United States Department of Labor
Employees' Compensation Appeals Board

E.A., Appellant	)	
and	)	**Docket No. 13-1958**
	)	**Issued: March 18, 2014**
U.S. POSTAL SERVICE, POSTAL SERVICE, Houston, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On August 12, 2013 appellant filed a timely appeal from a May 24, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 the case.

ISSUE

The issue is whether appellant has more than 15 percent permanent impairment of the right upper extremity for which she received a schedule award.

FACTUAL HISTORY

On March 10, 2004 appellant, then a 55-year-old letter carrier filed an occupational disease claim alleging that she developed inflammation of the left wrist, middle finger and thumb while performing repetitive work duties. OWCP accepted her claim for de Quervain's disease of

[1] 5 U.S.C. §§ 8101-8193.

the left wrist.[2] It authorized arthroscopic surgery on appellant's right shoulder, which was performed on February 21 and May 2, 2007.

Appellant submitted an October 17, 2006 right shoulder x-ray that revealed moderate osteoarthritis in the right shoulder joint, acromion osteophyte formation and mild right acromioclavicular joint osteoarthritis. A November 20, 2006 magnetic resonance imaging (MRI) scan of the right shoulder which revealed a supraspinatus and infraspinatus tendinosis with suspected superimposed small full thickness tear in the anterior aspect of the supraspinatus distal tendon and a partial tear of the subscapularis tendon.

Appellant came under the treatment of Dr. Mike Dean, a Board-certified orthopedist, from January 29 to July 9, 2007 for right shoulder pain. Dr. Dean noted limited range of motion of the right shoulder and an MRI scan revealed a rotator cuff tear. He diagnosed rotator cuff tear of the right shoulder and bursitis of the right shoulder. On February 21, 2007 Dr. Dean performed an arthroscopic subacromial decompression of the right shoulder, arthroscopic repair of the rotator cuff tear and biceps tenodesis and diagnosed right shoulder impingement syndrome, large supraspinatus and infraspinatus tear and biceps partial rupture. On May 2, 2007 he performed a manipulation under anesthesia of the right shoulder and diagnosed right shoulder postoperative adhesive capsulitis. On July 9, 2007 Dr. Dean noted that appellant was progressing well postoperatively but had pain and stiffness.

Appellant filed a claim for a schedule award. In a March 9, 2010 letter, OWCP requested that she provide a report from her physician, which evaluates the extent of permanent impairment of the bilateral upper extremities under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*).[3]

OWCP referred appellant for a second opinion to Dr. Jerome Carter, a Board-certified orthopedist, for an impairment rating pursuant to the A.M.A., *Guides.* In a March 6, 2013 report, Dr. Carter noted her history and findings. Palpation of the right shoulder revealed tenderness at cortacoids area; the impingement, drawer and crepitation test was negative. Right wrist palpation was normal, Finkelstein's, Phalen's and Tinel's tests were negative. Sensation at the median, radial and ulnar nerves was normal. Dr. Carter opined that appellant had reached maximum medical improvement. He noted active right shoulder range of motion for flexion of 125 degrees, extension of 25 degrees, abduction of 95 degrees, adduction of 30 degrees, internal rotation of 70 degrees and external rotation of 80 degrees. Right wrist range of motion for

[2] Appellant filed an occupational disease claim in July 2003 that was accepted for bilateral carpal tunnel syndrome and bilateral lateral epicondylitis, claim number xxxxxx655. On February 6, 2009 she was granted a schedule award for eight percent left arm impairment due to loss of wrist range of motion. A claim for a July 21, 2003 injury was accepted for right finger fracture, claim number xxxxxx296. A claim for a March 8, 2004 injury was accepted for left wrist tenosynovitis, claim number xxxxxx010. A claim for a May 2, 2006 injury was accepted for right shoulder sprain and right disorder of the bursae tendon, claim number xxxxxx395. In this claim, appellant was granted a schedule award for 14 percent right arm impairment on January 21, 2009 due to loss of shoulder range of motion and one percent right arm impairment on November 9, 2011 due to her wrist injury. She appealed her claim to the Board and in a decision dated July 19, 2012, the Board affirmed the November 9, 2011 OWCP decision. Docket No. 12-622. These claims have been combined with the present claim.

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

flexion was 60 degrees, extension 60 degrees, ulnar deviation 30 degrees and radial deviation 20 degrees. Dr. Carter noted positive tenderness to palpation at cortacoids. The Neer, Empty Can, Hawkins and Crossed Arm Adduction tests were positive on the right. There was mild right shoulder crepitus. Bilateral upper extremity reflexes were normal and sensory examination and motor examination was 4/5 on the right. The right wrist was normal to palpation as was range of motion.

Sensory, motor and reflexes were normal but right grip strength was diminished. Phalen's and Tinel's test were negative, with pain intermittently increased with use of right hand. Dr. Carter diagnosed right radial styloid tenosynovitis under Table 15-3, Wrist Regional Grid, page 395 of the A.M.A., *Guides*, for the wrist pain, nonspecific wrist pain postacute injury or surgery. Appellant had a class 1 rating for history of painful injury, residual symptoms without consistent objective findings, with a default rating of one percent arm impairment. Dr. Carter noted that, pursuant to the Adjustment Grid: Functional History, Table 15-7, she was assigned a grade modifier 1, mild problem, with pain/symptoms with strenuous/vigorous activity. For the Physical Examination Adjustment, Table 15-8, appellant was assigned a grade modifier 1 for mild problem, minimal palpatory findings, increased pain with constant use. For the Clinical Studies Adjustment, Table 15-9, appellant was assigned a grade modifier zero. Dr. Carter noted that the respective adjustments yielded a net adjustment of -1. This resulted in a grade B and zero percent arm impairment. For the right shoulder, under Table 15-34, A.M.A., *Guides*, at page 475, Dr. Carter found 11 percent right arm impairment due to loss of shoulder range of motion. Under Table 15-34, he determined that flexion of 125 degrees equaled three percent impairment, extension of 25 degrees equaled one percent impairment, abduction of 95 degrees equaled three percent impairment, adduction of 30 degrees equaled one percent impairment, external rotation of 80 degrees yielded zero percent impairment and internal rotation of 70 degrees equaled two percent impairment.[4] Dr. Carter added the range of motion values and indicated that would result in a 10 percent permanent impairment. He also referred to Table 15-35 and explained that the range of motion deficit qualified for a grade 1 modifier[5] and a functional history grade modifier 2 based on Table 15-7 therefore adjustment was made of +1. The grade adjustment under Table 15-36, page 477 for net modifier of one was five percent of total range of motion impairment. He multiplied 10 percent by 5 percent to equal .5 percent, which was rounded to 1 percent to yield 11 percent right arm impairment for loss of motion to the right shoulder.

In an April 8, 2013 report, an OWCP medical adviser reviewed the medical record and concurred in Dr. Carter's March 6, 2013 findings. The medical adviser indicated that Dr. Carter properly applied the sixth edition of the A.M.A., *Guides* to find that appellant had 11 percent impairment to the right upper extremity for loss of motion of the right shoulder.

On May 15, 2013 OWCP advised the medical adviser of appellant's previous schedule awards, including the award for 14 percent impairment of the right arm for an accepted right shoulder injury. It requested that the medical adviser review the prior schedule awards and

[4] *Id*. at 475.

[5] *Id.* at 477.

determine whether she was entitled to an additional schedule award for the right upper extremity above what was previously granted.

In a May 17, 2013 report, the medical adviser noted that appellant was previously paid 14 percent impairment for the right arm based on loss of motion of the right shoulder and did not have right arm impairment beyond what was previously granted. He noted that the prior schedule award for 14 percent impairment of the right upper extremity should be subtracted from the current determination of 11 percent impairment, which yielded 0 percent additional impairment for the right upper extremity for loss of motion of the right shoulder.

In a decision dated May 24, 2013, OWCP denied appellant's claim for an additional schedule award.

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing federal regulations,[7] 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.[8] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[10]

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).[11] Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + GMCS - CDX).[13] The grade modifiers are used on the net adjustment formula described above

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[10] FECA Bulletin No. 09-03 (issued March 15, 2009).

[11] A.M.A., *Guides*, 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[12] *Id.* at 387-419.

[13] *Id.* at 411.

to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[14]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the medical consultant for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the medical consultant providing rationale for the percentage of impairment specified.[15]

ANALYSIS

OWCP accepted various right arm conditions including carpal tunnel syndrome, finger fracture, shoulder sprain and disorder of the bursae tendon. It also authorized a February 21, 2007 authorized arthroscopic subacromial decompression of the right shoulder and repair of the rotator cuff tear. In claim number xxxxxx395, OWCP paid a schedule award for 14 percent right arm impairment due to the shoulder injury and 1 percent right arm impairment due to the wrist injury. Appellant requested an additional schedule award.

OWCP referred appellant for a second opinion to Dr. Carter who issued a March 6, 2012 report. Dr. Carter properly found that, in accordance with Table 15-3, Wrist Regional Grid, page 395 of the A.M.A., *Guides* her impairing diagnosis was a right radial styloid tenosynovitis, for the wrist pain, nonspecific wrist pain postacute injury or surgery, which he rated as class 1, painful injury, residual symptoms without consistent objective findings, equal to a 1 percent upper extremity impairment. He applied the modifiers for functional history, physical examination and clinical studies found in Table 15-7, Table 15-8 and Table 15-9. Dr. Carter rated a functional history modifier 1, a physical examination modifier 1 and a modifier 0 for clinical studies. He applied the net adjustment formula to find zero percent impairment due to the right wrist condition under the sixth edition of the A.M.A., *Guides*.

For the right shoulder, Dr. Carter rated appellant in accordance with Table 15-34, page 475 of the A.M.A., *Guides*, for lost shoulder range of motion. He found that flexion of 125 degrees equaled three percent impairment, extension of 25 degrees equaled one percent impairment, abduction of 95 degrees equaled three percent impairment, adduction of 30 degrees equaled one percent impairment, external rotation of 80 degrees equaled zero percent impairment and internal rotation of 70 degrees equaled two percent impairment.[16] Dr. Carter added the range of motion values to equal 10 percent default impairment. He also referred to Table 15-35 and explained that the range of motion deficit qualified for a grade 1 modifier[17] and a functional history grade modifier 2 based on Table 15-7, yielded an adjustment modifier +1. Under Table 15-36, page 477 a net modifier of one was 5 percent of total range of motion impairment. Dr. Carter multiplied 10 percent by 5 percent to equal .5 percent which was rounded to one

[14] *Id*. at 411-12.

[15] *See Federal* (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[16] A.M.A., *Guides* 475.

[17] *Id.* at 477.

percent to yield 11 percent arm impairment for the right shoulder condition under the A.M.A., *Guides*.

Dr. Carter properly explained his calculations under the sixth edition of the A.M.A., *Guides*. An OWCP medical adviser reviewed his report and agreed with his determination. There is no current medical evidence in the record, in accordance with the A.M.A., *Guides*, which supports that appellant sustained a higher impairment. The Board finds that the weight of medical evidence establishes that she has 11 percent right arm impairment attributable to her shoulder condition and no ratable impairment due to her right wrist condition. The medical adviser properly noted that appellant was previously paid 14 percent impairment for the right upper extremity based on loss of motion of the right shoulder and was not entitled to an additional schedule award for the right arm above what was previously granted.[18]

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 OWCP properly denied appellants request for an additional schedule award for the right upper extremity.

[18] FECA provides for reduction of compensation for subsequent injury to the same body member. It provides that schedule award compensation is reduced by the compensation paid for an earlier injury where the compensation in both cases are for impairment of the same member or function and where it is determined that the compensation for the later disability in whole or part would duplicate the compensation payable for the preexisting disability. 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

ORDER

IT IS HEREBY ORDERED that the May 24, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 18, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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