United States Department of Labor
Employees' Compensation Appeals Board

C.R., Appellant	)	
and	)	**Docket No. 09-2273**
	)	**Issued: June 17, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Montrose, CO, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 14, 2009 appellant filed a timely appeal from an April 10, 2009 decision of the Office of Workers' Compensation Programs concerning a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUE

The issue is whether appellant has established greater than 15 percent impairment of her right upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On October 24, 2007 appellant, then a 47-year-old clerk, filed an occupational disease claim (Form CA-2) for a rotator cuff tear. She indicated that lifting parcels above her shoulders caused her condition. The Office accepted the claim for impingement of the right shoulder and right rotator cuff tear. On December 21, 2007 appellant underwent right shoulder cuff repair, subacromial debridement, and biceps tendonesis, which the Office authorized. She returned to work with restrictions on January 31, 2008 but stopped work July 25, 2008 to undergo an

authorized open distal claviculectomy performed by Dr. Vineet Singh, a Board-certified orthopedic surgeon. Appellant was released to limited-duty work with restrictions on September 11, 2008. On January 6, 2009 she underwent a functional capacity evaluation that was ordered by Dr. Singh.[1] On February 10, 2009 Dr. Singh opined that appellant had reached maximum medical improvement and released her to modified work. The Office paid appropriate compensation benefits.

In a January 28, 2009 report, Dr. Glen E. Oren, a Board-certified orthopedic surgeon and associate of Dr. Singh, noted the history of injury and appellant's medical treatment thereafter. He noted his examination findings, which included well-healed arthroscopy portal site scars from which appellant was nontender on palpation and from which she had palpation contraction function in her posterior, middle and anterior right deltoid. No trapezial, paracervical or parascapular muscle spasm was appreciated. Dr. Oren reviewed appellant's restricted duty request and opined, once maximum medical impairment status was declared, appellant was capable of restricted duty, as outlined in her restricted-duty request, for eight hours a day.

On March 5, 2009 appellant filed a claim for a schedule award. She submitted a March 3, 2009 report, from Dr. Ellen W. Price, an osteopath Board-certified in physiatry. Dr. Price noted the history of injury, presented her physical examination findings from February 20, 2009 and assessed mild to moderate subluxation with synovial hypertrophy. She opined that appellant was at maximum medical improvement. Dr. Price noted appellant's elbow had 140 degree elbow flexion, 0 degree extension and 90 degrees supination and pronation. Shoulder flexion was 125 degrees, extension 20 degrees, abduction 150 degrees, adduction 30 degrees, internal rotation 60 degrees, external rotation 60 degrees. Dr. Price noted that appellant had evidence of mild to moderate crepitus and some mild to moderate instability while doing range of motion. Under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), she opined that appellant had 20 percent right upper extremity impairment. Dr. Price advised that appellant had nine percent range of motion impairment for the shoulder. She also advised that appellant had impairment of the glenohumeral joint secondary to multiple surgeries and synovial hypertrophy. Under Table 16-18 of the A.M.A., *Guides*, Dr. Price noted that the maximum glenohumeral impairment equated to 60 percent impairment of the upper extremity and, under Table 16-19 of the A.M.A., *Guides*, she found that appellant had a moderate or 20 percent joint impairment from the synovial hypertrophy. She multiplied the 60 percent impairment due to impairment of the glenohumeral joint by the 20 percent impairment to find 12 percent impairment of the glenohumeral joint. Dr. Price then combined the range of motion impairment of 9 percent with the glenohumeral joint impairment of 12 percent to find 20 percent right upper extremity impairment.

On April 3, 2009 an Office medical adviser reviewed the medical evidence of record. He opined that appellant reached maximum medical improvement on January 6, 2009, the date the functional capacity evaluation was performed. The medical adviser opined that appellant had 15 percent right arm impairment. He advised this was for loss of right shoulder range of motion and for undergoing a distal clavulectomy. The medical adviser disagreed with Dr. Price's rating for

[1] The functional capacity evaluation noted right arm active motion of 150 degrees of flexion, 85 degrees of external rotation, 65 degrees of internal rotation and 140 degrees of abduction.

synovial hypertrophy. He advised that, under Table 16-19, page 500 of the A.M.A., *Guides*, there must be a visibly apparent or palpatory evidence of synovial hypertrophy. The medical adviser noted that Dr. Price did not document what findings were present for synovial hypertrophy in the physical examination portion of her report. He noted that Dr. Oren had evaluated appellant one month earlier and indicated that appellant's scars had healed and there was no pain with palpation. Dr. Oren did not mention a finding of synovial hypertrophy. Thus, the Office medical adviser did not recommend a rating for synovial hypertrophy as the record did not support either visual or palpatory evidence of the condition as required under Table 16-19. Furthermore, he noted that Dr. Price had combined impairments for loss of range of motion with synovial hypertrophy which is not allowed under page 500 of the A.M.A., *Guides.*

The Office medical adviser noted that appellant underwent a distal clavicle resection and, under Table 16-27, page 506 of the A.M.A., *Guides*, she was eligible for 10 percent upper extremity impairment. He then stated that, under pages 475, 476 and 478 of the A.M.A., *Guides*, the "maximum active" shoulder motion taken by a goniometer must be used to rate impairment. The medical adviser noted the greatest shoulder range of motion was found during the functional capacity evaluation and used those values to rate appellant's impairment. Under Figure 16-40, page 476 of the A.M.A., *Guides*, he found 150 degrees flexion equaled two percent impairment and 20 degrees extension equaled two percent impairment. Under Figure 16-43, page 477 of the A.M.A., *Guides*, the Office medical adviser found that 30 degrees adduction equaled 1 percent impairment and 150 degrees abduction equaled 1 percent impairment. Under Figure 16-43, page 479 of the A.M.A., *Guides*, he found 65 degrees internal rotation equaled 2 percent impairment and 85 degrees external rotation equaled zero percent impairment. The medical adviser found that the total range of motion impairments equaled six percent. He combined the 6 percent range of motion impairment with 10 percent impairment for distal clavicle resection to total 15 percent right arm impairment.

By decision dated April 10, 2009, the Office granted appellant a schedule award for 15 percent right upper extremity. The award represented 46.8 weeks of compensation and covered the period January 6 to November 29, 2009.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[4] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure

[2] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[3] 20 C.F.R. § 10.404.

[4] 5 U.S.C. § 8107(c)(19).

equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[5]

ANALYSIS

The Office accepted appellant's claim for impingement of the right shoulder and right rotator cuff tear and authorized appellant's surgeries, which included right shoulder cuff repair, subacromial debridement, biceps tendonesis, and an open distal claviculectomy. By decision dated April 10, 2009, appellant received a schedule award for 15 percent permanent impairment of the right upper extremity. This was based on the Office medical adviser's review of the medical file.

The Board notes that the report of appellant's physician, Dr. Price, is not in conformance with the relevant standards of the A.M.A., *Guides,* with regard to her impairment finding of the glenohumeral joint secondary to surgery and synovial hypertrophy. Dr. Price calculated 12 percent impairment of the glenohumeral joint secondary to multiple surgeries and synovial hypertrophy under Tables 16-18 and 16-19 of the A.M.A., *Guides* and combined it with the range of motion impairment. Impairments from the disorders considered under section 16.7, which addresses impairment of the upper extremity due to synovial hypertrophy, are under the category of "other disorders" and are usually estimated by using other impairment evaluation criteria. The section states "[*t*]*he criteria described in this section should be used only when the other criteria have not adequately encompassed the extent of the impairment.*[6] (Emphasis in the original.) The A.M.A., *Guides* further provide, with regard to joint impairment due to synovial hypertrophy, that it is a sign of an inflammatory arthritic process that can progress through varying the manifestations listed above, including decreased motion. "If synovial hypertrophy is the only finding, the joint impairment is rated according to Table 16-19 and multiplied by the relative maximum value of the joint involved (Table 16-18). It cannot be combined with impairment due to decreased joint motion or other findings."[7] Since Dr. Price provided a range of motion rating for appellant's right shoulder, this impairment cannot be combined with impairment due to synovial hypertrophy under the A.M.A., *Guides*. Additionally, there is no evidence in Dr. Price's report as to what findings were present to support her finding of a moderate or palpably apparent joint swelling from synovial hypertrophy. The Office medical adviser properly noted that the other medical evidence of record did not support either visual or palpatory evidence of synovial hypertrophy as required under Table 16-19, page 500 of the A.M.A., *Guides*. Therefore, there is insufficient justification to allow a rating for synovial hypertrophy.

The Office medical adviser reviewed the medical evidence and opined that appellant had a right upper extremity impairment of 15 percent. He properly applied the A.M.A., *Guides* to the evidence of record. Under Table 16-27, page 506 of the A.M.A., *Guides*, the Office medical

[5] 20 C.F.R. § 10.404. Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001). *See also Linda Beale*, 57 ECAB 429 (2006).

[6] A.M.A., *Guides* 499.

[7] *See id.* at 500.

adviser could properly find 10 percent upper extremity impairment for the distal clavicle resection. The Board finds that this is proper under the A.M.A., *Guides*. For lost range of motion, the medical adviser stated that he correlated the findings of the January 6, 2009 functional capacity evaluation to the A.M.A., *Guides* to determine appellant's range of motion shoulder impairment. He noted basing range of motion findings on the functional capacity evaluation as these showed the greatest shoulder range of motion; however, a review of his report shows that the medical adviser actually used Dr. Price's findings for shoulder extension and adduction as the functional capacity evaluation does not contain measurements for these motions. The medical adviser did not explain why he found some of Dr. Price's range of motion findings to be accurate but not other range of motion findings. Thus, in these circumstances, the Board finds that Dr. Price's more recent and complete measurements should be used to calculate impairment due to lost shoulder range of motion.[8]

Under Figure 16-40, page 476 of the A.M.A., *Guides*, Dr. Price properly found 125 degrees of flexion equaled three percent impairment and 20 degrees extension equaled two percent impairment. Under Figure 16-43 page 477 of the A.M.A., *Guides*, she properly found that 30 degrees adduction equaled one percent impairment and 150 degrees abduction equaled one percent impairment. Under Figure 16-43, page 479 of the A.M.A., *Guides*, Dr. Price properly found 60 degrees internal rotation equaled two percent impairment and 60 degrees external rotation yielded no percent impairment. She properly added these range of measurements to equal nine percent impairment for lost shoulder range of motion. Under the Combined Values Chart on page 604, the 10 percent impairment due to open distal clavicle resection combined with 9 percent range of motion impairment equals 18 percent impairment. Thus, the Board will modify the Office's decision to find that appellant has 18 percent impairment of the right arm.

On appeal, appellant asserts that Dr. Price's opinion should prevail. As explained, Dr. Price provided insufficient findings to support 12 percent impairment of the glenohumeral joint secondary to multiple surgeries and synovial hypertrophy. Even if such impairment were supported, it could not be combined with impairment for lost range of motion. Also, as noted, the Board finds that Dr. Price's loss of shoulder motion findings were a proper basis on which to base the lost range of motion component of appellant's impairment.

CONCLUSION

The Board finds that appellant is entitled to 18 percent right upper extremity impairment.

[8] *Cf. Michelle L. Collins*, 56 ECAB 552 (2005) (the Board has held that the impairment rating of an examining physician may take precedence over the opinion of an Office medical adviser when considering subjective factors).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 10, 2009 is affirmed, as modified.

Issued: June 17, 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