United States Department of Labor
Employees' Compensation Appeals Board

WILLIAM F. DEXTER, Appellant	)	
and	)	**Docket No. 03-1795**
	)	**Issued: September 28, 2004**
U.S. POSTAL SERVICE, POST OFFICE, Huntington Beach, CA, Employer	)	

Appearances:
William F. Dexter, pro se
Office of the Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
WILLIE T.C. THOMAS, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On July 11, 2003 appellant filed a timely appeal of an Office of Workers' Compensation Programs' decision dated April 15, 2003, finding that appellant was entitled to a schedule award for a 25 percent permanent impairment to his right arm. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2), the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant has more than a 25 percent permanent impairment to his right arm.

FACTUAL HISTORY

On August 1, 2001 appellant, then a 42-year-old letter carrier, filed an occupational disease claim for compensation (Form CA-2) alleging that he sustained a right shoulder injury as a result of carrying a shoulder bag. The Office accepted the claim for a right shoulder impingement syndrome and right shoulder adhesive capsulitis. Appellant underwent right

shoulder surgery on January 11, 2002; he returned to a part-time light-duty position on May 24, 2002. On September 17, 2002 appellant began working a full-time position.

In a report dated October 14, 2002, Dr. Kevin Triggs, an attending orthopedic surgeon, provided a history and results on examination. Dr. Triggs noted shoulder atrophy in the periscapular region down onto the right arm, and further noted: "Motor exam[ination] shows 4/5 right deltoid, biceps, triceps and wrist extensor.… Shoulder range of motion is flexion 110 degrees, external rotation 70 degrees." Dr. Triggs diagnosed right shoulder impingement syndrome and acromioclavicular joint arthrosis, status post (January 11, 2002) subacromial decompression and Mumford procedure. He did not provide a specific opinion as to the degree of permanent impairment.

By report dated March 9, 2003, an Office medical adviser reviewed the October 14, 2002 report from Dr. Triggs and provided an opinion as to the percentage of permanent impairment to the right arm under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). The medical adviser indicated that appellant had a five percent impairment due to loss of shoulder flexion; with no impairment for loss of extension, adduction, abduction, internal rotation or external rotation. With respect to shoulder surgery, the medical adviser opined that appellant had a 10 percent impairment under Table 16-27. The medical adviser further stated: "Impairment due to loss of strength and impairment due to sensory deficit or pain: Level of impairment Grade 3 and 3, 60 percent (Tables 16-10 and 16-11, pages 482 and 484). Maximum combined impairment based on the suprascapular nerve is 20 percent (Table 16-15, page 492) 60 x 20 percent = 12 percent." The medical adviser then combined the impairments of 5 percent for loss of range of motion, 10 percent for distal clavical resection and 12 percent for loss of strength and sensory deficit/pain under the Combined Values Chart for a 25 percent impairment to the right arm.

By decision dated April 15, 2003, the Office issued a schedule award for a 25 percent permanent impairment to the right arm. The period of the award was 78 weeks commencing October 14, 2002.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulation[2] sets 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 regulation as the appropriate standard for evaluating schedule losses. The medical

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999).

evidence necessary to support a schedule award includes a physician's report that provides a detailed description of the impairment.[3]

ANALYSIS

The schedule award in this case was based on the October 14, 2002 report of the attending physician, Dr. Triggs. With regard to loss of range of motion in the right shoulder, Dr. Triggs provided results only for flexion and external rotation. Dr. Triggs did not provide range of motion results for extension, internal rotation, adduction or abduction, all of which should be provided for a complete assessment of permanent impairment due to loss of range of motion. The Office medical adviser found no impairment for extension, internal rotation, adduction or abduction, but the medical evidence was insufficient to make a proper determination as to loss of range of motion.

With respect to motor impairments and impairments due to sensory deficit or pain, the A.M.A., *Guides* clearly state that, when both sensory and motor functions are involved, the impairment for each must first be determined and then the two impairments are combined using the Combined Values Chart.[4] For sensory deficit or pain, the nerve is identified, the impairment is graded as to severity under Table 16-10, the maximum impairment value for the identified nerve is found and the severity grade is multiplied by the appropriate maximum to determine the impairment. For the motor deficits, a similar procedure is followed, with the severity grade determined according to Table 16-11. Once the individual impairments are determined, then they are combined using the Combined Values Chart.[5]

In this case, the Office medical adviser appeared to combine the separate impairment determinations into a single calculation. For example, both impairments were reported as Grade 3 and 60 percent of the maximum impairment, although a Grade 3 motor impairment is from 26 to 50 percent.[6] In addition, the 60 percent grade was applied to a combined maximum of 20 percent for suprascapular sensory and motor deficits. The proper method is to apply the severity grade to each maximum impairment and then combine the results.[7]

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[3] *See James E. Jenkins,* 39 ECAB 860 (1988); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(c) (August 2002).

[4] A.M.A., *Guides* 481 outlines the impairment evaluation method for peripheral nerves of the upper extremity.

[5] *See id* at 604-06, Combined Values Chart.

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

[7] *Id.* at 492, Table 16-15 provides a maximum of 5 percent for suprascapular sensory deficit or pain, 16 percent for motor deficit or 20 percent for combined motor and sensory deficits. The 20 percent represents the maximum impairment for motor and sensory deficits, but the impairments must be determined separately. For example, 60 percent of the maximum 16 percent for suprascapular motor deficit is 9.6 percent, which would be rounded to 10 percent (*see* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards,* Chapter 3.700(b) (June 2003). The impairment for sensory deficit or pain at 60 percent of the maximum 5 percent is 3 percent. Under the Combined Values Chart, 10 combined with 3 is 13 percent.

The case will be remanded to the Office for further development of the medical evidence. The Office should secure medical evidence that provides a detailed description of the impairment and a reasoned opinion as to the permanent impairment of the right arm under the A.M.A., *Guides.* After such further development as the Office deems necessary, it should issue an appropriate decision.

CONCLUSION

The Board finds that the record is not sufficient to establish the degree of permanent impairment to the right arm. The case will be remanded to the Office for an appropriate decision on the issue.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 15, 2003 is set aside and the case remanded to the Office for further action consistent with this decision of the Board.

Issued: September 28, 2004
Washington, DC

Alec J. Koromilas
Chairman

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member