

FACTUAL HISTORY

In a prior appeal,² the Board found that appellant did not meet her burden of proof to establish that her accepted employment injuries caused any permanent impairment to a scheduled member of the body. Appellant had failed to come forward with relevant medical evidence to support her claim for a schedule award.³

OWCP later issued a schedule award for a 15 percent impairment of the right upper extremity and a 4 percent impairment of the left upper extremity. A conflict subsequently arose between Dr. William N. Grant, the attending Board-certified internist, and Dr. Michael E. Holda, a Board-certified orthopedic surgeon and OWCP second opinion physician. Dr. Grant determined that appellant had a 24 percent impairment of her right upper extremity and an 18 percent impairment of her left. Dr. Holda determined that she had a five percent impairment of her right upper extremity and a four percent impairment of her left.

To resolve whether appellant had any increased impairment, OWCP referred her, together with the case file and a statement of accepted facts, to Dr. Emmanuel N. Obianwu, a Board-certified orthopedic surgeon, who related her complaints and his findings on examination. Dr. Obianwu found that appellant's acromioclavicular joint disease status post distal clavicle resection represented a 10 percent impairment of the right upper extremity with no modification for mild functional history, mild physical examination and mild clinical studies. He also found 1 percent impairment due to mild impingement and a 1 percent impairment due to mild subacromial bursitis, for a total 12 percent combined impairment of the right upper extremity.

On the left, Dr. Obianwu found that mild acromioclavicular joint disease represented three percent impairment with no modification for mild functional history, mild physical examination and mild clinical studies.

On September 27, 2011 OWCP denied an increased schedule award. On May 11, 2012 an OWCP hearing representative affirmed, finding that Dr. Obianwu's evaluation was entitled to the special weight accorded an impartial medical specialist.

² Docket No. 05-529 (issued May 13, 2005).

³ In 1996 appellant, a 38-year-old nixie/distribution clerk, filed a claim alleging that she developed carpal tunnel syndrome or tendinitis in the performance of duty. OWCP accepted her claim for right trapezius strain, resolved by February 29, 1996 and right wrist tendinitis, resolved by March 26, 1996. It later accepted aggravation of impingement syndrome, bilateral shoulder; aggravation of subacromial bursitis, bilateral shoulders; aggravation of osteoarthritis, bilateral acromioclavicular joints and cervical somatic dysfunction. The facts of this case as set forth in the Board's prior decision are hereby incorporated by reference.

LEGAL PRECEDENT

The schedule award provision of FECA⁴ and the implementing regulations⁵ 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. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.⁶

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. OWCP has adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate standard for evaluating schedule losses.⁷ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁸

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.⁹ When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.¹⁰

ANALYSIS

Diagnosis-based impairment is the primary method of evaluation for the upper extremities. The first step 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.¹¹

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404.

⁶ *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

⁷ 20 C.F.R. § 10.404; *Ronald R. Kraynak*, 53 ECAB 130 (2001).

⁸ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

⁹ 5 U.S.C. § 8123(a).

¹⁰ *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

¹¹ A.M.A., *Guides* 387, 389 (6th ed. 2009).

Specific criteria for that diagnosis determine which class is appropriate: no objective problem, mild problem, moderate problem, severe problem, very severe problem approaching total function loss. For each diagnosis class, the A.M.A., *Guides* assigns a default impairment rating, which may be slightly adjusted using such grade modifiers or nonkey factors as functional history, physical examination and clinical studies.¹²

To resolve whether appellant was entitled to an increased schedule award, OWCP properly referred appellant to Dr. Obianwu, the orthopedic surgeon and impartial medical specialist, who evaluated her upper extremity impairments using Table 15-5 of the A.M.A., *Guides*. Dr. Obianwu correctly found that her right distal clavicle resection represented a 10 percent default impairment.¹³ As all the grade modifiers or nonkey factors were mild, no adjustment was warranted.

What Dr. Obianwu did next is not well supported by the A.M.A., *Guides*. He combined the 10 percent impairment due to distal clavicle resection with two other diagnosis-based impairments: mild impingement and mild subacromial bursitis. As noted earlier, Dr. Obianwu should select one diagnosis, the one that is most significant. Multiple diagnosis-based impairments are rare.¹⁴ The default impairment value for mild shoulder impingement is one percent,¹⁵ and Dr. Obianwu assigned one percent impairment for mild bursitis.¹⁶ The combined value of all three diagnosis-based impairments of the right upper extremity was 12 percent. Notwithstanding the use of multiple diagnosis-based impairments, this was less than the 15 percent impairment for which appellant previously received a schedule award. This did not support an increased award for the right upper extremity.

Dr. Obianwu correctly found that appellant's left mild acromioclavicular joint disease represented a three percent default impairment.¹⁷ As all the grade modifiers or nonkey factors were mild, no adjustment was warranted. This was less than the four percent impairment for which appellant previously received a schedule award. This did not support an increased award on the left.

The Board finds that Dr. Obianwu's evaluation was based on a proper factual background and was sufficiently well reasoned that it must be given special weight in resolving the conflict between Dr. Grant, the attending internist, and Dr. Holda, the second opinion orthopedic surgeon, on the extent of appellant's permanent impairment. Accordingly, the Board finds that

¹² *Id.* at 497.

¹³ *Id.* at 403.

¹⁴ *Id.* at 390.

¹⁵ *Id.* at 402.

¹⁶ Table 15-5, the Shoulder Regional Grid, does not list bursitis as a specific diagnosis. In the event that a specific diagnosis is not listed, 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. *Id.* at 389.

¹⁷ *Id.* at 403.

appellant has no more than a 15 percent impairment of her right upper extremity and no more than a 4 percent impairment of her left. The Board will affirm OWCP's May 11, 2012 decision.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant is not entitled to an increased schedule award.

ORDER

IT IS HEREBY ORDERED THAT the May 11, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 20, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board