United States Department of Labor
Employees' Compensation Appeals Board

A.C., Appellant	)	
and	)	**Docket No. 10-1256**
	)	**Issued: March 1, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Coppell, TX, Employer	)	

Appearances:
Appellant, pro se
Office of the 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 April 1, 2010 appellant filed a timely appeal from a March 23, 2010 merit decision of the Office of Workers' Compensation Programs regarding schedule award compensation. Pursuant to 20 C.F.R. §§ 501.2 and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than 28 percent impairment of her left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On August 18, 2006 appellant, then a 49-year-old flats clerk, filed an occupational disease claim attributing her neck, left wrist and left hand conditions to loading mail on the ledge of the flat sorting machine (FSM) 1000 feeder. The Office accepted left carpal tunnel syndrome, left wrist enthesopathy, left wrist synovitis, cervical sprain, brachial radiculitis, closed dislocation of the left shoulder, displacement of cervical four disc and closed dislocation of cervical vertebra. Appellant underwent a left carpal tunnel release on February 28, 2007 and

anterior cervical discectomy and anterior cervical fusion C5-C6 and C6-C7 on November 26, 2007. The Office paid appropriate benefits. Under case number xxxxxx365, appellant received a schedule award for 16 percent left upper extremity impairment.[1]

On December 1, 2008 appellant filed a claim for a schedule award. In a December 12, 2008 report, Dr. Ronnie D. Shade, a Board-certified orthopedic surgeon, reviewed her history, which included prior left shoulder surgeries in June 2001 and February 2003 and provided findings on physical examination. He diagnosed left carpal tunnel syndrome, tendinitis of the left hand/wrist, synovitis and cervical radiculopathy. Dr. Shade advised that appellant reached maximum medical improvement on October 23, 2008. Under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), he noted 35 percent left upper extremity impairment.[2]

In a February 5, 2009 report, an Office medical adviser reviewed Dr. Shade's December 12, 2008 report and found maximum medical improvement was reached on October 23, 2008. Under the fifth edition of the A.M.A., *Guides*, the medical adviser opined that appellant had 41 percent impairment of the left upper extremity.[3]

On May 13, 2009 the Office requested its Office medical adviser to clarify the impairment to appellant's left upper extremity under the fifth edition of the A.M.A., *Guides*. In a July 14, 2009 report, the medical adviser indicated that he reviewed Dr. Shade's examination to rate 41 percent left arm impairment under the fifth edition of the A.M.A., *Guides*. This was based on loss of shoulder motion, loss of wrist motion and motor and sensory deficit in the C6 and C7 and median nerve distributions. Since appellant previously received 16 percent impairment for the left arm based on loss of shoulder motion and resection of the distal clavicle under case number xxxxxx365, that amount was subtracted from the current 41 percent impairment rating to find 25 percent additional impairment of the left arm.

In a November 25, 2009 letter, the Office requested that Dr. Shade reevaluate appellant and rate impairment under the sixth edition of the A.M.A., *Guides*. In a December 14, 2009 report, Dr. Shade referred to the prior examination findings to find 16 percent left arm impairment under the sixth edition of the A.M.A., *Guides*. He opined that appellant had left wrist upper extremity impairment of two percent. The diagnosis of carpal tunnel syndrome was confirmed electrodiagnostically and was ratable. Dr. Shade stated that appellant's examination revealed decreased sensation and weakness and she had consistent "significant, intermittent symptoms" symptoms and some difficulty performing some activities of daily living. Under Table 15-23, page 449, he stated that her test findings equated to grade modifier 1 for conduction delay, history was grade modifier 1 for significant intermittent symptoms and normal physical findings were grade modifier 1, which totaled 3 and averaged 1. Therefore, Dr. Shade selected

[1] The accepted condition was calcifying tendinitis of left shoulder. This claim is not presently before the Board.

[2] This was based on 20 percent impairment for motor and sensory loss at the C6 and C7 nerve roots; 15 percent impairment for loss of left shoulder range of motion; and 5 percent impairment for loss of left wrist range of motion.

[3] This was comprised of 15 percent lost shoulder range of motion; 9 percent lost wrist range of motion; 2 percent sensory deficit and 9 percent motor deficit for the C6 nerve root, totaling 11 percent; 1 percent sensory deficit and 9 percent motor deficit for C7 nerve root, totaling 10 percent; and 5 percent impairment for carpal tunnel syndrome.

grade modifier 1 as final rating category, which had a default upper extremity impairment of two percent. He indicated that the *Quick*DASH score of 115 was two grades more than the other modifiers and thus was unreliable. For left shoulder contusion, Dr. Shade opined that appellant had two percent impairment. Under Table 15-5, page 401 of the A.M.A., *Guides*, he selected a default grade of C with its corresponding two percent impairment. Dr. Shade stated that adjustment grid and grade modifiers per Table 15-7, Table 15-8 and Table 15-9, pages 406-11, yielded a net adjustment of zero.

For cervical/spine nerve impairment of the left upper extremity, Dr. Shade opined that appellant had 6 percent impairment for both the C6 and C7 nerve roots or a total of 12 percent impairment. He stated that she was Class 1 per *The Guides Newsletter* July/August 2009 under proposed Table 1 (spinal nerve impairment: upper extremity impairment). Under the proposed table, a mild sensory deficit of C6 and C7 nerve root equates to one percent impairment and mild motor deficit of C6 and C7 nerve roots equates to five percent impairment. Dr. Shade combined one percent sensory deficit with five percent motor deficit to find six percent impairment for each nerve. He further indicated that the adjustment grid and grade modifiers per Table 15-7, Table 15-8 and Table 15-9, pages 406-11 were utilized and the net adjustment was zero. For grade modifier based on functional history (GMFH) and physical examination (GMPE), Dr. Shade found that appellant had grade modifier of 1 for each nerve root. Grade modifier for clinical studies (GMCS) was found not to be applicable for each nerve root. Dr. Shade utilized the net adjustment formula of (GMFH - CDX) + (GMPE - DCX) + (GMCS - CDX) and found grade modifier 1 minus the impairment class for the diagnosed condition (CDX) of one equaled zero net adjustment for nerve roots C6 and C7. He found the 2 percent impairment for carpal tunnel syndrome, 2 percent impairment for left shoulder contusion and 12 percent impairment for spinal nerve impairment or 16 percent total left arm impairment.

In a February 8, 2010 report, the Office medical adviser advised that maximum medical improvement was reached on October 23, 2008. In reviewing Dr. Shade's most recent report, the medical adviser found that appellant had an additional 12 percent left arm impairment. Under Table 15-23, page 449, the Office medical adviser found that she had compression neuropathy of median nerve with a grade modifier of 1 for each category of test findings, history and physical findings, or a total of 3, which yield an average of 1, for the final rating category. He advised the default value was two percent arm impairment. The *Quick*DASH score of 115 was two grades higher and, therefore, not utilized. Under Table 15-5, page 401, the Office medical adviser found a shoulder contusion was Class 1, with default value of two percent arm impairment. He found the CDX was 1, the GMFH was 1, the GMPE was 1 and the GMCS was not applicable. Utilizing the net adjustment formula, the medical adviser found a net adjustment of 0: "(GMFH - CDX) (1-1) = 0; (GMPE - CDX) (1-1) = 0; (GMCS - CDX) (NA-1) = NA." Thus, he opined the result was Class 1 with no adjustment from the default value C which was Class 1 or two percent impairment.

The Office medical adviser stated that a March 17, 2006 electromyogram (EMG) showed evidence of left side C6 and C7 radiculopathy. For C6 and C7 radiculopathies, he opined that appellant had one percent sensory impairment and five percent motor impairment, for total six percent impairment each. Under *The Guides Newsletter*, July/August 2009, the Office medical adviser found a mild sensory radiculopathy for C6 and C7 with a default value of one percent under proposed Table 1. He accepted Dr. Shade's estimate that CDX was 1, GMFH was 1,

GMPE was 1 and GMCS was not applicable. Under the net adjustment formula, the Office medical adviser found a net adjustment of 0: "(GMFH - CDX) (1-1) = 0; (GMPE - CDX) (1-1) = 0; (GMCS - CDX) (NA-1) = NA." Thus, the medical adviser found that appellant was Class 1 with no adjustment from the default value C which equaled one percent impairment. For mild motor C6 and C7 radiculopathy, the Office medical adviser noted default value five percent. He applied Dr. Shade's estimates of CDX 1, GMFH 1, GMPE 1 and GMCS NA to net adjustment formula and found a net adjustment of 0: GMFH - CDX) (1-1) = 0; (GMPE-CDX) (1-1) = 0; (GMCS - CDX) (NA-1) = NA. The Office medical adviser advised a Class 1 with an adjustment 0 from the default value C equaled Class 1, grade C or 5 percent impairment. He combined the one percent sensory and five percent motor impairment for each nerve root to rate six percent impairment for both the C6 and C7 radiculopathies. The Office medical adviser combined the 6 percent impairment for the C6 radiculopathy and the 6 percent impairment for the C7 radiculopathy and found 12 percent impairment based on radiculopathy. Appellant previously received 16 percent impairment based rating on loss of shoulder motion and clavicle resection under case number xxxxxx365, this amount should be subtracted from any impairment based on shoulder abnormality. The Office medical adviser found that since she had 2 percent impairment for left shoulder contusion, 2 percent minus the previously awarded 16 percent amounted to no additional impairment for the shoulder. Therefore, the 12 percent impairment due to radiculopathies combined with 2 percent impairment for carpal tunnel syndrome equaled 14 percent impairment. The Office medical adviser stated that 14 percent combined with the 16 percent previous left arm impairment yielded 28 percent total left arm impairment or 12 percent additional impairment.

By decision dated March 23, 2010, the Office granted appellant a schedule award for an additional 12 percent left upper extremity impairment. The period of the award ran from October 27, 2008 to July 16, 2009 or a total of 37.44 weeks of compensation.[4]

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] provides 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 matter 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

[4] The Office advised the starting date of the schedule award was October 27, 2008 as appellant was in receipt of compensation for disability through October 26, 2008.

[5] 5 U.S.C. §§ 8101-8193.

adoption.[6] Effective May 1, 2009, the Office adopted the sixth edition of the A.M.A., *Guides*,[7] published in 2008, as the appropriate edition for all awards issued after that date.[8]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[9] Under the sixth edition, the evaluator identifies 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).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - DCX) + (GMCS - CDX).

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides.*[11]

ANALYSIS

On appeal, appellant contends that her schedule award should not have been calculated under the sixth edition of the A.M.A., *Guides* since the Office medical adviser previously reviewed her file on February 5, 2009, prior to the date the sixth edition of the A.M.A., *Guides* came into effect. Pursuant to FECA Bulletin 09-03, all schedule award decisions after May 1, 2009 must utilize the sixth edition of the A.M.A., *Guides*.[12] Even though the Office medical adviser had previously rated impairment under the fifth edition of the A.M.A., *Guides,* the office sought further medical reviewed under the sixth edition.[13] The schedule award was not issued until after May 1, 2009 and the Office properly based its decision on the sixth edition of the A.M.A., *Guides*.

The Board finds that appellant has no more than 28 percent impairment to her left upper extremity. Both Dr. Shade, in a December 14, 2009 report and the Office medical adviser, in a February 8, 2010 report, properly applied the A.M.A., *Guides* to rate impairment for

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

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

[8] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 9, 2010).

[9] A.M.A., *Guides* (6th ed., 2008), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[10] A.M.A., *Guides* 494-531 (6th ed. 2008).

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

[12] FECA Bulletin 09-03 (issued March 15, 2009); *B.M.*, 61 ECAB ___ (Docket No. 09-2231, issued May 14, 2010) (for decisions issued beginning May 1, 2009, the sixth edition will be used).

[13] *Id.* FECA Bulletin 09-03 states, "Correspondence with treating physicians, consultants and second opinion specialists should reflect the use of the new edition for decisions issued after May 1, 2009."

compression neuropathy, shoulder contusion and C6 and C7 neuropathies. Both physicians found two percent impairment for compression neuropathy. Under Table 15-23, page 449, both physicians properly rated appellant's test findings, history and physical findings as grade modifier 1, which totaled 3 and averaged 1. They further found that the *Quick*DASH score of 115 was unreliable as it was two grades more than the other modifiers.[14] Thus, the grade modifier 1 was selected with a default upper extremity impairment of two percent. Both physicians also found two percent impairment for shoulder contusion under Table 15-5, page 401. They indicated that appellant's findings fit into Class 1 with default grade of C, which corresponded with two percent impairment. Both physicians further calculated a net adjustment score of zero under Table 15-7, Table 15-8 and Table 15-9, pages 406-11. They further found 12 percent total impairment for C6 and C7 neuropathies. Both physicians noted EMG evidence of C6 and C7 radiculopathy on the left side and rated each radiculopathy as being a mild sensory and mild motor impairment at C6 and C7. Under proposed Table 1,[15] a mild sensory radiculopathy at C6 and C7 equals Class 1 or one percent impairment and a mild motor deficit at C6 and C7 equals Class 1 or five percent impairment. Since both physicians calculated a net adjustment of zero, appellant has one percent sensory impairment and five percent motor deficit for each C6 and C7 radiculopathy. They properly combined the 1 percent sensory impairment and 5 percent motor impairment for each C6 and C7 radiculopathy to find 6 percent impairment to each neuropathy, for a total 12 percent impairment.

Appellant was previously rated at 16 percent impairment to the left arm based on her shoulder conditions. Dr. Shade, however, did not take into account her prior left upper extremity rating. The Act and its implementing regulations provide for the reduction of compensation for subsequent injury to the same scheduled member.[16] Benefits payable under section 8107(c) shall be reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[17] The Office medical adviser noted that the 2 percent impairment rating for left shoulder contusion would duplicate the 16 percent impairment for which appellant previously received a schedule award. Thus, the medical adviser properly found that her current impairment was due to the C6 and C7 radiculopathy and the compression neuropathy.

The Board finds that the Office medical adviser used the appropriate tables and methodology of the A.M.A., *Guides* to determine the percentage of impairment to appellant's left upper extremity. The Board finds that, as the medical adviser properly applied the A.M.A.,

[14] The A.M.A., *Guides* provide that, when a grade for functional history differs by two or more grades from that described by physical examination or clinical studies, it should be assumed to be unreliable and should be excluded from the grading process. A.M.A., *Guides* 406-07.

[15] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 Exhibit 4 (January 2010).

[16] 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

[17] *Id.* at § 10.404(c)(1), (2).

Guides to Dr. Shade's clinical findings, his opinion represents the weight of the medical evidence in this case.[18]

Under the Combined Values Chart, the 12 percent impairment due to C6 and C7 radiculopathy combined with 2 percent impairment due to compression neuropathy equals 14 percent left upper extremity impairment. The current 14 percent upper extremity impairment combined with the 16 percent previously awarded upper extremity impairment under case number xxxxxx365 results in 28 percent total left upper extremity impairment.[19] As appellant previously received 16 percent impairment, she was entitled to the difference of 28 minus 16 or 12 percent additional impairment, which she received.

CONCLUSION

The Board finds that appellant has no more than 28 percent impairment of her left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the March 23, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 1, 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

[18] *See Bobby L. Jackson*, 40 ECAB 593, 601 (1989).

[19] *See* A.M.A., *Guides* 21-22 (provides that multiple impairments are combined using the Combined Values Chart.