U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LILLIE M. YOUNGER and U.S. POSTAL SERVICE,
NORTH SUBURBAN DIVISION, River Grove, IL

Docket No. 03-1658; Submitted on the Record;
Issued September 8, 2003

DECISION and ORDER

Before COLLEEN DUFFY KIKO, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant has more than 12 percent permanent impairment of her left upper extremity and more than 8 percent permanent impairment of her right upper extremity for which she received schedule awards.

Appellant, a 51-year-old distribution clerk, filed a notice of occupational disease on April 12, 1988 alleging that she developed bursitis in her shoulders bilaterally due to her employment duty of keying. The Office of Workers' Compensation Programs accepted appellant's claim for temporary aggravation of pain of preexisting cervical spondylosis, bilateral degenerative arthritis of the acrominal joints and impingement syndrome. The Office expanded appellant's claim to include a permanent aggravation of these conditions on March 12, 1990.

Appellant requested a schedule award and by decision dated July 29, 1991, the Office granted appellant a schedule award for eight percent permanent impairment of her left upper extremity and eight percent permanent impairment of her right upper extremity. Appellant requested an additional schedule award on March 1, 1997.[1] By decision dated May 21, 1998, the Office found that appellant had an additional 4 percent permanent impairment of her left upper extremity for a total left upper extremity impairment rating of 12 percent.

Appellant requested reconsideration of the Office's May 21, 1998 decision alleging that she had additional impairment of her right upper extremity entitling her to a schedule award. By decision dated December 11, 1998, the Office declined to modify its May 21, 1998 decision.

On December 28, 1999 appellant requested an additional schedule award. By decision dated February 22, 2001, the Office denied appellant's claim for an additional impairment of the right upper extremity entitling her to a schedule award. Appellant again requested an additional schedule award on April 27, 2001. The Office referred appellant for a second opinion evaluation

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[1] Appellant stopped work in 1987.

on March 6, 2002. In a decision dated October 7, 2002, the Office again found that the medical evidence did not support appellant's claim for an additional schedule award. Appellant requested reconsideration of this decision on November 18, 2002 alleging that the Office failed to consider all the medical evidence. By decision dated June 10, 2003, the Office declined to modify its October 7, 2002 decision.

The Board finds that this case is not in posture for decision due to a conflict of medical opinion evidence.

The schedule award provisions of the Federal Employees' Compensation Act[2] and its implementing regulation[3] 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

Appellant submitted a report dated October 15, 2001 from Dr. D.A. Minnis, a physician, concluding that appellant had 33 percent permanent impairment of her right upper extremity and 32 percent permanent impairment of her left upper extremity due to progressing cervical spondylosis with foraminal stenosis and spinal stenosis, predominantly at the C5-6 nerve root, causing upper extremity motor and sensory deficits as well as bilateral shoulder impingement syndrome with bilateral arthritis causing brachial plexus impingement. Dr. Minnis noted that appellant had ongoing neck pain as well as right and left upper extremity pain. He found that appellant had decreased range of motion in her shoulder bilaterally with pain. Dr. Minnis stated that both appellant's left and right upper extremities had 110 degrees of flexion, a 5 percent impairment;[4] that she demonstrated 105 degrees of abduction on the right, a 4 percent impairment and 100 degrees on the left, a 4 percent impairment;[5] that she had 5 degrees of adduction bilaterally, a 1 percent impairment;[6] 20 degrees of internal rotation on the right, a 4 percent impairment and 35 degrees on the left, a 3 percent impairment; 20 degrees of external rotation bilaterally, a 1 percent impairment;[7] and 10 degrees of extension on the right, a 2 percent impairment and 20 degrees of extension on the left, a 2 percent impairment.[8] He found that

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] A.M.A., *Guides*, 476, Figure 16-40.

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

[6] *Id.*

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

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

appellant's total impairment rating for loss of range of motion was 17 percent impairment on the right and 16 percent impairment on the left.

Dr. Minnis also found that appellant had weakness bilaterally in the supraspinatus, infraspinatus and deltoid muscles of plus four. He found that appellant had a Grade 4 weakness of 25 percent impairment, complete active range of motion against gravity with some resistance.[9] Dr. Minnis noted decreased sensation due to the C5-6 dermatomes affecting the auxiliary and radial nerves. He found that appellant had a Grade 4 sensory deficit, distorted superficial tactile sensibility with or without minimal abnormal sensations or pain that is forgotten during activity.[10] Dr. Minnis then utilized the combined motor and sensory deficits of the upper trunk of the brachial plexus or 81 percent,[11] multiplied by 25 percent to reach a combined motor and sensory impairment of 20 percent impairment of each of the upper extremities. He combined the percentages for loss of range of motion with those for sensory and motor deficits to reach a right upper extremity impairment of 33 percent and left upper extremity impairment of 32 percent.[12]

The Office's second opinion physician, Dr. Leonard R. Smith, a Board-certified orthopedic surgeon, completed a report on April 3, 2002 and found subjective tenderness in the trapezius muscles bilaterally. He found that deep tendon reflexes involving the upper extremities were equal and active with good grip bilaterally. Dr. Smith stated:

> "Examination of both shoulders reveals no swelling, atrophy or scars. There is a limitation of five degrees of external rotation of both shoulders. Internal rotation is normal. Abduction is normal to 180 degrees. Flexion to 150 degrees bilaterally which is normal. Cross shoulder adduction is normal backward deviation of the arm at possible point with tips of the outstretched fingers approximates the inferior angle of the scapula."

Dr. Smith concluded that appellant had two percent impairment of each shoulder due to loss of external rotation. Additionally, he found that appellant had permanent impairment due to the cervical spine resulting in total left upper extremity impairment of 12 percent and right upper extremity impairment of 5 percent.

Section 8123(a) of the Act,[13] provides, "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination." In this case, appellant's physician, Dr. Minnis, provided a detailed report concluding that appellant had loss of range of motion of her shoulder in almost all tested maneuvers, as well as sensory and motor deficits. He correlated his findings with the A.M.A., *Guides* to reach impairment ratings exceeding those for

[9] *Id.* at 484, Table 16-11.

[10] *Id.* at 482, Table 16-10.

[11] *Id.* at 490, Table 16-14.

[12] A.M.A., *Guides*, 604.

[13] 5 U.S.C. §§ 8101-8193, 8123(a).

which appellant previously received schedule awards. The Office second opinion physician, Dr. Smith, a Board-certified orthopedic surgeon, examined appellant and found that she had very little loss of range of motion of her shoulder and attributed her permanent impairment to her cervical spine. He reached the previously awarded impairment ratings in her left upper extremity and less than that previously awarded in her right upper extremity. Due to the conflicting medical findings regarding the extent of appellant's range of motion as well as motor and sensory deficits, the Board finds that the Office should refer appellant, a statement of accepted facts and a list of specific questions to an appropriate Board-certified physician, to resolve the existing conflict of medical opinion evidence.[14] After this and such other development of the medical evidence as the Office deems necessary, the Office should issue an appropriate decision regarding the extent of appellant's current permanent impairment.

The June 10, 2003 and October 7, 2002 decisions of the Office of Workers' Compensation Programs are hereby set aside and remanded for further development consistent with this decision of the Board.

Dated, Washington, DC
September 8, 2003

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

[14] This district medical adviser recommended this course of action in his June 3, 2003 report reviewing the reports of both Drs. Minnis and Smith.