United States Department of Labor
Employees' Compensation Appeals Board

T.Z., Appellant	)	
and	)	**Docket No. 13-834**
	)	**Issued: August 1, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Milan, IL, Employer	)	

Appearances:
Alan J. Shapiro, 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 February 26, 2013 appellant, through her attorney, filed a timely appeal from a January 16, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) affirming 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 merits of this case.

ISSUE

The issue is whether appellant has greater than a 10 percent impairment of the right upper extremity, for which she received a schedule award.

On appeal, counsel asserts that OWCP's January 16, 2013 decision is "contrary to fact and law."

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on or before August 1, 2004 appellant, then a 42-year-old postal clerk, sustained right carpal tunnel syndrome and impingement syndrome of the right shoulder due to repetitive upper extremity motions at work. Dr. Richard R. Ripperger, an attending Board-certified orthopedic surgeon, submitted reports from January 21, 2005 to May 7, 2009 diagnosing work-related right carpal tunnel syndrome and right shoulder impingement treated with steroid injections. On September 8, 2008 he performed an arthroscopic subacromial decompression of the right shoulder with limited joint debridement.

In a May 7, 2009 report, Dr. Ripperger explained that although the April 16, 2009 electromyography (EMG) and nerve conduction velocity (NCV) studies were normal, appellant's clinical findings of pain and paresthesias in the median nerve distribution were diagnostic of right carpal tunnel syndrome. He performed a right median nerve release on June 8, 2009. Dr. Ripperger submitted progress notes regarding the right wrist and shoulder, noting that appellant required additional right shoulder injections for postoperative irritation or subacromial bursitis.

On November 24, 2009 appellant claimed a schedule award. She submitted a January 8, 2010 impairment rating from Dr. Ripperger, who advised that her right wrist and shoulder had reached maximum medical improvement. Dr. Ripperger noted good strength and a normal sensory examination throughout the right arm. For the right shoulder, he found the following active ranges of motion: 165 degrees elevation, 65 degrees external rotation, internal rotation to L1, 150 degrees forward flexion, 40 degrees backward extension, 130 degrees abduction, 30 degrees adduction. For the right wrist, Dr. Ripperger measured 65 degrees dorsiflexion, 70 degrees palmar flexion, 20 degrees radial deviation, 25 degrees ulnar deviation and full pronation and supination. He also noted thickening at the incision site and slight pretentious cords in both hands, indicative of Dupuytren's contracture. Referring generally to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*), Dr. Ripperger found that appellant had a 14 percent impairment of the right upper extremity due to carpal tunnel syndrome and right shoulder impingement.

On March 10, 2010 an OWCP medical adviser reviewed Dr. Ripperger's report and agreed that appellant had attained maximum medical improvement. He noted that Dr. Ripperger did not report passive ranges of motion and listed internal rotation of the shoulder in a nonstandard manner. Referring to Table 15-23[2] of the A.M.A., *Guides*, the medical adviser stated that there were two diagnosis-based (CDX) methods to rate shoulder impairment, a class 1 full-thickness rotator cuff tear with a class C default of five percent or a class 1 for right shoulder impingement with residual loss of function and normal motion. He selected the higher CDX impairment for rotator cuff tear, equaling a five percent impairment of the upper extremity. Referring to Table 15-21,[3] the medical adviser found a five percent upper extremity impairment

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

[3] Table 15-21, page 436 of the sixth edition of the A.M.A., *Guides* is entitled "Peripheral Nerve Impairment: Upper Extremity Impairments."

for carpal tunnel syndrome with mild sensory deficit, incisional thickening and residual symptoms. The medical adviser combined the two 5 percent impairments to equal a 10 percent impairment of the right upper extremity.

By decision dated April 12, 2010, OWCP issued appellant a schedule award for a 10 percent impairment of the right arm. The period of the award ran from January 8 to August 14, 2010.

Appellant requested a review of the written record on April 24, 2010, contending 14 percent impairment as rated by Dr. Ripperger. She noted difficulty using a weed whacker and required additional shoulder injections. Appellant did not submit additional medical evidence. By decision dated and finalized August 17, 2010, an OWCP hearing representative affirmed the April 12, 2010 schedule award, finding that the medical adviser properly applied the appropriate portions of the A.M.A., *Guides* to Dr. Ripperger's findings on physical examination.

In a letter received on October 6, 2010, appellant requested reconsideration. She submitted a September 20, 2010 impairment rating from Dr. Ripperger, who rated a 5 percent impairment of the right upper extremity due to carpal syndrome, based on a "soft tissue [c]lass [1]" CDX from Table 15-7,[4] a grade modifier for Functional History (GMFH) of 1 according to Table 15-8[5] and a grade modifier for Clinical Studies (GMCS) of zero according to Table 15-9.[6] Applying the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) resulted in a modifier of -1, adjusting the class 1 CDX from the default grade of C to B. Dr. Ripperger used Table 15-10[7] to convert the grade B impairment to a five percent impairment of the right upper extremity. Regarding the right shoulder, Dr. Ripperger found a nine percent impairment, based on a class 1 CDX of "soft tissue" according to Table 15-5,[8] a GMFH of 2 according to Table 15-7, a Physical Examination (GMPE) of 1 according to Table 15-8 and a GMCS of 1 according to Table 15-9 based on arthritis visible on January 8, 2010 x-rays. Using the net adjustment formula, Dr. Ripperger calculated a modifier of +1, raising the CDX default grade of C to D, equaling a nine percent impairment of the right upper extremity according to Table 15-10. He combined the 5 and 9 percent impairments to total a 14 percent impairment of the right arm.

On October 19, 2010 an OWCP medical adviser reviewed Dr. Ripperger's September 20, 2010 report. He stated that Dr. Ripperger misapplied the A.M.A., *Guides*, as carpal tunnel

[4] Table 15-7, page 406 of the sixth edition of the A.M.A., *Guides* is entitled "Functional History Adjustment: Upper Extremities."

[5] Table 15-8, page 408 of the sixth edition of the A.M.A., *Guides* is entitled "Physical Examination Adjustment: Upper Extremities."

[6] Table 15-9, page 410 of the sixth edition of the A.M.A., *Guides* is entitled "Clinical Studies Adjustment: Upper Extremities."

[7] Table 15-10, page 412 of the sixth edition of the A.M.A., *Guides* is entitled "Methodology for Determining the Grade in an Impairment Class."

[8] Table 15-5, page 401 of the sixth edition of the A.M.A., *Guides* is entitled "Shoulder Regional Grid: Upper Extremity Impairments."

syndrome should be rated using Table 15-23 for entrapment and compression neuropathy. As appellant had negative EMG and NCV studies, the GMCS was properly zero. As appellant had normal sensation on examination, the GMPE was 1 and a GMFH of 2 for mild symptoms. Applying the net adjustment formula, the medical adviser found a five percent impairment of the right arm due to carpal tunnel syndrome. Regarding the right shoulder, the medical adviser found that Dr. Ripperger should not have used a soft tissue CDX rating method and that this method yielded only a three percent upper extremity impairment. He concluded that appellant did not sustain greater impairment.

By decision dated November 19, 2010, OWCP affirmed its April 12, 2010 schedule award, finding that Dr. Ripperger's September 20, 2010 rating, as reviewed by the medical adviser, did not establish a greater percentage of impairment than the 10 percent awarded.

OWCP accepted that appellant sustained a right rotator cuff strain in the performance of duty on December 8, 2010. doubled the new claim under File No. xxxxxx230 with the August 1, 2004 claim under File No. xxxxxx525, using File No. xxxxxx525 as the master file number.

A March 23, 2011 right shoulder magnetic resonance imaging (MRI) scan showed a recurrent full thickness supraspinatus tear and superior labrum anterior-posterior lesion. On May 2, 2011 Dr. Ripperger performed a repeat right shoulder arthroscopy and rotator cuff repair to address a partial thickness supraspinatus tear and glenohumeral arthritis visualized during the procedure. He released appellant to limited duty in July 2011 and to full duty on October 27, 2011.

On April 4, 2012 appellant claimed a schedule award. In an April 12, 2012 letter, OWCP advised her to submit a report from her attending physician confirming that she had attained maximum medical improvement and supplying an impairment rating using the sixth edition of the A.M.A., *Guides*.

In a May 3, 2012 impairment report, Dr. Jessica Glazer Volsky, an attending osteopathic physician, reviewed a history of injury and treatment and found that appellant had attained maximum medical improvement. She related appellant's complaints of chronic right shoulder pain and paresthesias, noting that a *Quick*DASH questionnaire yielded a score of 57. On examination Dr. Volsky found 4/5 grip strength on the right, a normal sensory examination, weakness in the right arm against resistance, 40 degrees shoulder extension and 160 degrees flexion, 60 degrees external rotation and internal rotation at L3. She diagnosed status post full-thicknes rotator cuff tear. Dr. Volsky found a CDX of 1 based on Table 15-5, a GMFH of 2 according to Table 15-7, a GMPE of 2 according to Table 15-8, which she calculated equaled a net adjustment of 2. She stated that appellant had a seven percent impairment of the right upper extremity due to the rotator cuff tear. Dr. Volsky did not address any impairment of the right wrist.[9]

In a June 21, 2012 report, an OWCP medical adviser reviewed Dr. Volsky's impairment rating. He found that, although the May 2, 2011 procedure revealed a partial thickness tear,

[9] In a May 11, 2012 report, Dr. Ripperger found that appellant had no palpable rotator cuff defect one year after the May 2, 2011 surgery.

Dr. Volsky rated a full thickness tear. The medical adviser found that a partial thickness tear should be rated as grade 1, class E, equaling a five percent impairment. As appellant had already received a schedule award for a 10 percent impairment of the upper extremity, including 5 percent for a right rotator cuff tear, she was not entitled to a schedule award.

By decision dated July 12, 2012, OWCP found that appellant was not entitled to an additional schedule award, as her present right upper extremity impairment rating of 5 percent was less than the 10 percent previously awarded.

On July 9, 2012 counsel requested a telephonic hearing, held November 5, 2012. At the hearing, he asserted that the medical adviser's report was contradictory.

By decision dated and finalized on January 16, 2013, an OWCP hearing representative affirmed the July 12, 2012 decision. The hearing representative found that, as Dr. Rippenger visualized a partial thickness tear during the May 2, 2011 surgery, it was inappropriate for Dr. Volsky to have rated appellant's right arm based on a full thickness rotator cuff tear.

LEGAL PRECEDENT

The schedule award provisions of FECA[10] 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.[11] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[12]

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).[13] 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.[14] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

[10] 5 U.S.C. § 8107.

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

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

[13] 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."

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

ANALYSIS

Appellant claimed a schedule award for right shoulder and right wrist impairment related to accepted impingement syndrome and carpal tunnel syndrome. She submitted a January 8, 2010 impairment rating from Dr. Ripperger, an attending Board-certified orthopedic surgeon, who without citing specific tables referred to the A.M.A., *Guides* to find a 14 percent impairment of the right upper extremity for wrist and shoulder impartments. An OWCP medical adviser applied specific portions of the A.M.A., *Guides* to Dr. Ripperger's findings on March 10, 2010. He rated a 5 percent impairment of the right upper extremity due to carpal tunnel syndrome and 5 percent for the rotator cuff tear, for a combined total of 10 percent. OWCP issued a schedule award on April 12, 2010 for a 10 percent impairment of the right arm, affirmed on August 17, 2010. In a report dated September 20, 2010, Dr. Ripperger submitted a second and more in depth impairment rating indicating specifically how he arrived at his 14 percent upper extremity rating. By response dated October 19, 2010, the medical adviser stated that Dr. Ripperger misapplied the A.M.A., *Guides* in his rating.

Appellant sustained a second right shoulder injury on December 8, 2010. A March 23, 2011 MRI scan showed possible full-thickness supraspinatus tear. Dr. Ripperger performed a repeat right shoulder arthroscopy on May 2, 2011 and visualized a partial thickness tear. Appellant claimed an additional schedule award on April 4, 2012. The May 3, 2012 impairment rating from Dr. Volsky, an attending osteopath, rated a seven percent impairment of the right upper extremity based on a full-thickness rotator cuff tear. On June 21, 2012 the medical adviser reviewed Dr. Volsky's report and found that she misinterpreted Dr. Ripperger's findings. The medical adviser found that the maximum rating for a partial thickness tear would be a class 1, grade E diagnosis-based impairment, a five percent impairment of the upper extremity. This was the same as previously rated for the right shoulder. By decision dated July 12, 2012 and affirmed on January 16, 2013, OWCP found that appellant had not sustained an additional impairment to the right upper extremity beyond the 10 percent previously awarded.

The Board finds that the medical adviser's rating of impairment is entitled to the weight of the medical evidence. The medical adviser properly applied the appropriate portions of the A.M.A., *Guides* to Dr. Volsky's detailed clinical findings. He explained each aspect of his rating and noted that Dr. Volsky misinterpreted Dr. Ripperger's findings, as it pertained to the extent of the torn rotator cuff. OWCP's January 16, 2013 decision finding that appellant had not established more than a 10 percent impairment of the right upper extremity was proper under the facts of this case.

On appeal, counsel asserts that OWCP's January 16, 2013 decision is contrary to fact and law. As noted, OWCP properly relied on the impairment rating of its medical adviser. Appellant may request a schedule award or increased schedule award regarding the right upper extremity, 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 did not meet her burden to establish more than 10 percent impairment of her right arm.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated January 16, 2013 is affirmed.

Issued: August 1, 2013
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