# United States Department of Labor
# Employees' Compensation Appeals Board

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| **M.H., Appellant** | ) | |
| **and** | ) | **Docket No. 11-335** |
| | ) | **Issued: September 20, 2011** |
| **U.S. POSTAL SERVICE, POST OFFICE, Corpus Christi, TX, Employer** | ) | |

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

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge

### ***JURISDICTION***

On November 23, 2010 appellant filed a timely appeal from an October 8, 2010 decision of the Office of Workers' Compensation Programs (OWCP) which granted her 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 the case.

### ***ISSUE***

The issue is whether appellant has more than six percent permanent impairment of the right upper extremity for which she received a schedule award.

### ***FACTUAL HISTORY***

On July 30, 2007 appellant, then a 63-year-old mail processing clerk filed a Form CA-2, occupational disease claim, alleging that she developed right arm and elbow pain and tendinitis as a result of working on a delivery bar code sorter machine. OWCP accepted sprain of the right

[1] 5 U.S.C. §§ 8101-8193.

shoulder and forearm. Appellant did not stop work but worked a light-duty position and retired on October 31, 2009.

Appellant underwent an electromyogram (EMG) on June 9, 2007 of both upper extremities which revealed no abnormalities. An April 24, 2008 magnetic resonance imaging (MRI) scan of the right shoulder revealed mild bursal surface fraying of the supraspinatus with small partial articular surface tear of the infraspinatus and acromioclavicular arthrosis with subacromial subdeltoid bursitis. On December 8, 2008 Dr. Richard Carlson, a Board-certified orthopedic surgeon, performed a right shoulder acromioplasty and right Mumford excision of the right subacromial bursa. A July 22, 2009 MRI scan of the right shoulder revealed a microscopic foci of metal artifact, moderate to severe signal alteration of the distal most anterior supraspinatus tendon, consistent with a moderate sized, likely incomplete, but very high grade subtotal tear. Dr. Carlson noted that age of the tear was not determined and may have predated the surgery. OWCP authorized surgery. In reports dated December 24, 2008 to July 2, 2010, Dr. Carlson noted that appellant was progressing well postoperatively but had restricted range of motion. He continued physical therapy and light-duty restrictions and referred appellant for a disability rating.

On July 6, 2010 appellant saw Dr. Charles W. Kennedy, Jr., a Board-certified orthopedic surgeon, for an impairment rating. He opined that pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] (A.M.A., *Guides*), appellant had six percent impairment of the right upper extremity. Dr. Kennedy noted the pain disability questionnaire totaled 46 which correlated with a mild disability rating pursuant to Table 17A of the A.M.A., *Guides*. He noted that activities of daily living questionnaire revealed some difficulty in care, bathing, dressing and recreation. Sensory function was tactile with difficulty in performing nonspecific hand functions of grasping, lifting with some difficulty with sleep. Dr. Kennedy noted that the range of motion for flexion was 135 degrees for three percent impairment,[3] extension was 50 degrees for zero percent impairment,[4] abduction was 130 degrees for three percent impairment[5] and adduction and internal and external rotation were normal for zero percent impairment.[6] He noted a range of motion modifier as one. Appellant sustained a six percent impairment of the right upper extremity for range of motion deficit. Dr. Kennedy noted that pursuant to the Shoulder Regional Grid, Table 15-5, appellant was a class 1 under ligament/bone conditions for partial right rotator cuff tear, with three percent impairment. He noted that the diagnosis-based impairment provided an inadequate rating. Dr. Kennedy opined that appellant would receive the largest impairment rating using the range of motion model as set forth in Table 15-34, Table 15-35 and Table 15-36 of the A.M.A., *Guides*. He noted the adjustment grid for physical examination and advised that, for functional history and physical

[2] A.M.A., *Guides* (6th ed. 2008).

[3] *Id.* at 475, Table 15-34.

[4] *Id.*

[5] *Supra* note 3.

[6] *Id.*

examination, appellant had mild problems. Dr. Kennedy concluded that she had six percent impairment of the right arm.

On August 3, 2010 appellant filed a claim for a schedule award.

OWCP referred Dr. Kennedy's report to a medical adviser who, in an August 23, 2010 report, concurred with Dr. Kennedy's opinion that appellant had six percent impairment of the right arm due to lost range of motion. Dr. Kennedy opined that maximum medical improvement occurred on July 6, 2010.

In a decision dated October 8, 2010, OWCP granted appellant a schedule award for six percent impairment of the right arm. The period of the award was from July 6 to November 14, 2010.

## ***LEGAL PRECEDENT***

The schedule award provision of FECA[7] and its implementing 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, FECA 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 to all claimants, good administrative practice necessitates 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 implementing regulations as the appropriate standard for evaluating schedule losses.[9] Effective May 1, 2009, schedule awards are determined in accordance with the A.M.A., *Guides* (6th ed. 2008).[10]

## ***ANALYSIS***

Although the diagnosis-based approach is the preferred method of evaluating permanent impairment under the sixth edition of the A.M.A., *Guides*, the shoulder regional grid, Table 15-5, A.M.A., *Guides* 401-05, provides that, if loss of motion is present, the impairment may alternatively be assessed using section 15-7, range of motion impairment.[11] A range of motion impairment stands alone and is not combined with a diagnosis-based impairment.[12] In Dr. Kennedy's July 6, 2010 report, in which OWCP's medical adviser concurred, he explained that the diagnosis-based impairment for a partial rotator cuff tear would not provide an

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *See id.*; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

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

[11] *See* A.M.A., *Guides* 459, 461, section 15-7.

[12] *Id.* at 461.

impairment rating as great as the range of motion rating, and therefore, the range of motion assessment was the better impairment model.

OWCP properly determined that appellant had six percent impairment of the right arm due to loss of motion in the shoulder. Appellant's physician Dr. Kennedy properly rated her impairment under the sixth edition of the A.M.A., *Guides*, and OWCP's medical adviser concurred in his impairment findings. According to Table 15-34, A.M.A., *Guides* 475, flexion of 135 degrees represents three percent impairment of the upper extremity. Abduction of 130 degrees also represents three percent upper extremity impairment under Table 15-34, extension of 50 degrees represents zero impairment[13] and adduction and internal and external rotation were normal for zero impairment.[14] Adding the above-noted shoulder range of motion impairments results in six percent impairment of the right upper extremity as correctly noted by the Dr. Kennedy and the OWCP's medical adviser. Both Dr. Kennedy and OWCP's medical adviser considered the grade modifier for Functional History, under Table 15-7 and Table 15-35, which Dr. Kennedy noted was mild. As appellant's functional history was mild and his range of motion impairment was also mild, Dr. Kennedy found no net adjustment to increase range of motion impairment under Table 15-36 on page 477. Consequently, both Dr. Kennedy and OWCP's medical adviser properly concluded that appellant had a total of six percent impairment of the right arm.

On appeal, appellant asserts that her schedule award is insufficient to compensate her noting that she continued to have pain, limitations in the arm and scarring. As explained, the medical evidence conforming with the A.M.A., *Guides*, supports that appellant has no more than six percent permanent impairment of her right arm. 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.

## ***CONCLUSION***

The Board finds that appellant has six percent impairment of the right upper extremity, for which she received a schedule award.

[13] *Id.*

[14] *Id.*

## ***ORDER***

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

Issued: September 20, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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