United States Department of Labor
Employees' Compensation Appeals Board

D.W., Administratrix of the Estate of J.W., Appellant	)	
	)	**Docket No. 12-1077**
and	)	**Issued: December 11, 2012**
DEPARTMENT OF THE NAVY, PHILADELPHIA NAVAL SHIPYARD, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 11, 2012 appellant, through her representative, filed a timely appeal from the December 23, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied an additional schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) 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 the employee had more than a 15 percent impairment of his right arm due to the accepted wrist and shoulder conditions.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On April 22, 1994 the employee, a 50-year-old welder, sustained a traumatic injury in the performance of duty while shoveling shot into a bucket. OWCP accepted his claim for right carpal tunnel syndrome. In 2001 the employee received a schedule award for a five percent impairment of his right upper extremity due to mild numbness following surgery.

In a subsidiary claim, OWCP File No. xxxxxx123, OWCP accepted that the employee developed right rotator cuff syndrome as of April 1989, for which he received a schedule award for a 10 percent impairment of the right upper extremity.[2]

The employee filed a claim for an additional schedule award. Following his death in 2005, appellant, the employee's widow, pursued the claim.

In a February 2, 2006 report, revised as of June 17, 2011, Dr. David O. Weiss, an osteopath, reviewed the employee's record. Using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2009), he found that the employee had a seven percent impairment of the right upper extremity due to entrapment neuropathy of the median nerve. Based on electrodiagnostic testing in 2002, Dr. Weiss assigned a grade modifier of 3 for test findings. Based on the history reported on March 21, 2003, he assigned a grade modifier of 2 for history and based on decreased sensory/grip on September 15, 2003, he assigned a grade modifier of 3 for physical examination. Following the procedures in Table 15-23, page 449 of the A.M.A., *Guides*, Dr. Weiss found that appellant had default impairment value of eight percent, which he reduced by one percent for a functional history of pain and medication.

Dr. Weiss also determined that the employee had a 12 percent impairment of the right upper extremity due to acromioclavicular joint arthropathy with distal clavicle resection. After indicating a default impairment value of 10 percent, he assigned a grade modifier of 1 for functional history, 2 for physical examination (observed and palpatory findings on September 15, 2003), and 2 for clinical studies, for a net adjustment of +2.

On December 1, 2011 an OWCP medical adviser reviewed Dr. Weiss' evaluation. He explained that the 2002 electrodiagnostic testing showed motor distal latency to be high normal and sensory distal latency prolonged. This did not qualify as axon loss. Rather, the testing showed only a sensory conduction delay, for a grade modifier of 1. Significant intermittent symptoms warranted a grade modifier of 2, and physical findings on at least one occasion indicated a grade modifier of 3. The average showed a default impairment value of five. As Dr. Weiss found, a functional history of pain and medication reduced this by one percent, for a final rating of four percent due to right carpal tunnel syndrome. The medical adviser agreed with Dr. Weiss on the 10 percent default impairment due to shoulder arthropathy. Grade modifiers were one for functional history, two for physical examination (slight instability, subluxable), and two for clinical studies. This increased the default value to 11 percent. Combining the 4 percent

[2] In another subsidiary claim, OWCP File No. xxxxxx714, OWCP accepted that the employee developed left carpal tunnel syndrome as of January 1995, for which he received a schedule award for a 10 percent impairment of his left upper extremity.

impairment at the wrist with the 11 percent impairment at the shoulder, the medical adviser concluded that the employee had a total right upper extremity impairment of 15 percent.

In a December 23, 2011 decision, OWCP denied an additional schedule award. It found that the weight of the medical evidence rested with evaluation of its medical adviser and showed no impairment greater than the total 15 percent previously awarded.

On appeal, appellant's representative argues that a conflict in medical opinion warrants referral to an impartial medical specialist under 5 U.S.C. § 8123(a).

LEGAL PRECEDENT

The schedule award provision of FECA[3] and the implementing regulations[4] 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. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[5]

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 regulations as the appropriate standard for evaluating schedule losses.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

ANALYSIS

Dr. Weiss, the osteopath evaluating the employee's impairment on behalf of appellant, found that the employee had a 7 percent right upper extremity impairment due to carpal tunnel syndrome and a 12 percent right upper extremity impairment due to acromioclavicular joint injury or disease status post distal clavicle resection, for a combined impairment of 18 percent. The medical adviser found a 4 and 11 percent impairment respectively, for a combined impairment of 15 percent.

The only difference in the carpal tunnel ratings is with respect to the grade modifier for test findings under Table 15-23, page 449 of the A.M.A., *Guides*. Dr. Weiss indicated that electrodiagnostic testing in 2002 showed axon loss, while the medical adviser explained that it showed only a sensory conduction delay.

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[6] 20 C.F.R. § 10.404; *Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

Dr. Weiss offered no rationale to explain how the test findings showed axon loss, indicative of grade modifier 3. By contrast, the medical adviser explained how the test findings showed a conduction delay, indicative of grade modifier 1. He noted that the test showed motor distal latency to be high normal and sensory distal latency prolonged. The Board has reviewed this test.[8] The testing was interpreted to show mild-to-moderate right median nerve compression at the wrist, not axon loss. Accordingly, the Board finds that the weight of the medical evidence rests with the medical adviser. The employee had a four percent right upper extremity impairment due to carpal tunnel syndrome.

The only difference in the shoulder ratings is with respect to the grade modifier for physical examination under Table 15-8, page 408. Dr. Weiss noted that a September 15, 2003 examination showed a moderate problem in observed and palpatory findings. The medical adviser noted that appellant's shoulder problem was mild.

The September 15, 2003 examination[9] showed the employee doing reasonably well. Shoulder findings appeared normal or mild. Appellant had negative impingement, negative arc of pain, 5/5 internal and external rotation strength. There was some tenderness over the lateral epicondyle, modestly decreased grip strength and a subjective decrease in sensibility in the median nerve distribution.

The tenderness did not relate to the shoulder and Dr. Weiss did not explain how grip strength or a subjective decrease in sensibility in the median nerve distribution reflected a moderate shoulder problem. The Board finds, therefore, that the September 15, 2003 examination does not clearly support a grade modifier of 2 under Table 15-8, page 408.

The medical adviser's grade modifier is given greater weight because it is region specific under Table 15-8. The Board has reviewed the physical examination findings since the employee's right shoulder surgery, with special attention to the most recent findings. The evidence does not support a grade 2 or moderate instability that is easily subluxable. Indeed, there is no evidence of a slight instability in the right shoulder. The employee is consistently described as doing well following his shoulder surgery. Giving the employee the benefit of a doubt, the Board finds that the weight of the medical evidence supports no more than a mild problem indicative of grade modifier 1. Accordingly, the Board finds that the employee had a diagnosis-based 11 percent impairment of the right upper extremity due to acromioclavicular joint injury or disease status post clavicle resection.

Upper extremity percentages in the same extremity are combined.[10] Using the Combined Values Chart on page 604 of the A.M.A., *Guides*, a 4 percent impairment and an 11 percent impairment combine for a 15 percent total impairment of the right upper extremity, which is

[8] OWCP File No. xxxxxx714.

[9] *Id*.

[10] A.M.A., *Guides* 389 (steps in performing an impairment rating), 419 (if there are multiple upper extremity impairments they are combined except for motion impairments of the digits (other than thumb) and multiple digit impairment).

what the employee previously received. For this reason, OWCP properly denied an additional schedule award. The Board will affirm OWCP's December 23, 2011 decision.

Appellant's representative argues there is a conflict in medical opinion. But a closer look at the impairment ratings and the medical record shows otherwise. The medical record better supports the grade modifiers chosen by the medical adviser. Dr. Weiss' evaluation does not carry the same probative weight.

CONCLUSION

The Board finds that the employee had no more than a 15 percent impairment of his right upper extremity due to his accepted wrist and shoulder conditions.

ORDER

IT IS HEREBY ORDERED THAT the December 23, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 11, 2012
Washington, DC

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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

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