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Issue Date: 31 December 2009

CASE NO.: 2008-LHC-01965
OWCP NO.: 01-152580

In the Matter of:

DAMON CUNNINGHAM
Claimant

v.

BATH IRON WORKS
Employer/Self-Insured

APPEARANCES:

Charles March, Esq.; Ruben, Benjamin, & March; Portland, Maine for the Claimant
Stephen Hessert, Esq.; Norman, Hanson & Detroy; Portland, Maine for the Employer

BEFORE: Jonathan C. Calianos, Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

I. Statement of the Case

This proceeding arises from a claim for worker's compensation benefits filed by Damon Cunningham ("the Claimant" or "Cunningham") against Bath Iron Works ("BIW" or "the Employer") under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 901 *et seq.* (the "Act"). After an informal conference before the District Director of the Department of Labor's Office of Workers' Compensation Programs ("OWCP"), the matter was referred to the Office of Administrative Law Judges ("OALJ") for a formal evidentiary hearing. *See* 33 U.S.C. § 919(d); Claimant's Exhibit ("CX") 1. The hearing was conducted before me on March 3, 2009 in Portland, Maine at which time all parties were afforded the opportunity to present evidence and oral argument. The parties appeared at the hearing represented by counsel. The official papers were admitted without objection as Administrative Law Judge Exhibits ("ALJX") 1-9. Hearing Transcript ("TR") 4-5. The parties offered oral stipulations. TR 7-8. Documentary evidence was admitted without objection as CX 1-5 and Employer's Exhibits ("EX") 1-28. TR 5-7. BIW's exhibit, EX-29, was submitted post-hearing without objection. TR 15. Testimony

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was heard from Cunningham. TR 16-28. After the hearing, Cunningham and BIW submitted briefs ("Cl. Br." and "Emp. Br." respectively) and the record is now closed.

Upon consideration of the evidence and the arguments presented, I conclude that Cunningham is entitled to an award of permanent partial disability compensation under 33 U.S.C. § 908(c)(1) for a 33% loss of the use of his left upper extremity, as well as interest, medical care and attorney's fees. BIW is entitled to a credit for 17% permanent partial disability benefits already paid. My findings of fact and conclusions of law are set forth below.

II. Stipulations and Issues Presented

The parties have stipulated to the following facts: (1) The Act applies to the instant claim; (2) There was an employer/employee relationship between Cunningham and BIW at the time of injury; (3) On May 10, 1994, Cunningham sustained an injury to his left wrist that arose out of and in the course of his employment with BIW; (4) Cunningham's average weekly wage at the time of injury was \$500.18¹, EX-8; (5) BIW was timely notified of the injuries, EX-1, 3, 7; (6) The claim for benefits was timely filed, EX-4; and (7) The Notice of Controversion was timely filed, EX-2, 5, 12. TR 7-8.

There are two issues in dispute: (1) Which edition of the American Medical Association ("AMA") *Guides* (hereinafter "AMA *Guides*" or "*Guides*"), the Fourth, Fifth, or Sixth Edition, should be utilized in rating Cunningham's impairment; and (2) What is the extent of Cunningham's injury to his left upper extremity? TR 8. BIW has paid compensation based upon a 17% permanent partial disability to the left upper extremity and it has paid all of Cunningham's medical treatment to date. TR 17, 27. Cunningham argues that his impairment rating should be 33% based upon the medical opinion of Dr. David Phillips who utilized the Fifth Edition of the *AMA Guides*. Cl. Br. at 16. BIW suggests through its expert, Dr. William Boucher, that the Sixth Edition is more appropriate and based upon that edition, Cunningham has a permanent partial disability of 12%. Emp. Br. at 5-6. BIW also argues that it is entitled to a credit for the permanent partial disability benefits already paid at the higher, 17% level. Emp. Br. at 6; EX-13, 15, 18. Remarkably all of the doctors who have examined Mr. Cunningham reach the same conclusions regarding their physical findings. Most notably is that they all agree that Cunningham has lost 50% of the grip strength in his dominant left hand as a result of his injury at BIW. They part company over whether Cunningham's impairment rating under the *Guides* should be increased on account of the lost grip strength.

¹ The transcript from the hearing states that the average weekly wage was \$518.00. TR 7. However, the wage statement from the State of Maine Workers' Compensation Board shows that the average weekly wage was \$500.18. EX-8. I find this to be a more accurate reflection of the average weekly wage. See also EX-10; EX-11; EX-13; EX-14; EX-15; CX-1 (average weekly wage \$500.18)

III. Findings of Fact

A. Cunningham's Testimony

Damon Cunningham is a 60 year old gentleman who has worked for BIW for approximately thirty years as a pipe fitter. TR 17. On May 10, 1994, he sustained an injury to his left thumb and wrist from repetitive use in performing his duties at BIW. TR 17; EX-3. He initially treated with two orthopedic surgeons: Dr. Donald Kalvoda and Dr. William Rogers, and he consulted with orthopedist Dr. John Chance regarding the necessity for surgical intervention. TR 17; EX-27. Cunningham was diagnosed with degenerative arthritis of the left thumb and on September 27, 2005, Dr. Rogers performed surgery involving ligament reconstruction and interpositional arthroplasty of the trapezium of Cunningham's left hand. TR 18, 26; EX-28 at 1-2; CX-3 at 38-39.

After recovering from surgery, Cunningham returned to light-duty work at BIW in February 2006. TR 18-19. The work is described as "resource recovery" which involves reconditioning all the fittings, nuts, and bolts that are stripped from ships so they can be reused. TR 19. Because he lost 50% of the grip strength in his dominant left hand after surgery, Cunningham has been unable to perform his usual duties as a pipefitter. TR 19-20. He continues to work in this light-duty position under the permanent restrictions imposed by Dr. Rogers which include: no lifting more than 15 pounds; limited use of vibratory tools to no more than six minutes per hour; and avoiding rapid, repetitive wrist activities greater than three cycles per minute. TR 20; CX-3 at 21.

Cunningham testified that while the surgery was successful in reducing his pain, he does not have significantly greater function in his left hand than he did before surgery. TR 21. Since the surgery, Cunningham has had a problem with overall grip strength in his left, dominant hand. TR 21, 26. He explains that while he now uses his right hand more to grip things, he still drops items such as eating utensils, glasses, and food. TR 21-23. He also testified that he has difficulty opening jars, taking things apart, grocery shopping, using a hammer, cutting the lawn, and shoveling snow. TR 21-24. Essentially, he stated that he has difficulty performing many of the tasks one would encounter on any given day. *Id.*

B. The Medical Evidence

i. Dr. William Rogers' Reports and Impairment Rating

Cunningham treated primarily with orthopedic surgeon, Dr. William Rogers. On August 26, 2005, Dr. Rogers diagnosed Cunningham with degenerative arthritis of the left thumb, specifically at the CMC joint and the triscaphe joint. CX-3 at 43. On September 27, 2005, Dr. Rogers performed ligament reconstruction and interpositional arthroplasty of the trapezium on Cunningham's left hand. EX-28. While it initially appeared that the surgery went well, in his reports dated December 1, 2005, February 6, 2006, and March 27, 2006, Dr. Rogers stated that Cunningham's major concern post-surgery was his decreased strength in his left hand. EX-24 at 44(i), 44(g), 44(e). Dr. Rogers had hoped that Cunningham's strength would return over time

with therapy and increased use, however Cunningham never seemed to make much headway in this regard. *Id.*; EX-24 at 44(c).

On September 25, 2006, Dr. Rogers saw Cunningham one year post surgery. CX-3 at 21. Dr. Rogers noted fatigue, weakness and discomfort in Cunningham's left hand. *Id.* In his report, Rogers observed that while there was no increased pain with compression of the hand, Cunningham had a significant loss of grip strength, and measured his grip at 50% of his non-dominant right hand. *Id.* Dr. Rogers noted that while Cunningham's recovery has been satisfactory, "grip strength is a problem for the nature of his work." *Id.* Given that the condition persisted for over one year post-surgery, Dr. Rogers did not anticipate a substantial change in Cunningham's overall grip strength. *Id.* Dr. Rogers placed permanent restrictions on Cunningham which included no lifting more than 15 pounds; limited use of vibratory tools; and avoiding repetitive wrist activities. CX-3 at 21-22; EX-24 at 44-44(a).

Dr. Rogers concluded that Cunningham reached maximum medical improvement as of September 25, 2006. CX-3 at 21; EX-24 at 44. On October 29, 2006, using the *AMA Guides*, Fourth Edition, Dr. Rogers assessed a 29% permanent impairment of Cunningham's left upper extremity. CX-3 at 21. He calculated this as follows: Using tables 27 and 34 of the *AMA Guides*, he rated the resectional arthroplasty of the thumb at 11%, and because he felt that this did not adequately address the loss of grip strength, he added 20% from table 34 to account for the strength deficiency.² *Id.*

ii. Dr. William Boucher's Impairment Ratings

Dr. William Boucher is a medical doctor licensed to practice in the state of Maine. EX-20 at 3. He was hired by BIW to perform an independent medical exam on Mr. Cunningham and provide an impairment rating for his injury. Dr. Boucher describes his background as a founding member of the American Board of Independent Medical Examiners ("ABIME"), having served on the Selection Committee, and currently he is certified by the ABIME. EX-22 at 38. He began performing independent medical evaluations in 1989 while maintaining a clinical practice at Southern Maine Medical Center. EX-22 at 38; EX-20 at 5. Today, Dr. Boucher's practice consists almost exclusively of independent medical evaluations and medical file reviews that he conducts for insurance companies and employers. EX-20 at 4 and 50. While he has done work on the claimants' side, he testified that he has done so less than 5% of the time. *Id.* He states that he still has a minor clinical practice but he has no patients that he follows. EX-20 at 4 and 50. He has spoken to national groups on work fitness and disability issues, and he has been a contributor to publications regarding disability issues and permanent impairment ratings. EX-22 at 38. He is Board Certified in Occupational Medicine, and he is a Fellow of the American College of Occupational and Environmental Medicine ("ACOEM") and the American College of Preventative Medicine. *Id.* He was the past Chairman and current Secretary of ACOEM's Work Fitness and Disability Evaluation Section. *Id.*; see EX-23 for full Curriculum Vitae.

When the Fourth Edition of the *AMA Guides* was published, Dr. Boucher took some courses on how to use the *Guides* and he subsequently trained others on how to make impairment

² While 11% and 20% add up to 31%, I can only assume that Dr. Rogers utilized the combined value chart contained in the *Guides* to arrive at the lower figure of 29%.

ratings using the *Guides*. EX-20 at 5. When the Fifth Edition was released, Dr. Boucher continued to train others in various jurisdictions on implementing this new edition of the *AMA Guides*. *Id.* He served on the review board for the Sixth Edition of the *Guides*, and continues to conduct training for that edition as well. *Id.*; see EX-20, Exhibit 4. As a reviewer for the Sixth Edition, he was assigned select chapters by the primary authors and he was responsible for making recommendations for changes and checking for accuracy and clarity. EX-20 at 5.

On December 15, 2006, Dr. Boucher conducted an examination of Mr. Cunningham, spending approximately one hour with him. EX-22 at 30; EX-20 at 6, 8. Dr. Boucher had Cunningham complete a series of questionnaires and he reviewed Cunningham's medical records. EX-20 at 6-7, 28; see EX-20, Exhibit 7. On physical examination, Dr. Boucher noted "moderate left thenar atrophy" of Cunningham's left hand. EX-22 at 35. He also found that Cunningham's grip strength in his left hand was decreased by approximately 50% when compared to his right hand. *Id.* Dr. Boucher diagnosed Cunningham with left first carpal metacarpal (CMC) arthritis, which is arthritis at the base of the thumb where it connects to the wrist. EX-20 at 9. Dr. Boucher testified that the surgery Cunningham had undergone typically produces varying results. EX-20 at 9. He stated that some people regain almost full function of the joint while others are not so fortunate. *Id.* In general, he stated "there is going to be weakness and some decreased motion in that joint even in the best of results." *Id.* Dr. Boucher opined that Cunningham's surgical outcome was "not a fantastic result ... probably in the middle of the range." *Id.*

As of the date of his report, December 15, 2006, Dr. Boucher concluded that Cunningham had reached maximum medical improvement. EX-22 at 37. This is a few months later than Dr. Roger's finding of September 25, 2006, but there is not significant controversy of one date versus another. Using the Fifth Edition of the *AMA Guides*, which was the most current edition at the time of Dr. Boucher's exam of Cunningham, he assessed a 17% permanent impairment rating of the left upper extremity. EX-22 at 37; EX-20 at 9, 15-16. Dr. Boucher calculated the impairment as follows: He started with table 16-27 which provides a base upper extremity impairment of 11% resulting from the CMC resectional arthroplasty, the surgery performed by Dr. Rogers on Cunningham's left hand. EX-22 at 37; EX-20 at 10. Dr. Boucher then quantified the reduced range of motion in Cunningham's thumb and assessed an additional 2% permanent impairment on account of the motion deficit. EX-22 at 37. To conclude his calculations, he looked at wrist motion and added another 4% permanent impairment for Cunningham's left wrist motion deficit. EX-22 at 37. Combining these values, Dr. Boucher reached a permanent impairment rating of 17% of the upper extremity. *Id.* Dr. Boucher also calculated permanent impairment using the Fourth Edition of the *AMA Guides*, and he came to the same result – a 17% permanent impairment of the upper extremity.³ EX-22 at 38; EX-20 at 11.

At the time of Dr. Boucher's deposition in February of 2009, the Sixth Edition of the *AMA Guides* was the most current version in circulation and it had been available to

³ Dr. Boucher testified that he referred to the Fourth Edition of the *AMA Guides* because the Maine Worker's Compensation Statue requires use of that edition, and when he performed his review he believed there would be a jurisdictional question in this case. EX-20 at 11.

practitioners since December 28, 2007. EX-20 at 16, 28. Given that the Sixth Edition was not available when Dr. Boucher originally examined Cunningham, Dr. Boucher was asked to rate Cunningham's impairment under the Sixth Edition of the *Guides*. EX-20 at 18-19. While Dr. Boucher stated that he would have to look more closely at the Sixth Edition, and notwithstanding the fact that Cunningham was never asked to complete the upper extremity questionnaire required by the Sixth Edition, Dr. Boucher concluded that Cunningham's thumb impairment is 34% under the Sixth Edition for the CMC arthroplasty of the thumb. EX-20 at 18-19. This digit impairment converted to a 12% impairment of the upper extremity, which is the highest rating allowed under the Sixth Edition for a person having the same surgery as Cunningham. EX-20 at 19-20, 53-54.

iii. Dr. David Phillips' Reports and Impairment Rating

In July 2008, Cunningham retained Dr. David L. Phillips II, M.D to review the impairment ratings assessed by Doctors Rogers and Boucher and provide his own opinion regarding Cunningham's level of impairment. After conducting the review, Dr. Phillips made the following conclusions:

It is my medical opinion using the 4th edition of the *AMA Guides* that Dr. Rogers analysis of permanent impairment is the best assessment that considers the impairing factors causing Damon's permanent impairment due to his work related injury at BIW.

I agree Damon's 50% loss of strength, as compared to the opposite side, documented by Dr. Rogers is an impairing factor not adequately assessed by the resectional arthroplasty alone. It is my medical opinion Damon has 11% arm impairment for resectional arthroplasty of the CMC joint of the left thumb from table 27, page 61, and an additional 20% arm impairment from table 34, page 65, for loss of strength to the left hand. These are then combined using the Combined value chart, p 322, to equal 29% arm impairment due to his work-related injury of May 10, 1994 at BIW.

Technically the *Guides* would allow Dr. Boucher's additional 6% arm impairment for reduced range of motion to be combined with the 29% arm impairment to equal 33% arm impairment for the work related injury of May 10, 1994. But it is my medical opinion that the 29% arm impairment is the best estimate of Damon's arm impairment.

EX-21 at 29. In summary, Dr. Phillips believes it is essential to factor in Cunningham's loss of grip strength as part of the equation when assessing the level of impairment.

On November 17, 2008, Dr. Phillips examined Cunningham for purposes of performing an independent permanent impairment evaluation. EX-21 at 25-27. Like the two other doctors who examined Cunningham, Phillips found a strength deficit of 31% in Cunningham's left hand,

and similar to Dr. Boucher, he noted a loss of thenar muscle at the left thumb and decreased range of motion at the thumb and wrist. EX-21 at 26.

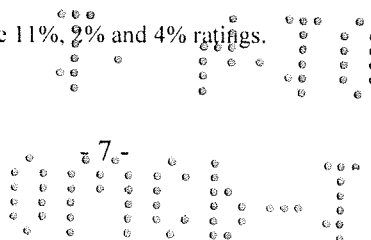
Using the Fifth Edition of the *AMA Guides*, Dr. Phillips revised his earlier opinion and increased Cunningham's permanent impairment rating from 29% to 33% for the upper extremity. EX-21 at 26-27. His revised calculations were made as follows: He again started with the base of an 11% upper extremity impairment for the resectional arthroplasty of the CMC joint from table 16-27. EX-21 at 26. Dr. Phillips then increased his rating for loss of range of motion to the thumb and wrist, similar to the calculations made by Dr. Boucher. *Id.* Using tables 16-8a, 16-8b, and 16-9, Dr. Phillips found a 6% thumb impairment on account of Cunningham's reduced range of motion at the thumb. *Id.* This equates to an additional 2% impairment of the upper extremity under tables 16-1 and 16-2. *Id.* In assessing reduced range of motion to the wrist, Dr. Phillips agreed with Dr. Boucher that Cunningham's limitations equated to an additional 4% upper extremity impairment. *Id.* Combining these values, it appears that Dr. Phillips and Dr. Boucher arrive at the same impairment rating under the Fifth Edition of the *Guides*—17%.⁴ *Id.* This is where the professionals part company.

Dr. Phillips advocates for increasing the 17% upper extremity impairment to account for Cunningham's 51% grip strength deficit in his left hand. EX-21 at 26. He concludes that when accounting for grip strength, Cunningham's total impairment to his upper extremity is 33% under the Fifth Edition of the *Guides*. *Id.* He arrived at this conclusion as follows: Using table 16-34, he converts the 51% grip strength loss to a 20% upper extremity impairment. *Id.* He then looked to the combined value chart on page 604, to combine the 11% impairment for the surgery with the 20% impairment for the strength deficit to reach a combined value of 29%. *Id.* Using the same chart, he then factored in the loss of motion of the thumb and wrist to arrive at the total impairment rating of 33%. *Id.*

iv. Dr. Boucher's Rebuttal

During his deposition, Dr. Boucher reviewed the impairment ratings assessed by Doctors Rogers and Phillips. EX-20. With regard to Dr. Rogers, Dr. Boucher takes issue with assessing additional impairment on account of Cunningham's grip strength deficit. EX-20 at 12-15, 20-22. While Dr. Boucher concedes that the Fourth Edition of the *Guides* is vague on using grip strength to enhance an impairment rating based on resectional arthroplasty of the CMC joint, and the *Guides* essentially gives physicians discretion to do so, the better practice is to use the Fifth Edition which clarifies that grip strength should not be used in a final rating. *Id.* He explained that by using the rating assigned for the surgery under the Fifth Edition, the practitioner has already accounted for grip strength loss within the rating. *Id.* To add grip strength again would amount to double counting according to Dr. Boucher. *Id.* Dr. Boucher states that the Fifth Edition is firm that grip strength should only be used to calculate a permanent impairment when other methods are unavailable. EX-20 at 21-22. Here, the arthroplasty is used to calculate the permanent impairment, and the strength deficit should not be rated separately. *Id.*

⁴ The 17% impairment is achieved by adding the 11%, 2% and 4% ratings.



The second shortcoming Dr. Boucher finds is that Dr. Rogers neglected to enhance his base rating of 11% to account for the range of motion deficits in Cunningham's thumb and wrist. EX-20 at 20-22. Unlike grip strength, range of motion is clearly something that must be added to the underlying impairment for the surgical procedure under both the Fourth and Fifth Editions of the *Guides*.⁵ *Id.* According to Dr. Boucher, had Dr. Rogers used the *Guides* in the manner he suggests, they would have reached the same conclusion on a permanent impairment rating of 17% for the upper extremity.

In critiquing Dr. Phillips' assessment, Dr. Boucher first finds fault with his use of the Fourth Edition of the *Guides* in his initial calculations. EX-20 at 22-26. Dr. Boucher believes when making an impairment assessment, a physician should utilize the most current version of the *Guides*—in this case the Sixth Edition.⁶ EX-20 at 23. With regard to Dr. Phillips' revised calculations under the Fifth Edition of the *Guides*, Dr. Boucher finds fault with Dr. Phillips' use of strength deficiency to increase Cunningham's overall impairment rating. EX-20 at 22-26. As discussed *supra*, he believes the Fifth Edition firmly discourages this practice.

IV. Conclusions of Law

A. AMA *Guides* Edition

BIW has paid Cunningham permanent partial disability benefits under 33 U.S.C. § 908(c)(1) for a 17% impairment of the left upper extremity. Cunningham now seeks a determination that he has sustained a 33% permanent partial disability of his left upper extremity as of September 25, 2006 on account of the work-related injury. To achieve this result, I must follow the paths blazed by Doctors Phillips and Rogers and increase Cunningham's impairment rating to account for the significant loss of grip strength in Cunningham's left hand.

It is undisputed that Cunningham's impairment is permanent and that he has reached maximum medical improvement. While the parties have not stipulated when Cunningham's injury can be deemed permanent, the date of maximum medical improvement is the typical guidepost and that is a question of fact based upon the medical evidence of record. *Louisiana Insurance Guar. Ass'n. v. Abbott*, 40 F.3d 122, 125 (5th Cir. 1994); *Ballesteros v. Willamette Western Corp.*, 20 BRBS 184, 186 (1988). An employee reaches maximum medical improvement when his condition becomes stabilized. *Thompson v. Quinton Eng'rs, Ltd.*, 14 BRBS 395, 401 (1981). Both parties agree that Cunningham reached maximum medical improvement on September 25, 2006 when he returned to Dr. Rogers one year following his arthroplasty. Cl. Br. at 9; Emp. Br. at 2. Based upon the evidence, I find that permanency is established as of the same date-- September 25, 2006.

⁵ Under the section entitled "Arthroplasty," the Fifth Edition states that "[i]mpairment ratings for the upper extremity following arthroplasty of specific joints are listed in Table 16-27. . . . In the presence of *decreased motion*, motion impairments are derived separately . . . and *combined* with the arthroplasty impairment. . . ." EX-29 at 505.

⁶ In the First Chapter of the Fifth Edition of the AMA *Guides*, "it is strongly recommended" that physicians use the latest edition of the *Guides* when rating impairment. CX-2 at 6.

Both parties have urged me to use the AMA *Guides* to determine an impairment rating in this case, but the evidence is based on three competing versions: the Fourth Edition, the Fifth Edition, and the Sixth Edition. There is no agreement on which edition controls, and neither party advocates for use of the oldest edition which is the Fourth Edition. Cunningham argues that the Fifth Edition should be adopted, while BIW argues that the Sixth Edition controls. An administrative law judge (“ALJ”) is not bound to apply the AMA *Guides*, nor is he or she bound by a doctor’s opinion. *Peterson v. Washington Metro. Area Transit Auth.*, 13 BRBS 891, 897 (1981); *Mazze v. Frank J. Holleran, Inc.*, 9 BRBS 1053, 1055 (1978). However, the AMA *Guides* are commonly relied on in the medical profession, so I find it appropriate to use them as a guide in this case.

As this case demonstrates, a person’s medical condition changes over time and more often than not, that period can span several published versions of the AMA *Guides*. In one camp, we could always insist that the most current version of the *Guides* be utilized in assessing a person’s impairment. However, I think such an edict could result in prolonged litigation because as the trial date approaches, litigants would be compelled to update medical evidence based upon the newest available guide. This was evident at Dr. Boucher’s deposition. The deposition was conducted a month before the scheduled trial in this matter and the Sixth Edition of the *Guides* had been in circulation for about one year. Dr. Boucher was asked for the first time to opine on an impairment rating under the Sixth Edition. Putting aside the issue of whether or not the doctor was adequately prepared to render such an opinion without having provided Cunningham the questionnaire required by the Sixth Edition, it now opens the door for Claimant’s experts to assess Cunningham’s impairment under the Sixth Edition. All of this additional discovery is occurring at a time when discovery should be winding down, not ramping up. I believe in cases like this, where a claimant has reached maximum medical improvement, it is better to have the impairment assessed pursuant to the most current AMA *Guides* Edition in circulation as of the date of maximum medical improvement. This date is readily determinable and it is typically the date that permanency is established—a logical time to fix an impairment under the applicable AMA *Guides* Edition in effect. This is also a point in the litigation well before any trial date is established, and the parties can focus on one version of the *Guides* during the discovery process. In the instant case, Cunningham reached maximum medical improvement on September 25, 2006, and the Fifth Edition of the AMA *Guides* was the most current edition in circulation. I will use the Fifth Edition as a guide in assessing Cunningham’s impairment in this case.

B. Extent of Disability

The Claimant bears the burden of proving the extent of a disability. *Trask v. Lockheed Shipbuilding & Constr. Co.*, 17 BRBS 56, 59 (1985). An ALJ is not bound by any particular standard or formula and may determine the extent of a disability under the schedule on credible medical opinions and observations, as well as the claimant’s testimony regarding his symptoms and the physical effects of his injury. *Pimpinella v. Universal Maritime Service Inc.*, 27 BRBS 154, 159-160 (1993). It is within the ALJ’s discretion to assess the degree of disability and differ from the ratings given by the physicians as long as the degree is reasonable. *Peterson v. Washington Metro. Area Transit Auth.*, 13 BRBS 891, 897 (1981); *Michael v. Sun Shipbuilding*

& *Dry Dock Co.*, 7 BRBS 5, 6-8 (1977) (judge properly awarded 4% partial loss of use of the right foot where the claimant's treating physician rated such impairment as 2% and the second physician issued a rating of from 3-5% according to the *AMA Guides*). Both Dr. Phillips and Dr. Boucher referred to the Fifth Edition of the *AMA Guides* and both actually concur on a base rating of 17% to Cunningham's left upper extremity for the surgical joint reconstruction and the diminished range of motion at thumb and wrist. The discord is over diminished grip strength and whether that should increase Cunningham's impairment rating.

My work is made easier by the fact that all of the medical experts who examined the Claimant agree that he has a 50% loss of grip strength in his left, dominant hand. They also agree that there is a visible loss of the thenar muscle at the left thumb. Furthermore, Cunningham testified that the reduced strength in his left hand has adversely impacted his ability to perform the tasks of daily living such as cooking, cleaning, and home maintenance. Dr. Phillips (and Dr. Rogers for that matter) believes that the impairment rating for the resectional arthroplasty alone does not account for the significant strength loss in Cunningham's left hand. While Dr. Boucher readily acknowledges that patients who undergo resectional arthroplasty may experience differing results vis-à-vis diminished grip strength, he suggests they all should have the same impairment rating under the Fifth Edition of the *Guides*, regardless of whether their strength is diminished only slightly or, as in Cunningham's case, rather significantly.

After reviewing the Fifth Edition of the *Guides* as supplied by the parties, see EX-29 and CX-2, I do not view this as a case where one doctor is more qualified or more credible than another doctor. Rather, I find that Dr. Boucher, in reaching his impairment rating, has chosen to read the *Guides* in a very strict, inflexible manner, and as such he has left little or no room for taking into account any subjective symptoms of the Claimant and the poor results of the joint reconstruction surgery which Dr. Boucher himself described as "not a fantastic result." Dr. Boucher bases his conclusion on the following language in the Fifth Edition of the *AMA Guides*:

In a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the *Guides*, the loss of strength may be rated separately. An example of this situation would be loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. If the examiner judges that loss of strength should be rated separately in an extremity that presents other impairments, the impairment due to loss of strength *could be combined* with the other impairments, *only* if based on unrelated etiologic or pathomechanical causes. *Otherwise, the impairment ratings based on objective anatomic findings take precedence.* Decreased strength *cannot* be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts . . . that prevent effective application of maximal force in the region being evaluated.

EX-20, Exhibit 1; EX-29 at 508 (emphasis in original). While not explained thoroughly in his deposition testimony, I assume Dr. Boucher believes that Cunningham's loss of strength is due solely to the resectional arthroplasty of the CMC joint and, therefore, cannot be "based on unrelated etiologic or pathomechanical causes." I do not reach the same conclusion, especially when I look at other language in the *Guides*.

It appears that the authors of the *Guides* have put little weight on strength measurements in impairment ratings because they are inherently subjective and are easily manipulated. The *Guides* state:

Because strength measurements are functional tests influenced by subjective factors that are difficult to control and the *Guides* for the most part is based on anatomic impairment, the *Guides* does not assign a large role to such measurements. Those who have contributed to the *Guides* believe that further research is needed before loss of grip and pinch strength is given a larger role in impairment evaluation. . . . Many subjective or nonmeasurable factors, including fatigue, handedness, time of day, age, nutritional state, pain, and the individual's cooperation, further influence strength measurements. Voluntary muscle strength testing remains somewhat subjective until a precise way of measuring muscle contraction is generally available. It should also be noted that the correlation of strength with performance of activities of daily living is poor and that increased strength does not necessarily equate with increased function.

EX-29 at 507. Notwithstanding the skepticism on strength measurements, the authors recommend as part of the impairment evaluation that physicians "ascertain and document subjective concerns." CX-2 at 14. The *Guides* state: "Because the presence and severity of subjective concerns varies among individuals with the same condition, the *Guides* has not yet identified an accepted method within the scientific literature to ascertain how these concerns consistently affect organ or body system functioning. The physician is encouraged to discuss these concerns and symptoms in the impairment evaluation." *Id.*

In the instant case, we have a significant strength deficiency which has been verified by three independent medical experts. The *Guides* allow a physician, in a rare case, to rate the loss of strength separately if the examiner believes the diminished strength represents an impairing factor that has not been considered adequately by other methods in the *Guides*. EX-29 at 508. It is impossible for me to reconcile the fact that under Dr. Boucher's reading of the *Guides*, I would give an individual who had successful resectional arthroplasty of the CMC joint, with similar range of motion deficiencies as Cunningham, but with little or no strength deficit, the same rating as I would give Cunningham. Under the *Guides*, an impairment rating reflects, in part, an individual's ability to perform common activities of daily living. See CX-2 at 8. Many activities of daily living involve grasping and lifting, which Cunningham testified he can barely do. The patient without strength deficiencies would not have issues carrying glassware, holding a hammer, or trying to cook a steak. By ignoring the strength deficiency, Cunningham's impairment rating does not fully account for the additional activities of daily living that cannot be performed because of the reduced grip strength. This is not a case where manipulation or other subjective factors can creep into the equation. Rather, this is the rare case where three experts agree that there is a 50% loss in grip strength. It is only appropriate to add a 20% upper extremity impairment, as did Dr. Phillips, to account for the diminished grip strength.

Accordingly, based upon the foregoing, I adopt Dr. Phillips' final impairment rating and find that Mr. Cunningham has a 33% impairment of his left upper extremity.

C. Compensation Due

Cunningham is entitled to permanent partial disability benefits for a 33% impairment of the left upper extremity pursuant to Section 8(c)(1) of the Act. 33 U.S.C. § 908(c)(1). Permanent partial disability resulting from the loss of a worker's upper extremity (the arm) under Section 8(c)(1) of the Act provides for compensation at 2/3 of the worker's average weekly wage for 312 weeks. 33 U.S.C. § 908(c)(1). In a case such as this where the loss (or loss of use) is partial, compensation is based on the proportionate loss (or loss of use) of the member. 33 U.S.C. § 908(c)(19). That is, the percentage of Cunningham's loss of use of his upper extremity must be applied to the number of weeks set forth in Section 8(c)(1) to arrive at the proportionate number of weeks of compensation. *Nash v. Strachan Shipping Co.*, 15 BRBS 386, 391-92 (1983), *aff'd in relevant part but rev'd on other grounds*, 760 F.2d 569 (5th Cir. 1985), *aff'd on recon. en banc*, 782 F.2d 513 (5th Cir. 1986). For his 33% impairment of his left upper extremity, Cunningham is entitled to 102.96 weeks of disability compensation benefits. The parties have stipulated that as of the date of injury, Cunningham's average weekly wage was \$500.18; so 2/3 of his average weekly wage is \$333.45. Therefore, Cunningham is entitled to disability compensation benefits of \$333.45 per week beginning on September 25, 2006, the date of permanency, and continuing for a period of 102.96 weeks.

D. Credit

Under the credit doctrine, an employer is not liable for any portion of an employee's disability for which the employee has actually received compensation under the Act. *Strachan Shipping Co. v. Nash*, 782 F.2d 513, 515 (5th Cir. 1986). BIW has already paid permanent partial disability compensation benefits based upon a 17% permanent partial impairment rating under Section 8(c)(1) for Cunningham's left upper extremity covering a period of 53.04 weeks. EX-15. BIW is entitled to a credit for these payments.

E. Medical Care

An employer found liable for the payment of compensation is additionally responsible pursuant to Section 7(a) of the Act for those medical expenses reasonably and necessarily incurred as a result of a work-related injury. 33 U.S.C. § 907; *Dupre v. Cape Romaine Contractors, Inc.*, 23 BRBS 86, 94 (1989) (citing *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979)). Accordingly, BIW shall remain liable for all reasonable and necessary medical care as required by Cunningham for treatment of his work-related injury.

F. Interest

Although not specifically authorized in the Act, the Benefits Review Board and the courts have consistently upheld interest awards on past due benefits to ensure that the employee receives the full amount of compensation due. *Foundation Constructors, Inc. v. Director*,

OWCP, 950 F.2d 621, 625 (9th Cir. 1991); *Cowart v. Nicklos Drilling Co.*, 23 BRBS 42, 47 (1989), *rev'd in part*, 907 F.2d 1552 (5th Cir. 1990), *aff'd en banc*, 927 F.2d 828 (5th Cir. 1991), *aff'd*, 505 U.S. 469 (1992); *Grant v. Portland Stevedoring Co.*, 16 BRBS 267, 269 (1984), *on recon.*, 17 BRBS 20, 23 (1985). Interest is due on all unpaid compensation. *Adams v. Newport News Shipbuilding & Dry Dock Co.*, 22 BRBS 78, 84 (1989). Interest is mandatory and cannot be waived in a contested case. *Byrum v. Newport News Shipbuilding & Dry Dock Co.*, 14 BRBS 833, 837 (1982). Interest is computed from the date each compensation payment becomes overdue. The first installment of compensation under the Act becomes due fourteen days after a claimant gives notice to the employer of an injury or the employer has knowledge of the injury. 33 U.S.C. § 914(b). Since compensation payments were not timely made, I find that Cunningham is entitled to an award of prejudgment interest. The interest shall be assessed as of the date Cunningham's compensation became due. *Wilkerson*, 125 F.3d at 907-08 (5th Cir. 1997). The appropriate interest rate is the rate employed by the United States District Courts under 28 U.S.C. § 1961, which is periodically changed to reflect the yield on United States Treasury Bills. *Grant*, 16 BRBS at 270. The compensation incorporates 28 U.S.C. § 1961 by reference and provides for its specific administrative application by the District Director. The appropriate rate shall be determined as of the filing date of this Decision and Order with the District Director.

G. Attorney's Fees

Having successfully established his right to compensation, Cunningham is entitled to an award of attorney fees under Section 28 of the Act. 33 U.S.C. § 928; *American Stevedores v. Salzano*, 538 F. 2d 933, 937 (2d Cir. 1976).

V. ORDER

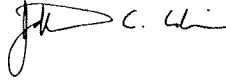
Accordingly, it is hereby ORDERED that:

1. Pursuant to 33 U.S.C. § 908(c)(1), the Employer, BIW, shall pay directly to the Claimant, Damon Cunningham, permanent partial disability compensation benefits for a 33% impairment of his left upper extremity at a rate of \$333.45 per week beginning on September 25, 2006 and continuing for a period of 102.96 weeks, subject to a credit for permanent partial disability compensation benefits BIW has already paid;
2. Pursuant to 33 U.S.C. § 907, BIW shall continue to pay all reasonable and necessary medical care for treatment of all of Cunningham's work-related injury;
3. BIW shall pay to Cunningham interest on any past due compensation benefits at the Treasury Bill rate applicable under 28 U.S.C. § 1961 (1982), computed from the date each payment was originally due until paid; and
4. If Cunningham seeks an award of attorney's fees and costs pursuant to 33 U.S.C. § 928, an application conforming to the requirements of 20 C.F.R. § 702.132(a) (2008) shall be filed within **30 days** of the date on which this order is filed in the office of the District

Director. Should the Employer object to any fees or costs requested in the application, the parties' attorneys shall discuss and attempt to informally resolve the objections. Any agreement reached between the parties as a result of these discussions shall be filed with the court in the form of a stipulation. In the event that the parties are unable to resolve all issues relating to the requested fees and costs, the Employer's objections shall be filed not later than **30 days** following service of the fee application. **The objections must be accompanied by a certification that the objecting party made a good faith effort to resolve the issues with the Claimant's attorney prior to the filing of the objections;** and

5. All computations of benefits and other calculations provided for in this Decision and Order are subject to verification and adjustment by the District Director.

SO ORDERED.



JONATHAN C. CALIANOS
Administrative Law Judge

Boston, Massachusetts

