United States Department of Labor
Employees' Compensation Appeals Board

JOHN E. GURWELL, Appellant	)	
and	)	**Docket No. 03-1444**
	)	**Issued: April 29, 2004**
U.S. POSTAL SERVICE, POST OFFICE, Des Moines, IA, Employer	)	

Appearances:
John E. Gurwell, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On May 13, 2003 appellant filed a timely appeal of the Office of Workers' Compensation Programs' schedule award decision dated March 10, 2003. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award claim.

ISSUE

The issue is whether appellant has more than 10 percent impairment of the left upper extremity, for which he received a schedule award. On appeal appellant contends that the Office failed to include a 10 percent baseline percent impairment rating for his left distal clavicle excision pursuant to Table 16-27 at page 506 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).

FACTUAL HISTORY

On January 5, 1998 appellant, a 49-year-old mailhandler, filed an occupational disease claim alleging that on December 30, 1997 he first realized his bilateral epicondylitis was

employment related.[1] The Office accepted the claim for bilateral epicondylitis and subsequently accepted the condition of left shoulder impingement syndrome and authorized right shoulder arthroscopy with decompression of the subacromial space and right endoscopic carpal tunnel release.

On July 6, 1998 appellant filed an occupational disease claim alleging that on May 11, 1999 he first realized his right wrist and elbow condition were due to his repetitive employment duties.[2] The Office accepted the claim for aggravated degenerative joint disease of the right shoulder and right elbow. The Office authorized right shoulder surgical repair, which occurred on June 1, 2001. On September 6, 2001 the Office authorized arthroscopic repair of the left shoulder and excision of the left distal clavicle, which occurred on October 8, 2001.

On June 12, 1999 appellant filed an occupational disease claim for bilateral carpal tunnel of his wrists and pain in his shoulder due to his repetitive employment work.[3] The Office accepted the claim for bilateral carpal tunnel and right carpal tunnel release was performed on January 10, 2000.[4]

On November 1, 2000 appellant filed claims for a schedule award for his upper extremity conditions.[5]

On October 8, 2001 appellant underwent left shoulder arthroscopy surgery and excision of his left distal clavicle.

In an April 11, 2002 report, Dr. Delwin E. Quenzer, an attending Board-certified orthopedic surgeon, concluded that appellant had 10 percent impairment rating due to a right shoulder distal clavicle resection, 5 percent impairment due to loss of range of motion and 2 percent impairment for his right hand based upon Tables 16-11 and 16-15 of the A.M.A., *Guides* (5th ed. 2001). The physician stated that he had not considered an impairment rating for the left upper extremity as appellant had not reached maximum medical improvement. In an April 12, 2002 report, Dr. Quenzer provided an impairment rating for appellant's left upper extremity. Regarding appellant's loss of range of motion, the physician concluded that appellant had a 2 percent impairment due to flexion of 150 degrees, a 1 percent impairment for 40 degrees extension and a 2 percent impairment for 140 degrees abduction for a total 5 percent impairment.

[1] This was assigned claim number 11-0164506.

[2] This was assigned claim number 11-0166680.

[3] This was assigned claim number 11-0172208.

[4] The record contains evidence of other claims filed by appellant. Claim number 11-0075932 was accepted for aggravation of osteochondritic lesion of the left knee and was combined with claim number 11-0100206 with this number listed the master number. The Office accepted a claim for a right tibial plateau fracture and assigned it claim number 11-0173182. On October 28, 2002 the Office accepted appellant's claim for a left knee strain and assigned this claim number 11-2001850. The Office denied appellant's emotional condition claim, which was assigned claim number 11-0015336. In claim number 11-0160846, the Office accepted appellant's claim for contusion of the right elbow.

[5] Appellant noted that the schedule award pertained to claim numbers 11-0166680 and 11-0112208.

Dr. Quenzer concluded that appellant had a total 15 percent impairment of the left upper extremity based upon 5 percent impairment for loss of range of motion and 10 percent impairment for his left resection arthroplasty of the distal clavicle.

On July 1, 2002 the Office medical adviser requested Dr. Quenzer to provide an addendum on the range of motions for both wrists.

In a July 30, 2002 letter, Dr. Quenzer provided range of motions measurements for the wrists as requested. He reported that appellant had 55 degrees of flexion in both wrists, which amounted to a one percent impairment, and 15 degrees of radial deviation, which was a one percent impairment. Dr. Quenzer opined that appellant's accepted carpal tunnel syndrome did not cause loss of range of motion in the wrists, but that the slight decrease in appellant's range of motion in the wrist was "more likely due to personal factors" such as osteoarthritis.

In an August 21, 2002 report, the Office medical adviser reviewed reports dated April 11 and July 30, 2002 from Dr. Quenzer and concluded that appellant had an 18 percent impairment rating of the right upper extremity and a 3 percent impairment of the left upper extremity. Regarding the left upper extremity impairment determination, the Office medical adviser concluded that appellant had a two percent impairment due to his left wrist range of motion. He then combined this with a one percent impairment due to residuals of the carpal tunnel syndrome to total a three percent impairment of the left upper extremity.

By decision dated October 18, 2002, the Office granted appellant a schedule award for an 18 percent impairment of the right upper extremity and a 3 percent impairment of the left upper extremity.

In a January 17, 2003 report, Dr. Charles F. Denhart, a second opinion Board-certified physiatrist, diagnosed left shoulder degenerative joint disease and shoulder impingement syndrome and status postarthroscopic surgery, for decompression of the subacromial space, partial acromioplaty, coracoacromial ligament release and excision of left distal clavicle. Regarding an impairment rating, the physician concluded that appellant had a three percent impairment due to flexion, a two percent impairment due to abduction and a two percent impairment due to internal rotation for a total loss of range of motion impairment of seven percent. In reaching this conclusion, the physician noted that appellant did not have any loss of sensation or loss of neurologic motor strength. Regarding an impairment rating for appellant's pain, Dr. Denhart opined that "this pain is reflected in his loss of range of motions measurements." He determined October 8, 2002 as the date of maximum medical improvement as this was one year after the date of appellant's surgery.

In a report dated January 29, 2003, the Office medical adviser reviewed Dr. Denhart's report and concluded that appellant was entitled to a seven percent impairment rating for his left upper extremity based upon appellant's loss of range of shoulder motion.

In a letter dated February 9, 2003, appellant disagreed with Dr. Denhart's impairment rating for his left upper extremity. He believed that he was entitled to a 10 percent impairment rating for the left distal clavicle resection based on Table 16-27 at page 506 of the A.M.A.,

Guides plus the 7 percent impairment rating for his loss of range of motion for a total impairment rating of 17 percent for the left upper extremity.

By decision dated March 10, 2003, the Office granted appellant a schedule award for a 10 percent permanent impairment of the left upper extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[6] and its implementing 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, the Act 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides*[8] has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[9]

ANALYSIS

In his April 12, 2002 report, Dr. Quenzer concluded appellant had a 2 percent impairment due to flexion of 150 degrees, a 1 percent impairment for 40 degrees extension and a 2 percent impairment for 140 degrees abduction for a total 5 percent impairment due to loss of range of motion. Dr. Quenzer then combined the impairment ratings for appellant's loss of range of motion with his impairment rating of 10 percent for his distal clavicle arthroplasty to reach a total impairment of 15 percent for appellant's left upper extremity. Neither the Office medical adviser nor Dr. Denhart included an impairment rating for appellant's distal clavicle arthroplasty. Both the Office medical adviser and Dr. Denhart based their impairment ratings solely upon appellant's loss of range of motion in the left upper extremity.

Section 16.7b, of the fifth edition of the A.M.A., *Guides*, "Arthroplasty," indicates:

> "In the presence of *decreased motion*, motion impairments are derived separately (Section 16.4) and *combined* with the arthroplasty impairment. (Combined Values Chart, p.604) If the same joint presents other findings, the rules outlined on page 499 must be followed to avoid duplication of impairments. However, impairment due to arthroplasty *cannot be combined* with impairments due to instability, subluxation, or dislocation."[10]

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[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB ___ (Docket No. 01-1361, issued February 4, 2002).

[9] *Ronald R. Kraynak*, 53 ECAB ___ (Docket No. 00-1541, issued October 2, 2001).

[10] A.M.A., *Guides* at 505 (emphasis in the original) (5th ed. 2001).

Impairment of the upper extremity due to decreased motion may be combined with impairment due to arthroplasty.[11] This is significant because on October 8, 2001 appellant underwent a left shoulder acromioplasty and resection of the distal clavicle according to the surgical report. 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. This impairment would combine with the decreased motion impairment of 5 percent for a total upper extremity impairment of 15 percent.

As Dr. Quenzer is the only physician who included the impairment rating for appellant's left distal clavicle arthroscopy and the record contains the surgical report, his April 12, 2002 report is the weight of the evidence and supports a finding that appellant has greater impairment of the left upper extremity.

CONCLUSION

The Board finds that the case is not in posture for decision and will set aside the Office's March 10, 2003 decision and remand the case for further development to determine whether impairment from arthroplasty, combined with impairment from decreased motion, entitles appellant to a greater schedule award than he received.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 10, 2003 is set aside and the case remanded for further action in conformance with this decision.

Issued: April 29, 2004
Washington, DC

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

[11] *Id.*