United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 10-1216**
	)	**Issued: March 2, 2011**
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:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 30, 2010 appellant, through her attorney, filed a timely appeal from February 16, 2010 merit decisions of the Office of Workers' Compensation Programs granting her an increased schedule award. 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 has more than a 23 percent permanent impairment of the right upper extremity and a 7 percent permanent impairment of the left upper extremity.

FACTUAL HISTORY

This case has previously been before the Board. On February 27, 2003 the Board affirmed a May 1, 2001 decision finding that appellant did not establish an employment-related recurrence of disability on December 8, 2000. The Board set aside an August 22, 2001 nonmerit

decision after finding that she timely filed a request for reconsideration.[1] By decision dated October 17, 2006, the Board set aside a February 22, 2006 decision denying appellant's claim for an increased schedule award. The Board remanded the case for the Office to refer her for a second opinion examination.[2] On January 29, 2008 the Board set aside a June 14, 2007 decision denying appellant's claim for an increased schedule award. The Board found that both the physician who provided a second opinion and the Office medical adviser failed to properly apply the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).[3] The Board instructed the Office to further development the medical evidence. On August 18, 2009 the Board set aside September 24 and May 21, 2008 decisions denying appellant's claim for an increased schedule award.[4] The Board noted that the Office had referred her for an impartial medical examiner rather than for a second opinion examination. The Board found that the Office improperly found a conflict existed given that neither the Office medical adviser nor the second opinion physician provided a probative opinion in accordance with the A.M.A., *Guides*. Therefore, the physician identified by the Office as an impartial medical examiner constituted a second opinion physician.[5] Moreover, the physician addressed only whether appellant had an impairment due to AC joint arthritis instead of her entire right upper extremity impairment. The Board remanded the case for further development. The findings of fact and conclusions of law from the prior decisions are hereby incorporated by reference.

On October 6, 2009 the Office referred appellant to Dr. Visespong Punyanitya, a Board-certified orthopedic surgeon, for an impairment evaluation. On October 20, 2009 Dr. Punyanitya reviewed her history of a subacrdomial decompression of the right shoulder on June 30, 1998 and noted that a September 25, 2003 electromyogram (EMG) of the right upper extremity was normal. He determined that electrodiagnostic studies showed severe right carpal tunnel syndrome and mild left carpal tunnel syndrome. Dr. Punyanitya discussed appellant's complaints of right shoulder pain, bilateral elbow pain and bilateral pain and numbness from carpal tunnel syndrome. On examination, he found mild atrophy of the deltoid muscle of the right shoulder with mild to moderate tenderness at the AC joint with no instability and mild crepitance. Dr. Punyanitya listed range of motion of the right shoulder as 100 degrees flexion, 60 degrees extension, 100 degrees adduction, 80 degrees external rotation and 30 degrees internal rotation. For the right wrist, he found a positive Tinel's sign and negative Phalen's test, mild atrophy of the thenar muscles and mild hypesthesia of the volar aspect of the thumb and

[1] Docket No. 02-273 (issued February 27, 2003). The Office accepted that appellant sustained bilateral epicondylitis, fibromyalgia, bilateral carpal tunnel syndrome, acromioclavicular (AC) joint arthritis, rotator cuff tendinisis and right shoulder impingement syndrome due to factors of her federal employment. By decision dated March 6, 1995, it granted her a schedule award for an 11 percent impairment of the right upper extremity and a 6 percent impairment of the left upper extremity. On March 7, 2000 the Office granted appellant a schedule award for an additional 12 percent impairment of the right upper extremity.

[2] Docket No. 06-879 (issued October 17, 2006).

[3] Docket No. 07-1880 (issued January 29, 2008).

[4] Docket No. 09-310 (issued August 18, 2009).

[5] The Board further noted that the physician identified as the impartial medical examiner addressed only whether appellant had an impairment due to AC joint arthritis instead of her entire right upper extremity impairment.

index fingers. Dr. Punyanitya also found a positive Tinel's sign of the left wrist and a 20 percent loss of grip strength. He diagnosed AC joint arthritis and rotator cuff tendinitis of the right shoulder, bilateral lateral epicondylitis, bilateral carpal tunnel syndrome and fibromyalgia.

Applying the sixth edition of the A.M.A., *Guides*, Dr. Punyanitya determined that, for the right shoulder, appellant had a Class 1 impairment due to her rotator cuff tear under Table 15-5 on page 403. He found grade modifiers for functional history of two, physical examination of two and clinical studies of zero, for a Grade B or four percent upper extremity impairment. Dr. Punyanitya further found a one percent impairment for AC joint arthritis of the shoulder under Table 15-5 and a one percent impairment for epicondylitis of the elbow using Table 15-4 on page 399, which he added to find an upper extremity impairment of six. For right carpal tunnel syndrome, he determined that, under Table 14-23 on page 449, he had a grade modifier of one for testing, two for history, two for physical examination and a *Quick*DASH (QD) score of 32, which yielded a four percent impairment. Dr. Punyanitya next determined that appellant had a Class 1 impairment for her right ganglion cyst according to Table 15-3 on page 395. He applied grade modifiers for functional history of two, physical examination of one and clinical studies of one, to find a Grade D or two percent impairment of the right upper extremity. For the left arm, Dr. Punyanitya found that appellant had Class 1 epicondylitis of the elbow according to Table 15-4. He applied grade modifiers for functional history of zero, physical examination of one and clinical studies of minus one to find a Grade B or one percent left upper extremity impairment. For left carpal tunnel syndrome, Dr. Punyanitya found grade modifiers of one for testing, two for history, two for physical examination for an average of 2 and a QD score of 41, which he found yielded a five percent upper extremity impairment.[6] He added the impairment scores for both upper extremities to find a bilateral total impairment of 18 percent. Dr. Punyanitya opined that appellant reached maximum medical improvement on December 31, 2005.

On December 5, 2009 an Office medical adviser determined that, based on Dr. Punyanitya's report, 100 degrees of right shoulder flexion constituted a 3 percent impairment, 100 degrees adduction constituted a 3 percent impairment and 30 degrees internal rotation constituted a 4 percent impairment, for a total impairment of the right shoulder due to loss of range of motion of 10 percent. He concurred with Dr. Punyanitya's finding of a one percent impairment due to bilateral epicondylitis. The Office medical adviser disagreed with the four percent rating for carpal tunnel syndrome and found that it should be six percent based on the findings on examination. The medical adviser stated, "It is noted that studies in September 2003 showed prolonged bilateral median nerve sensory studies and prolonged right median motor study. There was a normal EMG of the [right upper extremity]. I feel that the impairment for carpal tunnel syndrome should include impairment for mild motor deficit and mild sensory deficit…." The Office medical adviser found that appellant had a six percent impairment due to carpal tunnel syndrome of each upper extremity. He added the impairment findings and concluded that appellant had a 17 percent permanent impairment of the right upper extremity and a 7 percent permanent impairment of the left upper extremity. The Office medical adviser found that she reached maximum medical improvement on December 31, 2005, one year after her last shoulder surgery.

[6] A.M.A., *Guides* 449, Table 15-23.

By decision dated February 16, 2010, the Office granted a schedule award for an additional one percent impairment of the left arm. The period of the award ran for 3.12 weeks from December 31, 2005 to January 21, 2006.

In another decision dated February 16, 2010, the Office found that appellant was not entitled to an additional schedule award for the right arm as the evidence established that she had a 17 percent impairment, less than the 23 percent previously awarded.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] and its implementing federal regulations,[8] 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.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10]

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS).[11] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

ANALYSIS

The Office accepted that appellant sustained bilateral epicondylitis, fibromyalgia, bilateral carpal tunnel syndrome, AC joint arthritis, rotator cuff tendinisis and right shoulder impingement syndrome due to factors of her federal employment. In a decision dated March 6, 1995, it granted her a schedule award for an 11 percent permanent impairment of the right upper extremity and a 6 percent impairment of the left upper extremity. By decision dated March 7, 2000, the Office granted appellant an additional schedule award for the right upper extremity of 12 percent.

Appellant requested an increased schedule award. In accordance with the Board's instructions, on October 6, 2009 the Office referred her to Dr. Punyanitya for an impairment evaluation. Dr. Punyanitya reviewed the medical evidence of record and measured range of

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id*. at § 10.404(a).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[11] A.M.A., *Guides* 494-531.

motion of the upper extremities. He determined that appellant had decreased motion in the right shoulder and elbow, a bilateral loss of grip strength, positive findings of carpal tunnel syndrome, decreased sensation of the right hand and atrophy of the right deltoid and right thenar eminence. For the right side, Dr. Punyanitya found that she had a Class 1 impairment due to her rotator cuff tear, which has a default impairment value of five.[12] He adjusted the impairment value using grade modifiers for functional history of two, physical examination of two and clinical findings of zero. Applying the net adjustment formula described above, Dr. Punyanitya found a Grade B or four percent right shoulder impairment.[13] He further found a one percent impairment of the right shoulder due to AC joint arthritis; however, in most cases only one diagnosis in a region will be appropriate.[14] The shoulder impairment due to the right rotator cuff tear yields the higher impairment rating and thus is the applicable diagnosis.[15] For the right elbow, Dr. Punyanitya determined that appellant had a Class 1 impairment due to epicondylitis of the elbow, which has a default value of one. After adjusting for grade modifiers for functional history of zero, physical examination of one, clinical studies of negative one, he found a Grade B or one percent impairment.[16] Regarding the right ganglion cyst, Dr. Punyanitya found a Class 1 impairment. He applied grade modifiers for functional history of two, physical examination of one and clinical studies of one, to find a Grade D or two percent impairment of the right upper extremity.[17] Dr. Punyanitya further found that appellant had carpal tunnel syndrome based on the results of diagnostic studies. Using Table 15-23, he determined the grade of her impairment by averaging the severity levels for test findings of one, history of two and physical findings of two, to find an average of two. Dr. Punyanitya also used the QD score of 32 to further modify the grade, which he found to be a Grade 2 or four percent impairment.[18] He found a total right upper extremity impairment of 12 percent, less than that previously awarded appellant. The Board notes that Dr. Punyanitya's ratings conforms to the sixth edition of the A.M.A., *Guides*.

An Office medical adviser reviewed Dr. Punyanitya's report. He determined appellant's right shoulder impairment using range of motion measurements rather than the diagnosis-based method.[19] The Office medical adviser found that 100 degrees flexion yielded a 3 percent impairment, 100 degrees abduction yielded a 3 percent impairment and 30 degrees internal rotation yielded a 4 percent impairment, for a total impairment of the right shoulder due to loss

[12] *Id*. at 403, Table 15-5.

[13] Applying the net adjustment formula would yield (2-1) + (2-1) + (0-1) =1 or a Class 1, Grade D impairment of four percent. *Id*. at 403, Table 15-5.

[14] *Id*. at 497; *H.P.*, 62 ECAB ___ (Docket No. 10-962, issued November 10, 2010).

[15] *Id*.

[16] *Id*. at 399, Table 15-4. The Board notes that applying the net adjustment formula would yield (0-1) + (1-1) + 0-1) = -2, which is less than that found by Dr. Punyanitya.

[17] *Id*. at 395, Table 15-3. Applying the net adjustment formula yields (2-1) + (1-1) + (1-1) +1 or a Class 1, Grade D impairment of two percent.

[18] A.M.A., *Guides* 449, Table 15-23.

[19] The sixth edition of the A.M.A., *Guides* provides that if motion loss is present, a shoulder impairment may alternatively be assessed using range of motion. A.M.A., *Guides* 403, 405, Table 15-5.

of range of motion of 10 percent.[20] He concurred with Dr. Punyanitya's finding of a one percent impairment for epicondylitis on the right side. The Office medical adviser determined, however, that appellant had a 6 percent impairment due to carpal tunnel syndrome, for a total right upper arm impairment of 17 percent. There is no evidence that appellant has more than a 17 percent impairment of the right arm. As this is less than the 23 percent impairment previously awarded, she is not entitled to an increased schedule award.

For the left side, Dr. Punyanitya found that appellant had a one percent impairment due to epicondylitis of the elbow. For left carpal tunnel syndrome, he averaged grade modifiers of one for testing, two for history, two for physical examination and a QD score of 41, to find a five percent upper extremity impairment. The Office medical adviser concurred with his finding of a one percent impairment due to epicondylitis but modified the impairment due to carpal tunnel syndrome to six percent, to find a total left arm impairment of seven percent. The Board finds there is no evidence supporting that appellant has more than a seven percent left arm impairment.

CONCLUSION

The Board finds that appellant has no more than a 23 percent permanent impairment of the right upper extremity and a 7 percent permanent impairment of the left upper extremity.

[20] *Id.* at 475, Table 15-34. The Office medical adviser indicated that the impairment was for adduction rather than abduction; however, it appears this is a typographical error.

ORDER

IT IS HEREBY ORDERED THAT the February 16, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 2, 2011
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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