U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of REBECCA L. NIEVES and U.S. POSTAL SERVICE,
POST OFFICE, San Diego, CA

Docket No. 02-268; Submitted on the Record;
Issued July 2, 2002

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
A. PETER KANJORSKI

The issue is whether appellant has more than a 12 percent impairment of her right upper extremity for which she received a schedule award.

On April 20, 1999 appellant, then a 42-year-old machine operator clerk, filed an occupational disease claim alleging that she injured her right shoulder in the performance of duty. The Office of Workers' Compensation Programs accepted appellant's claim for right shoulder subluxation and tear and authorized surgical repair. On June 23, 2000 she underwent a right shoulder inferior capsular shift, performed by Dr. Wesley R. Smidt, her treating Board-certified orthopedic surgeon.

On January 12, 2001 the Office asked Dr. Smidt to evaluate appellant for the purpose of determining whether she had any permanent impairment of her shoulder which would entitle her to receive a schedule award. In a report dated November 7, 2000, Dr. Smidt stated that appellant was "prophylactically precluded from very heavy lifting with the right arm, contemplating a loss of approximately 25 percent of her preinjury capacity for lifting with that arm." He further stated that appellant's condition had reached a permanent and stationary status and that based on the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, appellant had a one percent upper extremity impairment due to loss of abduction, a two percent upper extremity impairment due to loss of forward flexion and a one percent upper extremity impairment due to loss of external rotation, for a total upper extremity impairment of four percent. The physician stated that all other motions were within normal limits. In an addendum to his report, Dr. Smidt stated that in addition to the objective findings previously reported, subjectively appellant had constant minimal symptoms in the right shoulder, increasing to slight with repetitive overhead activities and very heavy lifting.

On February 8, 2001 an Office medical adviser reviewed Dr. Smidt's reports and applied his findings to the fifth edition of the A.M.A., *Guides*, which became effective February 1, 2001. The Office medical adviser determined that appellant was entitled to a four percent schedule award for the right upper extremity.

By decision dated April 12, 2001, the Office granted appellant a schedule award for a four percent permanent impairment of the right upper extremity. The period of the award ran for 12.48 weeks from November 8, 2000 to February 3, 2001.

On July 13, 2001 appellant submitted a claim for an additional schedule award due to her worsening condition. In support of her claim, appellant submitted a May 10, 2001 report from Dr. Smidt, in which he stated that there had been a decrease in appellant's range of motion since his November 7, 2000 report and that testing of the right shoulder revealed 90 degrees of abduction, 160 degrees of forward flexion, 30 degrees of external rotation and 40 degrees of extension. Dr. Smidt further stated that appellant had tenderness at all end ranges of motion and discomfort with impingement testing, but negative anterior and posterior apprehension tests. Appellant's reflexes were 2+ and symmetric in biceps and brachioradialis reflexes and she had normal 5/5 strength of wrist flexion and extension and with biceps and triceps strength. Dr. Smidt also noted that appellant's grip strength, tested in pounds with a Jamar dynamometer, measured 25/17/23 on the right and that she had pain with forceful grip limits with maximal effort. He assessed appellant as being status-post chronic right shoulder instability treated by stabilization procedure and stated that subjective factors of disability would currently be classified as slight frequent pain in the right shoulder increasing to moderate with overhead activities and forceful activities using the right hand and arm. The physician further noted, however, that appellant had no pain at rest. Dr. Smidt listed the objective factors of disability as decreased range of motion, decreased strength as demonstrated by Jamar grip strength testing and pain at the end ranges of motion. He concluded that additional work restrictions were necessary to prevent deterioration of appellant's function and to allow improvement, "contemplating a loss of 50 percent of her preinjury capacity for lifting, pushing, pulling, grasping, pinching, holding, torquing and performing other activities of comparable physical effort." Dr. Smidt did not reference the A.M.A., *Guides* in support of his conclusion.

In a September 2, 2001 memorandum, an Office medical adviser reviewed Dr. Smidt's findings, as set forth in his May 10, 2001 report and, applying the standards outlined in the fifth edition of the A.M.A., *Guides,* determined that appellant had a total of 12 percent permanent impairment of her right upper extremity.[1] In arriving at this figure, the Office medical adviser initially calculated that appellant had a 1 percent impairment in her right upper extremity based on 160 degrees forward flexion in accordance with Figure 16-40, page 476 of the A.M.A., *Guides*; extension of 40 degrees, which equated to a 1 percent impairment in accordance with Figure 16-40, page 476 of the A.M.A., *Guides*; a 4 percent impairment based on 90 degrees abduction in accordance with Figure 16-43, page 477 of the A.M.A., *Guides*; a 1 percent impairment for 30 degrees of external rotation in accordance with Figure 16-46, page 479 of the A.M.A., *Guides;* and a 5 percent impairment of the right upper extremity based on shoulder

[1] FECA Bulletin No. 01-05 issued January 29, 2001 provides that all claims examiners and hearing representatives should begin using the fifth edition of the A.M.A., *Guides* effective February 1, 2001.

instability pattern in accordance with Table 16-26, page 505 of the A.M.A., *Guides*.[2] The Office medical adviser, therefore, found that, based on the total of the above calculations, appellant had a 12 percent permanent impairment of the right upper extremity, which equated to an additional 8 percent impairment over the previous rating.

On October 15, 2001 the Office awarded appellant an additional 8 percent, for a total schedule award of 12 percent.

The Board finds that appellant has no more than a 12 percent permanent impairment of the right upper extremity for which she received a schedule award.

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulation[4] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use of scheduled members or functions of the body. However, the Act does not specify the manner in which the percentage of loss shall be determined. 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 A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.

In the instant case, the Office determined that appellant had a 12 percent permanent impairment of her right upper extremity by adopting the findings of the Office medical adviser, who determined the precise impairment rating by gauging the loss of flexion, extension, abduction, external rotation and instability pattern in appellant's right upper extremity, based on the applicable figures and tables of the A.M.A., *Guides.*

The Board concludes that the Office medical adviser correctly applied the A.M.A., *Guides* to the range of motion measurements provided by Dr. Smidt in determining that appellant has no more than a total of 12 percent permanent impairment of the right upper extremity, for which she has received a schedule award from the Office and that appellant has failed to provide probative, supportable medical evidence that she has greater than the 12 percent impairment already awarded. Because Dr. Smidt did not use the uniform standards adopted by the Office and approved by the Board, it was proper for an Office medical adviser to apply the A.M.A., *Guides* to the findings reported by Dr. Smidt on examination.[5] While the Office medical adviser did not accord appellant any additional impairment for loss of grip strength, the A.M.A., *Guides* provides that because strength measurements are functional tests influenced by subjective

[2] The Board notes that Table 16-26, page 505 of the A.M.A., *Guides* provides three levels of upper extremity impairment due to symptomatic shoulder instability patterns: 6 percent for occult; 12 percent for patterns with subluxating humeral head; and 24 percent for patterns with dislocating humeral head. While the Office medical adviser assigned appellant only 5 percent impairment for this condition, the Board notes that this is consistent with the A.M.A., *Guides*, at Chapter 2.5d, page 20, which provides that a physician may consider all criteria in deciding where to place an individual's impairment within a range. In addition, the Board notes that appellant's treating physician did not assign any specific impairment rating to this condition.

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] *John L. McClenic*, 48 ECAB 552 (1997); *Lena P. Huntley*, 46 ECAB 643 (1995).

factors, impairment ratings based on objective anatomic findings where applicable, take precedence.[6] Furthermore, while the Office medical adviser did not allow appellant any additional percentages for pain, the Board notes that this is also consistent with the A.M.A., *Guides*, which provides that "the impairment ratings in the body system organ chapters make allowance for any accompanying pain."[7] While additional impairments may be granted for chronic pain, appellant's treating physician, Dr. Smidt, did not characterize her pain as chronic, but rather noted that when at rest, appellant had no pain at all.[8] As the Office medical adviser's report provides the only evaluation that conforms with the A.M.A., *Guides*, it constitutes the weight of the medical evidence.[9]

Accordingly, the decisions of the Office of Workers' Compensation Programs dated October 15 and April 12, 2001 are hereby affirmed.

Dated, Washington, DC
July 2, 2002

Michael J. Walsh
Chairman

David S. Gerson
Alternate Member

A. Peter Kanjorski
Alternate Member

[6] *See* A.M.A., *Guides* at Chapter 16.8, pages 508-9, which provides: "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.*" (Emphasis in the original.)

[7] A.M.A., *Guides* at Chapter 2.5e, page 20.

[8] Chapter 18 of the fifth edition of the A.M.A., *Guides*, which provides for the assessment of chronic pain, states that "examiners should not use this chapter to rate pain related impairment for any condition that can be adequately rated on the basis of body and organ impairment rating systems given in other chapters of the A.M.A., *Guides*. A.M.A., *Guides* at Chapter 18.3b, page 571.

[9] *Lena P. Huntley, supra* note 5; *Michael C. Norman*, 42 ECAB 768 (1991).