United States Department of Labor
Employees' Compensation Appeals Board

P.M., Appellant	)	
and	)	**Docket No. 14-996**
	)	**Issued: October 7, 2014**
DEPARTMENT OF LABOR, OFFICE OF WORKERS'COMPENSATION PROGRAMS, San Francisco, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 21, 2014 appellant filed a timely appeal of a February 11, 2014 Office of Workers' Compensation Programs' (OWCP) merit decision denying her claim for 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 to consider the merits of the case.

ISSUE

The issue is whether appellant has more than 5 percent impairment of her left upper extremity and 19 percent of her right upper extremity for which she has received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board on appeal on various aspects of appellant's five claims which have been combined in the current case. On March 30, 2009

[1] 5 U.S.C. § 8101 *et seq.*

appellant, then a 49-year-old senior claims examiner, filed a traumatic injury claim alleging that she developed pain in her left hip and the back of her left thigh on March 24, 2009 while walking down 16 flights of stairs during a fire drill. OWCP accepted her claim for lumbar sprain and lumbar radiculitis on May 21, 2009; OWCP File No. xxxxxx867. By decision dated October 1, 2010, it denied appellant's claim for a schedule award finding that the medical evidence did not establish a ratable impairment to either lower extremity. The Board reviewed this claim on November 23, 2011 and affirmed OWCP's decision denying appellant's claim for a schedule award.[2]

On March 18, 2010 appellant filed a traumatic injury claim alleging on February 25, 2010 she injured her left forearm, wrist and thumb attempting to lower her desk height. OWCP accepted her claim for de Quervain's tenosynovitis left and left forearm tendinitis on July 13, 2010; OWCP File No. xxxxxx189. By decision dated January 2, 2014, it granted appellant a schedule award for one percent impairment of her left upper extremity. The Board affirmed the January 2, 2014 decision on August 5, 2014.[3]

On December 2, 2010 appellant filed a traumatic injury claim alleging that she twisted her right knee on November 23, 2010 when her right foot became entangled in a coil of telephone wire under a table. OWCP accepted this claim for right knee sprain on February 16, 2011; OWCP File No. xxxxxx900. In a decision dated January 25, 2013, OWCP terminated appellant's eligibility for medical and wage-loss compensation benefits effective that date. The Board reviewed this decision on April 17, 2014 and affirmed the termination.[4]

On March 24, 2004 appellant,[5] then a 44-year-old senior claims examiner, filed an occupational disease claim alleging that she developed conditions in her shoulders, forearms, elbows and neck from reaching, typing and indexing mail in the performance of duty. OWCP accepted her claim for bilateral trapezius strain, bilateral rotator cuff strain and cervical strain on April 16, 2004; OWCP File No. xxxxxx134. It included the additional conditions of bilateral shoulder impingements and right shoulder adhesive capsulitis on May 3, 2004. Appellant underwent nerve conduction velocity (NCV) and electromyogram (EMG) testing on May 21, 2004 which were read as within normal limits. A magnetic resonance imaging (MRI) scan of her left shoulder dated June 11, 2004 demonstrated probable tendinitis or a partial tear of the distal rotator cuff tendon and mild hypertrophic changes of the acromioclavicular (AC) joint. The MRI scan of appellant's right shoulder on June 11, 2004 demonstrated either prominent tendinitis or partial tear of the distal anterior portion of the rotator cuff tendon as well as moderate hypertrophic degenerative changes of the AC joint with possible downward impingement upon the rotator cuff at the musculotendinous junction. Appellant underwent an additional left shoulder MRI scan on February 11, 2005 which demonstrated an area of interstitial partial

[2] Docket No. 11-1072 (issued November 23, 2011). OWCP issued final decisions in this claim on June 11 and August 6, 2014, terminating appellant's medical benefits and denying modification of that decision, respectively. Appellant has not appealed from these decisions and thus they are not before the Board. *See* 20 C.F.R. § 501.3(a).

[3] Docket No. 14-718 (issued August 5, 2014). OWCP issued an additional decision in this claim on May 5, 2014 which appellant has not filed an appeal from. Thus, it is not currently before this Board. *See* 20 C.F.R. § 501.3(a).

[4] Docket No. 13-1621 (issued April 17, 2014).

[5] Appellant filed a traumatic injury claim on March 13, 2001 for neck sprain occurring on March 7, 2001; OWCP File No. xxxxxx767. OWCP did not issue a final decision regarding this claim.

tearing of the posterior aspect of the supraspinatus tendon with a possible small perforation through the bursal fibers and associated subacromial/subdeltoid bursitis. She underwent left arthroscopy shoulder surgery on May 31, 2005 with limited intra-articular debridement, subacromial decompression and distal clavicle resection. Appellant returned to full-time limited duty on August 1, 2005.

By decision dated May 3, 2006, OWCP granted appellant a schedule award for 5 percent permanent impairment of the right upper extremity and 19 percent impairment of the left upper extremity.

In a report dated May 21, 2012, Dr. Gregory Horner, a Board-certified orthopedic surgeon, reviewed appellant's history of employment injuries. He found that she had normal range of motion in her cervical and lumbar spine. Dr. Horner also noted that appellant demonstrated tenderness to deep palpation in her lumbosacral spine and limited range of motion due to severe discomfort. He reported that her deep tendon reflexes were within normal limits with normal sensation and motor function. Dr. Horner examined appellant's upper extremities and found 130 degrees of forward flexion, external rotation of 65 degrees and equal internal rotation. He stated that she had normal range of motion of her elbows, wrists and fingers with full motor strength and normal sensation and normal deep tendon reflexes. Dr. Horner found no atrophy. He provided work restrictions.

Appellant filed a claim for compensation on July 11, 2013 and requested a schedule award. She requested that OWCP refer her to a second opinion physician to determine her permanent impairment for schedule award purposes on July 18, 2013. On July 29, 2013 OWCP requested that appellant submit a detailed medical report in support of her claim for a schedule award. On August 5 and October 25, 2013 appellant again requested that OWCP refer her to a physician to evaluate her permanent impairment.

OWCP referred appellant for a second opinion evaluation with Dr. Aubrey A. Swartz, a Board-certified orthopedic surgeon, on October 18, 2013. Dr. Swartz completed a report on November 4, 2013 and examined appellant's upper extremities. He found that she had intact sensation in both upper extremities and that she had tenderness in the right shoulder. Dr. Swartz listed appellant's range of motion as 115 degrees of flexion on the right and 120 degrees on the left, 80 degrees of abduction on the right and 120 on the left, 60 degrees of extension on the right and 65 on the left as well as 40 degrees of adduction, 80 degrees of internal rotation and 110 degrees of external rotation bilaterally. He found that she had give-away weakness with all strength testing of both shoulders and reported pain with strength testing in both shoulders.

Dr. Swartz provided the range of motion of appellant's wrists as 70 degrees of dorsiflexion on the right and 60 degrees on the left, 70 degrees of palmar flexion on the right and 60 degrees on the left, 30 degrees of ulnar deviation on the right and 25 on the left with 20 degrees of radial deviation bilaterally. He stated that her right grip strength testing was 10, 11 and 11 kilograms while her left was 22, 20 and 19 kilograms. Dr. Swartz reported that there was minimal flexor forearm contractility with grip strength testing on the right and slightly less with grip testing on the left. He reported positive impingement testing in the right shoulder with pain on Speed, O'Brien and Abbott-Saunders tests.

Dr. Swartz provided appellant's cervical range of motion as flexion 30 degrees, extension 25 degrees, lateral flexion 30 degrees and rotation 40 degrees. He stated that she reported mild

tenderness or soreness with palpation of the cervical spine with no spasm. Dr. Swartz noted that appellant had no history of radiculopathy referable to her cervical spine and no neurologic findings. He concluded that she had no radiculopathy, no peripheral nerve or nerve root injury in her cervical spine and therefore no ratable impairment due to her cervical spine.

With regard to appellant's right shoulder, Dr. Swartz found that, under the A.M.A., *Guides*, an impingement syndrome was three percent default impairment.[6] He found a functional history grade modifier of 1, *Quick*DASH score of 39, physical examination grade modifier 2 based on limited motion,[7] and that clinical studies grade modifier would not apply as imaging studies were required in order to diagnose the condition. Dr. Swartz applied the formula of the A.M.A., *Guides* and concluded that appellant had grade D, four percent impairment of the right upper extremity. He applied the A.M.A., *Guides* to the findings related to her left shoulder and stated that the values were identical again resulting in four percent impairment of the left upper extremity. Dr. Swartz diagnosed de Quervain's tenosynovitis of the left wrist and found that this diagnosis had a one percent default diagnosis.[8] He stated that appellant's functional history adjustment would be grade modifier 1, and physical examination would also be grade modifier 1 resulting in one percent impairment for this diagnosis. Dr. Swartz concluded that she had five percent left upper extremity impairment and four percent right upper extremity impairment.

OWCP's medical adviser reviewed this report on November 29, 2013 and agreed with Dr. Swartz's ratings. He further noted that appellant had previously received schedule awards in excess of these amounts and was not entitled to any additional schedule awards.

By decision dated February 11, 2014, OWCP denied appellant's claim for an additional schedule award finding that she had not established more than 5 percent impairment of the left upper extremity and 19 percent impairment of her right upper extremity for which she had previously received schedule awards.

LEGAL PRECEDENT

The schedule award provision of FECA[9] and its implementing regulations[10] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions 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 matter which rests in the 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. OWCP evaluates the

[6] A.M.A., *Guides* 402, Table 15-5.

[7] *Id*. at 408, Table 15-8.

[8] *Id*. at 395, Table 15-2.

[9] 5 U.S.C. §§ 8101-8193, 8107.

[10] 20 C.F.R. § 10.404.

degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[11]

The protocol and formula of the sixth edition of the A.M.A., *Guides* requires that the physician determine the class of diagnosis (CDX) and apply the appropriate grade modifiers for Functional History, (GMFH) Physical Examination (GMPE) and Clinical Studies (GMCS) and apply the following formula (GMFH - CDX) + (GMPE - CDX) + (GMCS – CDX) to reach the appropriate grade within the class of diagnosis.[12]

ANALYSIS

In the case currently before the Board, appellant requested an additional schedule award due to her upper extremity impairments. She did not submit any medical evidence in support of her request, so OWCP referred her to Dr. Swartz. In his November 4, 2013 report, Dr. Swartz reported his findings on physical examination and applied the A.M.A., *Guides*. He noted impingement syndrome was three percent default impairment[13] and then found a functional history grade modifier of 1,[14] *Quick*DASH score of 39,[15] and physical examination grade modifier of 2 based on limited motion.[16] Dr. Swartz properly found that a clinical studies grade modifier would not apply as imaging studies were required in order to diagnose the condition.[17] He applied the formula of the A.M.A., *Guides* (GMFH - CDX) + (GMPE - CDX) and concluded that appellant demonstrated (1-1) + (2-1) =1 or an increase to grade D, four percent impairment of the right upper extremity. Dr. Swartz applied the A.M.A., *Guides* to the findings related to her left shoulder again finding functional history grade modifier of 1 and physical examination grade modifier of 2, which with application of the formula resulted in four percent impairment of the left upper extremity. He diagnosed de Quervain's tenosynovitis of the left wrist and found that this diagnosis had a one percent default diagnosis.[18] Dr. Swartz stated that appellant's functional history adjustment would be grade modifier 1, and physical examination would also be grade modifier 1 resulting in (GMFH - CDX) + (GMPE - CDX) or (1-1) +(1-1) = 0 or 1 percent impairment for this diagnosis. Combining the left upper extremity impairments, he concluded that she had five percent left upper extremity impairment and four percent right upper extremity impairment. OWCP's medical adviser agreed with these impairment ratings. There is

[11] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6a (January 2010); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[12] A.M.A., *Guides* 411.

[13] *Id*. at 402, Table 15-5.

[14] *Id*. at 406, Table 15-7.

[15] *Id.*

[16] *Id*. at 408, Table 15-8.

[17] The A.M.A., *Guides* stated that only if more than one pathology is present on clinical studies then the grade can be modified according to the Clinical Studies Adjustment Table. A.M.A., *Guides* 409.

[18] A.M.A., *Guides* 395, Table 15-2.

no other current medical evidence in the record addressing appellant's upper extremity impairment.

The Board finds that the weight of the medical opinion evidence establishes that appellant has no more than 5 percent impairment of her left upper extremity and 19 percent of her right upper extremity for which she has previously received schedule awards.

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 not met her burden of proof in establishing that she has more than 5 percent impairment of her left upper extremity and 19 percent of her right upper extremity for which she has previously received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the February 11, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 7, 2014
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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