. Smith failed to combine the two impairment values using the Combined Values Chart on page 604 of the sixth edition of the A.M.A., *Guides*. The combination of the two values yielded a total right arm impairment of 16 percent.

By decision dated September 15, 2011, OWCP granted appellant a schedule award for 16 percent permanent impairment of his right arm. It advised him that no award was payable for his left leg. The award ran for 49.92 weeks from February 24, 2011 to February 8, 2012.

In a December 7, 2011 report, Dr. Ellis determined that appellant had 34 percent impairment of his right arm and 15 percent permanent impairment of his left leg under the standards of the sixth edition of the A.M.A., *Guides*. Appellant requested an additional schedule award.

On January 18, 2012 Dr. Blum noted that there was conflict in medical opinion regarding appellant's permanent impairment between Dr. Smith and Dr. Ellis. OWCP referred appellant to Dr. Sami R. Framjee, a Board-certified orthopedic surgeon, for an examination and impartial medical opinion.

In a February 29, 2012 report, Dr. Framjee determined that appellant had 13 percent permanent impairment of his right arm under the sixth edition of the A.M.A., *Guides* due to the partial tear of his right rotator cuff. He did not find that appellant had any lower extremity impairment. Dr. Framjee conducted an examination of appellant's cervical spine and right arm and indicated that he had 14 percent whole man impairment of his cervical spine.

On March 23, 2012 Dr. Blum stated that no award could be made for impairment to the spine or whole person under FECA. He disagreed with Dr. Framjee's impairment rating for the right arm, noting that he assigned too high a value for the partial tear of appellant's right rotator cuff. Dr. Blum found that appellant only had a five percent impairment of his right arm based on his right rotator cuff condition and indicated that, therefore, he was not entitled to any additional schedule award compensation.

By decision dated April 17, 2012, OWCP denied appellant entitlement to any additional schedule award compensation for his right arm and repeated its denial of any award for his left leg.

In a July 24, 2012 decision, an OWCP hearing representative set aside the April 17, 2012 decision and remanded the case to OWCP for further development. The hearing representative found various deficiencies in Dr. Framjee's evaluation, noting that it did not appear that he examined appellant's lower extremities or adequately considered whether he had peripheral nerve impairment to his extremities stemming from accepted or preexisting injuries to his neck or back. He stated:

> "Therefore, this case is remanded to [OWCP] for further development. Upon receipt of the case, [OWCP] should refer [appellant] back to Dr. Framjee, [who] should be first be instructed to refrain from using reference[s] to whole person impairment and should also be advised that if any impairment is present in either the right upper or left lower extremity, [*The Guides Newsletter* (July and August 2009)] should be used in calculating that part of [appellant's] impairment. He should also be advised that he should provide an opinion concerning whether [appellant's] degenerative [acromioclavicular (AC) joint] conditions are related to

the accepted injuries or surgeries, which were approved and performed and to perform a complete low back and left lower extremity examination."

On remand, OWCP requested that Dr. Framjee conduct an additional evaluation of appellant's permanent impairment. In a September 14, 2012 report, Dr. Framjee set forth examination findings and determined that appellant had 13 percent permanent impairment of his right arm under the sixth edition of the A.M.A., *Guides.* OWCP subsequently found that he did not adequately evaluate appellant's permanent impairment under the relevant standards. It referred appellant to Dr. Timothy Pettingell, a Board-certified physical medicine and rehabilitation physician, for an examination and impartial medical examination regarding his permanent impairment.

In a January 28, 2013 report, Dr. Pettingell discussed appellant's medical history and reported findings on examination. He noted that FECA did not allow for impairment to the spine but did allow for impairment to the upper or lower extremities based on nerve root pathology and radiculopathy. Dr. Pettingell detailed electrodiagnostic testing of appellant's right upper extremity and left lower extremity, which did not show objective evidence of cervical or lumbar radiculopathy. He indicated that the medical records did not consistently provide a diagnosis of right or left cervical or lumbar radiculopathy. Dr. Pettingell stated that his examination of appellant was not consistent with right or left cervical or lumbar radiculopathy and noted, "Therefore, per 3-700 Exhibit 4, July and August 2009, [*The Guides Newsletter*], there is [no] evidence of permanent impairment regarding right or left cervical radiculopathy or right or left lumbar spine radiculopathy." He determined that, under Table 15-5 (Shoulder Regional Grid) on page 403 of the sixth edition, appellant had 11 percent permanent impairment of his right arm due to the AC joint injury of his right shoulder.[2] Under Table 15-23 on page 449, appellant had two percent permanent impairment of his right arm due to right carpal tunnel syndrome.[3] Combining these values using the Combined Values Table on page 604 resulted in total right arm impairment of 13 percent.

On March 21, 2013 Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, noted a typographical error in the portion of Dr. Pettingell's January 28, 2013 report. He recommended that Dr. Pettingell be contacted for clarification of

[2] With respect to the method of calculation, Dr. Pettingell stated, "Regarding the right shoulder, the claimant is status post arthroscopic subacromial decompression with distal clavicle resection. Therefore, Table 15-5, [p]age 403, [c]lass 1 default [g]rade C is a 10 percent upper extremity impairment (distal clavicle resection). Functional [h]istory, [g]rade [m]odifier 1, per Table 15-7 (regarding independent with activities of daily living, yet symptomatic). [p]hysical [e]xamination, [g]rade [m]odifier 1 (per Table 15-34, [r]ange of [m]otion). Clinical [s]tudies, [g]rade [m]odifier 2 per Table 15-9 (right shoulder [magnetic resonance imaging scan] June 29, 2012). Therefore, a net shift to the right of 1 or an 11 percent upper extremity impairment."

[3] Dr. Pettingell noted, "Regarding right median neuropathy at the wrist/carpal tunnel status post carpal tunnel release, the preoperative electrodiagnostic study September 22, 2009, demonstrated no evidence of median motor or sensory axonal loss. Conduction slowing borderline of the right median motor nerve across the wrist, but with prolongation of the right median sensory latency across the wrist. Therefore, per Table 15-23, [p]age 449, Test Findings are a [g]rade [m]odifier 1, History [g]rade [m]odifier 2 and Physical Exam[ination] Findings grade [m]odifier 1. Therefore, an average of 1 for [g]rade [m]odifiers. Therefore, a [two] percent upper extremity impairment. Regarding Functional Scale, [g]rade [m]odifier 1 or mild problem, per Table 15-7. Therefore, no additional adjustment is required."

the existence or nonexistence of any spinal nerve impairment and to correct the typographical error.

OWCP asked Dr. Pettingell to provide clarification and he responded with a corrected version of his January 28, 2013 report advising that there was no evidence of permanent impairment regarding right or left cervical radiculopathy or right or left lumbar spine radiculopathy. On a May 10, 2013 Dr. Blum agreed with Dr. Pettingell's assessment that appellant did not have any impairment of his extremities due to peripheral nerve impairment. He concurred that appellant had 13 percent right arm impairment comprised of an 11 percent permanent impairment of his right arm due to the AC joint injury of his right shoulder and 2 percent permanent impairment of his right arm due to right carpal tunnel syndrome.

In a June 26, 2013 decision, OWCP determined that appellant was not entitled to additional schedule award compensation. It found that the well-rationalized opinion of Dr. Pettingell, the impartial medical specialist, did not establish greater impairment than previously awarded

## ***LEGAL PRECEDENT***

The schedule award provision of FECA[4] and its implementing regulations[5] 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.[6] For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used for evaluating permanent impairment.[7] 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.[8]

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. After the Class of Diagnosis (CDX) is determined from

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999).

[6] *Id*.

[7] *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.

[8] *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."

the 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) + (GMCS - CDX).[9]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[10] In Table 15-23, grade modifiers levels (ranging from 0 to 4) are described for the categories Test Findings, History and Physical Findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on Functional Scale, an assessment of impact on daily living activities.[11]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. Recognizing that certain jurisdictions, such as under FECA, mandate ratings for extremities and preclude ratings for the spine, the A.M.A., *Guides* has offered an approach to rating spinal nerve impairments consistent with sixth edition methodology.[12] OWCP has adopted this approach for rating impairment to the upper or lower extremities caused by a spinal injury.[13]

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."[14] 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.[15] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the

[9] *See* A.M.A., *Guides* (6th ed. 2009) 401-11. 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-based impairment. *Id.* at 405, 475-78.

[10] *See* A.M.A., *Guides* 449, Table 15-23.

[11] A survey completed by a given claimant, known by the name *Quick*DASH, may be used to determine the Functional Scale score. *Id.* at 448-49.

[12] Christopher R. Brigham, MD, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition, *The Guides Newsletter* (July and August 2009).

[13] *See also G.N.*, Docket No. 10-850 (issued November 12, 2010). Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 (January 2010) (Exhibits 1, 4).

[14] 5 U.S.C. § 8123(a).

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

conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[16]

## ***ANALYSIS***

OWCP accepted that on June 25, 2009 appellant sustained a neck sprain, lumbar sprain, recurrent dislocation of his right shoulder, sprains of his right upper arm, elbow, lower arm, wrist and shoulder, cervical disc displacement at C4, aggravation of cervical degenerative disc disease and right carpal tunnel syndrome due to the June 25, 2009 work incident. Appellant underwent cervical discectomy and fusion at C5-6 and C6-7 on February 24, 2010; neurolysis of his right median nerve, tenolysis of the flexor tendons of his right wrist and placement of his right neural sleeve on June 16, 2010; and synovectomy, subacromial decompression, distal clavicle excision and bursectomy of his right shoulder on August 18, 2010. OWCP authorized these procedures.

On September 15, 2011 OWCP granted appellant a schedule award for a 16 percent permanent impairment of his right arm and advised him that no award was payable for his left leg. Appellant claimed that he was entitled to additional schedule award compensation.

After granting appellant a schedule award, OWCP properly determined that there was a conflict in the medical opinion evidence regarding his permanent impairment between Dr. Smith, a Board-certified physical medicine and rehabilitation physician serving as an OWCP referral physician, and Dr. Ellis, an attending Board-certified family practitioner.[17]

After proper development of the evidence, OWCP referred appellant to Dr. Pettingell, a Board-certified physical medicine and rehabilitation physician, for an examination and impartial medical examination regarding appellant's permanent impairment. The Board finds that the well-rationalized opinion of Dr. Pettingell represents the weight of the medical evidence with respect to appellant's permanent impairment and that the opinion shows that he is not entitled to any additional schedule award compensation.[18]

[16] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[17] *See supra* notes 14 and 15. In an August 24, 2011 report, Dr. Smith found that, under the standard of the sixth edition of the A.M.A., *Guides*, appellant had a 12 percent permanent impairment of his right arm due to his right shoulder surgery and a 5 percent permanent impairment of his right arm due to carpal tunnel syndrome for a total right arm impairment of 17 percent. In contrast, Dr. Ellis determined on a December 7, 2011 that appellant had a 34 percent impairment of his right arm and a 15 percent permanent impairment of his left leg under the standards of the sixth edition of the A.M.A., *Guides*.

[18] *See supra* note 16. Appellant was originally referred to Dr. Framjee for an impartial opinion, but neither his February 29, 2012 report nor his September 14, 2012 supplemental reports were fully rationalized. *See Guiseppe Aversa*, 55 ECAB 164 (2003) (where OWCP secures an opinion from an impartial specialist for the purpose of resolving a medical conflict and the opinion from the specialist needs clarification, it has the responsibility to secure a supplemental report from the specialist to correct the defect in the original opinion; if the specialist is unwilling or unable to clarify the opinion, the case should be referred to another appropriate impartial specialist). Dr. Framjee also did not find that appellant had greater impairment than that for which he had already been compensated.

In a January 28, 2013 report,[19] Dr. Pettingell discussed appellant's medical history and described electrodiagnostic testing of his right upper extremity and left lower extremity, which did not show objective evidence of cervical or lumbar radiculopathy. He indicated that the medical records did not consistently provide a diagnosis of right or left cervical or lumbar radiculopathy. Dr. Pettingell stated that his own examination was not consistent with right or left cervical or lumbar radiculopathy and noted, "Therefore, per 3.700 Exhibit 4, July [and] August 2009, [*The Guides Newsletter*], there is no evidence of permanent impairment regarding right or left cervical radiculopathy or right or left lumbar spine radiculopathy."[20] The Board finds that he provided medical rationale for his determination that appellant did not have permanent impairment of his extremities due to a work-related or preexisting peripheral nerve injury.

Dr. Pettingell determined that, under Table 15-5 (Shoulder Regional Grid) on page 403 of the sixth edition of the A.M.A., *Guides*, appellant had 11 percent permanent impairment of his right arm due to the AC joint injury of his right shoulder. Under Table 15-23 on page 449, appellant had two percent permanent impairment of his right arm due to right carpal tunnel syndrome. Combining these values using the Combined Values Chart on page 604 totaled right arm impairment of 13 percent. The Board finds that Dr. Pettingell correctly calculated grade modifier values and applied the Net Adjustment Formula. Dr. Blum subsequently agreed with Dr. Pettingell's rating that appellant had 13 percent permanent impairment of his right arm. For these reasons, the medical evidence of record does not establish that appellant has more than 16 percent permanent impairment of his right arm, for which he received a schedule award. OWCP properly denied his request for additional schedule award compensation.

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.

## ***CONCLUSION***

The Board finds that appellant did not meet his burden of proof to establish that he has more than 16 percent permanent impairment of his right arm, for which he received a schedule award.

[19] In May 2013, Dr. Pettingell submitted a version of this report which corrected a typographic error.

[20] *See supra* notes 12 and 13.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the June 26, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 14, 2014
Washington, DC

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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