United States Department of Labor
Employees' Compensation Appeals Board

M.V., Appellant	)	
and	)	**Docket No. 06-1230**
	)	**Issued: September 20, 2006**
DEPARTMENT OF HOMELAND SECURITY, IMMIGRATION & NATURALIZATION SERVICE, SHERIFF'S ACADEMY, El Paso, TX, Employer	)	

Appearances:
M.V., pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On May 9, 2006 appellant filed a timely appeal from an April 11, 2006 decision of the Office of Workers' Compensation Programs affirming a prior schedule award decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501(d)(3), the Board has jurisdiction over the merits of the claim.

ISSUE

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

FACTUAL HISTORY

The Office accepted that on May 10, 2002 appellant, then a 49-year-old senior special agent, sustained a left elbow sprain/strain and disorder of the bursae and tendons in the left shoulder when he slipped and fell during a training exercise. He was followed by Dr. James W.

Bean, an attending Board-certified orthopedic surgeon.[1] In a January 8, 2003 report, Dr. Bean diagnosed adhesive capsulitis and rotator cuff syndrome. On May 8, 2003 he performed arthroscopic decompression, distal clavicle excision and a superior bursal tendon repair of the left shoulder. Appellant returned to full duty on approximately October 15, 2003.

On September 25, 2003 appellant claimed a schedule award.

In an October 20, 2003 report, Dr. Bean opined that appellant had reached maximum medical improvement. According to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), appellant had a 13 percent impairment of the left upper extremity due to loss of elbow motion, including a 3 percent impairment due to restricted extension and a 1 percent impairment due to loss of flexion. Dr. Bean also found a 6 percent impairment of the left upper extremity due to crepitation in the shoulder and a 10 percent impairment of the left upper extremity due to the May 2003 resection arthroplasty. He combined the 13 and 10 percent impairments to equal a 22 percent impairment of the left upper extremity. Dr. Bean then added the 6 percent impairment for crepitation, to equal a 27 percent impairment of the upper extremity. He then added a 4 percent impairment for the left elbow, to total a 30 percent impairment of the left upper extremity.

On December 18, 2003 the Office referred a statement of accepted facts and the medical record to an Office medical adviser for a schedule award calculation. In a January 8, 2004 report, an Office medical adviser found that appellant had reached maximum medical improvement as of October 15, 2003. He opined that according to Table 16-27, page 506[2] of the A.M.A., *Guides*, appellant had a 10 percent impairment of the left upper extremity due to the resection arthroplasty. Regarding loss of motion of the left shoulder, the medical adviser found that according to Figures 16-40,[3] 16-43[4] and 16-46[5] at pages 476 to 479 of the A.M.A., *Guides*, appellant had a 3 percent impairment due to flexion limited to 130 degrees, a 1 percent impairment due to extension limited to 45 degrees, a 3 percent impairment due to abduction limited to 120 degrees, a 1 percent impairment due to adduction limited to 30 degrees, a 4 percent impairment due to internal rotation limited to 20 degrees and a 1 percent impairment due to external rotation limited to 45 degrees. He added the left shoulder range of motion impairments to equal a 13 percent upper extremity impairment. Regarding the left elbow, the medical adviser found a 1 percent upper extremity impairment due to flexion limited to 130

[1] An October 24, 2002 magnetic resonance imaging (MRI) scan showed osteophytic changes in the medial and lateral aspects of the left elbow. A December 17, 2002 MRI scan of the left shoulder showed a possible tear of the supraspinatus tendon and degenerative changes in the humeral head.

[2] Table 16-27, page 506 of the fifth edition of the A.M.A., *Guides* is entitled "Impairment of the Upper Extremity After Arthroplasty of Specific Bones or Joints."

[3] 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."

[4] 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."

[5] 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."

degrees and a 3 percent impairment due to extension limited to 30 degrees, according to Figure 16-34, page 472[6] and Figure 16-37, page 474.[7] He added the three and one percent impairments to equal a four percent impairment of the left elbow. Using the Combined Values Chart on page 604 of the A.M.A., *Guides*, the Office medical adviser found that the 10, 13 and 4 percent impairments equaled a 25 percent impairment of the left upper extremity. He noted that the fifth edition of the A.M.A., *Guides* did not "recognize crepitus as a cause for impairment."

By decision dated March 2, 2004, the Office granted appellant a schedule award for a 25 percent impairment of the left upper extremity.

In a May 3, 2005 letter, appellant asserted that his accepted left upper extremity conditions had worsened.[8] He submitted new medical evidence.[9]

In a January 14, 2005 report, Dr. Caryl S. Brailsford, an attending physician Board-certified in occupational medicine, noted appellant's complaints of left shoulder pain which he attributed to his post-surgical status. On examination of the left shoulder, she found 110 degrees flexion and 20 degrees abduction. She found a further reduction in left shoulder mobility in a June 3, 2005 examination. Dr. Brailsford obtained x-rays showing the left humeral head directly impinging on the distal acromion. She diagnosed severe degenerative joint disease of the left shoulder, status post rotator cuff repair and a probable recurrent rotator cuff tear requiring surgical consultation.[10] In a June 28, 2005 report, Dr. Brailsford noted the following ranges of left shoulder motion: flexion 130 degrees; extension 30 degrees; abduction 110 degrees; adduction 5 degrees; internal rotation 20 degrees; external rotation 30 degrees. In a December 20, 2005 report, she noted flexion reduced to 120 degrees. She did not provide any impairment assessment or rating in her treatment notes.

On January 10, 2006 the Office referred appellant, the medical record and a statement of accepted facts to Dr. Borislav Stojic, a Board-certified orthopedic surgeon, for a second opinion examination.

In a February 24, 2006 report, Dr. Stojic reviewed the medical record and statement of accepted facts. He noted that after a 2001 occupational left elbow injury, appellant underwent surgical excision of a bone spur and fully recovered. Dr. Stojic observed the following ranges of motion in the left shoulder: 160 degrees flexion; 50 degrees extension; 140 degrees abduction;

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[6] Figure 16-34, page 472 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 Elbow Joint."

[7] Figure 16-37, page 474 of the fifth edition of the A.M.A., *Guides* is entitled "Pie Chart of Upper Extremity Motion Impairments Due to Lack of Pronation and Supination."

[8] In April 2005, appellant relocated to Arizona.

[9] In a June 9, 2004 chart note, Dr. Bean noted left shoulder soreness.

[10] A June 22, 2005 MRI scan of the left shoulder demonstrated subacromial/subdeltoid bursitis and focal tendinopathy anterior to the supraspinatus.

40 degrees adduction; 60 degrees internal rotation; 60 degrees external rotation. He noted that there was no atrophy, weakness or instability in the left rotator cuff. The impingement, sulcus and O'Brien's signs were negative. Dr. Stojic also reported appellant's complaints of left shoulder pain in the posterior aspect. The left elbow had full range of motion with no weakness, atrophy or reported pain. Dr. Stojic found no neurologic deficits in the upper extremities. He diagnosed status post left shoulder surgery and rotator cuff repair and "[h]istory of sprain left elbow, removal of bone spur." Dr. Stojic opined that appellant had reached maximum medical improvement but did not perform a schedule award calculation.

On March 9, 2006 the Office referred the medical record to an Office medical adviser for calculation of a schedule award. In a March 18, 2006 report, an Office medical adviser reviewed the medical record and opined that appellant had reached maximum medical improvement as of February 24, 2006. Referring to the fifth edition of the A.M.A., *Guides*, the Office medical adviser found a one percent impairment of the left shoulder for diminished flexion according to Figure 16-40, page 476, an additional two percent impairment for limited abduction according to Figure 16-43, page 477 and a two percent impairment for diminished internal rotation according to Figure 16-46, page 479. The medical adviser added these impairments to equal a five percent upper extremity impairment for loss of motion. He opined that appellant had an additional 10 percent impairment of the left upper extremity for excision of the distal clavicle according to Table 16-27, page 506.[11] The medical adviser then used the Combined Values Chart to determine that a 5 percent impairment for loss of motion and 10 percent impairment for excision of the distal clavicle resulted in a 15 percent impairment of the left upper extremity. He noted that appellant had a full range of motion of the left elbow, without weakness, instability, atrophy or neurologic deficit. The medical adviser, therefore, opined that appellant had a zero percent impairment of the left elbow. He noted that his impairment at that time was less than the 25 percent impairment previously awarded, as appellant no longer had any impairment of the left elbow and the range of left shoulder motion had improved.

By decision dated April 11, 2006, the Office affirmed the March 2, 2004 decision awarding appellant a schedule award for a 25 percent impairment of the left upper extremity. The Office found that, based on Dr. Stojic's report as reviewed by the Office medical adviser, appellant did not have any increased impairment of the left upper extremity.

LEGAL PRECEDENT

The schedule award provisions of the Federal Employees' Compensation Act[12] 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

[11] Table 16-27, page 506 of the fifth edition of the A.M.A., *Guides* is entitled "Impairment of the Upper Extremity After Arthroplasty of Specific Bones or Joints." According to Table 16-27, resection arthroplasty of the distal clavicle equals a 10 percent impairment of the upper extremity.

[12] 5 U.S.C. §§ 8101-8193.

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.[13] As of February 1, 2001 schedule awards are calculated according to the fifth edition of the A.M.A., *Guides*, published in 2000.[14]

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).[15] 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.[16] 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."[17]

ANALYSIS

In this case, the Office accepted that appellant sustained a left elbow sprain/strain and a disorder of the tendons and bursae of the left shoulder in the performance of duty on May 10, 2002, necessitating an arthroscopic decompression, rotator cuff repair and resection of the distal clavicle. By decision dated March 2, 2004, the Office awarded appellant a schedule award for a 25 percent impairment of the left upper extremity related to the accepted left shoulder and elbow conditions. The Office predicated the award on an Office medical adviser's application of the A.M.A., *Guides* to the October 20, 2003 findings of Dr. Bean, an attending Board-certified orthopedic surgeon. Dr. Bean opined and the Office medical adviser concurred that appellant had a 10 percent impairment of the left upper extremity due to resection arthroplasty, a 13 percent impairment due to restricted left shoulder motion and a 4 percent impairment due to restricted left elbow motion. The Office medical adviser used the Combined Values Chart of the A.M.A., *Guides* to determine that the 10, 13 and 4 percent impairments equaled a 25 percent impairment of the left upper extremity. Appellant did not dispute Dr. Bean's findings or the Office medical adviser's application of the A.M.A., *Guides*. Rather, he asserted that he sustained an additional percentage of impairment, claiming an augmented schedule award on May 3, 2005.

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

[14] *See* FECA Bulletin No. 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*).

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

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

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

To determine if appellant's accepted left shoulder and elbow conditions had deteriorated such that he warranted an additional schedule award, the Office referred him to Dr. Stojic, a Board-certified orthopedic surgeon, for a second opinion examination. He submitted a detailed February 24, 2006 report finding, restricted left shoulder motion. Dr. Stojic found no impairment of appellant's left elbow. In a March 18, 2006 report, an Office medical adviser applied the appropriate tables and grading schemes of the fifth edition of the A.M.A., *Guides* to Dr. Stojic's findings. Using Figures 16-40, 16-43 and 16-46, he found a five percent impairment due to restricted left shoulder motion. Dr. Stojic also found a 10 percent impairment due to resection of the distal clavicle according to Table 16-27. The Office medical adviser then combined the impairments to equal a 15 percent impairment of the left upper extremity. Therefore, by April 11, 2006 decision, the Office denied modification of the March 2, 2004 schedule award as Dr. Stojic's findings, as interpreted by the Office medical adviser, showed a lesser percentage of impairment than the 25 percent previously awarded.

The Board finds that the Office medical adviser properly applied the appropriate tables and grading schemes of the A.M.A., *Guides* to Dr. Stojic's findings and performed a correct schedule award calculation. The Office medical adviser found a 15 percent impairment of the left upper extremity, less than the 25 percent previously awarded. Therefore, appellant has received the correct amount of schedule award compensation in the present case.[18]

CONCLUSION

The Board finds that appellant has not established that he sustained greater than a 25 percent impairment of the left upper extremity as the medical evidence submitted subsequent to the March 2, 2004 schedule award demonstrates lesser percentages of impairment.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Worker's Compensation Programs dated April 11, 2006 is affirmed.

Issued: September 20, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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