United States Department of Labor
Employees' Compensation Appeals Board

J.D., Appellant	)	
and	)	**Docket No. 17-0143**
	)	**Issued: July 20, 2017**
DEPARTMENT OF LABOR, EMPLOYMENT & TRAINING ADMINISTRATION, Denver, CO, Employer	)	

Appearances:
John Evangelisti, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On October 28, 2016 appellant, through counsel, filed a timely appeal from a May 10, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] The record contains a November 3, 2016 OWCP decision, issued after appellant filed the appeal with the Board. It is well established that the Board and OWCP may not have concurrent jurisdiction over the same case, and those OWCP decisions which change the status of the decision on appeal are null and void. *Douglas E. Billings*, 41 ECAB 880, 895 (1990).

the Federal Employees' Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[4]

ISSUE

The issue is whether appellant has more than nine percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On September 16, 2014 appellant, then a 48-year-old manpower development specialist, filed an occupational disease claim (Form CA-2) alleging that she sustained shoulder, arm, and hand pain causally related to her federal employment. She indicated on the claim form that during frequent teleconferences she held the telephone between her shoulder and neck. Appellant also referred to daily use of the computer. The employing establishment indicated on the reverse side of the claim form that she did not stop work.

OWCP accepted the claim on December 10, 2004 for a trapezius strain. On July 15, 2005 it indicated that the accepted conditions were sprain/strains of the right shoulder/arm, right neck, and right thoracic region.

Appellant submitted a claim for compensation (Form CA-7) dated March 29, 2006, indicating that she was claiming a schedule award.

In a January 3, 2006 report, Dr. Allison Fall, a Board-certified physiatrist, provided results on examination and diagnosed right shoulder girdle and upper trapezius pain, mild right supraspinatus degenerative changes, and secondary cervical myofascial pain. He opined that appellant had four percent right upper extremity permanent impairment based on loss of shoulder range of motion.

By decision dated September 28, 2006, OWCP denied the claim for a schedule award. It found that the medical evidence of record was insufficient to establish employment-related permanent impairment.

In a report dated April 12, 2007, Dr. Charles Brantigan, a vascular surgeon, diagnosed lower brachial plexus thoracic outlet syndrome on the right. OWCP referred appellant to Dr. Richard Sanders, a second opinion Board-certified vascular surgeon, for an opinion regarding the brachial plexus diagnosis. In a report dated November 29, 2007, Dr. Sanders diagnosed thoracic outlet syndrome and pectoralis minor syndrome. He wrote that appellant's history was typical of repetitive stress causing thoracic outlet syndrome.

[3] 5 U.S.C. § 8101 *et seq.*

[4] Together with her appeal request appellant submitted a timely request for oral argument pursuant to 20 C.F.R. § 501.5(b). By order dated April 19, 2017, the Board, after exercising its discretion, denied the request as her arguments on appeal could be adequately addressed in a decision based on a review of the case record. *Order Denying Request for Oral Argument*, Docket No. 17-0143 (issued April 19, 2017).

OWCP accepted the claim for thoracic outlet syndrome on January 16, 2008.[5] Appellant stopped work and received wage-loss compensation from February 12, 2008 to July 28, 2012, the date she returned to work

Appellant submitted an August 28, 2012 report from Dr. Christopher Ryan, a Board-certified physiatrist. Dr. Ryan opined that she had impairment to the brachial plexus under Table 15-20 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2009) (hereafter A.M.A., *Guides*). He found that appellant's right upper extremity permanent impairment was 35 percent. Dr. Ryan submitted a report dated January 3, 2013, asserting that his August 28, 2012 report properly applied the A.M.A., *Guides*.

OWCP referred appellant to Dr. John Douthit, a Board-certified orthopedic surgeon, for a second opinion examination. In a report dated April 22, 2013, Dr. Douthit provided a history and results on examination. He found that there were no physical findings to support a diagnosis of thoracic outlet syndrome. Dr. Douthit opined that appellant had seven percent right upper extremity permanent impairment due to limitation on shoulder range of motion.

An OWCP medical adviser, Dr. Daniel Zimmerman, a Board-certified internist, reviewed Dr. Douthit's report, and in a May 2, 2013 report noted that as Dr. Douthit had failed to provide range of motion test results, his impairment rating could not be accepted.

Dr. Douthit responded in a May 31, 2013 letter that he had performed range of motion measurements in accordance with the A.M.A., *Guides*. He did not provide specific range of motion results for the right shoulder. In a June 13, 2013 report, Dr. Zimmerman noted that Dr. Douthit had again failed to provide actual range of motion results.

OWCP referred appellant to Dr. A.C. Lotman, a Board-certified orthopedic surgeon, for a second opinion examination. In a report dated August 15, 2013, Dr. Lotman provided a history and results on examination. He applied Table 15-20 of the A.M.A., *Guides* and opined that for lower trunk brachial plexus impairment, appellant had one percent right upper extremity permanent impairment. Dr. Lotman identified C8-T1 nerves.

By letter dated September 26, 2013, OWCP's medical adviser, Dr. Zimmerman, requested that Dr. Lotman submit an additional report. The medical adviser noted that the condition of right thoracic outlet syndrome had been accepted by OWCP. In a report dated October 27, 2013, Dr. Lotman indicated that his opinion of one percent right upper extremity permanent impairment had included the diagnosis of thoracic outlet syndrome.

Dr. Ryan submitted a report dated November 26, 2013. He wrote that, although one could argue that thoracic outlet syndrome frequently involved the lower trunk of the brachial plexus, appellant had symptoms involving other areas of the brachial plexus. Dr. Ryan indicated that his permanent impairment rating under Table 15-20 was based on the entire brachial plexus.

[5] The ICD-9 (International Classification of Diseases, ninth edition) code was 353.0, which corresponds with the diagnosis of brachial plexus lesions. OWCP also accepted the claim for right pectoral syndrome.

By report dated December 16, 2013, Dr. Zimmerman opined that appellant had one percent right upper extremity permanent impairment. The medical adviser relied upon Dr. Lotman's opinion.

Appellant was again referred for a second opinion examination. In a report dated June 26, 2014, Dr. Alicia Feldman, a Board-certified physiatrist, provided a history and results on examination. She reported impaired sensation with greater than two inch, two point discrimination. Dr. Feldman opined that appellant had nine percent permanent impairment of the right upper extremity under Table15-20, for the lower trunk (C8, T1). She indicated that, if thoracic outlet was not considered, there was no permanent impairment for cervical and thoracic strains.

By report dated July 28, 2014, Dr. Zimmerman opined that there was no right upper extremity permanent impairment based on the accepted strains.

In a decision dated August 13, 2014, OWCP determined that appellant was not entitled to a schedule award. It found the opinion of OWCP's medical adviser, Dr. Zimmerman, represented the weight of the medical evidence.

Appellant, through counsel, requested a hearing before an OWCP hearing representative on September 10, 2014. A hearing was held on March 9, 2015.

By decision dated April 15, 2015, the hearing representative remanded the case for further development. The hearing representative noted that thoracic outlet syndrome was an accepted condition and further development of the medical evidence was required.

In a report dated June 17, 2014, Dr. Zimmerman opined that appellant had nine percent right upper extremity permanent impairment under Table 15-20. The medical adviser found that the default diagnosis-based impairment for lower trunk (C8, T1) brachial plexus impairment was appropriate. He also noted that Dr. Feldman had not tested the left upper extremity and questioned the finding regarding two point discrimination.

By decision dated July 13, 2015, OWCP issued a schedule award for nine percent right upper extremity permanent impairment. The period of the award was 28.08 weeks from June 26, 2014.

On August 6, 2015 counsel requested a hearing before an OWCP hearing representative. A hearing was held on March 18, 2016. Counsel argued that it was unclear why the brachial plexus injury should be limited to the lower trunk.

By decision dated May 10, 2016, the hearing representative affirmed the July 13, 2015 schedule award decision. He found that the weight of the medical evidence established nine percent right upper extremity permanent impairment.

LEGAL PRECEDENT

5 U.S.C. § 8107 provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the

permanent impairment of the scheduled member or function.[6] Neither FECA nor the implementing regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition.[8]

ANALYSIS

OWCP accepted sprain/strains of the right shoulder/arm, right neck, and right thoracic region, as well as thoracic outlet syndrome. With respect to permanent impairment in the right upper extremity, based on the diagnosed thoracic outlet syndrome, second opinion physician Dr. Feldman opined that appellant had nine percent permanent impairment under Table 15-20. Under this table, for brachial plexus impairments, sensory and motor deficits are identified for either the entire brachial plexus (C5 through T1), or for the upper, middle, or lower trunk.[9] Dr. Feldman identified the lower trunk (C8-T1), and moderate sensory deficit, which is a Class of Diagnosis (CDX) 1 impairment with a default (grade C) permanent impairment of nine percent.[10] The default impairment may then be adjusted using a net adjustment formula involving grade modifiers for Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[11]

Dr. Feldman found that the GMFH was two (moderate problem), GMPE one (mild problem) and GMCS zero, (no available studies or relevant findings). Applying the net adjustment formula to a class 1 permanent impairment, there was no adjustment from the default upper extremity permanent impairment of nine percent.[12]

OWCP followed its procedures and referred the case to an OWCP medical adviser for review.[13] OWCP's medical adviser, Dr. Zimmerman, also found that appellant had nine percent

[6] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found at 20 C.F.R. § 10.404(a).

[7] *A. George Lampo*, 45 ECAB 441 (1994).

[8] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010). Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013).

[9] A.M.A., *Guides* 434-35, Table 15-20.

[10] *Id.*

[11] *See id.*, 406 Table 15-7 (functional history), 408 Table 15-8 (physical examination), 410, Table 15-9 (clinical studies).

[12] *Id.* 411. The formula is (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX).

[13] *Supra* note 8 at Chapter 2.808.6(f) (February 2013).

right upper extremity permanent impairment under Table 15-20 for the accepted thoracic outlet syndrome affecting the lower trunk.

The Board finds that this medical evidence consisting of the opinions of Drs. Feldman and Zimmerman represents the weight of the medical evidence.

Dr. Ryan's opinion as to 35 percent permanent impairment of the right upper extremity is of diminished probative value. He did not clearly explain how he would apply Table 15-20 using C5 through T1 for the diagnosed condition of thoracic outlet syndrome to obtain the class 3 impairment rating. The other physicians of record identified the lower trunk (C8-T1), and Dr. Ryan in his November 26, 2013 report acknowledges that thoracic outlet syndrome frequently involves the lower trunk. Dr. Ryan makes a brief reference to appellant having reported symptoms in some other areas of the brachial plexus, without further explanation. He did not explain how he determined that appellant had moderate sensory deficits, which with appropriate grade modifiers, would result in 35 percent permanent impairment under Table 15-20. To be of probative value, the medical opinion must provide a medically sound explanation for the opinion offered.[14] Dr. Ryan's opinion is of diminished probative value and does not represent the weight of the medical evidence.

On appeal, counsel reiterates the argument that OWCP erred in providing a permanent impairment rating for only the lower trunk of the brachial plexus, but for the reasons discussed above, that argument is rejected by the Board. The Board finds that appellant has not established more than nine percent right upper extremity permanent impairment.

Appellant may request a schedule award or increased schedule award at any time 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 has not established more than nine percent right upper extremity permanent impairment, for which she previously received a schedule award.

[14] *See Ronald D. James, Sr.*, Docket No. 03-1700 (issued August 27, 2003); *Kenneth J. Deerman*, 34 ECAB 641 (1983) (the evidence must convince the adjudicator that the conclusion drawn is rational, sound, and logical).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 10, 2016 is affirmed.

Issued: July 20, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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