United States Department of Labor
Employees' Compensation Appeals Board

L.C., Appellant	)	
and	)	**Docket No. 11-214**
	)	**Issued: October 7, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Columbus, OH, Employer	)	

Appearances:
Appellant, pro se
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 November 1, 2010 appellant filed a timely appeal from an October 8, 2010 decision of the Office of Workers' Compensation Programs (OWCP) regarding a schedule award. Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 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 20 percent permanent impairment of the right upper extremity and a 21 percent impairment of the left upper extremity, for which he received schedule awards.

On appeal, appellant contends that he was entitled to an additional schedule award based on the reports of a second opinion physician and an OWCP medical adviser.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on or before October 17, 1993 appellant, then a 47-year-old flat sorter machine operator, sustained bilateral tenosynovitis of the hands and wrists and bilateral carpal tunnel syndrome. Appellant underwent a right median nerve release on July 15, 1994 with a repeat procedure on March 5, 1996. He underwent a left median nerve release on August 23, 1994 with repeat surgery on May 9, 1996. Appellant worked modified duty from early 1994 onward with intermittent absences for surgery and recovery.

On July 31, 1997 appellant claimed a schedule award. In a December 28, 1997 report, an OWCP medical adviser found a 20 percent impairment of each upper extremity due to moderate median nerve impairment, according to Table 16, page 57 of the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).[2]

By decision dated January 8, 1998, OWCP issued appellant schedule awards for a 20 percent impairment of each upper extremity due to bilateral carpal tunnel syndrome.

Beginning in 1996, appellant developed bilateral shoulder symptoms. In a December 9, 1996 report, Dr. Stephen J. Voto, an attending Board-certified orthopedic surgeon diagnosed bilateral shoulder tendinitis, progressing by June 3, 2002 to bilateral shoulder impingement syndrome. Appellant filed an occupational disease claim on April 21, 2002 for bilateral shoulder tendinitis. Based on Dr. Voto's reports, OWCP accepted bilateral bicipital tenosynovitis, a right shoulder and rotator cuff sprain, right subacromial impingement and bilateral shoulder tendinitis.

On February 4, 2003 Dr. Voto performed a diagnostic arthroscopy of the right shoulder, limited open decompression acromioplasty and an open Mumford resection of the distal clavicle. He observed that the right rotator cuff was intact. On May 6, 2003 Dr. Voto performed a diagnostic arthroscopy of the left shoulder, limited open decompression acromioplasty and an open Mumford resection of the distal clavicle. He observed that the left rotator cuff was intact. OWCP authorized both procedures.

Appellant returned to modified duty in July 2003. Dr. Voto submitted reports through October 17, 2003 noting recurrent bilateral shoulder impingement with tendinitis.

On October 23, 2003 appellant claimed an additional schedule award. On December 17, 2003 OWCP obtained a second opinion from Dr. E. Gregory Fisher, a Board-certified orthopedic surgeon, who reviewed the medical record and statement of accepted facts provided by OWCP. Dr. Fisher observed the following ranges of motion of the right shoulder: 140 degrees abduction, 170 degrees forward flexion; 20 degrees extension, 70 degrees internal rotation; 80 degrees external rotation. He noted the following ranges of motion for the left shoulder: 95 degrees abduction; 140 degrees forward flexion; 20 degrees extension; 40 degrees internal rotation; 60 degrees external rotation. Dr. Fisher observed surgical scars on both shoulders and both wrists, no atrophy in either hand, decreased sensation of the index and long fingers bilaterally,

[2] Table 16, page 57 of the fourth edition of the A.M.A., *Guides* is entitled "Upper Extremity Impairment Due to Entrapment Neuropathy."

bilaterally positive Tinel's and Phalen's signs, and full ranges of motion of both wrists and all fingers. He opined that appellant had reached maximum medical improvement. Utilizing the fifth edition of the A.M.A., *Guides*, Dr. Fisher calculated a 6 percent impairment of the right shoulder due to restricted motion and a 10 percent impairment of the left hand due to median nerve impairment. He also found a 12 percent impairment of the left shoulder due to restricted motion and a 10 percent impairment of the left hand due to median nerve impairment. Dr. Fisher combined these impairments to equal a 33 percent impairment of both upper extremities.

On March 9, 2004 an OWCP medical adviser reviewed Dr. Fisher's findings. He found the following impairments of the right shoulder: one percent for flexion at 170 degrees and two percent for extension at 20 degrees according to Figure 16-40, page 476;[3] two percent for abduction at 140 degrees according to Figure 16-43, page 477;[4] one percent for internal rotation at 70 degrees and zero percent for external rotation at 80 degrees, according to Figure 16-46, page 479.[5] The medical adviser added these percentages to equal a six percent impairment of the right shoulder. Regarding the right hand and wrist, he found a grade 4 sensory deficit of the right median nerve, equaling a 25 percent deficit according to Table 16-10, page 482,[6] equaling a 39 percent impairment of the upper extremity according to Table 16-15, page 492.[7] Multiplying the 25 percent deficit by 39 percent resulted in a 9.75 percent impairment of the right upper extremity, rounded up to 10 percent. The medical adviser combined the 6 and 10 percent impairments to total a 15 percent impairment of the right upper extremity.

Regarding the left shoulder, the medical adviser found the following impairments: three percent for flexion at 140 degrees and two percent for extension at 20 degrees, according to Figure 16-40; four percent for abduction at 95 degrees, according to Figure 16-43; three percent for internal rotation at 40 degrees and zero percent for external rotation at 60 degrees, according to Figure 16-46. He added these impairments to total 12 percent. Regarding the left hand and wrist, the medical adviser found a grade 4 sensory deficit of the right median nerve, equaling a 25 percent deficit according to Table 16-10, equaling a 39 percent impairment of the upper extremity according to Table 16-15. Multiplying the 25 percent deficit by 39 percent resulted in a 9.75 percent impairment of the right upper extremity, rounded up to 10 percent. The medical adviser then combined the 10 and 12 percent impairments to equal a 21 percent impairment of the left upper extremity.

[3] 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."

[4] 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."

[5] Figure 16-46, page 479 of the fifth edition of the A.M.A., *Guides* is entitled "Pie Chart of Upper Extremity Motion Impairments Due to Lack of Internal and External Rotation of Shoulder."

[6] Table 16-10, page 482 of the fifth edition of the A.M.A., *Guides* is entitled "Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting From Peripheral Nerve Disorders."

[7] Table 16-15, page 492 of the fifth edition of the A.M.A., *Guides* is entitled "Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to *Combined* 100 percent Deficits of the Major Peripheral Nerves."

By decision dated May 12, 2004, OWCP granted appellant a schedule award for an additional one percent impairment of the left upper extremity. It denied any additional award for the right upper extremity, based on Dr. Fisher's clinical findings as interpreted by OWCP's medical adviser.

Appellant requested an oral hearing, held February 15, 2005. At the hearing, OWCP's hearing representative advised appellant of the additional evidence needed to establish his claim for an augmented schedule award. Following the hearing, appellant submitted February 28 and March 3, 2005 reports from Dr. Voto diagnosing bilateral carpal tunnel syndrome and bilateral shoulder impingement, unchanged. He renewed prior work restrictions.

By decision dated and finalized June 3, 2005, OWCP affirmed the May 12, 2004 decision, finding that appellant did not establish that he sustained greater than a 20 percent impairment of the right upper extremity and a 21 percent impairment of the left upper extremity.

Dr. Voto submitted periodic reports from November 21, 2005 through July 30, 2010 diagnosing bilateral shoulder impingement and bilateral carpal tunnel syndrome.[8] He found that appellant's condition remained unchanged and that he had attained maximum medical improvement.

In January 8 and 26, 2007 reports, Dr. Ron P. Linehan, an attending Board-certified anesthesiologist, diagnosed disc protrusions at C4-5, C6-7, C7-T1 and spur formation at C5-6. He opined that these findings caused neck pain radiating into the left arm as appellant had no peripheral neuropathy.[9] On January 30, 2007 Dr. Linehan opined that the disc protrusions and cervical neuritis were a direct result of appellant's work conditions.

On July 6, 2010 appellant claimed a schedule award for additional upper extremity impairment. He submitted Dr. Voto's August 17, 2010 report diagnosing unchanged bilateral carpal tunnel syndrome and right shoulder impingement.

OWCP obtained a second opinion from Dr. Manhal A. Ghanma, a Board-certified orthopedic surgeon. In an August 24, 2010 report, Dr. Ghanma summarized the medical record and statement of accepted facts OWCP provided for his review. He noted that appellant had attained maximum medical improvement in August 1996. Dr. Ghanma administered the *Quick*DASH questionnaire, with a score of 27 for each upper extremity, indicating a "mild-to-moderate degree of difficulty due to subjective complaints." He measured forearm circumferences of 33 centimeters (cm) on the right and 31.5 cm on the left, and bicep circumferences of 38 cm on the right and 37 cm on the left. There were no objective findings of tendinitis in either arm. On examination of the right wrist, Dr. Ghanma observed 40 degrees extension, 60 degrees flexion, 25 degrees radial deviation, 40 degrees ulnar deviation. He noted two surgical scars on the volar aspect of the left wrist, decreased sensation in the left fifth finger

[8] An August 1, 2006 electromyogram (EMG) showed median mononeuropathy at both wrists indicative of mild carpal tunnel syndrome, without any neuropathy or radiculopathy of the left upper extremity.

[9] December 29, 2006 EMG and nerve conduction velocity (NCV) studies showed a C8 nerve root irritation, with no peripheral nerve root compression in the upper extremities.

and normal grip strength. On examination of the right wrist, Dr. Ghanma observed 40 degrees extension, 62 degrees flexion, 25 degrees radial deviation and 50 degrees ulnar deviation. He noted two surgical scars on the volar aspect of the right wrist and decreased sensation in the fourth and fifth fingers. Regarding the right shoulder, Dr. Ghanma found 50 degrees extension, 150 degrees forward flexion, 140 degrees abduction, 32 degrees adduction, and 90 degrees of external and internal rotation. For the left shoulder, he observed 60 degrees extension, 155 degrees forward flexion, 120 degrees abduction, 40 degrees adduction, and 90 degrees of external and internal rotation.

Referring to Table 15-23, page 449[10] of the sixth edition of the A.M.A., *Guides*, Dr. Ghanma opined that appellant had a grade 1 modifier based on "functional scale" and grade zero modifiers for clinical studies, physical examination and "history." He opined that appellant had no ratable impairment due to carpal tunnel syndrome. Dr. Ghanma found no impairment for a torn right rotator cuff as it was intact according to a February 4, 2003 surgical report. Regarding right subacromial impingement, Dr. Ghanma calculated 10 percent impairment of the right upper extremity due to class 1 acromioclavicular injury or disease, according to Table 15-5.[11] He found a grade modifier for Functional History (GMFH) of 1, a grade modifier for Physical Examination (GMPE) of zero, and a diagnosis grade of one (CDX). Using the net adjustment formula of (GMFH-CDX) + (GMPE-DCX) + (GMCS-CDX), he calculated a zero grade adjustment, resulting in 10 percent right upper extremity impairment. Dr. Ghanma also found zero percent impairment of the left upper extremity.

OWCP referred the record to an OWCP medical adviser for review. In a September 26, 2010 report, an OWCP medical adviser applied the sixth edition of the A.M.A., *Guides* to Dr. Ghanma's findings. He found that according to Table 15-23, appellant had a zero percent impairment for carpal tunnel syndrome as he had no objective residuals of the condition. The OWCP medical adviser attributed appellant's symptoms to "impairment of the ulnar nerve, which is not involved in carpal tunnel syndrome." The medical adviser explained that according to Table 15-5, appellant's shoulder impairments should be rated based on restricted motion as opposed to diagnosis-based impairments. Referring to Table 15-34, page 475,[12] OWCP's medical adviser assessed the following impairments for restricted motion of the left shoulder: three percent for flexion at 155 degrees; three percent for abduction at 120 degrees; zero percent for extension at 60 degrees, adduction at 40 degrees, and internal and external rotation at 90 degrees. The medical adviser noted the following impairments for the right shoulder: three percent for flexion at 165 degrees; three percent for abduction at 140 degrees; one percent for adduction at 32 degrees; zero percent for extension at 50 degrees, internal and external rotation at 90 degrees. He added these percentages to equal a six percent impairment of the left upper extremity and a seven percent impairment of the right upper extremity.

[10] Table 15-23, page 449 of the sixth edition of the A.M.A., *Guides* is entitled "Entrapment/Compression Neuropathy Impairment."

[11] Table 15-5, pages 401 to 405 of the sixth edition of the A.M.A., *Guides* is entitled "Shoulder Regional Grid."

[12] Table 15-34, page 475 of the sixth edition of the A.M.A., *Guides* is entitled "Shoulder Range of Motion."

By decision dated October 8, 2010, OWCP denied appellant's claim for an additional schedule award. It found that Dr. Ghanma's clinical findings, as interpreted by OWCP's medical adviser, demonstrated a 6 percent impairment of the left arm and a 7 percent impairment of the right arm, less than the previous awards of 20 percent for the right upper extremity and 21 percent for the left upper extremity.

LEGAL PRECEDENT

The schedule award provisions of FECA provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, 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 OWCP. 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 OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[13] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[14]

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).[15] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[16] The net adjustment formula is GMFH-CDX + GMPE-DCX + GMCS-CDX.

ANALYSIS

OWCP accepted that appellant sustained bilateral tenosynovitis of the hands and wrists, bilateral carpal tunnel syndrome, bilateral bicipital tenosynovitis, bilateral shoulder tendinitis, right subacromial impingement and a right shoulder and rotator cuff sprain. Appellant underwent two bilateral median nerve releases and bilateral subacromial decompression with open Mumford distal clavicle resections.

On January 8, 1998 OWCP granted appellant a schedule award for a 20 percent impairment of each upper extremity due to median nerve impairment. Appellant claimed an additional schedule award on October 23, 2003. Based on the second opinion report of Dr. Fisher, a Board-certified orthopedic surgeon, OWCP awarded appellant an additional one percent impairment of the left arm on May 12, 2004 due to restricted shoulder motion.

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

[14] 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).

[15] 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."

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

Appellant claimed an additional schedule award on July 6, 2010. He submitted reports from November 2005 to July 2010 by Dr. Voto, an attending Board-certified orthopedic surgeon, diagnosing unchanged bilateral carpal tunnel syndrome and bilateral shoulder impingement. Appellant also provided January 2007 reports from Dr. Linehan, an attending Board-certified anesthesiologist, diagnosing cervical disc protrusions and a C8 nerve root irritation causing cervical neuritis into the left upper extremity. Dr. Linehan opined that these findings were work related.

On August 24, 2010 OWCP obtained a second opinion from Dr. Ghanma, a Board-certified orthopedic surgeon, who reviewed the statement of accepted facts and the medical record. Dr. Ghanma provided detailed findings on examination and ranges of motion for both shoulders and wrists. An OWCP medical adviser applied the sixth edition of the A.M.A., *Guides* to Dr. Ghanma's findings. He explained that appellant had no objective residuals of the accepted conditions other than limited shoulder motion. Therefore, there was no additional impairment warranted for carpal tunnel syndrome or tendinitis. The medical adviser used Table 15-34, Shoulder Ranges of Motion, to find a six percent impairment of the left arm: three percent for flexion at 155 degrees and three percent for abduction at 120 degrees. He used Table 15-34 to calculate a seven percent impairment of the right arm: three percent for flexion at 165 degrees; three percent for abduction at 140 degrees; one percent for adduction at 32 degrees. Based on the medical adviser's schedule award calculation, OWCP found on October 8, 2010 that appellant was not entitled to an additional schedule award.

Appellant did not provide medical evidence supporting a greater percentage of permanent impairment than that previously awarded. Dr. Voto opined that appellant's bilateral carpal tunnel syndrome and bilateral shoulder impingement remained present and unchanged from November 2005 through July 2010. However, he did not perform an impairment rating or explain the objective findings supporting the continued presence of bilateral carpal tunnel syndrome. Additionally, Dr. Linehan found no peripheral neuropathy, and instead attributed appellant's left upper extremity symptoms to cervical neuritis.

Dr. Ghanma provided extensive rationale, based on the complete medical record and statement of accepted facts, explaining that the accepted tendinitis, hand and wrist conditions had resolved without objective residuals. The Board finds that OWCP's medical adviser correctly applied the appropriate tables and grading schemes of the A.M.A., *Guides* to Dr. Ghanma's clinical findings, resulting in an impairment rating of six percent for the left arm and seven percent for the right arm. Therefore, OWCP properly relied on OWCP medical adviser's calculation in denying appellant's claim for an increased schedule award. The October 8, 2010 decision is proper under the law and facts of this case.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

On appeal, appellant contends that he is entitled to an additional schedule award above and beyond the 20 percent awarded for the right and left arm on January 8, 1998 and the additional 1 percent award for the left arm on May 12, 2004. As stated, the medical evidence does not establish a greater percentage of permanent impairment.

CONCLUSION

The Board finds that appellant has not established that he sustained more than a 20 percent permanent impairment of the right upper extremity and a 21 percent impairment of the left upper extremity, for which he received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 8, 2010 is affirmed.

Issued: October 7, 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