U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JULIO C. FELICIANO-PEREZ and DEPARTMENT OF JUSTICE, DRUG ENFORCEMENT AGENCY, McAllen, TX

Docket No. 03-766; Submitted on the Record;
Issued May 15, 2003

DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether appellant has more than a 12 percent permanent impairment of his left arm.

Appellant, born on September 19, 1937, sustained an injury in the performance of duty on November 17, 1999 while moving bundles from one place to another. As he was pulling a dolly, a bundle dropped and struck his left shoulder. The Office of Workers' Compensation Programs accepted his claim for left shoulder/arm sprain, cervical herniated nucleus pulposus, left shoulder impingement syndrome and calcifying tendinitis of the left shoulder.

On December 7, 2001 appellant filed a claim for a schedule award and submitted a December 4, 2001 report from his attending internist, Dr. Monzer H. Yazj, who related appellant's history of injury and medical treatment. He noted that appellant underwent a left shoulder acromioplasty on July 25, 2000. Dr. Yazji reported that appellant reached maximum medical improvement by November 8, 2001 and was asked to return in one week for an impairment rating. He described his evaluation of appellant on November 15, 2001 and reported an impairment rating of 24 percent of the whole person based on the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[1]

The Office advised Dr. Yazji that all impairment ratings must be based on the fifth edition of the A.M.A., *Guides*.[2]

Dr. Yazji submitted a report on August 1, 2002 based on his evaluation of appellant on July 25, 2002. He rated the impairment of appellant's cervical spine at 15 percent of the whole

[1] A.M.A., *Guides* at 58, 59 (Tables 19 and 18) (4th ed. 1993).

[2] The fifth edition of the A.M.A., *Guides* became effective on February 1, 2001. FECA Bulletin No. 01-05 (January 29, 2001).

person.[3] Dr. Yazji reported that appellant had an upper extremity impairment of 12 percent due to synovial hypertrophy.[4] He reported an upper extremity impairment of 8 percent due to loss of motion, with 128 degrees of shoulder flexion, 28 degrees of extension, 115 degrees of abduction and 20 degrees of adduction.[5] There was no impairment due to motor deficit secondary to cervical radiculopathy. Dr. Yazji reported that appellant had a total impairment of the left upper extremity of 20 percent, or 12 percent of the whole person. Combining impairment of the cervical spine and left upper extremity, he concluded that appellant had an impairment of 25 percent of the whole person.[6]

On October 23, 2002 an Office medical adviser reviewed Dr. Yazji's evaluation and concurred that appellant had a left upper extremity impairment of 12 percent due to synovial hypertrophy. He explained, however, that no consideration could be given to range of motion deficits because the A.M.A., *Guides* prohibited combining impairments due to synovial hypertrophy and decreased joint motion or other findings.

On November 13, 2002 the Office issued a schedule award for a 12 percent permanent impairment of appellant's left arm.

The Board finds that this case is not in posture for decision. Additional information is needed to determine the impairment of appellant's left upper extremity.

Section 8107 of the Federal Employees' Compensation Act[7] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides.*[8]

In his August 1, 2002 report, Dr. Yazji, appellant's attending internist, rated the impairment of appellant's cervical spine at 15 percent of the whole person. This rating is unacceptable for two reasons. First, the Act does not authorize the payment of schedule awards for impairment of the "whole person."[9] Payment is authorized only for the permanent impairment of specified members, organs or functions of the body. Dr. Yazji's "whole person"

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[3] Dr. Yazji noted significant pain with radiculopathy but did not explain whether this pain radiated into or caused a sensory deficit in either upper extremity.

[4] A.M.A., *Guides* at 500, 499 (Tables 16-19, 16-18) (5th ed. 2001).

[5] Dr. Yazji measured each motion three times. In each case, the three measurements are so consistent that it makes no difference to appellant's schedule award which measurement is used to determine impairment due to decreased motion. In reporting Dr. Yazji's findings, the Board has selected the measurements representing, in theory, the greatest impairment.

[6] A.M.A., *Guides* at 604 (5th ed. 2001) (Combined Values Chart).

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999).

[9] *Ernest P. Govednick*, 27 ECAB 77 (1975).

ratings, with respect to the cervical spine or left upper extremity or spine and extremity combined, provide no basis for a schedule award.

Second, no schedule award is payable for a member, function or organ of the body that is not specified in the Act or in the regulations.[10] Because neither the Act nor the regulations provide for the payment of a schedule award for impairment of the back or cervical spine, no claimant is entitled to such an award.[11] Indeed, the Act specifically excludes the back from the definition of "organ."[12] Appellant may not receive a schedule award based on impairment to his cervical spine.

Appellant may, however, receive a schedule award for permanent impairment to his left arm.[13] Dr. Yazji reported that appellant had a left upper extremity impairment of 12 percent due to synovial hypertrophy and 8 percent due to decreased motion.

Table 16-19, page 500, of the A.M.A., *Guides* shows that moderate, palpably apparent joint swelling represents a joint impairment of 20 percent. As the maximum impairment value of the shoulder joint is 60 percent of the upper extremity,[14] appellant has a left upper extremity impairment of 12 percent (0.20 x 0.60) due to synovial hypertrophy, as Dr. Yazji reported.[15]

According to Table 16-40, page 476, of the A.M.A., *Guides*, 128 degrees of shoulder flexion represents an upper extremity impairment of 3 percent and 28 degrees of extension represents an impairment of 1 percent. According to Table 16-43, page 477, 115 degrees of abduction represents an upper extremity impairment of 3 percent, and 30 degrees of adduction represents an impairment of 1 percent. Appellant, therefore, has a left upper extremity impairment of eight percent due to decreased motion, as Dr. Yazji reported.[16]

The question raised by the Office's November 13, 2002 decision is whether appellant may receive a schedule award that combines impairment due to synovial hypertrophy and impairment due to decreased motion, and if not, which impairment the schedule award should reflect.

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[10] *William Edwin Muir*, 27 ECAB 579 (1976) (this principle applies equally to body members that are not enumerated in the schedule provision as it read before the 1974 amendment and to organs that are not enumerated in the regulations promulgated pursuant to the 1974 amendment).

[11] *E.g., Timothy J. McGuire*, 34 ECAB 189 (1982).

[12] 5 U.S.C. § 8101(19).

[13] *Id*. § 8107(c)(1) (providing 312 weeks of compensation for complete loss of an arm).

[14] A.M.A., *Guides* at 499 (Table 16-18) (5th ed. 2001).

[15] *Id*. at 500 (if synovial hypertrophy is the only finding, the joint impairment is rated according to Table 16-19 and multiplied by the relative maximum value of the joint involved, which is found in Table 16-18).

[16] The total impairment value of a joint is obtained by adding the impairment values contributed by each unit of motion. *Id*. at 452.

Section 16.7 of the fifth edition of the A.M.A., *Guides*, "Impairment of the Upper Extremities Due to Other Disorders," addresses impairment of the upper extremity due to synovial hypertrophy:

> "Impairments from the disorders considered in this section under the category of 'other disorders' are usually estimated by using other impairment evaluation criteria. *The criteria described in this section should be used only when the other criteria have not adequately encompassed the extent of the impairment.* Some of the conditions described in this section can be concurrent with each other and with decreased motion because they share overlapping pathomechanics. The evaluator must have good understanding of pathomechanics of deformities and apply proper judgment to avoid duplication of impairment ratings."[17]

Section 16.7a, "Bone and Joint Deformities," indicates that such a duplication of ratings will occur if impairment due to decreased motion is combined with impairment due to joint swelling from synovial hypertrophy:

> "Limited motion impairment is rated according to Section 16.4 and can be appropriately combined with impairments due to 'other disorders' listed in this section, except with those due to joint swelling from synovial hypertrophy, persistent joint subluxation or dislocation, and musculotendinous disorders (section 16.7c). Joint instability impairment values can be combined with other appropriate impairment values, including decreased motion, but not with arthroplasty. Joint swelling due to synovial hypertrophy is rated only when no other findings are present. Joint crepitation is not rated separately because other findings, such as those listed above, are more reliable indicators of the severity of the same arthritic process."[18]

The following section of the A.M.A., *Guides* expressly states that joint impairment due to synovial hypertrophy cannot be combined with impairment due to decreased motion:

> "Synovial hypertrophy is a sign of an inflammatory arthritic process that can progress through varying the [sic] manifestations listed above, including decreased motion. If synovial hypertrophy is the *only finding*, the joint impairment is rated according to Table 16-19 and multiplied by the relative maximum value of the joint involved (Table 16-18). It *cannot* be combined with impairment due to decreased joint motion or other findings."[19]

The Office correctly found that appellant may not receive an impairment rating for both joint swelling due to synovial hypertrophy and decreased motion; however, its decision to issue a schedule award based on the former is not supported by the A.M.A., *Guides*. The A.M.A., *Guides* makes clear, as noted above, that joint swelling due to synovial hypertrophy is rated only

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[17] *Id*. at 499 (emphasis in the original).

[18] *Id*.

[19] *Id*. at 500 (emphasis in the original).

when no other findings are present, and in this case Dr. Yazji also made findings of decreased motion. Appellant's schedule award should be based, therefore, on findings of decreased motion.

Impairment of the upper extremity due to decreased motion may be combined with impairment due to arthroplasty.[20] This is significant because on December 4, 2001 Dr. Yazji reported that appellant underwent a left shoulder acromioplasty on July 25, 2000. According to Table 16-27, page 506, of the A.M.A., *Guides*, resection arthroplasty of the distal clavicle (isolated) represents an upper extremity impairment of 10 percent, and a total shoulder arthroplasty represents an upper extremity of 30 percent. Either of these impairments would combine with the decreased motion impairment of 8 percent for a total upper extremity impairment greater than 12 percent.[21] Dr. Yazji did not describe the nature of appellant's arthroplasty on July 25, 2000, and no operative report appears in the case record. Further development of the evidence is required.

The Board will set aside the Office's November 13, 2002 decision and remand the case for further development to determine the nature of appellant's July 25, 2000 surgery and whether impairment from arthroplasty, combined with impairment from decreased motion, entitles appellant to a greater schedule award than he received.[22]

[20] *Id*. at 505.

[21] A resection arthroplasty of the proximal clavicle (isolated) represents an upper extremity impairment of only three percent and would not support an increased schedule award.

[22] Findings of significant pain with radiculopathy on cervical examination might entitle appellant to an award for impairment due to sensory loss if the pain radiates into either upper extremity and causes an impairment therein as described in Table 15-15 and Table 15-17, page 424, of the A.M.A., *Guides*. *Rozella L. Skinner*, 37 ECAB 398 (1986) (a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine, a nonscheduled member). On remand the Office should seek clarification on the nature and extent of appellant's cervical radiculopathy and whether it entitles him to a greater award.

The November 13, 2002 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Dated, Washington, DC
May 15, 2003

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member