United States Department of Labor
Employees' Compensation Appeals Board

BETTY J. WATSON, Appellant	)	
and	)	**Docket No. 05-271**
	)	**Issued: May 20, 2005**
U.S. POSTAL SERVICE, SAN FRANCISCO BULK MAIL FACILITY, Richmond, CA, Employer	)	

Appearances:
Betty J. Watson, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
COLLEEN DUFFY KIKO, Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On November 9, 2004 appellant filed a timely appeal from decisions of the Office of Workers' Compensation Programs dated January 30 and September 21, 2004, denying her claims for an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the schedule award issue in the case.

ISSUE

The issue is whether appellant has established that she sustained greater than a 25 percent impairment of the right upper extremity, for which she received a schedule award.

FACTUAL HISTORY

The Office accepted that on or before May 2, 1997 appellant, then a 48-year-old clerk, sustained adhesive capsulitis and tendinitis of the right shoulder, necessitating arthroscopic repair of a torn rotator cuff on May 26, 1998. She was treated by Dr. Kanwaljit S. Gill, an attending Board-certified orthopedic surgeon. Following surgery, appellant returned to part-time limited-duty work as a modified clerk. Dr. Gill submitted periodic reports through March 15, 1999,

noting continuing right shoulder pain and stiffness, but that appellant was able to perform modified work up to six hours a day.[1] The Office accepted that she sustained tendinitis of the right wrist in the performance of duty on or before September 1, 1999.[2]

On October 30, 2000 appellant claimed a schedule award for impairment of her right upper extremity. To determine the percentage of impairment, the Office referred her to Dr. Gerald W. Cady, a Board-certified orthopedic surgeon, for a second opinion examination.

In a December 14, 2000 report, Dr. Cady provided a history of injury and treatment. He opined that appellant reached maximum medical improvement September 2000. On examination Dr. Cady found decreased grip strength in the right hand and tenderness to palpation of both shoulders and the right wrist and forearm. He provided range of motion measurements for the right shoulder: 110 out of 180 degrees forward elevation; 20 out of 50 degrees backward elevation; 110 out of 170 degrees abduction; 60 out of 80 degrees internal rotation, 70 out of 90 degrees external rotation; 40 out of 50 degrees extension. Dr. Cady noted no loss of range of motion in the right elbow, wrist, hand and fingers. He characterized appellant's right shoulder pain as mild, with localization to a particular area or nerve distribution. Dr. Cady stated an impression of status post rotator cuff repair of the right shoulder with partial arthrofibrosis and restricted motion, nonoccupational arthrofibrosis of the left shoulder, chronic tendinitis of the right forearm and fingers, a chronic lumbosacral strain and chronic left knee pain. He provided permanent restrictions of lifting and carrying no more than 10 pounds, no bending or stooping and no reaching above shoulder level.

In a January 16, 2001 report, an Office medical adviser reviewed Dr. Cady's December 14, 2000 report and applied the tables and grading schemes of the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*.)[3] The medical adviser first addressed impairment due to loss of range of motion. She found that, according to Figure 38, page 43,[4] appellant exhibited a 5 percent loss of flexion and a 2 percent loss of extension in the right shoulder, a 3 percent loss of abduction according to Figure 41, page 44[5] and a 2 percent loss of internal rotation according to Figure 44, page 45.[6] The medical adviser totaled these percentages to equal 12 percent. Regarding

[1] By decision dated August 5, 1999, the Office reduced appellant's wage-loss compensation effective March 19, 1999 based on her actual earnings in the modified clerk position.

[2] The Office assigned the right shoulder claim File No. 13-1158181 and the right wrist claim File No. 13-1198486. The Office doubled the claims under File No. 13-1158181 as they both pertained to the right upper extremity.

[3] The fifth edition of the A.M.A., *Guides* did not go into effect until February 1, 2001. *See* FECA Bulletin 01-05 (issued January 29, 2001).

[4] Figure 38, page 43 of the fourth edition of the A.M. A., *Guides* is entitled, "Upper Extremity Impairments Due to Lack of Flexion and Extension of Shoulder."

[5] Figure 41, page 44 of the fourth edition of the A.M. A., *Guides* is entitled, "Upper Extremity Impairments Due to Lack of Abduction and Adduction of Shoulder."

[6] Figure 44, page 45 of the fourth edition of the A.M. A., *Guides* is entitled, "Upper Extremity Impairments Due to Lack of Internal and External Rotation of Shoulder."

impairment "due to loss of strength and impairment due to sensory deficit or pain: level of symptoms as Grade 2 and 4, 25 percent (Tables 11 and 12, pages 48 and 49).[7] Maximum combined impairment based on the radial (below the elbow) and suprascapular nerves is 58 percent and 25 percent times 58 percent equals 15 percent." The Office medical adviser then used the Combined Values Chart on page 322 of the A.M.A., *Guides* to determine that the 12 percent impairment due to loss of range of motion combined with the 15 percent impairment due to weakness and pain totaled a 25 percent impairment of the right upper extremity.

By decision dated January 18, 2001, the Office granted appellant a schedule award for a 25 percent impairment of the right upper extremity. The period of award ran from November 5, 2000 to May 4, 2002.[8]

On June 9, 2003 appellant claimed an additional schedule award. The Office referred her, the medical record and a statement of accepted facts to Dr. Philip Wirganowicz, a Board-certified orthopedic surgeon, for a second opinion examination.

In an August 14, 2003 report, Dr. Wirganowicz provided a history of injury and treatment and reviewed the medical record. On examination he found no swelling, atrophy or deformity of the right shoulder, with normal strength in the shoulder girdle. Dr. Wirganowicz obtained measurements for range of motion showing flexion and abduction of 110 degrees, a 40 degree loss, a loss of 10 degrees external rotation and internal rotation limited to 40 out of 80 degrees. He diagnosed a right shoulder rotator cuff tear, status post repair.

In a September 29, 2003 report, an Office medical adviser reviewed Dr. Wirganowicz's August 14, 2003 report and determined that appellant had reached maximum medical improvement August 9, 2003. Regarding his measurements, the Office medical adviser found that, according to Figure 16-40, page 476 of the fifth edition of the A.M.A., *Guides*,[9] appellant had a 5 percent loss of flexion and a 1 percent loss of extension. According to Figure 16-43, page 477,[10] she had a three percent loss of abduction and a three percent loss of internal rotation according to Figure 16-46, page 479.[11] The Office medical adviser totaled these deficits to equal 12 percent. Regarding sensory deficit, the Office medical adviser noted that, according to Table

[7] Table 11, page 48 of the fourth edition of the A.M. A., *Guides* is entitled, "Determining Impairment of the Upper Extremity Due to Pain or Sensory Deficit Resulting from Peripheral Nerve Disorders." Table 12, page 49 of the fourth edition of the A.M. A., *Guides* is entitled, "Determining Impairment of the Upper Extremity Due to Loss of Power and Motor Deficits Resulting from Peripheral Nerve Disorders Based on Individual Muscle Rating."

[8] By decision dated January 19, 2001, the Office reduced appellant's compensation to zero on the grounds that she had no loss of wage-earning capacity. The Office found that her actual earnings as a modified general clerk effective October 2, 2000 were identical to the current pay rate for her job and step when injured.

[9] Figure 16-40, page 476 of the fifth edition of the A.M.A., *Guides* is entitled "Pie Chart of Upper Extremity Motion Impairments Due to Lack of Flexion and Extension of Shoulder."

[10] Figure 16-43, page 477 of the fifth edition of the A.M.A., *Guides* is entitled "Pie Chart of Upper Extremity Motion Impairments Due to Lack of Abduction and Adduction of Shoulder."

[11] Figure 16-46, page 479 of the fifth edition of the A.M.A., *Guides* is entitled "Pie Chart of Upper Extremity Impairments Due to Lack of Internal and External Rotation of Shoulder."

16-10, page 482,[12] appellant had a Grade 4 impairment due to pain or an 80 percent impairment. Referring to Table 16-15, page 492,[13] the Office medical adviser multiplied the 80 percent impairment by the 5 percent maximum value for impairment of the suprascapular nerve, resulting in a 4 percent impairment of the right upper extremity. She found no impairment due to loss of strength. Using the Combined Values Chart, the Office medical adviser combined the 12 percent and 4 percent impairments to equal a 16 percent impairment of the right upper extremity.[14]

By decision dated October 16, 2003, the Office found that the Office medical adviser's review of Dr. Wirganowicz's report correctly applied the appropriate portions of the A.M.A., *Guides* and demonstrated that appellant had only a 16 percent impairment of the right upper extremity, less than the 25 percent previously awarded. For this reason no additional schedule award was made.

In a November 18, 2003 letter, appellant requested reconsideration. She submitted an October 30, 2003 work capacity evaluation (Form OWCP-5) from Dr. Jennifer B. Byrd, an attending physiatrist, who diagnosed tendinitis of the right hand and arthrofibrosis of the right shoulder with restricted motion. Dr. Byrd limited appellant to lifting no more than two pounds for one hour a day and no reaching above shoulder level. She also prescribed frequent breaks and an "ergonomic seating arrangement." Dr. Byrd stated that appellant could not work eight hours a day "unless limitations are satisfied." She indicated that additional surgery might improve appellant's range of right shoulder motion.

By decision dated January 30, 2004, the Office denied modification of January 18, 2001 decision. The Office found that Dr. Byrd's October 30, 2003 form report did not indicate that appellant had sustained any additional impairment of the right upper extremity.

In an August 5, 2004 letter, appellant requested reconsideration and submitted two additional reports from Dr. Byrd. In an April 20, 2004 note, she diagnosed degenerative joint disease of the left shoulder with possible pathology of the labrum.[15] In an undated report received by the Office on August 2, 2004, Dr. Byrd provided a history of injury and treatment of the right shoulder. On examination she found severe tenderness to palpation of the bicipital groove. Dr. Byrd found a 47 percent loss of forward flexion with motion limited to 90 degrees, a

[12] Table 16-10, page 482 of the fifth edition of the A.M.A., *Guides* is entitled, "Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting From Peripheral Nerve Disorders."

[13] Table 16-15, page 492 of the fifth edition of the A.M.A., *Guides* is entitled "Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to *Combined* 100% Deficits of the Major Peripheral Nerves." (Emphasis in original).

[14] The Office medical adviser previously reviewed Dr. Wirganowicz's August 14 2003 report on September 1, 2003 and determined that she demonstrated a 16 percent impairment of the right upper extremity. However, the Office medical adviser's September 1, 2003 report differs slightly from her September 29, 2003 report in that the former indicated a one percent impairment for loss of adduction and the latter found no impairment for loss of adduction.

[15] X-rays of the left shoulder obtained on April 20, 2004 were "normal."

35 percent loss of abduction with motion limited to 110 degrees and a 7 percent loss of internal rotation with motion limited to 50 degrees. She diagnosed status post right rotator cuff repair, frozen right shoulder, chronic bursitis and tendinitis of the right shoulder and fibrositis of the soft tissues of the right shoulder. Dr. Byrd opined that all diagnoses were related to the accepted injuries.

On September 3 and 9, 2004 the Office requested that an Office medical adviser review Dr. Byrd's report to determine if it indicated any additional percentage of impairment.

In a September 9, 2004 report, an Office medical adviser determined that appellant had reached maximum medical improvement August 9, 2004. Regarding Dr. Byrd's measurements, the Office medical adviser found that, according to Figure 16-40, page 476 of the fifth edition of the A.M.A., *Guides*, she had a six percent loss of flexion and no loss of extension. According to Figure 16-43, page 477, appellant had a three percent loss of abduction and a one percent loss of external rotation according to Figure 16-46, Table 479. The Office medical adviser totaled these percentages to equal 10 percent. Regarding sensory deficit or pain, she noted that according to Table 16-10, page 482, appellant had a Grade 3 impairment due to pain or a 60 percent impairment. Referring to Table 16-15, page 492, the Office medical adviser multiplied the 60 percent impairment by the 5 percent maximum value for impairment of the suprascapular nerve, resulting in a 3 percent impairment of the right upper extremity. The Office medical adviser found no impairment due to loss of strength. Using the Combined Values Chart, the Office medical adviser combined the 10 and 3 percent impairments, resulting in a 13 percent impairment of the right upper extremity.

By decision dated September 21, 2004, the Office found that the evidence submitted did not support any additional percentage of impairment.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[16] provide for compensation to employees sustaining impairment from loss or loss of use, of specified members of the body. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a mater which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized 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 Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[17] As of February 1, 2001, schedule awards are calculated according to the fifth edition of the A.M.A., *Guides*, published in 2000.[18]

[16] 5 U.S.C. §§ 8101-8193.

[17] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[18] *See* FECA Bulletin 01-05 (issued January 29, 2001) (schedule awards calculated as of February 1, 2001 should be evaluated according to the fifth edition of the A.M.A., *Guides*. Any recalculations of previous awards which result from hearings, reconsideration or appeals should, however, be based on the fifth edition of the A.M.A. *Guides* effective February 1, 2001).

The standards for evaluating the percentage of impairment of upper extremities can be found in Chapter 16 of the fifth edition of the A.M.A., Guides. Upper extremity impairment ratings evaluate factors such as abnormal motion, pain, weakness and sensory loss. Multiple impairments are combined to determine the total impairment of the unit (*e.g.*, finger) before conversion to the next larger unit (*e.g.*, hand).[19] Similarly, multiple regional impairments, such as those of the hand, wrist, elbow and shoulder, are first expressed individually as upper extremity impairments and then combined to determine the total upper extremity impairment.[20] Section 16.1 states that "[r]egional impairments resulting from the hand, wrist, elbow and shoulder regions are combined to provide the upper extremity impairment." Regarding the combined values chart, section 1.4 of the A.M.A., *Guides*, provides that "[i]n general, impairment ratings within the same region are combined before combining the regional impairment rating from another region."[21]

ANALYSIS

The Office accepted that appellant sustained adhesive capsulitis and tendinitis of the right shoulder in the performance of duty on or before May 2, 1997 necessitating an arthroscopic repair of the rotator cuff. The Office also accepted that she sustained tendinitis of the right wrist in the performance of duty on or before September 1, 1999. By decision dated January 18, 2001, the Office granted appellant a schedule award for a 25 percent impairment of the right upper extremity related to the accepted right shoulder conditions. The Office based the award on an Office medical adviser's application of the fourth edition of the A.M.A., *Guides* to the December 14, 2000 findings of Dr. Cady, a Board-certified orthopedic surgeon and second opinion physician. Appellant did not dispute Dr. Cady's findings or the Office medical adviser's application of the A.M.A., *Guides*. Rather, she asserted that she sustained greater impairment, claiming an additional schedule award on June 9, 2003.

To determine if appellant's accepted right shoulder condition had deteriorated such that it warranted an additional percentage of impairment, the Office referred appellant to Dr. Wirganowicz, a Board-certified orthopedic surgeon, for a second opinion examination. He submitted a detailed August 14, 2003 report, finding restricted right shoulder motion with no weakness. In a September 29, 2003 report, an Office medical adviser applied the appropriate tables and grading schemes of the fifth edition of the A.M.A., *Guides* to Dr. Wirganowicz's findings. Using Figures 16-40, 16-43 and 16-46, the Office medical adviser found a 12 percent impairment due to restricted right shoulder motion. She also found a 4 percent impairment due to pain according to Table 16-10, page 492. The Office medical adviser then combined the impairments to equal a 16 percent impairment of the right upper extremity. Therefore, by October 16, 2003 decision, the Office denied modification of the January 18, 2001 schedule award as Dr. Wirganowicz's findings as interpreted by the Office medical adviser showed a lesser percentage of impairment than that previously awarded.

[19] *See* A.M.A., *Guides*, Chapter 16.1(c), *Combining Impairment Ratings*, page 438.

[20] A.M.A., *Guides*, 16.1c, page 438.

[21] A.M.A., *Guides*, pages 9-10. *See also Cristeen Falls*, 55 ECAB ___ (Docket No. 03-1665, issued March 29, 2004).

Appellant requested reconsideration and submitted reports from Dr. Byrd, an attending Board-certified physiatrist. On August 2, 2004 Dr. Byrd provided range of motion measurements for the right shoulder. On September 9, 2004 an Office medical adviser applied the appropriate sections of the fifth edition of the A.M.A., *Guides* to her August 2, 2004 findings. The Office medical adviser found that the described restrictions of range of motion equaled a 10 percent impairment of the right upper extremity according to Figures 16-40, 16-43 and 16-46. She noted that a Grade 3 impairment of the suprascapular nerve due to pain equaled a three percent impairment of the right upper extremity according to Table 16-10. The medical adviser applied the Combined Values Chart to arrive at a 13 percent impairment of the right upper extremity. The reports of Dr. Byrd are not sufficient to establish impairment more than the 25 percent previously awarded. Therefore, appellant has not demonstrated a greater impairment warranting an additional schedule award.[22]

CONCLUSION

The Board finds that appellant has not established that she sustained greater than a 25 percent impairment of the right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated September 21 and January 30, 2004 are affirmed.

Issued: May 20, 2005
Washington, DC

Alec J. Koromilas
Chairman

Colleen Duffy Kiko
Member

Michael E. Groom
Alternate Member

[22] *See Linda R. Sherman*, 56 ECAB ___ (Docket No. 04-1510, issued October 14, 2004).