United States Department of Labor
Employees' Compensation Appeals Board

M.H., Appellant	)	
and	)	**Docket No. 09-1888**
	)	**Issued: July 6, 2010**
SOCIAL SECURITY ADMINISTRATION, Baltimore, MD, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 17, 2009 appellant filed a timely appeal from an April 24, 2009 decision of the Office of Workers' Compensation Programs regarding a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(e), the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant sustained more than a 22 percent impairment of the right upper extremity, for which she received a schedule award.

On appeal, appellant asserts that the Office issued the schedule award prematurely. The Office made the first payment in December 2006 although she did not reach maximum medical improvement until January 21, 2009.

FACTUAL HISTORY

The Office accepted that on November 2, 2004 appellant, then a 47-year-old benefits authorizer, opened a heavy door and sustained lumbar, thoracic, chest wall, right arm and shoulder sprains, subacromial and acromioclavicular joint impingement of the right shoulder and a right

rotator cuff tear. It later accepted the claim for a recurrence of T10-11 radiculitis[1] and aggravation of preexisting asthma.[2] Appellant underwent fiber optic bronchoscopy on November 10, 2004. She was off work through December 2004, then returned to light duty. Appellant stopped work again in January 2006.

On February 20, 2006 Dr. Ronald B. Delanois, an attending Board-certified orthopedic surgeon, performed a right rotator cuff repair with subacromial decompression, distal clavicle excision and SLAP (superior labrum anterior-posterior) lesion debridement and repair. Following a four-week physical therapy program, appellant returned to full duty on March 20, 2006.

On May 24, 2006 appellant claimed a schedule award. The Office advised her to submit an impairment rating from her attending physician in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*). In a November 15, 2006 report, Dr. Delanois noted that her postsurgical functioning had not improved despite physical therapy. A magnetic resonance imaging (MRI) scan of the right shoulder showed supraspinatus tendinopathy in the rotator cuff region and a partial thickness rotator cuff tear consistent with the surgical reconstruction. Dr. Delanois found forward flexion of the right shoulder limited to 80 degrees, abduction at 60 degrees, limited internal rotation, external rotation at 20 degrees, 4/5 strength and 3/5 of the supraspinatus with pain, abduction strength 4/5. He opined that appellant had a 70 to 80 percent impairment of the right upper extremity. Dr. Delanois proscribed lifting, overhead activities and significant pulling or pushing with the right arm. He instructed appellant to report for a follow-up appointment in three months.

The Office requested that an Office medical adviser review the medical record and provide an impairment rating. In a November 29, 2006 report, an Office medical adviser opined that appellant attained maximum medical improvement as of November 15, 2006. According to Table 16-27, page 506 of the fifth edition of the A.M.A., *Guides*,[3] appellant had a 10 percent impairment of the right upper extremity due to distal clavicle resection. The Office medical adviser noted additional impairments of the right upper extremity, as follows: seven percent impairment due to flexion limited to 80 degrees according to Figure 16-40, page 476;[4] six percent due to abduction limited to 60 degrees according to Figure 16-43, page 477;[5] one percent

[1] On May 6, 2002, appellant underwent excision of spinal mass from T9 to T12 with spinal cord compression.

[2] By decision dated April 17, 2008, the Office denied a schedule award for asthma as the medical evidence did not support an occupationally related lung impairment. The April 17, 2008 decision is not before the Board on the present appeal as it was not issued within 180 days of July 17, 2009, the date appellant filed her appeal with the Board. 20 C.F.R. §§ 501.2(c) and 501.3.

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

[4] 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."

[5] 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."

due to external rotation limited to 20 degrees according to Figure 16-46, page 479.[6] The Office medical adviser used the Combined Values Chart on page 604 of the A.M.A., *Guides* to combine the 10 and 7 percent impairments to equal 16. He then combined the 16 percent impairment with the 6 percent impairment to equal 21. Finally, he combined the 21 percent impairment with the 1 percent impairment to equal a total 22 percent impairment of the right upper extremity.

On December 12, 2006 the Office found a 22 percent upper extremity impairment that entitled appellant to 68.64 weeks of compensation for the period November 15, 2006 to March 9, 2008. Payments began on December 21, 2006.

In January 4 and 19, 2007 letters, appellant requested that the Office issue the remainder of the award as a lump sum. On February 22, 2007 the Office issued appellant a lump-sum payment of $34,693.20. In a May 3, 2007 telephone memorandum, it noted that it had not yet issued a formal schedule award decision.

By decision dated May 4, 2007, the Office granted a schedule award for a 22 percent permanent impairment of the right upper extremity.

In a January 7, 2008 letter, appellant requested reconsideration. She asserted that she had not reached maximum medical improvement. Appellant contended that the Office erroneously issued schedule award payments prior to the February 2006 surgery.

In a February 1, 2006 report, Dr. Delanois diagnosed right rotator cuff arthropathy versus a retear. He did "not feel that she ha[d] reached maximum medical improvement." Dr. Delanois newly diagnosed right lateral epicondylitis on February 7, 2007 and administered periodic injections. In a May 2, 2007 report, he related appellant's complaints of right shoulder pain radiating into her neck and right arm. Dr. Delanois administered an injection to the right shoulder and ordered updated tests to assess the need for additional surgery.

By decision dated May 1, 2008, the Office denied modification of the May 4, 2007 schedule award decision. It found that the additional reports from Dr. Delanois were insufficient to establish a greater percentage of permanent impairment than the 22 percent awarded.

In a February 17, 2009 letter, appellant requested reconsideration. She contended that the Office misled her into accepting a lump-sum payment by failing to issue a schedule award decision until nearly one year after the first payment was issued. Appellant argued that the Office improperly issued the schedule award in January 2006 as she did not have surgery until February 2006. Also, Dr. Delanois did not find that appellant attained maximum medical improvement until January 21, 2009. Appellant submitted a January 21, 2009 report from Dr. Delanois finding improved ranges of right shoulder motion, as follows: 135 degrees forward flexion; 95 degrees abduction; 70 degrees external rotation; internal rotation to L4. Her pain symptoms had resolved. Dr. Delanois opined that appellant had reached maximum medical improvement and released her to activities as tolerated.

[6] 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."

In an April 19, 2009 report, an Office medical adviser reviewed the findings of Dr. Delanois. He noted that, according to Figure 16-40, appellant had a three percent impairment of the right upper extremity due to flexion limited to 135 degrees and a four percent impairment due to shoulder abduction limited to 90 degrees. All other ranges of motion were within normal limits. The medical adviser found a 7 percent right upper extremity impairment due to restricted shoulder motion and a 10 percent impairment due to distal clavicle resection. He used the Combined Values Chart to combine the 10 and 7 percent impairments to total 16 percent, less than the 22 percent previously awarded. The medical adviser opined that appellant had reached maximum medical improvement as of November 15, 2006.

By decision dated April 24, 2009, the Office denied modification of the May 1, 2008 decision. It found that Dr. Delanois' January 21, 2009 report established a 16 percent right upper extremity impairment, less than the 22 percent previously awarded. The Office noted that, although it did not issue a formal schedule award decision until after the first payment was issued, this was to appellant's advantage as it extended the time to exercise her appeal rights.

LEGAL PRECEDENT

The schedule award provisions of the Federal Employees' Compensation Act[7] 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.[8]

It is well established that the period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the employment injury. The Board has defined maximum medical improvement as meaning that the physical condition of the injured member of the body has stabilized and will not improve further. The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[9]

Office procedures provide that maximum medical improvement must be reached before a schedule award is made.[10] After obtaining all necessary medical evidence, the file should be

[7] 5 U.S.C. §§ 8101-8193.

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

[9] *Mark A. Holloway*, 55 ECAB 321, 325 (2004).

[10] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3(a)(1) (October 1990).

routed to the Office medical adviser for a rationalized opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*.[11]

The standards for evaluation the permanent impairment of an extremity under the A.M.A., *Guides* are based on loss of range of motion, together with all factors that prevent a limb from functioning normally, such as pain, sensory deficit and loss of strength. All of the factors should be considered together in evaluating the degree of permanent impairment.[12] Chapter 16 of the fifth edition of the A.M.A., *Guides* provides a detailed grading scheme and procedures for determining impairments of the upper extremities due to pain, discomfort, loss of sensation or loss of strength.[13]

ANALYSIS

The Office accepted that appellant sustained lumbar, thoracic, chest wall, right arm and shoulder sprains, right shoulder impingement, a right rotator cuff tear, a recurrence of T10-11 radiculitis and aggravation of preexisting asthma. Appellant underwent a right rotator cuff repair, SLAP lesion repair and distal clavicle excision on February 20, 2006. By decision dated May 4, 2007, the Office granted appellant a schedule award for a 22 percent permanent impairment of the right upper extremity. It based the award on an Office medical adviser's application of the fifth edition of the A.M.A., *Guides* to the November 15, 2006 findings of Dr. Delanois, an attending Board-certified orthopedic surgeon.

The Office medical adviser opined that appellant reached maximum medical improvement as of Dr. Delanois' November 15, 2006 impairment rating. He rated a 10 percent right upper extremity impairment for distal clavicle resection according to Table 16-27 of the A.M.A., *Guides*, a 7 percent impairment due to limited flexion according to Figure 16-40, a 6 percent impairment due to limited abduction according to Figure 16-43, and a 1 percent impairment due to limited external rotation according to Figure 16-46. The Office medical adviser combined these impairments using the chart on page 604, totaling a 22 percent impairment of the right upper extremity. The Board finds that the Office medical adviser properly applied the appropriate portions of the A.M.A., *Guides* and made accurate calculations.

The Office denied modification on May 1, 2008 as the medical evidence supporting appellant's January 7, 2008 reconsideration request did not establish an increased percentage of impairment. Appellant again requested reconsideration on February 17, 2009, contending that the Office erred by issuing the December 2006 schedule award payments before she had reached maximum medical improvement. She provided a January 21, 2009 report from Dr. Delanois finding improved right shoulder motion. Dr. Delanois commented that appellant had then reached "maximum medical improvement." An Office medical adviser reviewed the findings of Dr. Delanois on April 19, 2009, again opining that appellant reached maximum medical improvement as of November 15, 2006. He assessed three percent impairment due to limited

[11] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[12] *See Paul A. Toms*, 28 ECAB 403 (1987).

[13] A.M.A., *Guides* (5th ed. 2001) 433-521, Chapter 16, "The Upper Extremities."

shoulder flexion and four percent impairment for limited abduction. Combined with the 10 percent impairment for distal clavicle resection, appellant had a 16 percent upper extremity impairment. In an April 24, 2009 decision, the Office denied modification of the May 4, 2007 schedule award as the medical evidence did not demonstrate an increased impairment beyond the 22 percent previously awarded. Therefore, appellant has received the correct amount of schedule award compensation.[14]

On appeal, appellant does not dispute Dr. Delanois' findings or the Office medical adviser's application of the A.M.A., *Guides*. Rather, she asserts that the Office erred by beginning schedule award payments in December 2006 before she reached maximum medical improvement in January 2009. The Board finds that the medical evidence supports that appellant attained maximum medical improvement as of November 15, 2006, the date of Dr. Delanois' impairment assessment.

The Office medical adviser found that appellant reached maximum medical improvement on November 15, 2006, the date of the examination by Dr. Delanois. On November 15, 2006 Dr. Delanois opined that her condition had not improved more than six months after the February 20, 2006 surgery despite physical therapy. He provided an impairment rating and activity restrictions. Although Dr. Delanois noted in a January 21, 2009 report that appellant had reached maximum medical improvement that day, this is not sufficient to supersede his previous opinion. The A.M.A., *Guides* explains that while "[m]aximum medical improvement [MMI] refers to a date from which further recovery or deterioration is not anticipated … over time there may be some expected change."[15] The eventual improvement in appellant's range of motion appears to be an "expected change" as contemplated by the A.M.A., *Guides*. Such a change does not supersede the finding that she had reached maximum medical improvement from her employment injuries as of November 15, 2006. Therefore the issuance of schedule award payments beginning on December 21, 2006, after appellant reached maximum medical improvement, was not premature.

CONCLUSION

The Board finds that appellant has not established that she sustained more than a 22 percent impairment of the right upper extremity as the medical evidence submitted subsequent to the May 4, 2007 schedule award demonstrates lesser percentages of impairment.

[14] *See Linda R. Sherman*, 56 ECAB 127 (2004).

[15] A.M.A., *Guides* at paragraph 2.4, page 19, entitled "When Are Impairment Ratings Performed?"; *Patricia J. Penney-Guzman*, 55 ECAB 757 (2004).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 24, 2009 is affirmed.

Issued: July 6, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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