United States Department of Labor
Employees' Compensation Appeals Board

G.P., Appellant	)	
and	)	**Docket No. 13-2031**
	)	**Issued: March 25, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Colorado Springs, CO, 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
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On September 3, 2013 appellant filed a timely appeal from the July 24, 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 has established more than 17 percent permanent impairment of his right upper extremity, for which he received a schedule award or any impairment to the left upper extremity.

FACTUAL HISTORY

On June 8, 2010 appellant, then a 63-year-old manual distribution clerk, filed an occupational disease claim alleging that he sustained severe pain and weakness in both elbows

[1] 5 U.S.C. § 8101 *et seq.*

and the right shoulder. OWCP accepted his claim for right shoulder impingement syndrome and lateral epicondylitis of the bilateral elbows. It expanded the claim to include the following right shoulder conditions: rotator cuff tear; other specified disorder of bursae and tendons; nerve root and plexus disorder; and acromioclavicular (AC) joint and degenerative joint disease. Appellant also underwent an authorized right arthroscopic subacromial decompression and right arthroscopic rotator cuff repair, right suprascapular nerve decompression at the scapular notch and right ulnar neurolysis at the elbow on December 30, 2010 and a left ulnar neurolysis at the elbow on July 12, 2011. He stopped work on December 29, 2010 and returned on October 3, 2011 with restrictions. Appellant received appropriate compensation benefits.[2]

In a December 13, 2011 report, Dr. Jack Rook, an internist and pain management specialist, examined appellant and utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*) (6th ed. 2009). He provided an impairment rating of 24 percent to the right upper extremity. Dr. Rook provided right shoulder findings of tenderness of the anterior shoulder capsule and at the tip of the shoulder where the AC joint resection was performed; severe tenderness of the subacromial space and a marked increase in shoulder pain with active or passive range of motion (ROM) of the shoulder joint. Appellant could not actively forward flex or abduct his right shoulder above shoulder level and his right shoulder pain increased with any movement at the shoulder joint. ROM measurements include: flexion 80, 85, 85 degrees; extension 29, 20, 29 degrees; abduction 75, 7l, 75 degrees; adduction 19, 20, 20 degrees; external rotation 25, 25, 25 degrees; and internal rotation 9, 10, 10 degrees. The right hand had no evidence of muscle atrophy; the grip strength was functional and small finger abduction strength was normal. Pinprick sensation was intact in all fingers of the right hand.

For the left hand, there was no evidence of muscle atrophy; grip strength was functional; small finger abduction strength was normal; pinprick sensation was diminished in an ulnar nerve distribution on the left and two-point discrimination testing revealed diminished pinprick with all testing at six millimeters and above. The Tinel's sign was strongly positive at the left cubital tunnel and the left lateral epicondyle was nontender.

For the right shoulder, Dr. Rook advised that appellant had a class 1 impairment for the distal clavicle resection procedure pursuant to Table 15-5.[3] He explained that this had a default impairment of 10 percent to the arm. Dr. Rook noted that the value was modified using Table 15-7, Table 15-8 and Table 15-9.[4] He advised that appellant's *Quick*DASH was 80. Dr. Rook provided a functional history grade modifier 3. For the physical examination grade modifier he explained that based upon palpatory findings and ROM loss it would qualify for a grade modifier 2. Dr. Rook also found that appellant's clinical studies grade modifier was grade modifier 2. He utilized the net adjustment formula and determined that appellant had an impairment of

[2] The record reflects that appellant has a prior Claim No. xxxxxx621, which was accepted for bilateral carpal tunnel syndrome. He received a schedule award of six percent to the right and left upper extremities. This claim is not before the Board.

[3] A.M.A., *Guides* 403.

[4] *Id*. at 406, 408, 410.

12 percent of the right arm. Dr. Rook also utilized the ROM method according to Table 15-34.[5] He determined that appellant had nine percent impairment for loss of flexion; one percent for extension; six percent for abduction; one percent for adduction; two percent for external rotation; and four percent for internal rotation. Dr. Rook added the values for a total upper extremity ROM impairment for the right shoulder of 23 percent. He further modified the 23 percent value utilizing Table 15-35 and Table 15-36.[6] Dr. Rook explained that appellant qualified for a grade modifier 2 according to Table 15-35.[7] He advised that the functional history grade adjustment of one higher suggested that appellant's impairment rating should be increased according to the following equation: 23 percent times 5 percent = 1 percent. Dr. Rook opined that this yielded total shoulder ROM impairment of 24 percent to the right arm. He also explained how he found three percent left arm impairment for cubital tunnel syndrome by rating ulnar neuropathy under Table 15-23, page 449 of the A.M.A., *Guides*.

On March 2, 2012 appellant requested a schedule award.

In a July 18, 2012 report, the OWCP medical adviser determined that Dr. Rook's rating was incorrect. For example he advised that Dr. Rook documented ulnar nerve clinical findings in the left upper extremity. However, the medical adviser advised that there was no documentation of that condition from other providers of record. He explained that he rated appellant using the compression neuropathy table[8] but he was not eligible to be rated under that table as his testing did not meet the A.M.A., *Guides* electrodiagnostic criteria.[9] The medical adviser indicated that Dr. Rook also found significantly worse right shoulder ROM measurements than two providers of record, resulting in a very large rating (relative to the other provider's findings). He also noted that one prior physician found significant pain behavior (which Dr. Rook did not observe). The medical adviser recommended a second opinion examination to determine which findings were consistent. He explained that the provider must review the electrodiagnostic tests and determine if they met the A.M.A., *Guides* criteria (Appendix 15B, page 488) for rating the ulnar nerves at the elbow (cubital tunnel syndrome) using the compression neuropathy (Table 15-23, page 449). The medical adviser noted that, if appellant was ineligible for this table, the provider would have to determine if there was objective clinical evidence of ulnar nerve deficits and rate using the peripheral nerve impairment grid (Table 15-21, page 443). He also explained that, for the right shoulder, the second opinion physician would have to perform at least three measurements for each joint motion (six in the shoulder) and document all the criteria for valid ROM measurements. Furthermore, the medical adviser would have to determine if the ROM method or the diagnostic-based impairment method applied to the right shoulder and rate accordingly. He explained that because of the incorrect application of appellant's examination findings to the A.M.A., *Guides* and discrepancies between

[5] *Id*. at 475.

[6] *Id*. at 477.

[7] *Id.*

[8] *Id*. at 449.

[9] The medical adviser referenced Appendix 15B, page 488, of the A.M.A., *Guides.*

Dr. Rook's findings and those of other examining physicians of record, a second opinion examination was needed.

By letter dated August 14, 2012, OWCP referred appellant to Dr. John D. Douthit, a Board-certified orthopedic surgeon, for a second opinion.

In an August 31, 2012 report, Dr. Douthit noted appellant's history of injury and treatment and examined him. He provided findings which included ROM measurements of the right shoulder and elbow. The medical adviser diagnosed chronic right shoulder pain post rotator cuff tendinitis, rupture and surgical repair and ulnar nerve symptoms, left elbow, with history of ulnar neuropathy and epicondylitis of the elbows. He advised that appellant had continued limited motion of his right shoulder and dysesthesias of his left elbow with pain related to the June 8, 2010 injury. Dr. Douthit related that the objective findings included right shoulder surgery along with his observations of atrophy and restricted motion. Regarding the left elbow, he noted that appellant had a scar and subjective dysesthesias. Dr. Douthit noted some mild nerve conduction abnormalities. He explained that he did not find objective evidence of ulnar neuropathy; that appellant had good musculature of the left hand and no hypothenar weakness, intact sensation and no clawing or weakness of interossei and lumbricales. Dr. Douthit advised that appellant had no objective basis for an impairment rating of the ulnar nerve regardless of nerve conduction. He advised that appellant had authentic right shoulder problems, which prevented him from working without restrictions. Dr. Douthit indicated that appellant did not meet the criteria for rating the ulnar nerves. He explained that he documented the measurements of the right shoulder and opined that appellant had 9 percent impairment for lost ROM, a +1 modifier for functional loss of use which yielded 10 percent right arm impairment. Dr. Douthit advised that appellant showed some symptom magnification. He noted that appellant had limited ROM of the right shoulder and problems with pain syndrome. Appellant reached maximum medical improvement on August 31, 2012.

In an October 26, 2012 report, an OWCP medical adviser noted appellant's history of injury and treatment and utilized the A.M.A., *Guides.* He determined that appellant had impairment of 11 percent to the right upper extremity. The medical adviser explained that his rating differed from Dr. Douthit because he used the diagnosis-based impairment method and Dr. Douthit used the ROM method. He also indicated that there was no impairment for appellant's cubital tunnel syndrome.

On December 11, 2012 OWCP requested that the medical adviser provide an addendum. It noted that appellant previously received an award of three percent to the right upper extremity on February 19 and an additional three percent on August 27, 2010 under Claim No. xxxxxx621. OWCP requested that the medical adviser provide an opinion in accordance with the previous calculation.

In a December 15, 2012 report, the medical adviser noted appellant's history and utilized the A.M.A., *Guides.* He noted that both Dr. Douthit and Dr. Rook used the ROM method, which was not the preferred method. The medical adviser explained that he would use the preferred diagnosis-based impairment method and used the ROM measurements as a grade modifier. He indicated that the most impairing diagnosis in the right shoulder region was AC joint disease and status post distal clavicle resection. The medical adviser advised that both physicians provided

valid measurements. He utilized Dr. Rook's measurements as they were higher and noted that the final grade modifier was one. The final net adjustment was two, final grade was E and final impairment was 12 percent right upper extremity impairment.

For the bilateral elbow impingement syndrome and lateral epicondylitis, the medical adviser advised that appellant was post right ulnar neurolysis at the elbows. Dr. Douthit found no evidence of impingement of the elbow and electrodiagnostic testing did not allow the ulnar nerves (at the elbow) to be rated using the compression neuropathy (Table 15-23, page 449). The medical adviser also indicated that Dr. Douthit found no clinical evidence of ulnar neuropathy. He concluded that there was no applicable rating for ulnar neuropathy at the elbows for cubital tunnel syndrome. The medical adviser also noted that Dr. Douthit found dysesthesias when percussing the medial part of the elbow. However, he found no objective evidence of lateral epicondylitis. The medical adviser referred to the elbow impairment grid (Table 15-4, page 399) and determined that this placed the elbow into class 0 for lateral epicondylitis which equaled no impairment. He also noted that electrodiagnostic testing did not reveal nerve root or plexus disorders. The medical adviser indicated that Dr. Douthit found no clinical evidence of these conditions and opined that there was no basis for an impairment rating related to these disorders. He referred to the Combined Values Chart[10] and explained that appellant had an impairment for the right shoulder of 12 percent to the right upper extremity combined with the previously accepted award to the right upper extremity of 6 percent for a total of 17 percent to the right arm. Dr. Douthit indicated that appellant reached maximum medical improvement on August 31, 2012.

By decision dated January 23, 2013, OWCP granted appellant a schedule award for a total of 34.32 weeks of compensation for an 11 percent permanent impairment of the right upper extremity (17 percent less 6 percent previously paid).

In a January 14, 2013 report, Dr. Rook disagreed with the rating provided by Dr. Douthit. He noted that Dr. Douthit provided appellant with an impairment rating of 10 percent to the upper extremity based only upon right shoulder ROM loss. However, Dr. Rook explained that appellant had undergone a distal clavicle resection and had severe functional limitations in his right shoulder. He explained his previous award based upon ROM loss, which was greater than 20 percent. Dr. Rook explained that appellant had limited right shoulder ROM and questioned the validity of the calculations performed by Dr. Douthit. He explained that, "[a]t the very least, he would warrant the specific diagnosis impairment based upon the distal clavicle resection." Dr. Rook also explained that appellant had residual left cubital tunnel syndrome and noted that he had provided him with three percent impairment for that condition, which was found based upon electrical studies to have moderate abnormalities.

On February 11, 2013 appellant requested a hearing, which was held on May 6, 2013. He noted that he was planning to retire as he was unable to continue working. Appellant also questioned the validity of Dr. Douthit's report and noted that there were no measurements of any kind. He indicated that Dr. Douthit merely flecked his left elbow with his finger. Appellant also noted that his surgeon, recommended additional surgery.

[10] A.M.A., *Guides* 604.

By decision dated July 24, 2013, the hearing representative affirmed the January 23, 2013 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[11] and its implementing federal regulations,[12] 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.[13] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[14] For decisions issued after May 1, 2009, the sixth edition will be used.[15]

In addressing upper extremity impairments, 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).[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides,* with the medical adviser providing rationale for the percentage of impairment specified.[18]

Section 8123(a), in pertinent part, provides that if there is a 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.[19]

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

[13] *Id*. at § 10.404(a).

[14] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[15] FECA Bulletin No. 09-03 (issued March 15, 2009).

[16] A.M.A., *Guides* 494-531; *see J.B.*, Docket No. 09-2191 (issued May 14, 2010).

[17] *Id*. at 521.

[18] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[19] 5 U.S.C. § 8123(a).

ANALYSIS

The Board finds that this case is not in posture for decision. The Board finds that there is an unresolved conflict in the medical evidence between appellant's treating physician, Dr. Rook, who found that appellant had 24 percent impairment to the right arm and 3 percent of the left arm and both the medical adviser and the second opinion physician, Dr. Douthit. The Board notes that Dr. Douthit found impairment of 10 percent to the right upper extremity and the medical adviser determined that appellant had no more than 17 percent to the right upper extremity and both physicians found no left arm impairment. The Board notes that Dr. Rook provided an updated impairment rating on January 14, 2013 and explained his disagreement with the findings provided by the second opinion physician, who indicated that appellant had 10 percent right arm impairment. Dr. Rook noted that he believed that appellant qualified for an impairment of more than 20 percent for the right arm. He also explained that appellant qualified for the rating to the right upper extremity based solely upon his distal clavicle resection loss, as he had severe functional limitations regarding the right shoulder. Dr. Rook also noted that appellant qualified for three percent arm impairment for left cubital tunnel syndrome based upon moderate abnormalities in his electrical studies.

As a conflict exists between Dr. Rook and OWCP's physicians, Dr. Douthit and the medical adviser, OWCP should have referred appellant to an impartial medical examiner to resolve the medical conflict. Its regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[20] The Board will set aside OWCP's July 24, 2013 decision and remand the case to OWCP for referral to an impartial medical examiner for further medical development pertaining to permanent impairment of appellant's right and left upper extremities. Following this and any such further development as may be deemed necessary, OWCP shall issue an appropriate final decision on appellant's entitlement to schedule award compensation for the upper extremities.[21]

Appellant made several arguments regarding his claim on appeal. However, in light of the Board's disposition it is premature to address those arguments at this time. Appellant also submitted additional evidence on appeal.

[20] 20 C.F.R. § 10.321(b). *See also R.H.*, 59 ECAB 382 (2008).

[21] OWCP should also combine with the present claim any other claim by appellant under which he has received a schedule award for either arm. *See supra* note 18 at *File Maintenance and Management*, Chapter 2.400.8(c) (February 2000) (cases should be doubled when correct adjudication of the issues depends on frequent cross-reference between files such as where a new injury case is reported for an employee who previously filed an injury claim for a similar condition or the same part of the body).

CONCLUSION

The Board finds that this case is not in posture for decision regarding appellant's entitlement to a schedule award for his upper extremities due to a conflict in the medical evidence.

ORDER

IT IS HEREBY ORDERED THAT the July 24, 2013 decision of the Office of Workers' Compensation Programs is set aside and remanded for further action consistent with this decision.

Issued: March 25, 2014
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board