United States Department of Labor
Employees' Compensation Appeals Board

L.N., Appellant	)	
	)	
and	)	**Docket No. 09-635**
	)	**Issued: January 27, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Kansas City, MO, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 2, 2009 appellant filed a timely appeal from an October 31, 2008 decision of the Office of Workers' Compensation Programs that denied her claim for compensation and a November 21, 2008 decision regarding a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUES

The issues are: (1) whether appellant is entitled to disability compensation from September 1, 2007 to July 3, 2008 causally related to her accepted employment conditions; and (2) whether she has more than 24 percent permanent impairment of the right upper extremity for which she received a schedule award.

FACTUAL HISTORY

On August 10, 2001 appellant, then a 40-year-old clerk filed an occupational disease claim for neck and shoulder pain as a result of lifting, pushing and pulling heavy mail. The Office accepted a left rotator cuff tear.[1]

An October 3, 2001 magnetic resonance imaging scan of the left shoulder revealed a partial tear of the supraspinatus tendon in the middle and distal aspects. Dr. Larry F. Frevert, a Board-certified orthopedic surgeon, diagnosed left rotator cuff tear, impingement and possible right rotator cuff tear. On March 13, 2003 he performed a left subacromial decompression, excision of lateral clavicle open rotator cuff repair. Dr. Frevert noted that appellant experienced persistent left shoulder pain and noted an arthrogram revealed a recurrent tear which required arthroscopic repair. On November 16, 2004 he performed a open left rotator cuff repair with lysis of adhesions and graft jacket patch augmentation and diagnosed recurrent left rotator cuff tear. On August 3, 2006 Dr. Frevert returned appellant to work full-time, limited duty with restrictions.

On February 26, 2007 appellant came under the care of Dr. Paul F. Nassab, a Board-certified orthopedic surgeon, who noted appellant's history was significant for bilateral carpal tunnel syndrome with surgical releases and left rotator cuff tear with arthroscopic surgery. Dr. Nassab diagnosed right shoulder rotator cuff tear, right medial and lateral epicondylitis, right hand arthritis and multiple left-sided complaints not addressed in his examination. He saw appellant on October 2, 2007 and recommended right shoulder surgery. In a work status report dated October 2, 2007, Dr. Nassab diagnosed right rotator cuff tear and advised that appellant could work at modified duty with right arm restrictions pending surgery. On November 2, 2007 he noted that appellant was undecided about surgery. Dr. Nassab noted that appellant reached maximum medical improvement with the right rotator cuff tear and provided work restrictions. On March 27, 2008 he opined that appellant had 15 percent permanent impairment of the right arm. In an April 29, 2008 report, Dr. Nassab noted that he had not treated appellant since November 2007 and her condition remained unchanged. Appellant decided to forego right shoulder surgery and had reached maximum medical improvement.

On March 9, 2007 Dr. John F. Ervins, a Board-certified rheumatologist, diagnosed ruptured rotator cuff. He opined that appellant had three prior shoulder surgeries and had residuals of her work injury without further recovery expected. Appellant had an electromyogram (EMG) on October 18, 2007, which revealed mild to moderate right median neuropathy at the wrist consistent with mild to moderate right carpal tunnel syndrome with no evidence of cervical radiculopathy. On October 18, 2007 Dr. Ann Y. Lee, a Board-certified neurologist, noted that appellant presented with right shoulder and elbow pain with radiculopathy. Appellant's history was significant for bilateral carpal tunnel releases and a left rotator cuff repair. In an October 18, 2007 work status report, Dr. Lee advised that appellant could work modified duty with restrictions.

[1] Appellant filed the following claims for compensation: File No. xxxxxx306, the Office accepted left trigger thumb; File No. xxxxxx291, the Office accepted bilateral carpal tunnel syndrome and File No. xxxxxx738, the Office accepted a right rotator cuff tear. These claims were combined with the current claim before the Board.

On September 21 and 25, 2007 the employing establishment offered appellant a job as a modified mail processor subject to the restrictions from Dr. Frevert on August 3, 2006, with a tour of duty from 3:00 p.m. to 11:30 p.m. On September 27, 2007 appellant rejected the offer contending that she should have been offered tour two, a daylight shift.

On April 25, 2008 the Office referred appellant for a second opinion to Dr. Ronald Zipper, an osteopath and Board-certified orthopedic surgeon, for determination of permanent impairment based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment.*[2] In a May 15, 2008 report, Dr. Zipper reviewed the history of appellant's shoulder conditions and diagnosed full thickness tear of the right rotator cuff with symptomatic acromioclavicular arthritis, status post left rotator cuff tear with multiple revision surgeries, status post bilateral carpal tunnel releases with residual right carpal tunnel syndrome. He found that right shoulder abduction was 154 degrees, adduction was 24 degrees, internal rotation was 38 degrees, external rotation was 60 degrees, flexion was 148 degrees and extension was 46. Dr. Zipper noted triceps strength deficit was mild measured at four out of five. He advised that maximum medical improvement was reached as of that date. Dr. Zipper opined that appellant had 16 percent right arm impairment based on lost range of motion, 20 percent decrease in strength of the supraspinatus (suprascapular nerve) and 10 percent weakness of the triceps (upper radial nerve).

On July 13, 2008 an Office medical adviser found that Dr. Zipper did not adequately explain his impairment rating pursuant to the A.M.A., *Guides* because he failed to cite to tables or charts to support his rating.

Appellant submitted several CA-7 forms, claiming compensation for intermittent periods of partial disability from September 1, 2007 to July 3, 2008. The employer submitted corresponding time analysis forms, Form Ca-7a. The claim was controverted as were there were no medical records placing appellant off work and that she had the ability to work limited duty.

On July 17, 2008 the Office requested that appellant submit additional medical evidence to support total disability from work beginning September 1, 2007. In statements dated July 18 and 21, 2008, appellant advised that she had not received any pay from the employer since 2005 and requested her claims be processed.

On July 19, 2008 the Office requested clarification from Dr. Zipper regarding his May 15, 2008 impairment rating. On August 5, 2008 Dr. Zipper reviewed the medical adviser's comments and opined that the criteria of Table 16-35 of the A.M.A, *Guides,* was inapplicable in this case because appellant had multiple co-morbid diagnosis including entrapment neuropathy and cervical radiculopathy which overlap. He reiterated his May 15, 2008 impairment estimate.

In an August 27, 2008 letter, the Office advised appellant that she would be referred to another physician for an impairment rating.

On September 10, 2008 appellant filed a claim for a schedule award.

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[2] A.M.A., *Guides* (5th ed. 2001).

The Office referred appellant to Dr. William O. Hopkins, a Board-certified orthopedic surgeon, for a determination of permanent impairment in accordance with the A.M.A, *Guides.* In a September 24, 2008 report, Dr. Hopkins reviewed the history of appellant's shoulder conditions and diagnosed right full thickness rotator cuff tear involving the supraspinatus with arthritis of the acromioclavicular joint. He noted right shoulder abduction was 68 degrees for 5 percent impairment,[3] external rotation was 20 degrees for 10 percent impairment[4] and loss of flexion was 7 percent impairment,[5] for 22 percent impairment of the right arm for loss of range of motion. Dr. Hopkins noted additional impairment for loss of strength on external rotation of two percent impairment[6] and one percent for pain related impairment.[7] He recommended 25 percent impairment for the right arm pursuant to the A.M.A., *Guides*. Dr. Hopkins noted that appellant reached maximum medical improvement.

On September 30, 2008 the Office requested clarification from Dr. Hopkins requesting the degrees of lost range of motion for flexion of the right shoulder and a revised impairment rating if appropriate. In an October 16, 2008 report, Dr. Hopkins noted flexion of the right shoulder measured 170 degrees for two percent impairment pursuant to the A.M.A., *Guides.*[8]

In an October 31, 2008 decision, the Office denied appellant's claim for compensation for intermittent partial disability from September 1, 2007 to July 3, 2008. It found that she was entitled to compensation on October 13, 18 and November 2, 2007 and March 27, 2008. The Office noted that Dr. Frevert returned appellant to work full-time limited duty effective August 3, 2006.

On November 8, 2008 an Office medical adviser reviewed the reports from Dr. Hopkins. Based on the A.M.A., *Guides*, appellant had nine percent impairment of the right arm. The medical adviser noted right shoulder abduction was 68 degrees for five percent impairment,[9] adduction was 50 degrees for zero percent impairment,[10] internal rotation was 100 degrees for zero percent impairment,[11] external rotation was 20 degrees for a one percent impairment,[12] extension was 51 degrees for a zero percent impairment[13] and flexion was 170 degrees for a one

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[3] *Id.* at 477, Figure 16-43.

[4] *Id.* at 479, Figure 16-46.

[5] *Id.* at 476, Figure 16-40.

[6] *Id.* at 510, Table 16-35.

[7] *Id.* at 574, Figure 18-1.

[8] *Id.* at 475, Table 16-39.

[9] *Id.* at 477, Figure 16-43.

[10] *Id.*

[11] *Id.* at 479, Figure 16-46.

[12] *Id.*

[13] *Id.* at 476, Figure 16-40.

percent impairment.[14] He noted additional impairment for loss of strength on external rotation would be two percent impairment.[15] The medical adviser noted that Dr. Hopkins erroneously attributed pain-related impairment under Chapter 18 without any supporting information as required under the A.M.A., *Guides*. Using the Combined Values Chart on page 604 of the A.M.A., *Guides*, appellant had nine percent impairment of the right upper extremity.

On November 13, 2008 the Office informed the medical adviser that appellant previously received a schedule award for 16 percent impairment of the right upper extremity for work-related carpal tunnel syndrome and requested that he address whether the prior award would effect his final impairment determination. On November 14, 2008 the medical adviser opined that based on the Combined Values Chart, appellant had a total 24 percent impairment of the right upper extremity.

In a decision dated November 21, 2008, the Office granted appellant a schedule award for 24 percent permanent impairment of the right upper extremity. As appellant previously received an award for 16 percent impairment to the right arm for her accepted carpal tunnel syndrome in File No. xxxxxx291, she was entitled to an additional 8 percent impairment. The award ran from August 27, 2006 to February 17, 2007.

LEGAL PRECEDENT -- ISSUE 1

A claimant has the burden of proving by a preponderance of the evidence that he or she is disabled for work as a result of an accepted employment injury and submit medical evidence for each period of disability claimed.[16] Whether a particular injury causes an employee to be disabled for employment and the duration of that disability are medical issues.[17] The issue of whether a particular injury causes disability for work must be resolved by competent medical evidence.[18]

The Board will not require the Office to pay compensation for disability in the absence of medical evidence directly addressing the specific dates of disability for which compensation is claimed. To do so, would essentially allow an employee to self-certify his or her disability and entitlement to compensation. For each period of disability claimed, the employee has the burden of establishing that he or she was disabled for work as a result of the accepted employment injury.[19]

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[14] *Id.*

[15] *Id.* at 510, Table 16-35.

[16] *See Fereidoon Kharabi,* 52 ECAB 291 (2001).

[17] *Id.*

[18] *See Jacqueline M. Nixon-Steward,* 52 ECAB 140 (2000).

[19] *Sandra D. Pruitt*, 57 ECAB 126 (2005).

ANALYSIS -- ISSUE 1

The Office accepted appellant's claim for left rotator cuff tear, left trigger thumb, bilateral carpal tunnel syndrome and right rotator cuff tear. It found that she was partially disabled on October 13, October 18 and November 2, 2007 and March 27, 2008. The record supports that appellant had an appointment with Dr. Nassab on October 13, 2007 and used 2.83 hours of leave without pay and on November 2, 2007 and March 27, 2008 used 8 hours of leave without pay each day for treatment of her work-related injuries. The record further supports that on October 18, 2007, appellant underwent an EMG and was evaluated by Dr. Lee for her work injury and used eight hours leave without pay. For this reason, appellant received compensation for these days. She was advised to submit additional medical evidence to support other dates of disability for work.

The medical evidence submitted in support of wage-loss for intermittent disability from September 1, 2007 to July 3, 2008 is insufficient to establish that appellant was totally disabled due to the accepted conditions. The record indicates that the employing establishment made available appropriate modified-duty work.

On March 9, 2007 Dr. Ervins diagnosed ruptured rotator cuff and noted that appellant was status post three shoulder surgeries and had residuals of the work injury. However, this report predates the period of wage loss claimed and the physician did not otherwise address disability due to the accepted conditions.

On October 2 and November 2, 2007 Dr. Nassab diagnosed right rotator cuff tear but found that appellant could work modified duty with restrictions on her right arm pending surgery. He noted that she reached maximum medical improvement. However, Dr. Nassab did not find her disabled due to residuals of her accepted condition. In reports dated March 27 and April 29, 2008, he stated that appellant's condition was unchanged. Dr. Nassab provided a disability rating and noted appellant was released from his care. These reports reiterated that she could work full time within restrictions. Dr. Nassab did not support that her accepted left rotator cuff tear, left trigger thumb, bilateral carpal tunnel syndrome or right rotator cuff tear precluded her from working full-time modified duty on any particular date during the claimed period. These reports are insufficient to establish that appellant sustained compensable wage loss.

On October 18, 2007 Dr. Lee noted that appellant presented with right shoulder and elbow pain with radiculopathy. She advised that appellant could work full-time modified duty within restrictions. The reports of Dr. Lee do not support work-related disability for any dates from September 1, 2007 to July 3, 2008. Therefore, this evidence is insufficient to discharge appellant's burden of proof.

The Board finds that there is insufficient probative medical evidence to establish appellant's claim of intermittent disability beginning September 1, 2007. Consequently, appellant is not entitled to wage-loss compensation.

LEGAL PRECEDENT -- ISSUE 2

The schedule award provision of the Federal Employees' Compensation Act[20] and its implementing regulations[21] 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.

ANALYSIS -- ISSUE 2

The Office accepted appellant's claim for sprain of the left rotator cuff tear, left trigger thumb, bilateral carpal tunnel syndrome and right rotator cuff tear. It authorized arthroscopic surgery on the left shoulder which was performed on March 13, 2003 and November 16, 2004. The Board finds that appellant has no more than 24 percent permanent impairment of the right upper extremity.

The Office referred appellant to Dr. William O. Hopkins, a Board-certified orthopedic surgeon, for a determination of permanent impairment under the A.M.A., *Guides.*[22] In a September 24, 2008 report, Dr. Hopkins reviewed the records provided to him and set forth findings on examination. He diagnosed right full thickness rotator cuff tear involving the supraspinatus with arthritis of the acromioclavicular joint. The Board notes that Dr. Hopkins incorrectly found that external rotation of 20 degrees constituted 10 percent impairment. The A.M.A., *Guides* provide one percent impairment for 20 degrees of external rotation.[23] Dr. Hopkins further noted that flexion was 170 degrees for seven percent impairment; however, the A.M.A., *Guides* provide one percent impairment for 170 degrees of flexion.[24] The Board notes that Dr. Hopkins properly found that appellant had five percent impairment for a range of motion deficit for abduction measured at 68 degrees.[25]

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[20] 5 U.S.C. § 8107.

[21] 20 C.F.R. § 10.404.

[22] The Board notes that, after the Office initially referred appellant for a second opinion with Dr. Zipper, it requested a supplemental report from Dr. Zipper who issued an August 5, 2008 report but did not adequately address the discrepancy in his impairment rating. The Office acted properly in referring appellant for another opinion. *See Ayanle A. Hashi*, 56 ECAB 234 (2004) (when the Office refers a claimant for a second opinion evaluation and the report does not adequately address the relevant issues, the Office should secure an appropriate report on the relevant issues).

[23] *Id.* at 479, Figure 16-46.

[24] *Id.* at 476, Figure 16-40.

[25] *Id.* at 477, Figure 16-43.

Dr. Hopkins noted additional impairment for loss of strength for external rotation for two percent impairment and the medical adviser concurred in this finding.[26] However, the Board notes that section 16.8, page 508 of the A.M.A., *Guides,* specifically states that decreased strength cannot be rated in the presence of decreased motion.[27] Therefore, impairment attributable for decreased strength under section 16.8 cannot be combined with impairment for decreased motion. Dr. Hopkins also rated pain under Chapter 18 of the A.M.A., *Guides*. The medical adviser properly noted, however, that Chapter 18 may not be utilized to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides.*[28]

The Office medical adviser properly applied the A.M.A., *Guides* to the findings in Dr. Hopkin's report. Based on the A.M.A., *Guides,* appellant had five percent impairment for the range of motion deficit for abduction of 68 degrees,[29] zero percent impairment for range of motion deficit for adduction of 50 degrees,[30] zero percent impairment for the range of motion deficit for internal rotation of 100 degrees,[31] one percent impairment for the range of motion deficit for external rotation of 20 degrees,[32] zero percent impairment for the range of motion deficit for extension measured at 51 degrees[33] and one percent impairment for the range of motion deficit for flexion measured at 170 degrees,[34] seven percent impairment for loss of range of motion to the right shoulder. The medical adviser noted in a November 14, 2008 report that appellant was previously granted a 16 percent schedule award for the accepted carpal tunnel syndrome in File No. xxxxxx291. Using the Combined Values Chart on page 604 of the A.M.A., *Guides*, the revised rating is 22 percent permanent impairment of the right upper extremity.

As the Office has issued schedule awards totaling 24 percent permanent impairment of the right upper extremity, the Board finds that the medical evidence does not establish greater impairment pursuant to the A.M.A., *Guides*.

CONCLUSION

The Board finds that appellant has failed to establish that her claimed disability for the intermittent period of September 1, 2007 to July 3, 2008 is causally related to the accepted

[26] *Id.* at 510, Table 16-35.

[27] *Id.* at 508, section 16.8a.

[28] *See Linda Beale*, 57 ECAB 429 (2006); *Frantz Ghassan*, 57 ECAB 349 (2006).

[29] *Id.*

[30] *Id.*

[31] *Id.* at 479, Figure 16-46.

[32] *Id.*

[33] *Id*. at 476, Figure 16-40.

[34] *Id.*

employment injury. The Board further finds that appellant has no more than 24 percent permanent impairment of the right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated November 21 and October 31, 2008 are affirmed, as modified.

Issued: January 27, 2010
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board