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

| | | |
|---|---|---|
| **F.R., Appellant** | ) | |
| **and** | ) | **Docket No. 10-179** |
| | ) | **Issued: September 24, 2010** |
| **DEPARTMENT OF THE NAVY, MARINE CORPS BASE, MAINTENANCE BRANCH, CAMP LEJEUNE, NC, Employer** | ) | |

*Appearances:*
*Martin Kaplan, 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 October 28, 2009 appellant filed a timely appeal from an October 7, 2009 decision of the Office of Workers' Compensation Programs regarding a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

### ***ISSUE***

The issue is whether appellant sustained more than a 27 percent impairment of the right upper extremity and 24 percent impairment of the left upper extremity, for which he received schedule awards.

On appeal, counsel contends that the Office erred by calculating the October 7, 2009 schedule award according to the 6th edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the evaluation was performed on April 29, 2009, prior to May 1, 2009 when the sixth edition went into effect. He also asserted that the Office should have allowed a rating for diminished grip strength in conjunction with limited motion.

## ***FACTUAL HISTORY***

The Office accepted that on December 18, 1997 appellant, then a 49-year-old electrical worker, sustained traumatic arthritis of both wrists and forearms when he lifted heavy tools from a vehicle.[1] It later expanded the claim to accept bilateral traumatic arthropathy of the forearm, bilateral enesopathy of the wrist and carpus. The Office also doubled the wrist impairment claim under File No. xxxxxx901 with File No. xxxxxx820, accepted for an aggravation of localized primary osteoarthritis of both shoulders.

From January 1998 through May 2000, appellant was followed by Dr. Ralph J. DiFiore, a Board-certified orthopedic surgeon, who diagnosed degenerative arthritis of both wrists, worse on the right.

On September 25, 2002 appellant claimed a schedule award. He submitted a December 12, 2002 report from Dr. Landon B. Anderson, an attending Board-certified orthopedic surgeon, finding a 1 percent permanent impairment of the left arm and a 12 percent impairment of the right arm due to restricted wrist motion. On January 28, 2003 an Office medical adviser reviewed Dr. Anderson's report and found an eight percent permanent impairment of the right upper extremity and a one percent impairment of the left upper extremity. The Office found a conflict of medical opinion between Dr. Anderson and the Office medical adviser and selected Dr. Robert M. Moore, a Board-certified orthopedic surgeon, to resolve it.

In a March 11, 2003 report, Dr. Moore diagnosed osteoarthritis of both wrists with advanced scapholunate collapse and instability. He opined that, according to the fifth edition of the A.M.A., *Guides*, appellant had 15 percent right upper extremity impairment and 8 percent left upper extremity impairment due to restricted wrist motion[2] according to Table 16-31, page 469. An Office medical adviser concurred with this calculation. By decision dated April 7, 2003, the Office awarded appellant a schedule award for a 15 percent impairment of the right upper extremity and 8 percent impairment of the left upper extremity.

On June 26, 2004 appellant claimed an additional schedule award. He submitted an October 4, 2004 evaluation from Dr. DiFiore finding a nine percent right upper extremity impairment and a five percent left upper extremity impairment due to restricted motion according to Figures 26 and 29 of the A.M.A., *Guides*.[3] Dr. DiFiore found that, according to

[1] Under File No. xxxxxx947, the Office accepted degenerative arthritis of both knees. This claim is not before the Board on the present appeal.

[2] On examination of the right wrist, Dr. Moore found 45 degrees dorsiflexion, 45 degrees volar flexion, 10 degrees radial deviation, 35 degrees ulnar deviation, 85 degrees pronation and 85 degrees supination of the forearm. On examination of the left wrist, Dr. Moore found mild tenderness in the mid-dorsal aspect, 60 degrees dorsiflexion, 65 degrees volar flexion, 30 degrees radial deviation, 35 degrees ulnar deviation, 85 degrees pronation and supination of the forearm. He noted full, painless ranges of motion of both shoulders and elbows.

[3] On the right, Dr. DiFiore found the following impairments: two percent for radial deviation limited to 15 degrees; three percent for ulnar deviation limited to 15 degrees; four percent for dorsiflexion limited to 45 degrees. On the left, he found that, according to Figures 26 and 29 of the A.M.A., *Guides*, appellant had a five percent left upper extremity impairment due to restricted motion: two percent for radial deviation limited to 15 degrees; three percent for ulnar deviation limited to 15 degrees.

Tables 32 and 34, appellant had a 20 percent impairment of each upper extremity impairment due to weakness. He combined these impairments to total 27 percent right upper extremity impairment and a 24 percent left upper extremity impairment. An Office medical adviser concurred with Dr. DiFiore's calculations. By decision dated October 22, 2004, the Office awarded appellant an additional schedule award of 12 percent for the right upper extremity and 16 percent to the left upper extremity. Combined with the April 7, 2003 schedule award, appellant then had a 27 percent impairment of the right upper extremity and a 24 percent impairment of the left upper extremity.

On April 10, 2007 appellant claimed an additional schedule award. He submitted an April 10, 2007 report by Dr. DiFiore assessing 14 percent right upper extremity impairment and 13 percent left upper extremity impairment due to restricted motion.[4] In an August 13, 2007 report, Dr. DiFiore provided an additional impairment of 30 percent to each upper extremity due to diminished grip strength according to Tables 16-32 and 16-34. In October 5, 2007 and January 16, 2008 reports, Office medical advisers opined that Dr. DiFiore did not report any additional impairment beyond that previously awarded. By decision dated February 1, 2008, the Office denied an additional schedule award.

In a February 21, 2008 letter, appellant requested a telephonic hearing, held on June 18, 2008. Appellant submitted a July 14, 2008 report from Dr. DiFiore finding a 15 percent impairment of the right upper extremity due to limited wrist motion.[5] Dr. DiFiore opined that the 15 percent impairment did "not reflect adequately [appellant's] functional loss." Therefore, he evaluated grip strength according to Tables 16-32 and 16-34. Appellant's grip strength was 18 kilograms (kg) on the dominant right hand using a Jamar dynamometer. According to Table 16-32, average grip strength for a patient appellant's age was 46 kg, equaling a 60 percent loss of grip strength. Using Table 16-34, this equaled a 20 percent impairment of the right upper extremity due to weakness. Dr. DiFiore found a 16 percent impairment of the left arm due to restricted wrist motion,[6] which he opined did not adequately reflect appellant's functional loss. He found that the 46 percent loss of grip strength[7] equaled a 20 percent left upper extremity impairment due to weakness according to Tables 16-32 and 16-34. Using the Combined Values Chart, appellant had a 33 percent impairment of the left upper extremity.

[4] On examination of the right wrist, he observed 50 degrees flexion, 35 degrees extension, 10 degrees ulnar deviation and 5 degrees radial deviation. On the left, he found 55 degrees flexion, 45 degrees extension, 10 degrees ulnar deviation and 5 degrees radial deviation. Grip strength was 45 pounds in the dominant right hand a 60 pounds on the left.

[5] On examination of the right wrist, Dr. DiFiore found that, according to Figure 16-28, page 467 and Figure 16-29, page 469 of the A.M.A., *Guides*, appellant had a two percent upper extremity impairment due to radial deviation limited to 10 degrees, a two percent impairment due to ulnar deviation limited to 20 degrees, a four percent impairment for dorsiflexion limited to 40 degrees and a seven percent impairment for palmar flexion limited to 20 degrees. He totaled these impairments to equal 15 percent.

[6] On examination of the left wrist, Dr. DeFiore found that according to Figure 16-28 page 467 and Figure 16-29, page 469 of the A.M.A., *Guides*, appellant had a two percent impairment due to ulnar deviation limited to 20 degrees, a seven percent impairment for dorsiflexion limited to 20 degrees and a seven percent impairment for palmar flexion limited to 20 degrees. He totaled these impairments to equal 16 percent.

[7] Dr. DiFiore did not provide grip strength measurements for the left hand.

In a September 9, 2008 report, an Office medical adviser concurred with Dr. DiFiore's rating for restricted wrist motion. He explained that, according to paragraph 16.8a at page 508 of the A.M.A., *Guides*, weakness may not be rated in conjunction with range-of-motion impairments. As appellant already received schedule awards for a 24 percent impairment of the right upper extremity and a 27 percent impairment of the left upper extremity, he was not entitled to an additional schedule award.

By decision dated and finalized October 23, 2008, the Office hearing representative found a conflict of medical opinion between Dr. DiFiore, for appellant, and the Office medical adviser, for the government, regarding the appropriate percentage of permanent impairment. The Office selected Dr. Edwin B. Cooper, Jr., a Board-certified orthopedic surgeon, to resolve the conflict.

In an April 9, 2009 report, Dr. Cooper noted mild limitation of shoulder motion, right greater than left, with glenohumeral abduction of the right shoulder limited to 90 degrees versus 120 on the left. There was also mild weakness of external rotation of the right shoulder, mild bilateral supraspinatus atrophy, right deltoid atrophy and bilaterally positive impingement tests bilaterally. Dr. Cooper found limited motion of both wrists.[8] He found 15 kg average grip strength in both hands, representing a 67 percent loss of grip strength in the dominant right hand and a 66 percent loss on the left according to Table 16-32, page 509, equaling a 30 percent impairment of each upper extremity. Dr. Cooper agreed with the "existing rating of 3 percent of the right upper extremity and three percent of the left upper extremity for the bilateral shoulder arthritis." Dr. Moore calculated a 32 percent impairment of each upper extremity, 3 percent due to restricted shoulder motion and 30 percent for loss of grip strength directly related to the bilateral wrist arthritis.

In an April 30, 2009 report, an Office medical adviser reviewed Dr. Cooper's report and schedule determinations under both File No. xxxxxx901 and xxxxxx820. He noted that appellant had received a schedule award for a nine percent impairment of the right arm and five percent impairment of the left arm for bilateral shoulder arthritis under File No. xxxxxx820. Under File No. xxxxxx901, appellant received schedule awards totaling a 24 percent impairment of the right upper extremity and a 27 percent impairment of the left upper extremity based on limited wrist motion. As grip strength could not be rated in conjunction with restricted motion, appellant was not entitled to an additional schedule award.

By decision dated April 30, 2009, the Office denied modification on the grounds that the medical evidence did not establish a greater percentage of permanent impairment than that previously awarded. It accorded the weight of the medical evidence to Dr. Cooper.

In a July 21, 2009 letter, appellant requested reconsideration. He submitted new medical evidence. In a June 16, 2009 report, Dr. DiFiore explained that because the restricted wrist motion was "very minimal compared to the grip strength loss" the Office should use the grip strength loss as it was the greater of the two impairments.

[8] On examination of the right wrist, Dr. Cooper found 35 degrees flexion, 20 degrees extension, 15 degrees radial deviation and 25 degrees ulnar deviation. On examination of the left wrist, he found 25 degrees flexion, 40 degrees extension, 20 degrees radial deviation and 25 degrees ulnar deviation. Dr. Cooper stated that appellant had more than a 50 percent decrease in range of motion of the right wrist.

In an August 24, 2009 report, Dr. DiFiore calculated a schedule award according to the sixth edition of the A.M.A., *Guides*. He found that the diagnosis-based impairment grid was inadequate and therefore used the range of motion method according to Table 15-32, page 473. Dr. DiFiore noted a total 22 percent impairment of the right upper extremity for restricted wrist motion, as follows: nine percent for flexion at 10 degrees; seven percent for extension limited to 20 degrees; two percent for radial deviation at 10 degrees; four percent for ulnar deviation at zero degrees. For the left wrist, he found a nine percent upper extremity impairment due to flexion at 10 degrees, a seven percent impairment for extension at 20 degrees, a two percent impairment due to radial deviation at 10 degrees, and a two percent impairment for ulnar deviation limited to 20 degrees. Dr. DiFiore opined that, although the sixth edition of the A.M.A., *Guides* did not allow a rating for diminished grip strength, the Office should consider an additional impairment in this category.

In an October 1, 2009 report, the Office medical adviser reviewed Dr. DiFiore's reports and calculated a 22 percent impairment of the right upper extremity and 20 percent of the left upper extremity. As appellant already received schedule awards for 27 percent impairment of the right upper extremity and 24 percent impairment of the left upper extremity, he was not entitled to an additional schedule award.

By decision dated October 7, 2009, the Office modification of the April 30, 2009 decision. It found that the Office medical adviser provided "sufficient reasoning against an increased award."

## ***LEGAL PRECEDENT***

The schedule award provision of the Federal Employees' Compensation Act[9] provides for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a mater which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[10]

Schedule award decisions issued between February 1, 2001 and April 30, 2009 utilize the fifth edition of the A.M.A., *Guides.*[11] Effective May 1, 2009, the Office adopted the sixth edition of the A.M.A., *Guides*,[12] published in 2008, as the appropriate edition for all awards issued after that date.[13] The Board has held that as of May 1, 2009, a request for an additional

[9] 5 U.S.C. §§ 8101-8193.

[10] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

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

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

[13] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 9, 2010).

schedule award based on new medical evidence should be calculated according to the sixth edition of the A.M.A., *Guides* even if the prior award was calculated under a previous edition.[14]

For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[15] The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[16] Under the sixth edition, the evaluator identifies 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).[17] The net adjustment formula is (GMFH - CDX) + (GMPE - DCX) + (GMCS - CDX).

## ***ANALYSIS***

The Office accepted that, under File No. xxxxxx901, appellant sustained traumatic arthritis of both wrists, bilateral traumatic arthropathy of the forearms and bilateral enesopathy of the wrists and carpus. It later doubled File No. xxxxxx901 with File xxxxxx820, accepted for aggravation of localized primary osteoarthritis of both shoulders.

Appellant received schedule awards totaling a 27 percent impairment of the right arm and a 24 percent impairment of the left arm due to restricted motion of the wrist. In its October 7, 2009 decision, the Office found that appellant did not submit medical evidence establishing greater impairment. The Board finds, however, that the Office did not consider the accepted shoulder condition in calculating the schedule awards for upper extremity impairment.

In an April 9, 2009 report, Dr. Cooper, a Board-certified orthopedic surgeon and impartial medical examiner, found limited motion of both shoulders, muscle atrophy and bilaterally positive impingements tests. He agreed with the "existing rating of three percent of the right upper extremity and three percent of the left upper extremity for the bilateral shoulder arthritis." However, there is no evidence of a schedule award for shoulder impairment under File No. xxxxxx901 or File No. xxxxxx820. The prior schedule awards under File No. xxxxxx901 did not include any impairment of the shoulders.

It is well established that all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.[18] In its October 7, 2009 decision, the Office found that appellant had not established an additional upper extremity impairment. Yet, it did not consider Dr. Cooper's finding of a three percent impairment of each upper extremity due to limited shoulder motion. The case will be remanded for further development.

---

[14] *M.F.*, Docket No. 09-1901 (issued July 1, 2010); *T.B.*, Docket No. 09-1903 (issued April 15, 2010).

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

[16] A.M.A., *Guides* (6th ed., 2008), page 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[17] A.M.A., *Guides* 494-531 (6th ed. 2008).

[18] *Robert V. Disalvatore*, 54 ECAB 351 (2003).

On remand of the case, the Office should determine if the shoulder impairments observed by Dr. Cooper warrant any additional schedule award. Following this and any other development deemed necessary, it will issue an appropriate decision in the case.

On appeal, counsel contends that the Office erred in its October 7, 2009 schedule determination by applying the sixth edition of the A.M.A., *Guides* as the schedule award evaluation was performed on April 29, 2009, prior to May 1, 2009 when the sixth edition went into effect. As noted, schedule award decisions on or after May 1, 2009 are calculated according to the sixth edition of the A.M.A., *Guides*. This includes cases involving augmented schedule awards where the original award was calculated under a previous edition. Therefore, the Office properly relied on the sixth edition of the A.M.A., *Guides*. There was no error in this regard.

Counsel also asserted that the Office should have allowed additional impairment for diminished grip strength. As noted, the case is remanded to the Office to determine the appropriate percentage of permanent impairment.

## ***CONCLUSION***

The Board finds that the case is not in posture for a decision on the extent of permanent impairment to each upper extremity.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the October 7, 2009 decision of the Office of Workers' Compensation Programs be set aside. The case is remanded for further development consistent with this decision.

Issued: September 24, 2010
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