U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of HARVEY J. TRIBBLE and U.S. POSTAL SERVICE,
POST OFFICE, Southeastern, PA

Docket No. 03-711; Submitted on the Record;
Issued June 12, 2003

DECISION and ORDER

Before COLLEEN DUFFY KIKO, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant has greater than 16 percent impairment of the right upper extremity, for which he received a schedule award.

On August 24, 1991 appellant, then a 38-year-old mailhandler, filed a notice of traumatic injury alleging that he hurt his shoulder that day while lifting a mail sack out of an all-purpose container. The claim was accepted by the Office of Workers' Compensation Programs for right shoulder and cervical strains. Appellant initially lost no work but was placed on light duty by his treating physician, Dr. Bruce Menkowitz, a Board-certified orthopedic surgeon. Appellant underwent physical therapy and epidural steroid injections for relief of his pain symptoms in the right shoulder and neck. Arthroscopic surgery was performed on November 8, 1991.[1]

On November 2, 1993 appellant received a schedule award for 16 percent permanent impairment of the right upper extremity due to his accepted work injury. The period of the award was July 28, 1993 to July 12, 1994.

The accepted conditions were later expanded to include right rotator cuff syndrome for which appellant underwent arthroscopic surgery of the right shoulder on May 5, 1995 consisting of repair of a glenoid labral tear with impingement.

On September 29, 1998 appellant filed a claim for a recurrence of disability beginning that date. In a decision dated February 8, 1999, the Office denied the claim finding the evidence insufficient to establish a correlation between appellant's alleged disability due to cervical degenerative joint disease and the accepted work injury.

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[1] An operative report dated November 8, 1991 shows that appellant underwent an arthroscopy and arthroscopic resection of the torn portion of the glenoid labrum with findings listed as tear of the anterior genoid labrum and early changes of the genoid consistent with post-traumatic degeneration. No acromioplasty was done at that time.

On June 29, 1999 appellant filed another notice of recurrence of disability, which was accepted by the Office and on October 7, 1999 underwent arthroscopic surgery consisting of arthrotomy and resection of the distal clavicle of the right shoulder.

On August 29, 2001 the Office determined that the position of mailhandler fairly and reasonably represented appellant's wage-earning capacity and terminated his compensation as he had no further wage-loss disability due to the accepted work injury. Appellant was to continue to receive medical benefits.

On October 3, 2001 appellant filed a Form CA-7 claim for a schedule award.

In a July 12, 2001 report, Dr. David Weiss, a Board-certified orthopedist, described appellant's August 24, 1991 work injury and his course of treatment. Dr. Weiss noted appellant's recent arthroscopic surgery consisting of arthrotomy and resection of the distal clavicle of the right shoulder. He also reported that appellant had been diagnosed with left carpal tunnel syndrome based on electromyography studies performed in 1995.

On physical examination Dr. Weiss noted well-healed portal arthroscopic scars and focal acromioclavicular point tenderness. He stated that appellant experienced right shoulder pain and stiffness on a daily basis. He related that, based on a pain level scale of 0 to 10, appellant described his pain as 8/10 involving the right shoulder. Range of motion revealed forward elevation of 150/180 degrees, abduction of 150/180 degrees, cross over abduction of 35/75 degrees, external rotation of 90/90 degrees. Tests were positive for crepitus within the acromioclavicular joint and Hawkin's impingement sign was positive. Manual muscle strength testing revealed a grade of 4/5 involving the supraspinatus muscle. The deltoid was graded 4+/5 and the triceps and biceps was graded 4/5.

Dr. Weiss further noted physical findings, including range of motion measurements for the right hand/wrist and left hand/wrist. The right hand examination revealed a positive Tinel's sign and positive Phalen's sign. Carpal compression was positive and resistive thumb abduction was graded 4/5. The left hand also showed positive Phalen's sign, positive carpal compression and resistive thumb abduction of grade 3+/5. Grip strength testing performed *via* Jamar and Dynamometer at level III revealed 27 kilogram (kg) of force strength in the right hand versus 29 kg of force strength in the left hand.

In his July 12, 2001 report, Dr. Weiss diagnosed the following: "(1) [s]tatus post tear of the glenoid labrum of the right shoulder; (2) [a]nterior cuff tendinitis to the right shoulder; (3) [s]tatus post arthroscopic surgery to the right shoulder with resection of torn glenoid labrum; (4) [s]tatus post debridement of glenoid of the right shoulder; (5) [s]tatus post acromioclavicular arthropathy with impingement; (6) [s]tatus post arthroscopic surgery to the right shoulder May 5, 1995; (7) [s]tatus post glenoid labral tear and impingement to the right shoulder; (8) [c]oracoacromial impingement; (9) [s]tatus post arthroscopic surgery to the right shoulder, October 7, 1999; (10) [s]tatus post arthrotomy to the right shoulder October 7, 1999; (11) [s]tatus post resection of distal clavicle of the right shoulder, October 7, 1999; (12) [c]umulative and repetitive trauma disorder; and (13) [b]ilateral carpal tunnel syndrome."

Dr. Weiss rated appellant's impairment under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). For range of motion deficit, he calculated four percent total impairment, representing range of motion deficit of right shoulder flexion at two percent at Figure 16-40, page 476; range of motion deficit right shoulder adduction at one percent and abduction at one percent according to Figure 16-43, page 477. For right shoulder arthroplasty, he found 24 percent impairment at Table 16-27, page 506. For 4/5 motor strength weakness and left thumb abduction weakness, he recorded 25 percent under Table 16-11, page 484 and Table 16-15, page 492. Right grip strength deficit was listed as 20 percent under Table 16-32 and Table 16-34, page 509. The combined total upper right extremity impairment was listed as 56 percent impairment. Dr. Weiss also noted that appellant had a combined total left upper extremity impairment of 55 percent. He concluded that appellant reached maximum medical improvement on July 12, 2001.

The Office sent a copy of Dr. Weiss' report to an Office medical adviser for review and application of the fifth edition of the A.M.A., *Guides* to ascertain an impairment rating for the accepted work injury. On October 2, 2001 the Office medical adviser noted that appellant's claim for carpal tunnel syndrome had been denied so he was not entitled to an impairment rating with respect to the right thumb for weakness and grip/strength loss as noted by Dr. Weiss. The Office medical adviser further disregarded left arm impairment listed by Dr. Weiss. He noted that, on page 2 of the report, Dr. Weiss called appellant's surgery "resection of the distal clavicle but uses the impairment rating of 24 percent for whole shoulder instead of correct [10] for distal clavicle." It is further noted that "Dr. Weiss gave 4 percent impairment for loss of [range of motion] of the shoulder, combined with correct rating for surgery -- comes to 14 percent." The Office medical adviser concluded that appellant had 14 percent impairment of the right shoulder and was, therefore, not entitled to an additional schedule award.

In a December 12, 2001 decision, the Office determined that appellant was not entitled to an additional schedule award. The Office noted that appellant had been previously awarded 16 percent impairment of the right shoulder while the Office medical adviser recently opined that he had only 14 percent impairment under the fifth edition of the A.M.A., *Guides*.

Appellant requested a hearing, which was held on July 29, 2002.

In a decision dated October 24, 2002, an Office hearing representative affirmed the Office's December 12, 2001 decision.

The Board finds that the case is not in posture for a decision.

The schedule award provisions of the Federal Employees' Compensation Act[2] and its implementing federal regulation,[3] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use of specified members, functions or organs of the body. Where the loss of use is less than 100 percent, the amount of

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

compensation is paid in proportion to the percentage loss of use.[4] 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 regulation as the appropriate standard for evaluating schedule losses.[5]

In this case, the Office accepted that appellant sustained a right shoulder and cervical strain as a result of his work injury. The Office later expanded the claim to include a right rotator cuff syndrome. Appellant was awarded a schedule award for 16 percent permanent impairment of the right shoulder. He currently seeks an increase in his schedule award pursuant to the Form CA-7 claim filed on October 3, 2001.

In support of his claim for an additional schedule award, appellant submitted a report from Dr. Weiss who opined that he had a total of 56 permanent impairment of the right upper extremity and a total of 55 percent permanent impairment of the left upper extremity according to the fifth edition of the A.M.A., *Guides*.

The Office forwarded a copy of Dr. Weiss' report to an Office medical adviser for review and approval of the calculated rating.[6] The Office medical adviser correctly pointed out that appellant was not entitled to a schedule award for impairment related to the left arm as the Office had only accepted his claim for a right arm injury. The Board also agrees that appellant is not entitled to an impairment related to the condition of carpal tunnel syndrome as the record reflects that the condition has not been accepted by the Office as work related. Thus, the focus is on permanent impairment of the right upper extremity causally related to appellant's work-related rotator cuff syndrome.

In reviewing Dr. Weiss' impairment rating with respect to the right upper extremity, the Office medical adviser disregarded his finding of 24 percent impairment for right shoulder arthroplasty at Table 16-27, page 506, noting that the physician incorrectly identified appellant's surgery under the A.M.A., *Guides* as involving total shoulder implant arthroplasty, when appellant actually had isolated resection arthroscopy of the distal clavicle. The Office medical adviser noted that, according to Table 16-27, appellant would only be entitled to 10 percent impairment for arthroscopic surgery involving resection of the distal clavicle. The Board has reviewed the A.M.A., *Guides* at Table 16-27 and finds that the Office medical adviser's calculation of 10 percent impairment as opposed to 24 percent impairment for resection of the distal clavicle to be correct. Thus, the total amount of impairment appellant is entitled to under this section is 10 percent.

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[4] 5 U.S.C. § 8107(c)(19).

[5] *See* 20 C.F.R. § 10.404 (1999).

[6] The A.M.A., *Guides* were prepared to establish reference tables and evaluation protocols, which if followed, may allow the clinical findings of the physician to be compared directly with the impairment criteria and related to impairment percentages. While the medical opinion of the treating physician may be accorded some weight, his or her clinical data can be readily extrapolated and evaluated within the tables and guidelines as presented. *Michael D. Nielsen*, 49 ECAB 453 (1996).

The Office medical adviser agreed with Dr. Weiss that appellant had 4 percent impairment due to deficits of range of motion of the right shoulder. The Board agrees that the calculation of 4 percent impairment is in accordance with Figures 16-40 and 16-43 at pages 476-477 respectively.

The Board also finds that the Office medical adviser properly rejected Dr. Weiss' calculation of 25 percent impairment for motor strength weakness of the right thumb and 20 percent impairment for right grip strength deficit. As previously noted, the Office has not accepted the claim for right carpal tunnel syndrome. Moreover, assuming that Dr. Weiss applied a rating for grip strength in relation to the accepted work injury, grip strength loss should not be rated because it shares the same pathomechanics as decreased motion.[7] The A.M.A., *Guides* at page 508, section 16.8a, specifically state that in evaluating upper extremity impairment the evaluator must remember that "[d]ecreased strength *cannot* be rated in the presence of decreased motion." Because appellant's rating for deficit in range of motion adequately subsumes any impairment rating due to loss of strength, he is not entitled to 20 percent impairment for right grip deficit.

Thus, the Board concludes that, based on the opinion of the Office medical adviser, appellant has at least 14 percent permanent impairment of the right upper extremity such that he has not demonstrated his entitlement to an increased schedule award.

The decision of the Office of Workers' Compensation Programs dated October 24, 2002 is affirmed.

Dated, Washington, DC
June 12, 2003

Colleen Duffy Kiko
Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

[7] A.M.A., *Guides*, fifth edition at page 508, section 16.8a (principles of strength evaluation).