United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 06-879**
	)	**Issued: October 17, 2006**
U.S. POSTAL SERVICE, POST OFFICE, Richmond, VA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 8, 2006 appellant, through her attorney, filed a timely appeal from a February 22, 2006 merit decision of the Office of Workers' Compensation Programs denying her claim for an increased schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has established that she has more than a 23 percent permanent impairment of the right upper extremity and a 6 percent permanent impairment of the left upper extremity, for which she received schedule awards.

FACTUAL HISTORY

This case is before the Board for the second time. In the first appeal, the Board set aside an August 22, 2001 decision after finding that the Office incorrectly determined that appellant's request for reconsideration was untimely.[1] The Board remanded the case for the Office to apply

[1] *Jacqueline F. Booker*, Docket No. 02-273 (issued February 27, 2003).

the appropriate legal standard to her reconsideration request. The Board affirmed a May 1, 2001 decision, finding that appellant did not establish a recurrence of disability on December 8, 2000 causally related to her June 1994 employment injury. The findings of fact and conclusions of law from the prior decision are hereby incorporated by reference.

In a decision dated May 8, 2003, the Office denied modification of its May 1, 2001 decision, finding that appellant did not establish a December 8, 2000 recurrence of disability.

The record indicates that appellant received schedule awards for a 6 percent permanent impairment of the left arm and a 23 percent permanent impairment of the right arm. On October 3, 2003 appellant filed a claim for an increased schedule award. In an impairment evaluation dated September 23, 2004, Dr. Gregory F. Leghart, a Board-certified physiatrist, diagnosed fibromyalgia, mood disorder, sleep disorder and chronic fatigue. He attributed her lower extremity pain to either fibromyalgia, neuropathy, radiculopathy or spinal stenosis. Dr. Leghart concluded that appellant had a 23 percent impairment of the left lower extremity and a 15 percent impairment of the right upper extremity.

An electromyogram (EMG) performed on September 25, 2003 revealed severe carpal tunnel syndrome on the right side and mild carpal tunnel syndrome on the left side. In a progress report dated October 14, 2003, Dr. William H. Bowers, a Board-certified orthopedic surgeon, diagnosed carpal tunnel syndrome or severe right median nerve neuropathy and indicated that her treatment should be approved by workers' compensation.

In a medical report dated July 14, 2003, received by the Office on November 7, 2003, Dr. William D. Brickhouse, a Board-certified orthopedic surgeon, discussed appellant's history of an employment-related right shoulder injury and a July 1, 1998 open decompression of the right shoulder. Dr. Brickhouse opined that "her shoulder problems are related to persistent rotator cuff tendinitis and AC [acromioclavicular] joint arthritis, which is part of her original injury."

By decision dated December 4, 2003, the Office vacated its May 1, 2001 decision and accepted appellant's claim for ongoing medical treatment due to impingement syndrome, AC joint arthritis and rotator cuff tendinitis of the right shoulder. The Office informed her that she should submit a report from a physician applying the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001) in support of her schedule award claim. In a letter dated April 26, 2004, the Office notified appellant that it had also accepted her claim for bilateral carpal tunnel syndrome and authorized a carpal tunnel release.

On May 5, 2004 Dr. Brickhouse referred appellant for an impairment evaluation of the right shoulder, elbow, hand and wrist. In a report dated May 25, 2004, signed by Dr. Brickhouse on June 16, 2004, Scott Winefordner, a physical therapist, obtained range of motion measurements for the hand, wrist, elbow and shoulder. Dr. Winefordner concluded that appellant had a 12 percent impairment due to loss of range of motion and a 10 percent impairment due to her distal clavicle resection for a total upper extremity impairment of 21 percent.

An Office medical adviser reviewed the medical evidence and concluded that there was no basis for an increased schedule award for either the right or left upper extremity. He noted that an impairment evaluation from a physical therapist was not acceptable and that Dr. Leghart did not apply the fifth edition of the A.M.A., *Guides*.

By letter dated September 29, 2004, the Office requested that Dr. Brickhouse reevaluate appellant to determine if she had an increased impairment of the right upper extremity. In a response dated October 20, 2004, Dr. Brickhouse noted that he had previously submitted the requested information.[2]

A December 16, 2004 magnetic resonance imaging scan study of appellant's right shoulder revealed a full thickness rotator cuff tear. On January 11, 2005 the Office authorized a repair of the right rotator cuff. Appellant underwent an arthroscopic subacromial decompression of the right shoulder on December 29, 2004.

By letter dated January 28, 2005, the Office referred appellant to Dr. William K. Fleming, a Board-certified orthopedic surgeon, to resolve a conflict in medical opinion found between Dr. Brickhouse and the Office medical adviser on the extent of her permanent impairment of the right upper extremity. On February 14, 2005 the Office cancelled the appointment due to her possible recurrence of disability and requested a medical report supporting that her rotator cuff surgery was due to her accepted employment injury.

Appellant attended the February 22, 2005 appointment with Dr. Fleming, who found that she had a 14 percent permanent impairment of the right upper extremity.

In a progress report dated July 18, 2005, Dr. Brickhouse opined that appellant had reached maximum medical improvement. He noted findings of nearly normal range of motion, good strength and mild discomfort of the shoulder. In an impairment evaluation dated November 7, 2005, Dr. Robert S. Adelaar, a Board-certified orthopedic surgeon, diagnosed bilateral carpal tunnel syndrome, greater on the right side, right shoulder impingement syndrome with rotator cuff tendinitis, fibromyalgia and a history of epicondylitis of the elbow and a right wrist ganglion cyst. On physical examination, he related:

> "The left and right shoulders have active range of motion to 150 [degrees] of abduction and forward flexion. External rotation strength on the right shoulder seems to be reasonably intact, although she has pain when resisting pressure on the right shoulder. The bicep tendon seems to be intact and she can only reach to her waistline with the right shoulder but can reach to her bra strap with the left shoulder, a difference of about 4 [to] 6 [inches]. Neurologic is intact in the upper extremities except for the sensory function which is decreased in the right median nerve with no evidence of motor loss. Reflexes are intact and, other than the median nerve on the right side, sensation is intact. The median nerve on the right

[2] On May 25, 2004 the Office authorized Dr. Leghart to perform an EMG of appellant's lower extremities. An EMG, performed on July 8, 2004, showed no evidence of peripheral neuropathy of the lower extremities. In a report dated October 18, 2004, Dr. Leghart attributed appellant's impairment of the lower extremity to rheumatoid arthritis and deconditioning.

side is diminished. Grip strength is down but symmetric. The elbows have full range of motion with no evidence of any tricep, medial epicondylar or lateral epicondylar tendinitis."

Citing the A.M.A., *Guides*, Dr. Adelaar opined that appellant had a 10 percent impairment bilaterally due to loss of grip strength of 0 to 30 degrees, a 5 percent impairment for right carpal tunnel syndrome and a 10 percent impairment for right rotator cuff tendinitis and loss of range of motion, for a total right arm impairment of 25 percent and a left arm impairment of 10 percent.

An Office medical adviser reviewed Dr. Adelaar's report on December 8, 2005. He noted that appellant was previously awarded 6 percent for the left upper extremity and a total of 23 percent for the right upper extremity. The Office medical adviser stated:

"In June 1998, she underwent diagnostic arthroscopy of her right shoulder and open subacromial decompression although her original diagnosis was bilateral epicondylitis. This diagnosis was eventually accepted in addition to an upgraded diagnosis of fibromyalgia and bilateral carpal tunnel syndrome in addition to [AC] joint arthritis and rotator cuff tendinitis. All of this seems to have sprung from the original diagnosis of bilateral epicondylitis."

The Office medical adviser indicated that he could provide a rating for the right but not the left upper extremity. He found that 150 degrees abduction constituted a 1 percent impairment and 150 degrees of forward flexion constituted a 2 percent impairment according to Figures 16-43 and 16-44 on pages 476-77 of the A.M.A., *Guides*. The Office medical adviser further found a 10 percent impairment for loss of grip strength according to Table 16-34 on pages 509. He determined that appellant had no objective rating for right rotator cuff tendinitis and opined that he was "unable to identify any objective criteria" to "provide a rating for the right carpal tunnel syndrome other than the loss of strength on the right." The Office medical adviser found that appellant had a 13 percent permanent impairment of the right upper extremity.

By decision dated February 22, 2006, the Office denied appellant's claim for an additional schedule award.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing federal regulation[4] 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 for all claimants, the Office has adopted the A.M.A., *Guides* (5th ed. 2001) as the uniform standard

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

applicable to all claimants.[5] Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[6]

Proceedings under the Act are not adversarial in nature and the Office is not a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[7]

ANALYSIS

The Office accepted appellant's claim for bilateral epicondylitis, bilateral carpal tunnel syndrome and right shoulder impingement syndrome, AC joint arthritis and rotator cuff tendinitis. Appellant received schedule awards for a 6 percent permanent impairment of her left upper extremity and a 23 percent permanent impairment of her right upper extremity. On October 3, 2003 appellant filed a claim for increased schedule awards. On December 29, 2004 she underwent an arthroscopic subacromial decompression of her right shoulder to repair a rotator cuff tear. Her attending physician, Dr. Brickhouse, found in a report dated July 18, 2005 that appellant had reached maximum medical improvement following her surgery. In an impairment evaluation dated November 7, 2005, Dr. Adelaar diagnosed bilateral carpal tunnel syndrome, right shoulder impingement syndrome and rotator cuff tendinitis, a history of epicondylitis and a history of a ganglion cyst. He found that she had 150 degrees of bilateral abduction and forward flexion and intact external rotation. Dr. Adelaar indicated that appellant's reach on the right side was limited to her waistline and noted that she had decreased sensation of the right median nerve. He concluded that she had a 10 percent bilateral impairment due to loss of grip strength. On the right side, Dr. Adelaar found that appellant had an additional 5 percent impairment for carpal tunnel syndrome and an additional 10 percent impairment for right rotator cuff tendinitis, for a total right arm impairment of 25 percent.

An Office medical adviser reviewed Dr. Adelaar's report and concurred with his finding of a 10 percent impairment for loss of grip strength on the right side. He further found that, for the right side, 150 degrees abduction constituted a 1 percent impairment and 150 degrees of forward flexion constituted a 2 percent impairment according to Figures 16-43 and 16-44 on pages 476-77 of the A.M.A., *Guides*, which he added to the impairment for loss of grip strength to find a total impairment on the right side of 13 percent. The Office medical adviser indicated that he was unable to provide an impairment rating on the left side due to the lack of objective criteria.

The Board finds that the case is not in posture for decision regarding appellant's entitlement to an increased schedule award. Dr. Adelaar's report, upon which the Office medical adviser based his findings, is incomplete as he did not provide range of motion measurements for adduction, extension and internal and external rotation. Consequently, his report contains

[5] 20 C.F.R. § 10.404(a).

[6] *See* FECA Bulletin No. 01-5, issued January 29, 2001.

[7] *Claudio Vazquez*, 52 ECAB 496 (2001).

insufficient clinical findings to evaluate appellant's shoulder impairment.[8] The Office medical adviser based his rating on the clinical findings contained in Dr. Adelaar's report but did not mention the omissions in range of motion measurements. It appears, therefore, that the Office issued its February 22, 2006 decision denying appellant's claim for an increased schedule award without a sufficiently described clinical picture of appellant's right shoulder condition.[9]

Additionally, both Dr. Adelaar and the Office medical adviser found that appellant had a 10 percent impairment of the right upper extremity due to loss of grip strength and an impairment of the right upper extremity due to a loss of range of motion. The A.M.A., *Guides*, however, provides that decreased strength cannot be rated in the presence of decreased motion.[10] Dr. Adelaar additionally found a 10 percent impairment of appellant's left upper extremity due to loss of grip strength and a 5 percent impairment due to carpal tunnel syndrome. It is unclear from his report, however, whether Dr. Adelaar's attributed appellant's decreased grip strength to her accepted condition of epicondylitis on the left side, particular in view of his finding on physical examination that she had no evidence of epicondylitis. The A.M.A., *Guides* generally do not allow using loss of grip strength in cases of carpal tunnel syndrome.[11]

Proceedings under the Act are not adversarial in nature and the Office is not a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[12] In this case, the reports of both Dr. Adelaar and the Office medical adviser are based on an incomplete description of the impairment and are not consistent with the A.M.A., *Guides*. The case, therefore, will be remanded for the Office to refer appellant for a second opinion evaluation on the issue of the extent of her permanent impairment of the upper extremities.

[8] *Patricia J. Penney-Guzman*, 55 ECAB ___ (Docket No. 04-1052, issued September 30, 2004).

[9] In obtaining medical evidence required for a schedule award, the evaluation must include a "detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, deceases in strength or disturbance of sensation or any other pertinent description of the impairment." Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Cases*, Chapter 2.808.6.c (August 2002). This description must be sufficiently detailed so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations. *Renee M. Straubinger*, 51 ECAB 667, 669 (2000).

[10] A.M.A., *Guides* at 508.

[11] *Id*. at 494; *David D. Cumings*, 55 ECAB ___ (Docket No. 03-1804, issued January 22, 2004).

[12] *Claudio Vazquez*, *supra* note 7.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 22, 2006 is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: October 17, 2006
Washington, DC

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

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

James A. Haynes, Alternate Judge
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