File Number:
HR20-D-H

RECEIVED NOV 24 2018

U.S. DEPARTMENT OF LABOR

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

Date of Injury:
Employee:

Dear

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

The review was completed. As a result of such review, 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 Jacksonville 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 6 JAC
LONDON, KY 40742-8300

Sincerely,

Electronically Signed

Division of Federal Employees' Compensation

PAUL H FELSER
ATTORNEY AT LAW
QUEENSBOROUGH BANK BUILDING
7393 HODGSON MEMORIAL DRIVE
SUITE 102
SAVANNAH, GA 31406

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

Washington DC, November 21, 2018

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.

Examination of the Written Record was completed in Washington, D.C. Based on this review, the District Office's decision dated is set aside for the reasons below.

The issue for determination is whether the evidence is sufficient to establish an increase in schedule award entitlement.

The claimant is an employee of the where she works as a \
Under the current claim, the Office accepted that she sustained a work-related injury in the performance of duty on when she was loading parcels into a BMC and the door flipped open, striking her in the right ear, right side of her head and right shoulder. The claim was accepted for the following work-related medical conditions: cervical disc herniation C5-6 and C6-7; headaches; split root tooth #7; face/scalp contusion; right shoulder contusion; right shoulder sprain and neck sprain.

The claimant underwent approved right shoulder surgery on performed by MD, consisting of right shoulder arthroscopic subacromial decompression and bursectomy; distal clavicle resection and arthroscopic debridement of the labrum. She also underwent approved surgery on consisting of C5-6, C6-7 anterior cervical discectomy, decompression and fusion performed by her attending physician, Dr.

The claimant underwent EMG/Nerve Conduction Studies of the upper extremities on

On , the claimant filed form CA-7 requesting approval of a schedule award.

In a report dated , Dr. opined the claimant had reached maximum medical improvement as of . He reported ongoing motor deficits of the left shoulder 4/5 with decreased grip strength bilaterally. Based on a diagnosis of radiculopathy he found the claimant had sustained 18% disability based on the 5th Edition *AMA Guides to the Evaluation of Permanent Impairment.* He added the disability rating would be 23% if cervical range of motion was considered.

The claimant was referred for a directed "second opinion" examination with Dr. . . a Board-certified Orthopedic Surgeon, on Dr. performed nerve conduction studies of the upper extremities as part of the evaluation. In his narrative report, he provided an accurate discussion of the history of injury according to the Statement of Accepted Facts (SOAF) and prior medical records. He provided his detailed physical examination findings. He discussed the objective test results, noting that x-rays of the right shoulder were normal and x-rays of the cervical spine showed well-placed anterior cervical plates C5 to C7 with excellent anterior fusion. Nerve conduction studies were consistent with left carpal tunnel syndrome which was not related to the work injury. There were no findings referable to the cervical spine injury or surgery. Dr. opined the claimant had reached maximum medical improvement and had sustained 1% permanent partial impairment of the right upper extremity based upon right shoulder surgery according to the *AMA Guides to the Evaluation of Permanent Impairment*, 6th Edition, table 15-5 on page 402.

In a report dated District Medical Advisor (DMA) MD, concurred with the impairment evaluation provided by Dr.

In a formal decision dated , the District Office approved a schedule award based upon 1% permanent partial impairment of the right upper extremity. A finding was made that the weight of medical evidence should be afforded to the opinion of Dr. as he provided a reasoned medical opinion based on examination of the claimant using the 6th Edition *AMA Guides* to arrive at the noted impairment figure as confirmed by the DMA. In contrast, the attending physician did not provide an assessment of permanent impairment based upon the 6th Edition *AMA Guides*, as required by the Office for determination of schedule award entitlement.

The schedule award decision of was affirmed by the Branch of Hearings and Review in a formal decision dated . The District Office had properly afforded the weight of medical evidence to the opinion of Dr. Although Dr. provided a medical report dated recommending 26% impairment of the whole body based upon the 6th Edition *AMA Guides*, the FECA does not recognize whole person impairment when determining schedule award entitlement.

The claimant requested another appeal of the schedule award decision through reconsideration by the District Office.

A narrative report was received from Dr. dated in which he discussed the prior medical records and provided his detailed examination findings. Dr. opined that he claimant had sustained 30% impairment (class IV) of the cervical spine based on the 6th Edition *AMA Guides to the Evaluation of Permanent Impairment*.

In a supplemental narrative report dated , from Dr. provided further discussion of his examination findings on and calculation of permanent impairment due to the accepted work injury. Dr. noted that EMG/NCV on showed left C6-7 radiculopathy with mild bilateral carpal tunnel syndrome. He opined the claimant suffered 30% impairment (class IV) to the upper extremities as a result

of her cervical spine injury according to the 6th Edition AMA Guides table 17.2 on page 565 due to anterior cervical fusion at C5-6 and C6-7 with continued radicular neck, shoulder pain and migraines.

The case file record was referred to the District Medical Advisor (DMA) for review and opinion addressing whether the medical evidence of record established an increase in permanent impairment due to the accepted work injury.

In a report dated , DMA , MD, advised that he disagreed with the impairment rating provided by Dr. He explained that although Dr. provided a chart showing 4/5 strength at C5, C6, C7, C8 and T1, these findings were not consistent with the physical examination findings reported at prior office visits. Physical examination only showed 4/5 grip strength on the left, and C5/C6 did not contribute to grip strength. Dr. opined the claimant reached maximum medical improvement on the date of Dr. Berinhout's examination, and provided his assessment of permanent impairment based on his review of the medical records. Dr. found the claimant had 5% impairment (Class 1) for the non-dominant left upper extremity and a total 5% impairment (Class 1) for the dominant right upper extremity: an additional 4% impairment to be added to the prior 1% impairment determination. He arrived at these figures utilizing table 13-11 of the 6th Edition AMA Guides at page 335. He explained he used this table as it represented impairment of the upper extremity due to central nervous system (CNS) dysfunction, as the impairment was the result of spinal cord compression that was treated surgically. A diagnosis-based impairment (DBI) rating could not be used.

In a formal decision dated , the District Office determined that the claimant was entitled to an increase in schedule award entitlement based on the weight of medical evidence, which as afforded to the opinion of DMA A schedule award was approved based upon 5% permanent impairment of the left upper extremity. Also, schedule award for the left upper extremity was increased by an additional 4% permanent impairment of the right upper extremity, which was added to the prior 1% impairment determination, resulting in a total 5% permanent partial impairment of the right upper extremity.

The claimant requested an appeal of the schedule award decision through an Oral Hearing before the Branch of Hearings and Review. A Hearing was held on

In a formal decision dated , the Branch of Hearings and Review set aside the prior schedule award decision and remanded the case for further development. It was noted that Dr. provided little rationale to explain how he arrived at his impairment rating. The DMA provided an impairment rating based on the 6th Edition *AMA Guides*, but he failed to apply the principles found in the July/August 2009 *AMA Guides Newsletter* "Rating Spinal Nerve Impairment Under the 6th Edition" as is required by the Office in determining permanent impairment of the upper extremities due to spinal nerve damage. The District Office was instructed to refer the case back to the DMA for consideration of permanent impairment of the upper extremities according to July/August 2009 *AMA Guides Newsletter*; and issuance of a *de novo* decision on schedule award entitlement following the conclusion of any additional development of the evidence as may be found warranted.

In a supplemental report dated , Dr. explained that the claimant had 5/5 strength in the right upper extremity and 4/5 in the left upper extremity, with decreased sensation in the left upper extremity in the C6 distribution. According to the July/August 2009 AMA Guides Newsletter for Rating Spinal Nerve Impairment under the 6th Edition, mild sensory and motor deficit is characterized as a Class 1 impairment with a sensory grade 4 described as 1 - 25% deficit and a motor grade of 4 described as 1 - 25% motor deficit. Table 1 also showed that for class 1 impairment with mild motor deficit, the default impairment rating for the C6 nerve was 9%. Therefore, the claimant had an impairment rating of 9% of the left upper extremity.

In a *de novo* decision dated , the District Office found the claimant was entitled to an increase in schedule award entitlement for the left upper extremity. Based on the opinion of the DMA, the schedule award for the left upper extremity was increased by 4%, which was added to the prior established 5% impairment rating, reflecting a total 9% permanent partial impairment of the left upper extremity. There was no change in schedule award entitlement for the right upper extremity.

The claimant disagreed with this decision and, through her authorized representative, requested an appeal in the form of an Oral Hearing before the Branch of Hearings and Review. A Hearing was scheduled to be held by telephone on On , the claimant's representative requested conversion of the appeal format to Review of the Written Record. In a letter dated , the claimant and her representative were advised that the request had been granted, an a Review of the Written Record had been initiated. They were advised that they were afforded an additional 15 days to submit any additional evidence for the appeal.

Medical evidence received to the record on appeal included numerous pain management treatment notes and MRI reports dated with evaluation of the brain and cervical spine. No new medical evidence was received from a physician with an assessment of permanent impairment.

Based on my careful consideration of the evidence of record at this time, I find that the claim is not in posture for a decision on schedule award entitlement at this time. Additional development of the medial evidence is necessary before a decision on this issue can be properly reached.

Section 8107 of the FECA provides that, if there is a 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. Neither the Act nor the 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, the Office has adopted the *AMA Guides to the Evaluation of Permanent Impairment* as a standard for evaluating schedule losses and the Board has concurred in such an adoption.[1]

[1] *A. George Lampo,* 45 ECAB 441 (1991.); *James J. Hjort,* 45 ECAB 595 (1994.)

The period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of his or her employment injury. Maximum improvement means that the physical condition of the injured member of the body has stabilized and will not improve further. A schedule award is appropriate where the physical condition of an injured member has stabilized despite the possibility of an eventual change in the degree of functional impairment of the member.[2]

FECA Bulletin 09-03 instructs that the 6th Edition *AMA Guides to the Evaluation of Permanent Impairment* will be utilized to determine schedule award entitlement for awards issued on and after May 1, 2009. FECA Bulletin 17-06 instructs that impairment ratings should be based upon the most recent version of the *AMA Guides*. Currently, the reprinted 2009 Edition is the most recent version.

Under Chapter 15, *The Upper Extremities*, the *AMA Guides* states: "Most impairment values for the upper extremity are calculated using the diagnosis-based impairments [(DBI)]."[3] Under section 15.2, the *AMA Guides* explain that "Most impairments are based on the DBI, in which an impairment class is determined by the diagnosis and specific criteria; this is then adjusted by 'non-key' factors (grade modifiers) that may include functional history (FH), physical examination (PE) and clinical studies (CS). Alternative approaches are also provided for basing impairment on peripheral nerve deficits, CRPS, amputation and range of motion. Range of motion ratings cannot be combined with other approaches, with the exception of amputation. Complex regional pain syndrome ratings cannot be combined with other approaches."[4]

The first step in determining an impairment rating is to choose the diagnosis that is most applicable for the region being assessed. Selection of the optimal diagnosis requires judgment and experience. If more than one diagnosis can be used, the highest causally related impairment rating should be used; this will generally be the more specific diagnosis. Typically, one diagnosis will adequately characterize the impairment and its impact on activities of daily living. In the event that a specific diagnosis is not listed in the diagnosis-based impairment grid, the examiner should identify a similar listed condition to be used as a guide to the impairment calculation. The rationale for this decision should be described.[5]

Table 15-5, page 401 of the *AMA Guides*, is the shoulder regional grid. It provides diagnosis-based upper extremity impairment values for various shoulder diagnoses. Nearly all of the listed diagnoses note that if motion loss is present, the impairment may alternatively be assessed using the range of motion section.[6]

According to Chapter 2, page 20, one of the fundamental principles of the *AMA Guides* is that if there is more than one method to rate a particular impairment or condition, the method producing the higher rating must be used.

---

[2] *Neil Papkin*, 39 ECAB ___ (1987); *James C. Hall, Sr.*, 39 ECAB ___ (1988).
[3] *Id.* at 385.
[4] *Id.*
[5] A.M.A., *Guides* at 389.
[6] A.M.A., *Guides* at 405.

It is well established that, in determining entitlement to a schedule award, preexisting impairments to the scheduled member are to be included.[7] However, where the evidence does not demonstrate any permanent impairment caused by the accepted occupational exposure, the claim is not ripe for consideration of any preexisting impairment.[8]

The FECA *Procedure Manual*, instructs that the attending physician should make the evaluation whenever possible, and the report should always include a detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment. Where this information is missing, the Office may ask the attending physician to provide it; if this fails, the Office may ask the District Medical Adviser (DMA) to calculate the percentage. Where the *AMA Guides* allow for expression of this percentage within a range, the physician may be asked why he or she assigned a particular percentage of impairment. Before the *AMA Guides* may be utilized, a description of the employee's impairment must be obtained from a physician, which is 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.[9] It is well established that, in determining entitlement to a schedule award, preexisting impairments to the scheduled member are to be included.[10]

After obtaining the necessary medical evidence, the file should be routed to the DMA for opinion concerning the nature and percentage of impairment:

(1) The percentage should be computed in accordance with the *AMA Guides*, Sixth Edition. As a matter of course, the DMA should provide rationale for the percentage of impairment specified. When more than one evaluation of the impairment is present, it will be especially important for the DMA to provide such medical reasoning.

(2) The CE (Claims Examiner) should review the DMA's findings and, if he or she believes that the impairment has not been correctly described or that the percentage is not reasonable, a new or supplemental evaluation should be obtained. The CE should not attempt to assign a different percentage of impairment without benefit of further medical advice.

In the current case, the claimant initially received a schedule award reflecting 1% permanent partial impairment of the right upper extremity based upon the opinion of Dr. Doman, the second opinion physician, who provided an impairment rating according to the 6th Edition *AMA Guides* utilizing the diagnosis-based method for the accepted right shoulder injury.

The District Office correctly disregarded the opinion of the attending physician, Dr. Khajavi, who only provided a permanent impairment rating of the whole person, which is not acceptable under the FECA for determination of a schedule award.

---

[7] *Michael C. Milner*, 53 ECAB 446, 450 (2002); *Raymond E. Gwynn*, 35 ECAB 247 (1983).
[8] *Thomas P. Lavin*, 57 ECAB 353, 358 (2006).
[9] *Patricia J. Lieb*, 42 ECAB ___ (Docket No. 91-0734, issued August 23, 1991).
[10] *Michael C. Milner*, 53 ECAB 446, 450 (2002); *Raymond E. Gwynn*, 35 ECAB 247 (1983).

FECA does not authorize the payment of schedule awards for the permanent impairment of the whole person.[11] Payment is authorized only for the permanent impairment of specified members, organs or functions of the body. No schedule award is payable for a member, function or organ of the body not specified in FECA or in the regulations.[12] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back or spine,[13] no claimant is entitled to such an award.[14] Amendments to FECA, however, modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. As the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to a limb even though the cause of the impairment originated in the spine.[15]

On appeal, the claimant provided an impairment evaluation from Dr. who examined the claimant and provided his report dated with his opinion that there was 30% impairment of the cervical spine according to the 6th Edition *AMA Guides*.

In a supplemental report dated Dr. calculated 30% permanent partial impairment of the upper extremities due to the accepted cervical injury with surgery according to the 6th Edition *AMA Guides*.

In accordance with proper procedure, the file was referred to the District Medical Advisor for assessment of whether the evidence of record was sufficient to establish permanent impairment of a scheduled member according to the 6th Edition *AMA Guides*.

In a report dated the DMA noted that Dr. found impairment of the spinal nerves and graded motor strength as 4/5 at C5, C6, C7 C8 and T1. The DMA questioned the reported examination findings of Dr. Berinhout as inconsistent with the prior medical records.

The DMA provided his own assessment of permanent impairment based on the *AMA Guides* 6th Edition calculating 5% permanent impairment of the left upper extremity and 5% permanent impairment of the right upper extremity due to central nervous system (CNS) dysfunction utilizing table 13-11 on page 335. The DMA explained that the 5% impairment rating of the right upper extremity represented an additional 4% impairment of the right upper extremity combined with the previously accepted 1% impairment rating for the prior schedule award. Based on the opinion of the DMA, the District Office authorized an increase in schedule award entitlement based on the opinion of the DMA, reflecting a total 5% permanent impairment of the left upper extremity and 5% permanent impairment of the right upper extremity.

---

[11] *W.D.*, Docket No. 10-274 (issued September 3, 2010); *Ernest P. Govednick*, 27 ECAB 77 (1975).
[12] *William Edwin Muir*, 27 ECAB 579 (1976).
[13] FECA itself specifically excludes the back from the definition of organ. 5 U.S.C. § 8101(19).
[14] *Timothy J. McGuire*, 34 ECAB 189 (1982).
[15] *Rozella L. Skinner*, 37 ECAB 398 (1986).

The Branch of Hearings and Review set aside the schedule award decision with a finding that the impairment evaluation opinion of the DMA was deficient, in that he did not utilize the *Guides Newsletter*, Rating Spinal Nerve Extremity Impairment using the sixth edition (July/August 2009) to assess impairment of the upper extremities due to spinal nerve injury, as required under the FECA.

This was a correct finding. Neither the DMA nor Dr. utilized the required methodology to assess permanent impairment of the upper extremities due to spinal injury.

The 6th Edition of the *AMA Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. Recognizing that certain jurisdictions, such as federal claims under FECA, mandate ratings for extremities and preclude ratings for the spine, the *AMA Guides* has offered an approach to rating spinal nerve impairments consistent with sixth edition methodology.[16] For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP's procedures provide that *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment using the sixth edition (July/August 2009) is to be applied as provided in section 3.700 of its procedures.[17] Specifically, OWCP will address lower extremity impairments originating in the spine through Table 16-11[18] and upper extremity impairment originating in the spine through Table 15-14.[19] In addressing lower extremity impairments, the sixth edition requires identifying the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[20]

As such, the District Office was instructed to refer the case back to the DMA for a supplemental report with his opinion on permanent impairment of the upper extremities properly utilizing the *Guides Newsletter*, Rating Spinal Nerve Extremity Impairment using the sixth edition (July/August 2009). The DMA issued a supplemental report calculating 9% permanent impairment of the left upper extremity based on mild sensory and motor deficit of the C6 nerve according to the *Guides Newsletter*, Rating Spinal Nerve Extremity Impairment using the sixth edition (July/August 2009).

Based on the supplemental opinion of the DMA, in a formal decision dated , the District Office authorized an increase in schedule award entitlement based upon 9% total permanent impairment for the left upper extremity. There was no change in the prior determination of 5% permanent impairment of the right upper extremity, as was previously calculated by the DMA.

Based on my careful consideration of the evidence of record at this time, I find that the schedule award decision dated should be set aside, and the case remanded for further medical development. The opinion of the DMA is insufficient to carry

[16] FECA Transmittal No. 10-04 (issued January 9, 2010).
[17] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards,* Chapter 3.700, Exhibit 1, 4 (January 2010).
[18] A.M.A., *Guides*, 533, Table 16-11.
[19] *Id.* at 425, Table 15-14.
[20] *Id.* at 521, Table 15-14. *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

the weight of medical evidence in this case, with regard to the issue of permanent impairment of the upper extremities.

In the current case, the claimant has accepted injuries to the right shoulder and cervical spine for which she underwent two separate surgeries. The Office has already determined the claimant suffered permanent impairment of the right upper extremity due to the accepted right shoulder injury; and has suffered permanent impairment of both right and left upper extremities due to nerve damage caused by the accepted cervical injury. The issue under consideration is the degree of permanent impairment.

The Office previously found the claimant sustained 1% permanent impairment of the right upper extremity due to the accepted right shoulder injury and approved surgery based on the opinion of Dr. who utilized the diagnosis-based method to calculate this impairment figure according to the 6th Edition *AMA Guides*.

In cases involving accepted conditions of the upper extremities, Bulletin 17-06 instructs that the DMA should identify the methodology used by the rating physician, diagnosis-based (DBI) or range-of-motion (ROM), and explain whether the applicable tables in Chapter 15 of the *AMA Guides* identify a diagnosis that can alternatively be rated by ROM. If the *Guides* do not allow for the use of ROM for the diagnosis in question, the DMA should independently calculate impairment using the DBI method and clearly explain this in the report, citing applicable tables in Chapter 15 of the *Guides* that ROM is not permitted as an alternative rating method for the diagnosis in question. If the *Guides* allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used. The DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating. The DMA should render an impairment rating, if possible, given the available evidence. If the DMA finds the medical evidence of record is not sufficient to render a proper impairment rating based on DBI or ROM, the DMA should advise what additional medical evidence would be necessary to complete the rating.

In this case, Dr. did not address whether impairment of the right upper extremity due to the accepted right shoulder condition could be rated using the alternate range of motion (ROM) method; and if so, whether utilizing the ROM method would result in a higher impairment figure. There is no physician of record to discuss any consideration of the ROM method in determining impairment of the right upper extremity due to the accepted work-related right shoulder condition. In addition, the DMA did not address this issue in any memo of record. Additional development of this issue is therefore warranted.

In reports dated and , the DMA provided an opinion reflecting 5% permanent impairment of the right upper extremity and 9% permanent impairment of the left upper extremity based upon spinal nerve injury.

Although the DMA asserted that the 5% impairment of the right upper extremity due to cervical spine injury included the prior 1% impairment rating for impairment of the right upper extremity due to the accepted shoulder injury; he offered no explanation as to how he

determined this. The DMA did not explain how he took into account the established 1% permanent impairment of the right upper extremity due to the right shoulder injury when determining impairment of the right upper extremity based upon cervical nerve injury.

Furthermore, it is clear from these DMA reports that, in arriving at these impairment figures, the DMA rejected the reported examination findings of the examining physician, Dr. who advised that he found 4/5 strength motor deficits at C5, C6, C7, C8 and T1 when he examined the claimant on The DMA argued that these reported findings were not consistent with the prior office visits and made a determination based on his record review that the claimant had mild sensory and motor deficits only at C6.

Although the DMA has the right to question findings reported by an examining physician as inconsistent with the other medical evidence of record; the DMA is not an examining physician, and is not in a position to directly refute the examination findings of an examining physician. In cases pertaining to schedule award entitlement, the Board has found that, when the DMA disagrees with the impairment evaluation of an attending physician because examination findings appear inconsistent with the prior medical records of file, additional development of the evidence is warranted by way of a second opinion examination with a board-certified specialist familiar with the use of the *AMA Guides*.[21]

Additionally, the schedule award decision of was based on an impairment evaluation performed by Dr. on The report was nearly two years old at that time. The Board has held that stale medical evidence cannot form the basis for current evaluation of residual symptomology or disability determination.[22] The Board has held that a medical report is of reduced probative value when a physician relies on stale examination findings to calculate an impairment rating.[23]

Lastly, it is noted that the claimant has also been diagnosed with carpal tunnel syndrome in the bilateral upper extremities according to EMG/NCV studies of record. According to the FECA *Procedure Manual*, Chapter 2-808.5(d) rated impairment should reflect the total loss as evaluated for the scheduled member (i.e. arm, leg, etc.) at the time of the rating examination. There are no provisions for apportionment under the FECA.[24] As such, schedule awards include permanent impairment resulting from conditions accepted by OWCP as job-related as well as and any non-industrial permanent impairment present in the same scheduled member at the time of the rating examination. As long as the work-related injury has affected any residual usefulness, in whole or in part, of a scheduled member, a schedule award may be appropriate.

In the current case, there is no indication in the record that any physician has taken into account non-occupational conditions that may be contributing to permanent impairment of the upper extremities.

---

[21] See *L.Y.* ECAB Docket No. 13-106, Issued: March 18, 2014; *J.L.* ECAB Docket No. 13-2124, Issued: April 21, 2014.
[22] *See Keith Hanselman*, 42 ECAB 680 (1991); *Ellen G. Trimmer*, 32 ECAB 1878 (1981) (reports almost two years old deemed invalid basis for disability determination and loss of wage-earning capacity determination).
[23] *L.T.*, Docket No.13-997 (issued June 10, 2014).
[24] See *Raymond E. Gwynn*, 35 ECAB 247, 253 (1983).

For all of these reasons, the claimant must be referred for a directed "second opinion" examination with a Board-certified specialist in the appropriate medical specialty, one who is familiar with the application of the 6th Edition *AMA Guides* to determine permanent impairment. The second opinion physician will perform a current physical examination and provide a permanent impairment evaluation of the upper extremities in accordance with the requirements of the 6th Edition *AMA Guides* and the July/August 2009 *AMA Guides Newsletter* "Rating Spinal Nerve Impairment Under the 6th Edition" to determine permanent impairment of the left and right upper extremities. Impairment must be calculated with due consideration of all accepted, work-related medical conditions as well as any non-occupational conditions medical conditions that may be contributing to permanent impairment of the upper extremities.

Copies of the Statement of Accepted Facts (SOAF) and medical records should be provided to the second opinion physician for review prior to the exam. The detailed narrative report of the second opinion physician should discuss the history of injury according to the SOAF and available medical records. The second opinion physician should conduct a thorough examination and provide his or her own detailed subjective and objective examination findings; discuss the objective test results; and provide a firm diagnosis for all medical conditions affecting the claimant's left and right upper extremities; both work-related and non-occupational in nature.

The second opinion physician should address whether the claimant has reached a state of maximum medical improvement; and provide a permanent impairment calculation for the left and right upper extremities based on the 6th Edition *AMA Guides to the Evaluation of Permanent Impairment*; taking into account impairment due to the work-related injuries; impairment due to any approved surgical procedures; and impairment due to any non-occupational conditions.

The second opinion physician should explain whether impairment of the left or right upper extremity can be assessed according to the 6th Edition *AMA Guides* alternative ROM method in addition to the DBI method. If so, the second opinion physician should provide impairment ratings based on ROM and DBI. If ROM is used to assess impairment, the second opinion physician should be reminded that the *AMA Guides* require three independent measurements and the greatest ROM should be used for the determination of impairment. The second opinion physician should explain how the 6th Edition *AMA Guides* were utilized to determine the provided permanent impairment ratings, citing tables and pages used, with sufficiently detailed calculations explaining how the impairment ratings were determined. If the second opinion physician finds that additional medical testing or any other information is necessary to render a proper opinion on MMI or permanent impairment, the Office should undertake appropriate steps to obtain such evidence and provide it.

The second opinion physician should explain whether the claimant has permanent partial impairment of the right or left upper extremity due to spinal nerve injury caused by the accepted work-related cervical injury or approved cervical spine surgery. If so, permanent

impairment should be assessed according to *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment using the sixth edition (July/August 2009).

The second opinion physician should explain whether non-occupational conditions such as carpal tunnel syndrome are causing or contributing to permanent partial impairment of the right or left upper extremity according to the 6th Edition *AMA Guides*.

The second opinion physician should provide a final total impairment calculation for the right and left upper extremities according to the 6th Edition *AMA Guides* explaining how the impairment figures were determined, citing tables and pages used, and identifying any supportive evidence.

Once the second opinion report is obtained, the District Office should undertake any additional development of the medical evidence such as it finds warranted, and issue a *de novo* decision on the issue of schedule award entitlement due to permanent impairment of the left and right upper extremity. Part of this additional development must include referral of the file back to the DMA to assess whether the impairment evaluation of the second opinion physician is correct, consistent with the reported medical findings of record, and in accordance with the procedures of the Office and the 6th Edition *AMA Guides*.

The *de novo* decision should address (1) whether the claimant has reached maximum medical improvement, and if so, on what date this occurred; and (2) the degree of permanent impairment of the left and right upper extremities; and (3) the claimant's schedule award entitlement.

On this basis, the schedule award decision dated February 28, 2018 is hereby set aside, and the case is remanded to the District Office for actions consistent with this decision.

Issued:
Washington, D.C.

Electronically Signed

Hearing Representative
Branch of Hearings and Review
for
Director, Office of Workers'
Compensation Programs