U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JENNIFER A. ZAPUTIL and U.S. POSTAL SERVICE,
POST OFFICE, Waterloo, IA

Docket No. 03-1515; Submitted on the Record;
Issued October 21, 2003

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

The issue is whether appellant sustained more than a 10 percent permanent impairment of the right upper extremity for which she received a schedule award.

On April 29, 1999 appellant, then a 25-year-old letter carrier, filed an occupational disease claim alleging that she sustained an injury to her right shoulder due to her mail casing duties. The Office of Workers' Compensation Programs accepted appellant's claim for bursitis and tendinitis of the right shoulder, aggravation of the long thoracic nerve and muscle transfer surgery on September 9, 1999.

On August 16, 2001 appellant filed a claim for a schedule award.

By decision dated April 5, 2002, the Office granted appellant a schedule award for a 10 percent permanent impairment of the right upper extremity.[1] By decisions dated July 16 and October 29, 2002 and April 30, 2003, the Office denied modification of its April 5, 2002 decision.[2]

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

The schedule award provisions of the Federal Employees' Compensation Act[3] and its implementing regulation[4] set forth the number of weeks of compensation payable to employees

[1] The Office inadvertently indicated in its April 5, 2002 decision that the schedule award was for the left upper extremity, rather than the right upper extremity.

[2] This record contains additional evidence submitted subsequent to the Office's April 30, 2003 decision. However, the jurisdiction of the Board is limited to the evidence that was before the Office at the time it issued its final decision; *see* 20 C.F.R. § 501.2(c).

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

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.

In a report dated September 14, 2001, Dr. Paul G. Guidos, a physiatrist and an Office referral physician, provided a history of appellant's condition, findings on examination and indicated that she had reached a point of maximum medical improvement. He noted that after working five or six hours appellant would begin to feel a dull ache, almost a numb feeling, in the shoulder region and could not raise her arm even to shoulder height. Dr. Guidos stated:

> "Motor examination of rhomboideus muscles or shoulder adductors is normal bilaterally. Motor testing of deltoid, biceps, triceps, wrist flexors, extensors, hand grip, grasp strength and hand intrinsic are normal…. However, there is severe wasting of the right serratus anterior…. [S]ensory testing in the upper extremities … is normal throughout…. Reflex examination of the upper extremities is normal throughout. Motor testing of the bilateral serratus anterior shows questionable or subtle weakness of the left serratus anterior but complete wasting or loss of the right serratus anterior most presumably from [long] thoracic nerve palsy. She has severe winging of the scapulae.
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> "Range of motion of the right shoulder shows normal testing with the following exceptions. [Appellant] can only abduct the shoulder to 55 degrees against gravity. She can only flex … to 60 degrees.… Shoulder extension is normal. Internal and external rotation of the shoulder when held at 90 degrees is normal. Shoulder retraction and protraction is mild to moderately impaired on the right side.
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> "[Appellant] [had] a procedure … in [September] 1999 to attempt to improve the right shoulder impairment from right long thoracic nerve palsy. She has also marked scarring from the operative procedure with a large incision site through the axilla and along the right lateral thigh region. [Appellant] has some sensory loss about the area of the incision site….
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> "Regarding [appellant's] impairment rating based on the American Medical Association, *[Guides] [to] the Evaluation of Permanent Impairment*, Fifth Edition, her impairment rating will be 15 [percent] which is the Maximum Upper Extremity Impairment due to Unilateral Sensory or Motor Deficits [at] page 492 … Table 16-15 under Combined Motor and Sensory deficits of the Long Thoracic Nerve."

In a memorandum dated March 22, 2002, Dr. Daniel Zimmerman, an internist and the Office's district medical adviser, determined that appellant had a 10 percent permanent

impairment of the right upper extremity based on the physical findings in Dr. Guidos' report. The Office based its April 5, 2002 schedule award decision on Dr. Zimmerman's memorandum.

In a report dated August 28, 2002, Dr. Arnold E. Delbridge, appellant's attending Board-certified orthopedic surgeon, stated that, in addition to loss of range of motion, she had considerable weakness in her shoulder in areas other than those supplied by the long thoracic nerve. Dr. Delbridge stated:

> "On page 492 in [the fifth] [e]dition, [of the A.M.A., *Guides*], a long thoracic nerve which is completely nonfunctional, as is [appellant's], has a 15 percent upper extremity impairment due to motor deficit.
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> "In addition to the motor deficit of the long thoracic nerve, [appellant] has sequela of the scapula in that she is unable to put her upper extremity into functional position. She also has weakness involving abduction and external rotation which involve other nerves, such as the suprascapular nerve and the subscapular nerve.
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> "In addition to her long thoracic nerve being compromised, [appellant] has other dysfunctions of her shoulder because of the long term effect of that nerve being nonfunctional.
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> "My conclusion is that [appellant] has an additional seven percent [impairment] of the upper extremity on that basis. A combined total of 15 percent from the long thoracic nerve and 7 percent impairment from weakness involving other portions of the brachial plexus on a combined value scale give a 21 percent impairment of the upper extremity."
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> In an addendum report dated March 31, 2003, Dr. Delbridge stated:
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> "Because of [appellant's] long-standing problems with her long thoracic nerve, she has, in addition, developed weakness of the abductor muscles of the rotator cuff and also the external rotator muscles of the rotator cuff.
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> "On page 484, Table 16-11 of [the A.M.A., *Guides*], it is noted that [appellant] has weakness of [the] abduction and external rotation component of her shoulder. Her weakness is noted to be Grade III for abduction and external rotation. The nerve identified in that particular case would be the suprascapular nerve. The maximum motor deficit of the suprascapular nerve is 16 [percent] of the upper extremity.[5] A 50 [percent] times 16 is an 8 [percent] impairment of the upper extremity. An 8 [percent] upper extremity impairment combined with a 15 [percent] upper extremity impairment is a 22 [percent] impairment of the right upper extremity. That correlates with the figure given previously. I actually reduced that by 1 [percent] because I did not think the weakness was quite 50 [percent]."

[5] *See* Table 16-15 at page 492.

The Board finds that there is an unresolved conflict between Dr. Guidos, the Office referral physician, and Dr. Delbridge, appellant's attending physician, as to the extent of appellant's permanent impairment to her right upper extremity. Dr. Guidos found that appellant had a 15 percent permanent impairment of the right upper extremity based on combined motor and sensory deficits of the long thoracic nerve according to Table 16-15 at page 492 of the A.M.A., *Guides*, fifth edition. Dr. Delbridge also determined that appellant had a 15 percent permanent impairment of the right upper extremity based on Table 16-15 at page 492, but he further determined that appellant had an additional 7 percent permanent impairment based on motor deficit of the suprascapular nerve according to Table 16-11 at page 484 of the A.M.A., *Guides*, fifth edition.

Section 8123(a) of the Act provides, in pertinent part: "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."[6]

On remand the Office should refer appellant to an appropriate Board-certified specialist for a physical examination and an evaluation, based on the fifth edition of the A.M.A., *Guides*, of the extent of her right upper extremity permanent impairment. Upon such further development as the Office deems necessary, it should issue an appropriate decision.

The decisions of the Office of Workers' Compensation Programs dated April 30, 2003 and October 29 and July 16, 2002 are set aside and the case is remanded for further development consistent with this decision.

Dated, Washington, DC
October 21, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

[6] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB ___ (Docket No. 01-1599, issued June 26, 2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207, 210 (1993).