United States Department of Labor
Employees' Compensation Appeals Board

A.W., Appellant	)	
	)	**Docket No. 11-1421**
and	)	**Issued: January 6, 2012**
U.S. POSTAL SERVICE, ANNEX, Oklahoma City, OK, 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 June 1, 2011 appellant filed a timely appeal from a December 14, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP) granting her a 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 schedule award decision.

ISSUE

The issue is whether appellant has more than a 14 percent permanent impairment of the left arm, for which she received a schedule award.

FACTUAL HISTORY

On May 7, 2008 appellant, then a 64-year-old flat sorter machine operator, filed an occupational disease claim alleging that she sustained pain in her neck and bilateral shoulders and elbows due to factors of her federal employment. OWCP accepted the claim for

[1] 5 U.S.C. § 8101 *et seq.*

bilateral/lateral epicondylitis, a bilateral sprain of the elbow, forearm and rotator cuff, neck sprain, a bilateral ulnar nerve lesion and bilateral carpal tunnel syndrome.

On December 7, 2009 appellant filed a claim for a schedule award. In an October 15, 2009 impairment evaluation, Dr. Michael Hebrard, an attending Board-certified physiatrist, diagnosed carpal tunnel syndrome, left shoulder adhesive capsulitis with a possible rotator cuff tear, cervical strain, left shoulder internal derangement and right shoulder bicipital tendinitis. Citing the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (6th ed. 2009) (A.M.A., *Guides*), he found that appellant had a 13 percent permanent impairment of each upper extremity.

An OWCP medical adviser reviewed Dr. Hebrard's report and found that he did not identify the diagnoses used to determine appellant's impairment. He requested that OWCP obtain a supplemental report from the physician. On March 9, 2010 OWCP requested that Dr. Hebrard review and respond to its medical adviser's request for additional information about the relevant diagnoses used when calculating the impairment rating; however, he did not provide the requested information.

By letter dated May 20, 2010, OWCP referred appellant to Dr. Michael Shawn Smith, a Board-certified physiatrist, for a second opinion examination. On June 9, 2010 Dr. Smith reviewed the magnetic resonance imaging (MRI) scan study findings of osteoarthritis changes of the left elbow with torn ligaments, a partial thickness tear with tendinosis of the right elbow, a C6-7 disc protrusion, and a supraspinatus tendon tear and bursitis of the left shoulder. He further noted that a 2008 electromyogram (EMG) study showed "significant ulnar and median compression neuropathy on the left as well as cervical radiculopathy at the C6 level." Dr. Smith measured range of motion of the left shoulder and elbows, noting that it was limited due to pain and guarding. He found a positive Tinel's sign of the left elbow and wrist with decreased sensation. Citing the sixth edition of the A.M.A., *Guides*, Dr. Smith identified the diagnosis of entrapment neuropathy under Table 15-23 on page 449 as documented by EMG study. He applied a grade modifier of 1 for clinical findings of conduction delays, a grade modifier of 3 for physical findings of atrophy and weakness and a grade modifier of 3 for history and a *Quick*DASH (Disabilities of the Arm, Shoulder and Hand) score of 84, which he found yielded a six percent impairment due to ulnar neuropathy and a six percent impairment for median neuropathy. Dr. Smith noted that the A.M.A., *Guides* provided that in the case of multiple neuropathies, the nerve qualifying for the larger impairment is given the full impairment, while the nerve qualifying for the smaller impairment is related at half the impairment listed. He thus found that appellant had a total impairment of the left upper extremity due to the median and ulnar neuropathies of nine percent, or six percent plus half of six percent.

For the left shoulder, Dr. Smith utilized the diagnosis of a class 1 partial thickness rotator cuff tear, which yielded a default value of one. He applied a grade modifier of 3 for functional history and physical examination due to appellant's pain and decreased motion and a grade modifier of 1 for clinical studies due to the MRI scan study findings of tendinitis and a mild tear. Dr. Smith found that this moved the default value to E for a three percent upper extremity impairment. He additionally determined that appellant had a class 1 impairment due to left ulnar and median collateral ligament tears of the elbow according to Table 15-4 on page 399. Dr. Smith applied a grade modifier of 2 for functional history due to pain and reduced motion, a

grade modifier of 1 for physical examination due to pain and a grade modifier of 2 for clinical examination findings of collateral changes on MRI scan study. He found that appellant had a default level of C or a two percent impairment of the elbow. Dr. Smith combined the 9 percent impairment due to neuropathy with the 2 percent impairment of the elbow and 3 percent impairment of the shoulder to find a 14 percent permanent left upper extremity impairment. He determined that appellant was not entitled to an additional impairment for cervical radiculopathy as it was included in grade modifiers. Dr. Smith opined that she reached maximum medical improvement on March 13, 2009.

On October 22, 2010 an OWCP medical adviser concurred with Dr. Smith's finding of a nine percent permanent impairment of the left arm due to median and ulnar neuropathy. He found that appellant had a class 1 impairment due to her partial thickness rotator cuff tear. OWCP's medical adviser applied Dr. Smith's finding of grade modifiers of 3 for functional history and physical examination and one for clinical studies, which he found yielded a five percent total impairment of the shoulder. He combined the 9 percent impairment due to neuropathy with the 5 percent shoulder impairment to find a total left upper extremity impairment of 14 percent.

By decision dated December 14, 2010, OWCP granted appellant a schedule award for a 14 percent permanent impairment of the left upper extremity. The period of the award ran from Mach 13, 2009 to January 12, 2010.

On appeal appellant argues that she is entitled to a schedule award for her right upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA,[2] and its implementing federal regulations,[3] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[4] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[5]

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),

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *Id*. at § 10.404(a).

[5] 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).

Physical Examination (GMPE) and Clinical Studies (GMCS).[6] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

ANALYSIS

OWCP accepted that appellant sustained bilateral lateral epicondylitis, a bilateral sprain of the elbow and forearm, a bilateral rotator cuff sprain, neck sprain, a bilateral ulnar nerve lesion and bilateral carpal tunnel syndrome due to factors of her federal employment.

Dr. Hebrard's October 15, 2009 evaluation, citing the sixth edition of the A.M.A., *Guides*, found that appellant had a 13 percent permanent impairment of each upper extremity. An OWCP medical adviser reviewed his report and noted that he did not identify the diagnoses used in determining the extent of impairment. OWCP requested that Dr. Hebrard clarify his opinion; however, he did not respond to the request. As Dr. Hebrard's opinion did not conform to the A.M.A., *Guides,* OWCP properly referred appellant to Dr. Smith for a second opinion examination.

On June 9, 2010 Dr. Smith related that an MRI scan study of the left elbow revealed osteoarthritis and torn ligaments and an MRI scan study of the left shoulder revealed a supraspinatus tendon tear and bursitis. He noted that a 2008 EMG study showed significant ulnar and median compression neuropathy on the left side and C6 cervical radiculopathy. On examination, Dr. Smith found a positive Tinel's sign of the left wrist and elbow with a loss of sensation. He measured range of motion of the left shoulder and elbows but found it limited by pain. Applying the provisions of the sixth edition of the A.M.A., *Guides* to his findings, Dr. Smith rated appellant's impairment due to entrapment neuropathy under Table 15-23 as diagnostic studies and clinical findings confirmed a significant ulnar and median neuropathy. He applied grade modifiers of 1 for clinical findings of a conduction delay, a grade modifier of 3 for physical examination findings of atrophy and weakness and a grade modifier of 3 for functional history. Dr. Smith further adjusted the value up from the default value based on appellant's *Quick*DASH score of 84, to find a six percent impairment for ulnar neuropathy and a six percent impairment for median neuropathy. In cases of multiple, concurrent focal nerve compromise syndromes in the same upper extremity, such as an ulnar and median neuropathy, the nerve qualifying for the larger impairment is given the full impairment. The nerve qualifying for the smaller impairment is given half the impairment listed in Table 15-23. The impairments are then combined.[7] Dr. Smith thus properly determined that appellant was entitled to only half the impairment for the one of the neuropathies, for a total impairment due to her ulnar and median neuropathy of nine percent.

For the left shoulder, Dr. Smith found that appellant had a class 1 partial thickness rotator cuff tear, for a default value of one. He applied grade modifiers for functional history and physical examination of three based on pain and loss of motion and a grade modifier of 1 for clinical studies based on an MRI scan study showing tendinitis and a small tear. Dr. Smith concluded that appellant had a three percent impairment due to her rotator cuff tear. However,

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

[7] *Id*. at 448.

utilizing the net adjustment formula discussed above, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (3-1) + (3-1) + (1-1) = 4. This yields an adjustment from the default value to grade E, which constitutes either a five percent impairment for an impairment with residual loss, or a two percent impairment without objective findings under Table 15-5.

For the left elbow, Dr. Smith found that appellant had an impairment due to class 1 chronic ulnar and median collateral ligament tears. After applying grade modifiers, he concluded that she had a two percent impairment of the left elbow under Table 15-4 on page 399. The diagnosis of collateral ligament injury, however, does not provide an impairment rating of two percent. It is thus unclear how Dr. Smith arrived at his impairment finding for appellant's left elbow.

An OWCP medical adviser reviewed Dr. Smith's report and concurred with the finding that appellant had a nine percent impairment due to median and ulnar neuropathy. He determined that she had a five percent permanent impairment of the shoulder using Table 15-5. The medical adviser, however, did not consider the elbow impairment in rating the extent of appellant's left upper extremity impairment. The A.M.A., *Guides* provides that an impairment of the shoulder and elbow can be combined in determining the extent of any impairment.[8] The medical adviser did not explain why he did not consider the rating for appellant's elbow. The case will be remanded for a supplemental opinion from the medical adviser regarding whether she has any additional impairment of the left upper extremity due to her elbow condition.

On appeal appellant argued that she is also entitled to a schedule award for the right upper extremity. The Board's jurisdiction, however, is limited to reviewing final decisions by OWCP.[9] OWCP has not issued a final decision on this issue and thus it is not before the Board at this time.

CONCLUSION

The Board finds that the case is not in posture for decision.

[8] *See* Figure 15-2 at 388.

[9] 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the December 14, 2010 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: January 6, 2012
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