United States Department of Labor
Employees' Compensation Appeals Board

G.W., Appellant	)	
and	)	**Docket No. 10-870**
	)	**Issued: December 21, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Hendersonville, NC, Employer	)	

Appearances:
Freddie E. Watkins, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 17, 2010 appellant filed a timely appeal from a November 23, 2009 merit decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met her burden of proof to establish that she is entitled to a schedule award for the right upper extremity greater than the 27 percent awarded.

On appeal appellant's representative asserts that the opinion of the referee physician is insufficient to carry the weight of the medical evidence since the Office did not provide a correct statement of accepted facts as it did not include that appellant was on total disability in 2004 and did not return to limited duty until 2005; that he was not informed of the correct edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[1] to be used in calculating a schedule award; and that he did not include the

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

scapula or preexisting osteoarthritis of the hand in his calculation. Appellant further asserted that, in calculating the schedule award, the Office erred by not including preexisting conditions or a strength calculation under Table 16-35 of the A.M.A., *Guides*; and that her claim should be expanded.

FACTUAL HISTORY

On September 17, 2002 appellant, then a 55-year-old rural carrier, filed an occupational disease claim, alleging that her postal duties caused calcific tendinitis. She had stopped work on September 13, 2002. On October 30, 2002 Dr. R.C. Estes, a Board-certified orthopedic surgeon, performed diagnostic arthroscopy with limited debridement with anterior subacromial decompression, and distal clavical resection and excision of a calcific deposit with rotator cuff repair. The Office accepted that appellant sustained employment-related tendinitis of the right shoulder on November 7, 2002,[2] and Dr. Ethan R. Wiesler, Board-certified in orthopedic surgery, performed a second arthroscopic procedure with right subacromial bursectomy and distal clavicle resection on October 28, 2003. Appellant received appropriate compensation and returned to part-time modified duty on November 17, 2003 and to full-time modified duty on December 15, 2003.

By decision dated May 24, 2005, the Office found that appellant's actual earnings as a modified rural carrier fairly and reasonably represented her wage-earning capacity and reduced her compensation accordingly. On April 11, 2007 appellant filed a recurrence claim, alleging that on April 2, 2007 she stopped work due to shoulder pain and scapular dyskinesis. In a June 19, 2007 decision, the Office denied her recurrence claim.[3]

On December 26, 2007 appellant filed a schedule award claim, and submitted a December 10, 2007 report in which Dr. Erik C. Johnson, a Board-certified orthopedist, noted right shoulder physical examination findings of forward flexion to 40, abduction of 60, external rotation of 60, and internal rotation of 20. She had positive impingements signs and diffuse tenderness through the shoulder region with a 50 percent strength deficit in forward flexion and abduction. Dr. Johnson diagnosed status post multiple right shoulder surgeries with adhesive capsulitis and secondary periscapular winging and advised that appellant had reached maximum medical improvement and that she could perform no work duties with the right upper extremity. He stated that, under the fifth edition of the A.M.A., *Guides*, appellant had 10 percent impairment for a distal clavicle resection, a total 20 percent impairment for diminished flexion, abduction and internal rotation, and 18 percent strength deficit impairment, for a total 48 percent impairment of the right upper extremity.

In a January 4, 2008 report, an Office medical adviser reviewed the medical evidence including Dr. Johnson's report. He advised that maximum medical improvement was reached on December 10, 2007 and found that appellant was entitled to a 27 percent impairment rating based

[2] The record also indicates that the accepted condition is disorder of bursae and tendons in the shoulder region, right.

[3] Appellant did not appeal either the May 24, 2005 loss of wage-earning capacity decision or the June 19, 2007 decision denying her recurrence claim.

on loss of motion and resection arthroplasty with distal clavicle excision. The Office medical adviser noted that the A.M.A., *Guides* precluded a rating for decreased strength in the presence of decreased motion, painful conditions or deformities.

By decision dated February 20, 2008, appellant was granted a schedule award for 27 percent loss of use of the right arm, for a total of 82.24 weeks, to run from December 10, 2007 to July 21, 2009.[4] She retired on disability effective May 28, 2008. On July 2, 2008 appellant requested reconsideration arguing that an incorrect schedule award pay rate was used and that a conflict in medical evidence had been created between the opinions of Dr. Johnson and the Office medical adviser. In an August 11, 2008 report, Dr. Jonathan D. Sherman, a Board-certified neurosurgeon, noted appellant's complaint of right shoulder pain radiating to her mid-biceps and winging of the right scapula. He provided neurological examination findings, noting a normal sensory examination and advised that he could not determine strength in appellant's right upper extremity due to significant pain. Dr. Sherman stated that he had nothing to offer appellant from a neurosurgical standpoint to treat her pain and recommended that she follow-up with her primary care provider. Appellant also submitted copies of the Office's procedure manual, Board decisions, and unsigned and unidentified medical reports.

The Office determined that a conflict in medical evidence had been created between the opinion of Dr. Johnson and the Office medical adviser, and on September 12, 2008 referred appellant, along with a statement of accepted facts, a set of questions, and the medical record, to Dr. George C. Green, a Board-certified orthopedic surgeon, for an impartial evaluation. The Office asked that he provide an impairment rating in accordance with the fifth edition of the A.M.A., *Guides*.

In an October 6, 2008 report, Dr. Green noted the history of injury, appellant's complaint of right shoulder limited motion and pain, and his review of the medical record. He provided physical examination findings including asymmetry in the right shoulder when compared to the left and mild winging of the right scapula with 10/10 tenderness to palpation of the anterior shoulder and parascapular region. Dr. Green provided right shoulder range of motion findings of 50/60 forward elevation, 40/40 extension, 60/65 abduction, 10/10 adduction, 85/85 external rotation and 10/10 internal rotation. Sensory examination of the right upper extremity demonstrated a slight decrease in sensation to light touch over the lateral brachial arm and volar aspect of the ring and middle fingers with a negative Tinel's sign over the carpal tunnel and no evidence of muscle atrophy in the hand. Dr. Green advised that rotator cuff muscle strength was difficult to complete due to appellant's subjective complaints of pain. He advised that, in accordance with the fifth edition of the A.M.A., *Guides*, under Figure 16-40, flexion of 50 degrees yielded 9 percent impairment, and extension of 40 degrees yielded 1 percent impairment rating; that, under Figure 16-43, abduction of 40 degrees yielded 6 percent impairment, and adduction of 10 degrees yielded 1 percent impairment; and that, under Figure 16-46, external rotation of 85 degrees yielded no impairment, and internal rotation of 65 degrees yielded 2 percent impairment, for a total 19 percent impairment of the right upper extremity based on loss of range of motion. Dr. Green also determined that, because appellant had undergone a

[4] An initial schedule award dated February 20, 2008 stated that appellant was granted a schedule award for "27 percent for loss of right arm." A corrected version, also dated February 20, 2008, stated that the award was "27 percent for loss in right arm."

resection arthroplasty of the distal clavicle, under Table 16-27, she was entitled to 10 percent impairment. He then utilized the Combined Values Chart and found that the 19 percent impairment for loss of range of motion, when combined (using the Combined Values Chart) with then 10 percent impairment for resection arthroplasty, resulted in a total 27 percent right upper extremity impairment. Dr. Green further noted that an additional impairment rating was not granted for loss of strength because, as described in the A.M.A., *Guides*, impairment ratings should be based, for the most part, on anatomic impairment, because strength testing is influenced by subjective factors, and that decreased strength could not be rated in the presence of decreased motion, painful conditions, deformity or absence of parts that prevent effective application of maximal force in the region being evaluated.

By report dated October 23, 2008, an Office medical adviser reviewed Dr. Green's report and advised that he had correctly applied the A.M.A., *Guides*, finding that appellant had a 27 percent impairment of the right upper extremity. In an October 29, 2008 decision, the Office denied modification of the February 20, 2008 decision, finding that the proper pay rate had been used for schedule award compensation purposes and that Dr. Green's report constituted the weight of the medical evidence.

On September 25, 2009 appellant requested reconsideration, arguing that the schedule award pay rate was incorrect, that the statement of accepted facts was incorrect because it did not state that she was on total disability beginning in January 2004 and did not return to full duty until 2005, that the claimed recurrence of disability in 2007 was improperly denied, that Dr. Green was not informed that the fifth edition of the A.M.A., *Guides* should be used, and that his report was insufficient to carry the weight of the medical evidence because he did not give an impairment rating for carpal tunnel syndrome, scapular winging and osteoarthritis of the hands. She submitted treatment notes from Dr. Paul Walker, Board-certified in family medicine, dated from January 25, 1996 to May 29, 2007. On January 25, 1996 Dr. Walker advised that appellant had osteoarthritis of the hands, and in 2000 diagnosed myofascial pain and generalized fibromyalgia. He also diagnosed sinusitis, bronchitis, restless leg syndrome, chronic pain syndrome, urinary tract infections, gastroesophageal reflux disease, and right shoulder bursitis and tendinitis. In a November 18, 2008 report, Dr. Johnson diagnosed right shoulder adhesive capsulitis with secondary scapular winging. He advised that appellant's physical examination was unchanged, that work-related injuries had not resolved and were permanent and irreversible, and that she was disabled from all work using her right upper extremity. An October 3, 2007 magnetic resonance imaging (MRI) scan of the cervical spine demonstrated degenerative disc disease at C3-4 and C4-5, diffuse bulging at C5-6 and mild bulging at C6-7. Appellant also submitted notes from an occupational therapist dated February 27 to March 13, 2003, unsigned and unidentified progress notes, a right lower extremity ultrasound report dated December 7, 2005 and duplicates of evidence previously of record.[5]

[5] The duplicate evidence consisted of a January 27, 2003 report from Dr. Kenneth Shauger, a Board-certified neurologist, reports dated February 17 to March 13, 2003 from Dr. Margaret O. Burke, a Board-certified physiatrist, a February 3, 2003 electrodiagnostic study of the right upper extremity that demonstrated no evidence of a brachial plexus lesion and mild carpal tunnel syndrome, a March 4, 2003 right brachial plexus MRI scan that was normal, and an April 5, 2007 MRI scan of the right shoulder that was interpreted as compatible with tendinosis with respect to the rotator cuff tendon with no evidence of tear and findings compatible with postsurgical changes and/or trauma involving the region of the acromioclavicular joint.

By decision dated November 23, 2009, the Office denied modification of the prior decisions. It noted that appellant submitted no new argument with regard to the pay rate issue, and did not submit new medical evidence addressing a permanent impairment. The Office concluded that Dr. Green properly reviewed the evidence and determined appellant's impairment in accordance with the A.M.A., *Guides*.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[6] and its implementing federal regulations,[7] set 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* as the uniform standard applicable to all claimants.[8] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9] For decisions issued after May 1, 2009, the sixth edition will be used.[10]

The Act identifies members such as the arm, leg, hand, foot, thumb and finger; functions such as loss of hearing and loss of vision and organs to include the eye. Section 8107(c)(22) of the Act provides for the payment of compensation for permanent loss of any other important external or internal organ of the body as determined by the Secretary of Labor who has made such a determination and pursuant to the authority granted in section 8107(c)(22), added the breast, kidney, larynx, lung, penis, testicle, tongue, ovary, uterus/cervix and vulva/vagina to the schedule.[11]

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[12] Before the A.M.A., *Guides*, can be utilized, a description of impairment must be obtained from the claimant's physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[10] FECA Bulletin No. 09-03 (issued March 15, 2009).

[11] 5 U.S.C. § 8107; *J.W.*, 59 ECAB 308 (2008).

[12] *Tammy L. Meehan*, 53 ECAB 229 (2001).

impairment with its resulting restrictions and limitations.[13] Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment.[14]

Section 8123(a) of the Act provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[15] When the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[16]

ANALYSIS

At the time the Office issued the February 20, 2008 schedule award, the fifth edition of the A.M.A., *Guides* was in effect.[17] The Board finds that appellant did not meet her burden of proof to establish that she is entitled to a schedule award for the right upper extremity greater than the 27 percent awarded.

Regarding her argument on appeal that Dr. Green, the referee physician, was not provided a correct statement of accepted facts because it did not advise him that appellant was on total disability in 2004 and did not return to limited duty until 2005, a search of the record does not show that appellant filed a claim for disability compensation during that period.[18] Appellant also asserted that the Office failed to inform Dr. Green that the fifth edition of the A.M.A., *Guides* was to be used in rating her impairment. The record, however, indicates that Dr. Green was provided a set of questions that clearly informed him the fifth edition was to be used. Appellant argues that Dr. Green did not consider preexisting arthritis of the hands. It is appellant's burden, however, to establish that he or she sustained a permanent impairment to a scheduled member.[19] It is well established that preexisting impairments to a scheduled member are to be included when determining entitlement to a schedule award,[20] and in this case, Dr. Walker mentioned that appellant had osteoarthritis of the hands in a brief treatment note in 1996. This report was submitted after Dr. Green's examination, and neither Dr. Walker nor

[13] *Patricia J. Penney-Guzman*, 55 ECAB 757 (2004).

[14] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002); *see J.P.*, 60 ECAB ___ (Docket No. 08-832, issued November 13, 2008).

[15] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[16] *Manuel Gill*, 52 ECAB 282 (2001).

[17] *Supra* note 9.

[18] The record indicates that, after a claim for compensation for the period November 17 through 28, 2003, appellant did not file a claim for compensation until April 11, 2007 when she filed a recurrence claim, that was denied by decision dated June 19, 2007.

[19] *A.L.*, 60 ECAB ___ (Docket No. 08-1730, issued March 16, 2009).

[20] *Carol A. Smart*, 57 ECAB 340 (2006).

Dr. Johnson provided an impairment rating for the hands, that is listed as a separate scheduled member.[21] There is therefore no probative evidence to establish entitlement to an additional schedule award for a preexisting impairment of the hands. Regarding the scapular winging diagnosis, there is no specific section of the A.M.A., *Guides* describing a scapular impairment on its own. As discussed below, Dr. Green carefully examined appellant's entire right upper extremity and provided a proper analysis in accordance with Chapter 16 of the A.M.A., *Guides* in reaching his conclusion that appellant had 27 percent right upper extremity impairment. The Board thus concludes that these arguments on appeal are without merit.

In his comprehensive October 6, 2008 report, Dr. Green noted his review of the record and provided physical examination findings. He advised that, in accordance with the fifth edition of the A.M.A., *Guides*, under Figure 16-40, flexion of 50 degrees yielded 9 percent impairment, and extension of 40 degrees yielded 1 percent impairment rating;[22] that, under Figure 16-43, abduction of 40 degrees yielded 6 percent impairment, and adduction of 10 degrees yielded 1 percent impairment;[23] and that, under Figure 16-46, external rotation of 85 degrees yielded no impairment, and internal rotation of 65 degrees yielded 2 percent impairment,[24] for a total 19 percent impairment of the right upper extremity based on loss of range of motion. Dr. Green also determined that, because appellant had undergone a resection arthroplasty of the distal clavicle, under Table 16-27, she was entitled to 10 percent impairment.[25] He then utilized the Combined Values Chart and found that the 19 percent impairment for loss of range of motion, when combined with then 10 percent impairment for resection arthroplasty, resulted in a total 27 percent right upper extremity impairment.[26]

Dr. Johnson also properly found that an additional impairment rating was not granted for loss of strength because, as described in the A.M.A., *Guides*, impairment ratings should be based, for the most part, on anatomic impairment, because strength testing is influenced by subjective factors, and that decreased strength could not be rated in the presence of decreased motion, painful conditions, deformity or absence of parts that prevent effective application of maximal force in the region being evaluated. While he assigned as 18 percent impairment for strength deficit, the A.M.A., *Guides* does not encourage the use of strength as an impairment rating because strength measurements are functional tests influenced by subjective factors that are difficult to control and the A.M.A., *Guides* for the most part is based on anatomic impairment. Thus, the A.M.A., *Guides* does not assign a large role to such measurements. Only in rare cases should strength be used, and only when it represents an impairing factor that has not been otherwise considered adequately.[27] Dr. Johnson provided no explanation as to why he

[21] 5 U.S.C. § 8107(c)(1), (3).

[22] A.M.A., *Guides supra* note 1 at 476.

[23] *Id*. at 477.

[24] *Id*. at 479.

[25] *Id*. at 506.

[26] *Id*. at 604.

[27] *Mary L. Henninger*, 52 ECAB 408 (2001).

assigned 18 percent impairment for strength deficit. Thus, without any explanation or rationale, his impairment rating based on abnormal strength is of diminished probative value and is insufficient to establish an increased schedule award.[28]

With her September 25, 2009 reconsideration request, appellant submitted additional medical evidence. None of the reports, however, included an impairment evaluation and were thus insufficient to establish a new conflict in medical evidence. The Board therefore concludes that the Office properly found that the weight of the medical evidence rested with the opinion of Dr. Green, the referee physician, who correctly determined, in accordance with the fifth edition of the A.M.A., *Guides*, that appellant had 27 percent right upper extremity impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she is entitled to a schedule award for her right upper extremity greater than the 27 percent awarded.

ORDER

IT IS HEREBY ORDERED THAT the November 23, 2009 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: December 21, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[28] *James R. Taylor*, 56 ECAB 537 (2005).