File Number:
HR10-D-H

U S DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 50
LONDON, KY 40742-8300
Phone: (202) 693-0045

MAY 1 2 2010

RECEIVED MAY 1 7 2010

Date of Injury:
Employee:

Dear Mr.

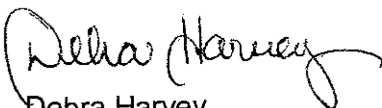
This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A hearing was held on 02/22/2010. As a result of such hearing, it has been determined that the decision issued by the District Office should be vacated and the case remanded to the district office for further action as explained in the enclosed copy of the Hearing Representative's Decision.

Your case file has been returned to the Chicago District Office. You may contact that office by writing to our Central Mail Room at the following address:

US DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 10 CHI
LONDON, KY 40742-8300

Sincerely,



Debra Harvey
Hearing Representative

PAUL H FELSER
ATTORNEY
FELSER LAW FIRM
7 EAST CONGRESS ST
SUITE 400
SAVANNAH, GA 31401

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U.S. Code 8101 et seq. of , Claimant; Employed by the . Case No: Oral hearing was held in Jacksonville, Florida, on February 22, 2010.

The issue is whether the claimant has sustained permanent impairment of the left upper extremity in excess of 15% for which schedule award benefits have been previously paid.

The claimant, date of birth, , , was employed by the in as an On , he sustained a traumatic injury while in the performance of his federal job duties. His claim was accepted for a left rotator cuff strain. The case was later expanded to include cervical stenosis and left shoulder adhesive capsulitis.

On June 18, 2004, he underwent a cervical laminectomy and decompression at the level C4-5. Medical treatment was provided by Dr. and Dr The claimant returned to restricted duty on December 4, 2004. However, effective March 11, 2006, the claimant began receiving disability retirement.

On July 14, 2006, the claim was expanded to include myofascial pain syndrome. The claimant submitted a request for a schedule award. On March 27, 2007, Dr. recommended 19% permanent partial impairment to the left upper extremity. On October 15, 2007, Dr. supplemented his report to add an additional 11% impairment to the whole person due to gait disturbance. Following clarification from Dr. , the matter was referred to the District Medical Advisor (DMA), Dr. . The DMA found that the claimant had sustained a 4% impairment to the left upper extremity. He noted that Dr. had awarded impairment based upon loss of strength, which in accordance with the AMA *Guides* could not be rated in the presence of pain or decreased motion. Dr. further noted that the FECA does not provide for impairment to the whole person; therefore, no impairment could be awarded for the gait disturbance.

On December 18, 2008, the Office granted a schedule award for 4% permanent partial impairment to the left upper extremity. The Claimant disagreed with this decision and requested an oral hearing before an OWCP Hearing Representative. On July 14, 2009, an Office Hearing Representative remanded the claim to the District Office for review of additional medical evidence from Dr. and a *de novo* decision on the issue of schedule award benefits.

In his report, dated March 31, 2009, Dr. noted the claimant had decreased range of motion of the neck with 33 degrees of flexion, 15 degrees of extension, 16 degrees of right lateral bending, 25 degrees of right rotation, and 28 degrees of left rotation. The claimant had a "tightness" of the posterior cervical muscles.

The right shoulder had a surgical scar and decreased range of motion and weakness of the right shoulder from a 1999 non-employment related injury. The left shoulder had tenderness of the AC joint and biceps tendon with decreased range of motion. There was 116 degrees of flexion, 55 degrees of extension, 36 degrees of adduction, 88 degrees of abduction, 33 degrees of internal rotation and 74 degrees of external rotation. Finkelstein, Tinel and Phalen signs were negative. Grip strength was decreased on the left as measured by the Jamar Hydraulic Hand Dynamometer.

The claimant had decreased range of motion of the lumbar spine with positive straight leg raising on the left and pain on dorsiflexion of the left foot. The right knee also had decreased range of motion with crepitation on movement of the knee. The left knee reveals laxity of the lateral collateral ligament and no crepitation on movement of the left knee. Dr. stated the claimant walked with a marked antalgic gait due to "marked lack of muscle stability in the quads and lower legs, much greater in the left leg." He was unable to stand without assistance. He noted the claimant had an L5 impingement and stated the claimant had abnormal sensitivity in the chest, trunk, legs, and arms "consistent with a spinal cord injury." His impression was strain and internal derangement of the left shoulder, strain of the neck with spinal cord compression causing upper and lower extremity impairment, and atrial fibrillation aggravated and contributed to by injury to the spinal cord.

Dr. stated the claimant had reached maximum medical improvement on February 28, 2007. He provided an impairment rating for the upper extremity based on the 5th edition of the AMA *Guides to the Evaluation of Permanent Impairment*, stating the claimant had a 9% impairment of the right upper extremity and 13% impairment of the left upper extremity due to "corticospinal tract impairment" based on Table 15-6, Rating Corticospinal Tract Impairment, page 398. He stated:

> "He has a 5% whole man impairment due to Class 1 right upper extremity, which is equivalent to 9% of the upper extremity. He has 8% impairment whole man due to nondominant extremity, which is equivalent to 13% of the upper extremity.
>
> 9% 26% Total Added Upper Extremity Impairment
>
> 9% 24% Total Combined Values Chart Upper Extremity Impairment
> Sections I, II, III, IV and V are combined (not added) using the Combined Values Chart, pp 604-606."

He also provided lower extremity impairments of 29% of the right and 45% of the left due to station and gait disorders.

On July 29, 2009, the Office forwarded the file back to the DMA for a new impairment rating based on the 6th edition of the AMA *Guides to the Evaluation of Permanent Impairment*, which became effective on May 1, 2009.[1] Dr. again reviewed the file including Dr. report. Dr. noted that no lower extremity condition had been accepted. He noted that the claimant had subjective complaints of persistent dizziness and neck pain along with complaints of upper and lower extremity weakness. The physical exam demonstrated diminished cervical spine range of motion. He noted the right shoulder "revealed decreased ROM but was not quantified." He noted the left shoulder range of motion. The DMA stated:

> "According to table 15-35, p. 477 of the AMA Guide, the ROM deficit qualifies for a grade 1 modifier. Referencing table 15-7, p. 406 of the AMA Guide, she has a moderate problem with pain and symptoms which qualifies for a grade 2 modifier. Thus, a grade difference of 1 exists. According to table 15-36, p. 477 of the AMA Guide, an additional 5% is awarded. Consequently, 14% X 5% = an additional .7% is awarded for a total of 14.7% (which rounds to 15%) LUE PPI.
>
> The remainder of the upper extremity examination was unremarkable.
>
> There was diminished ROM of the lumbar spine and the claimant walked with an antalgic gait. Dr. goes on to discuss a positive straight leg raise on the left, and diminished sensation in the left L5 dermatome. In addition, he describes abnormal sensitivity to two-point discrimination in the chest, trunk, legs, and arms. However, given this does not follow any specific dermatome, it is not validated by any particular nerve distribution and is disregarded.
>
> Dr. recommends 5% whole person impairment for the RUE due to a Class 1 disorder and 8% whole person impairment for the LUE. However, as the FECA does not recognize whole person impairment, these award recommendations are disregarded. As far as the lower extremity impairment, Dr. also makes recommendations based on whole person impairment. Thus, these too will be disregarded. Further, the claimant has no lower extremity condition that has been accepted as work-related. Finally, Dr. uses the AMA Guides to the Evaluation of Permanent Impairment, 5th edition which is no longer used as the definitive authoritative source for determining PPI.
>
> In conclusion, Dr. has identified and measured loss of motion in the left shoulder which should replace measurements made in my previous note from 10-27-08. Thus, I recommend the previous award of 4% LUE PPI be replaced with the updated measurement of 15% LUE PPI."

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[1] FECA Bulletin 09-03.

On September 22, 2009, the Office awarded an additional 11% award for left upper extremity impairment, to total 15%. The claimant disagreed with this decision and through his Attorney, Paul Felser, requested another hearing.

The hearing was held on February 22, 2010, in Jacksonville, Florida. The claimant was not present but was represented by Mr. Felser. Mr. Felser stated the instant rating had been based only on a review of Dr. report when, in fact, the claimant had multiple injuries. He noted a prior claim in which the claimant had a back and lumbar sprain. He noted that Dr. had noted an antalgic gait and lower extremity problems. He noted that the left shoulder problems could be related to the cervical spine issues. He stated that the claimant's physicians had noted lower extremity problems that they opined were related to a spinal condition. He argued that there was a lower extremity impairment that could be related to either the pre-existing claim or the instant claim. He noted abnormal EMG studies of the upper and lower extremities and stated these tests did not appear to have been considered by the DMA.

The file was held open for receipt of additional medical evidence for consideration. A copy of the hearing transcript was sent to the Employing Agency on March 10, 2010, for review and comment. There was no response.

Additional factual and medical evidence has been received to include a brief from Attorney Felser requesting expansion of the claim and impairment ratings for both upper and both lower extremities; physical therapy and treatment notes and an April 12, 2010, report from Dr.

In this report, Dr. states he re-examined the claimant and opined for a 22% impairment of the left upper extremity based on 13% impairment of the CS spinal nerve root impairment from Table 15-20, page 434 of the AMA *Guides,* 6th edition, and 10% impairment of the left shoulder due to decreased range of motion, based on Table 15-34, page 475. He stated the total combined permanent impairment of the left upper extremity is 23%. Dr. stated, "Whereas the decreased range of motion of the shoulder is due solely to the left shoulder joint and is not caused by the spinal nerve root impingement due to the neck, therefore, the spinal nerve root impairment is combined with the range of motion impairment."

Section 8107 of the Federal Employees' Compensation Act (FECA) provides that if there is a permanent disability involving the loss or loss of use of a member of function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function. Section 8107 also sets for the number of weeks of compensation to be paid for permanent loss of use of the members of the body that are listed in the schedule. Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. The Board has held, however, that 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 Office has adopted the American Medical Association's *Guide to the Evaluation of Permanent Impairment*

as the standard for determining the extent of permanent impairment and the Board has concurred such adoption of these *Guides*.[2]

The Office's Federal (FECA) Procedure Manual provides that in obtaining medical evidence required for a schedule award the evaluation made by the attending physician must include a detailed description of the impairment including, where applicable, the loss is degrees of active and passive motion of the affected member or functions, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment. This description must be of sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[3] When a medical report is received from the attending physician, the examining physician is not responsible for calculation of the percentage of impairment.[4] The District Medical Advisor (DMA) is responsible for taking the calculations provided by the examining physician and arriving at an overall impairment percentage rating.[5]

I find that the receipt of Dr. new report is sufficient to warrant a re-evaluation of the impairment rating of the left upper extremity. Therefore, the Office's decision of September 22, 2009, is hereby SET ASIDE and the file REMANDED for further review by the DMA. The DMA should review Dr. report to include the worksheets showing the calculations of the impairment. The DMA should then determine if the evidence establishes a left upper extremity impairment in excess of the 15% that has already been awarded. After completion of any additional development deemed necessary, the Office should issue a *de novo* decision on the left upper extremity impairment based on the 6th edition of the AMA *Guides*.

Furthermore, the claimant has requested expansion of his claim to include injuries to the right upper extremity and both lower extremities, as well as schedule award benefits for these members. The Office should review the evidence of record in the instant claim, as well as in the prior lumbar claim, and pursue development for expansion of the claim

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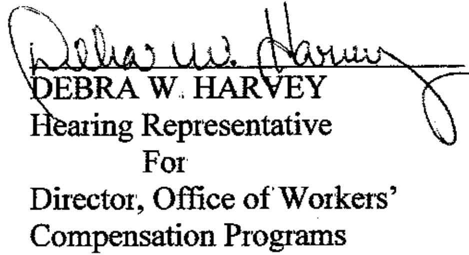
[2] *A. George Lampo*, 45 ECAB 441 (1994).
[3] *John H. Smith*, 41 ECAB ___ (Docket No. 89-1756, issued January 31, 1990).
[4] FECA Bulletin Number 96-17.
[5] FECA Bulletin Number 96-17.

and/or additional schedule award benefits, if any. The Office should issue formal decisions on expansion of the claim and/or schedule award benefits after completion of all necessary development.

Therefore, for the reasons set forth above, the file is REMANDED for further action.

DATED: MAY 1 2 2010

WASHINGTON, D.C.



DEBRA W. HARVEY
Hearing Representative
For
Director, Office of Workers' Compensation Programs