United States Department of Labor
Employees' Compensation Appeals Board

B.S., Appellant	)	
and	)	**Docket No. 06-1103**
	)	**Issued: August 24, 2006**
U.S. POSTAL SERVICE, POST OFFICE, Billings, MT, Employer	)	

Appearances:
B.S., pro se,
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On April 11, 2006 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decisions dated July 22, 2005 and January 9, 2006. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue is whether appellant sustained more than a three percent permanent impairment of his right and left upper extremities for which he received a schedule award.

FACTUAL HISTORY

On October 3, 2001 appellant then a 53-year-old flat sorter, filed a notice of recurrence of disability alleging a recurrence of disability on September 30, 2003 causally related to a February 5, 1997 employment injury. He alleged that his employment duties of flat sorting, prepping flats, cutting bands off of flat tubs, twisting his wrists and grasping objects put pressure on his hands, wrists and thumbs. By letter dated October 8, 2003, the Office advised appellant

that it would adjudicate the claim as an occupational disease. On January 13, 2004 the Office accepted appellant's claim for bilateral subacromial impingement and bilateral residual carpal tunnel syndrome. The Office authorized physical therapy. Appellant received appropriate compensation benefits.

On April 20, 2004 appellant's treating physician, Dr. Jeffrey N. Hansen, a Board-certified hand surgeon and orthopedic surgeon, performed an authorized left shoulder arthroscopy with debridement of anterior-superior labral degenerative tear and subacromial decompression with acromioplasty. On June 22, 2004 Dr. Hansen performed an authorized right shoulder arthroscopy with subacromial decompression and acromioplasty.

On November 29, 2004 appellant claimed a schedule award and submitted a November 29, 2004 report from Dr. Hansen.[1] Dr. Hansen utilized the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) and opined that appellant had reached maximum medical improvement and was "doing his normal work duty." He noted that appellant did not have a full range of motion and experienced a mild strength deficit. Dr. Hansen referred to Table 16-35[2] to rate appellant's strength deficit and noted that he had a 15 percent deficit in abduction and forward elevation on the right and 10 percent on the left. Appellant lacked internal rotation beyond the iliac crest on the right and to the level of L5 on the left. Dr. Hansen advised that forward elevation lacked 10 degrees in each shoulder and referred to Table 16-35.[3] He also referenced to Table 16-27[4] to obtain a comparable diagnosis for a subacromial impingement. Dr. Hansen explained that a distal clavicle resection arthroplasty was rated at 10 percent impairment of the upper extremity and advised that appellant had a similar degree of surgical trauma "so that anything in that category would be most likely appropriate." Based on the total degree of loss of strength and motion, appellant had a 12 percent impairment of the right upper extremity and a 9 percent impairment of the left upper extremity. Dr. Hansen indicated that appellant could return to regular duty.

By memorandum dated January 19, 2005, an Office medical adviser indicated that a second opinion was warranted as appellant's physician stated that he had full range of motion yet noted loss of range of motion. The Office medical adviser indicated that strength should not be used if more objective measures were available.

By letters dated March 24 and 30, 2005, the Office referred appellant to Dr. Michael H. Schabacker, a Board-certified physiatrist, to evaluate the extent of permanent impairment based on his employment injuries.

In a May 10, 2005 report, Dr. Schabacker noted appellant's history of injury and treatment and utilized the fifth edition of the A.M.A., *Guides.* He indicated that both shoulders

[1] The report also had a second date of December 14, 2004.

[2] A.M.A., *Guides* 510.

[3] *Id.*

[4] *Id.* at 506.

were stable and that appellant reached maximum medical improvement on November 29, 2004. Dr. Schabaker explained that, while Dr. Hansen provided appellant with an impairment rating for a distal clavicectomy, the operative reports did not indicate that he had removed any portion of the clavicle. He referred to section 16-4i[5] and noted that impairment is determined based upon range of motion. Dr. Schabaker advised that Figure 16-40[6] was used to determine impairment due to limited shoulder flexion and extension. For the right shoulder, he determined that appellant had shoulder flexion which was 150 degrees or a 2 percent upper extremity impairment and extension of 50 degrees which equated to a 0 percent upper extremity impairment. Dr. Schabacker also referred to Figure 16-43[7] to determine impairment due to altered shoulder adduction and abduction. He noted that appellant had abduction limitation to 150 degrees on the right shoulder, which was equivalent to a 1 percent upper extremity impairment and adduction of 50 degrees, which was equal to 0 percent upper extremity impairment. Dr. Schabaker referred to Figure 16-46[8] to determine impairment due to altered internal and external rotation and determined that external rotation to 80 degrees was equal to a 0 percent upper extremity impairment and internal rotation of the right shoulder to 90 degrees was equal to a 0 percent upper extremity impairment. He referred to page 479[9] and noted that the values due to altered range of motion in multiple planes were to be "summated," and determined that appellant had a three percent right upper impairment. Dr. Schabaker also calculated appellant's left upper extremity impairment and referred to Figure 16-40.[10] He noted that flexion of 150 degrees was equal to 2 percent upper extremity impairment and extension of 50 degrees was equal to 0 percent upper extremity impairment. Dr. Schabaker referred to Figure 16-43[11] and noted that abduction[12] of 150 degrees warranted a 1 percent upper extremity impairment and adduction of 50 degrees warranted 0 percent upper extremity impairment. He also referred to Figure 16-46[13] and noted that external rotation of 80 degrees and internal rotation of 90 degrees both warranted 0 percent upper extremity impairment. Dr. Schabaker added these values and determined that appellant was entitled to three percent impairment on the left.

Dr. Schabaker also referred to page 493 of the A.M.A., *Guides* to ascertain whether appellant had peripheral nerve entrapment, for his carpal tunnel syndrome, and explained that "only objectively verifiable diagnoses should be rated." He indicated that appellant did not have any objective findings supporting the diagnosis of carpal tunnel syndrome and thus, no additional

[5] *Id.* at 474.

[6] *Id.* at 476.

[7] *Id.* at 477.

[8] *Id.* at 479.

[9] *Id.*

[10] *Id.* at 476.

[11] *Id.* at 477.

[12] He actually indicated adduction, but this appears to be a typographical error.

[13] A.M.A., *Guides* 479. The physician also referred to Table 16-43, but it appears he was actually referring to Table 16-46 on page 479.

impairment was warranted for having undergone the carpal tunnel release, which was successful. Dr. Schabaker referred to the Combined Values Chart[14] and determined that the three percent upper extremity impairment on the right shoulder combined with three percent upper extremity impairment to the left shoulder yielded an overall six percent upper extremity impairment.

Appellant retired from the employing establishment on February 1, 2005.

In a June 16, 2005 report, the Office medical adviser reviewed the medical evidence and determined that appellant had a three percent permanent impairment of his right upper extremity and three percent permanent impairment of his left upper extremity. He opined that the date of maximum medical improvement was May 10, 2005.

By decision dated July 22, 2005, the Office awarded appellant compensation for 18.72 weeks from May 10 to September 18, 2005 based upon a three percent permanent impairment of the right upper extremity and a three percent impairment of the left upper extremity.

On October 11, 2005 the Office received appellant's request for reconsideration. Appellant enclosed an August 8, 2005 report from Dr. Hansen, who noted that a dispute had arisen regarding the extent of appellant's impairment and reiterated his previous findings. Dr. Hansen explained that the A.M.A., *Guides* were reviewed once again for conditions of the shoulder. He noted that appellant had mild grating and crepitus and some mild pain with use, along with slight loss of range of motion. Dr. Hansen indicated that, even if strength were excluded, the overall impairment of 12 percent on the right and 9 percent on the left could easily be justified. He explained that appellant's condition was not listed as a diagnosed specific condition and it was not as easily ratable as other conditions were. There was some subjectivity and explained that appellant was left with only three percent impairment and explained that appellant had significant strength loss. Dr. Hansen referred to section 16.8 at page 507, which was to be used, "otherwise the impairment ratings based on objective anatomic findings did not explain the total deficit appellant has." For example, he indicated that appellant had significant strength loss in overhead activities, a 20 percent reduction in strength of abduction and 15 percent reduction of external rotation strength of the right compared to the left, which was not normal. Dr. Hansen opined that he could easily justify a 12 percent right upper extremity impairment and a 9 percent left upper extremity impairment, and noted that even 20 percent would be justifiable, but advised that he was standing by his previous estimate of impairment, which was "fair and reasonable."

By decision dated January 9, 2006, the Office denied modification of the July 22, 2005 decision.

[14] A.M.A., *Guides* 604.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[15] and its implementing regulation[16] 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.[17]

ANALYSIS

In support of his claim for a schedule award, appellant provided the November 29, 2004 report from Dr. Hansen, his treating physician. Dr. Hansen referred to Table 16-35 to rate appellant's strength deficit. However, the A.M.A., *Guides,* specifically provides that strength deficits measured by manual muscle testing should only rarely be included in the calculation of upper extremity impairment.[18] Dr. Hansen did not explain why appellant's case fell into the rare category such that he could only use strength testing. This is true in light of the fact that range of motion testing was available. The medical evidence in this case does not explain why such impairment should be considered in light of the language of the A.M.A., *Guides.* Dr. Hansen also referred to Table 16-27[19] to obtain a comparable diagnosis to a subacromial impingement. He explained that a distal clavicle resection arthroplasty was rated at 10 percent impairment of the upper extremity and advised that appellant had a similar degree of surgical trauma "so that anything in that category would be most likely appropriate." However, the Board notes that appellant underwent an authorized left shoulder arthroscopy with debridement of anterior superior labral degenerative tear with subacromial decompression and acromioplasty and a right shoulder arthroscopy with subacromial decompression and acromioplasty. While Dr. Hansen explained that the degree of surgical trauma was similar, the second opinion physician explained that the operative reports did not establish any portion of the clavicle was removed. The Board notes that, pursuant to Table 16-27 of the A.M.A., *Guides,* appellant would be entitled to 10

[15] 5 U.S.C. § 8107.

[16] 20 C.F.R. § 10.404.

[17] A.M.A., *Guides* (5th ed. 2001).

[18] The A.M.A., *Guides* provides that loss of strength may be rated separately if such a deficit has not been considered adequately by other rating methods. An example of this situation would be loss of strength caused by a severe muscle tear that healed leaving "a palpable muscle defect." If the rating physician determines that loss of strength should be rated separately in an extremity that presents other impairments, "the impairment due to loss of strength could be combined with the other impairments, only if based on unrelated etiologic or pathomechanical causes. Otherwise, the impairment ratings based on objective anatomic findings take precedence." The A.M.A., *Guides* further provides that decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximum force. A.M.A., *Guides* 508, section 16.8a.

[19] A.M.A., *Guides* 506.

percent impairment for a resection acromioplasty.[20] However, the record does not address whether appellant underwent a resection acromioplasty.

Dr. Hansen noted that, even if strength were excluded, the overall impairment of 12 percent on the right and 9 percent on the left could easily be justified. He explained that appellant's specific condition was not listed as a diagnosed specific condition and was not as easily ratable as other conditions were. Dr. Hansen referred to section 16.8[21] to justify a higher rating. Although the physician indicated that appellant had significant strength loss in overhead activities, a 20 percent reduction in strength of abduction and 15 percent reduction of external rotation strength of the right compared to the left, which was not normal, he did not explain why he could not utilize the range of motion methods.[22] While, the physician opined that he could easily justify a 12 percent right upper extremity impairment and a 9 percent left upper extremity impairment, even 20 percent impairment, he did not adequately explain how he arrived at these estimates or why such impairments should be considered in light of the protocols of the A.M.A., *Guides.*

The Office subsequently referred appellant to Dr. Schabacker, who applied fifth edition of the A.M.A., *Guides* to find that appellant had a total impairment of three percent impairment to both his right and left upper extremities. The Office medical adviser concurred with his findings. Dr. Schabacker explained that, while appellant's physician offered an impairment rating for a distal clavicectomy, the operative reports did not indicate that a portion of the clavicle was removed. As noted, appellant is not entitled to an impairment rating for this procedure. Dr. Schabaker explained that there were no objective findings to rate appellant for his carpal tunnel syndrome, and he was not entitled to any impairment for this condition, as "only objectively verifiable diagnoses should be rated." For the right shoulder, Dr. Schabacker referred to Figure 16-40[23] for range of motion, noting that appellant had flexion of 150 degrees and determined that appellant was entitled to an impairment rating of 2 percent and no rating was warranted for shoulder extension of 50 degrees. Regarding abduction, he referred to Figure 16-43[24] and advised that abduction of 150 degrees would warrant a 1 percent rating and no rating was warranted for adduction of 50 degrees. Dr. Schabacker also referred to Figures 16-46[25] and explained that external rotation of 80 degrees warranted a 0 percent rating and that internal rotation of 80 degrees warranted a 0 percent rating. He added the aforementioned impairment ratings which resulted in a 3 percent rating for decreased range of motion of the right shoulder.

[20] *Id.*

[21] *Id.* at 508.

[22] *Id.* at 474.

[23] *Id.* at 476.

[24] *Id.* at 477.

[25] *Id*. at 479.

For the left shoulder, Dr. Schabacker referred to Figure 16-40[26] for range of motion, noting that appellant had flexion of 150 degrees and determined that appellant was entitled to an impairment rating of 2 percent and no rating was warranted for shoulder extension of 50 degrees. Regarding abduction, he referred to Figure 16-43[27] and advised that abduction of 150 degrees would warrant a 1 percent rating and no rating was warranted for adduction of 50 degrees. Dr. Schabacker also referred to Figure 16-46[28] and explained that external rotation of 80 degrees warranted a 0 percent rating and that internal rotation of 90 degrees warranted a 0 percent rating. He added the impairment ratings which resulted in a 3 percent rating for decreased range of motion of the left shoulder.

The Board finds that there is no other medical evidence of record, based upon a correct application of the A.M.A., *Guides*, to establish that appellant has more than a three percent permanent impairment of the right and left arms for which he received a schedule award. Accordingly, the Board finds that appellant has no more than a three percent permanent impairment of the right and left upper extremity.

On appeal, appellant alleged that he has greater than a three percent permanent impairment of the right and left arms. However, the evidence does not support a greater impairment. The Board notes that this does not preclude appellant from submitting relevant medical evidence to the Office in support of any request for an additional schedule award.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he sustained more than a three percent permanent impairment of his right upper extremity and more than a three percent permanent impairment of his left upper extremity, for which he received a schedule award.

[26] *Id*. at 476.

[27] *Id*. at 477.

[28] *Id*. at 479.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated January 9, 2006 and July 22, 2005 is affirmed.

Issued: August 24, 2006
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board