United States Department of Labor
Employees' Compensation Appeals Board

BRUNILDA I. LONG, Appellant	)	
and	)	**Docket No. 05-04**
	)	**Issued: August 5, 2005**
PANAMA CANAL COMMISSION, PANAMA, CITY, Republic of Panama, Employer	)	

Appearances:
Brunilda I. Long, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
DAVID S. GERSON, Judge

JURISDICTION

On September 24, 2004 appellant filed a timely appeal from an Office of Workers' Compensation Programs' schedule award decision dated August 12, 2004. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUES

The issues are: (1) whether appellant has more than a 40 percent permanent impairment of her right upper extremity for which she received a schedule award; and (2) whether the Office properly determined that appellant was not entitled to concurrent compensation payments for total disability and for a schedule award for the same period of time.

FACTUAL HISTORY

This case has previously been before the Board on appeal.[1] By decision dated April 16, 2004, the Board found that the Office improperly refused to reopen appellant's case for merit review under 5 U.S.C. § 8128(a) on the grounds that her application for review was not timely

[1] Docket No. 03-2224.

filed and failed to present clear evidence of error. The April 16, 2004 decision found that the case was not in posture for decision as the November 4, 2002 letter from appellant was not a request for reconsideration, but rather a request for an increase in her schedule award because her impairment had worsened. The Board vacated the May 1, 2003 decision and remanded the case for further consideration. The facts of the case up to that time are set forth in the April 16, 2004 decision and are hereby incorporated by reference.

Evidence relevant to the present appeal includes a September 9, 2002 report from Dr. Rolando Chin, an orthopedist, who noted appellant's history and advised that she had chronic pain in the right arm and shoulder, with limited function, marked weakness and instability. Right shoulder examination revealed abduction at 0 degrees to 100 degrees, with forward elevation of 0 degrees to 130 degrees. Dr. Chin noted that appellant had internal rotation of 0 degrees to 30 degrees, external rotation of 0 degrees to 70 degrees, backward elevation of 0 degrees to 30 degrees, abduction of 30 degrees, extension of 0 degrees to 30 degrees and a positive apprehension and impingement test. He noted that the deltoid measured a "3(26-50), triceps 3(26-50), trapezius 3(26-50), rotator cuff 4(1-25) and adductors for shoulder 3(26-50)." Regarding the right elbow, Dr. Chin advised that extension was 0 degrees, flexion was 130 degrees, pronation was 0 degrees to 80 degrees and supination was 0 degrees to 80 degrees. Regarding biceps weakness, he advised that it was a "4(1-25), triceps 3(26-50), supinators muscles 4(1-25) and pronators 4(1-25)." He noted that, for muscle atrophy, the right arm circumference was 30 centimeters, 25 centimeters and advised that there was swelling. Regarding the right wrist, Dr. Chin indicated that flexion was 0 degrees to 60 degrees, supination was 0 degrees to 60 degrees, radial deviation was 0 degrees to 20 degrees and ulnar deviation 0 degrees to 30 degrees. He advised that the extensors muscles warranted a grade of "3(26-50), flexors a grade of 3(26-50), ulnar deviation a grade of 4(1-25) and radial deviation of 4(1-25)." Regarding the right hand, Dr. Chin advised that appellant was right handed and that she had "full flexion and extension, visual atrophy of mass volume of both eminences and gross atrophy interdigital spaces, hand grip 3(26-50), interosseous 2(51-75), thumb adductor 3(26-50) and thumb abductor 3(51-75)." He advised that appellant had a "loss of function due to numbness, tingling and burning sensation in the lateral aspect, posterior aspect of the neck, right side, arm and forearm, thumb, index, middle and ring fingers." Dr. Chin also noted that appellant was unable to use her right upper limb to perform any activity during episodes of pain. Among his diagnoses were cervical spine and right shoulder osteoarthrosis, herniated discs at C2, C3-4, C4-5, C5-6 and C6-7, chronic denervation from C4 to C8/T1, glenoid labrum abnormal with anterior-inferior labrum rupture, bankart lesion from shoulder dislocation, labral and anterior inferior glenoid rim fracture, right shoulder instability and recurrent subluxation and dislocation. He advised that appellant had developed a reflex sympathetic dystrophy with chronic pain of the upper arm, swelling and paresthesia with a constant burning pain. Dr. Chin related that these were permanent impairments and would worsen with time. He opined that they were related to appellant's employment injury and were affecting her daily activities, such that they caused a change in her lifestyle. Dr. Chin opined that appellant had lost 90 percent of function in her right arm and noted that it affected her ability to write.

In a November 4, 2002 report, Dr. Jose D. Neira Bazan, an orthopedist, noted appellant's history and complaints of chronic neck pain, swelling, numbness and tingling radiating to the right upper extremity, as well as complaints of right shoulder chronic pain, weakness of her right

arm and limited function and instability. He also indicated that, in August 1998, appellant fell from stairs as she was unable to grip with her right hand and sustained a right shoulder dislocation. Dr. Bazan noted that these conditions exacerbated her cervical and right arm pain. He stated that a June 6, 2000 magnetic resonance image (MRI) scan showed chronic osteoarthritic changes in the cervical spine with bulging discs at C3-4, C4-5, C5-6 and C6-7 and chronic denervation from C4 to C8/T1. Dr. Bazan noted that appellant's duties, while working on a locomotive train, also caused her to develop multiple and chronic neurological and orthopedic illnesses, which were permanent impairments and would worsen with time and opined that they were related to her employment injury. He indicated that they affected appellant's daily living activities and changed her lifestyle. Dr. Bazan opined that appellant had a loss of 90 percent function of her right arm and indicated it was her dominant hand. He also advised that appellant was unable to write properly and that she did so with difficulty. Dr. Bazan diagnosed chronic cervicalgia, degenerative cervical disc disease, multiple cervical disc displacement at C3-4, C4-5, C5-6 and C6-7, whiplash syndrome, chronic denervation from C4 to C8/TI, bankart lesion from shoulder dislocation, anterior inferior glenoid labrum fracture and complex type I regional pain syndrome.

On June 22, 2004 the Office expanded appellant's claim to accept right shoulder dislocation. The Office also advised appellant that the Office medical adviser would review the medical evidence to determine whether she had sustained impairment over and above the 15 percent for which she already received an award to the right upper extremity.

In a July 1, 2004 report, the Office medical adviser reviewed the reports of Drs. Chin and Bazan. He utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*) (5th ed. 2001) to find that regarding shoulder range of motion, he noted abduction of 100 degrees was equal to 4 percent, forward flexion of 130 degrees was equal 3 percent and internal rotation of 30 degrees was equal to 4 percent. Regarding external rotation of 70 degrees, the Office medical adviser referred to Figure 16-46 and determined that this was equal to 0 percent. He noted that extension of 30 degrees was equal to 1 percent and adduction of 30 degrees was equal to 1 percent.[2] He also noted that elbow flexion of 130 degrees was equal to 1 percent and supination of 80 degrees was equal to 0 percent. Regarding motor deficits at C5, L C6, C7, C8, the Office medical adviser advised that the brachial plexus was at 100 percent. He noted that the average motor deficit was 3/5 which equated to 30 percent.[3] The Office medical adviser explained that 100 percent multiplied by 30 percent was equivalent to a 30 percent motor deficit. He indicated that no figures were given for sensory estimates, only a description of numbers and opined that the total right upper extremity impairment was 40 percent, using combined values of 30 percent and 14 percent and that appellant reached maximum medical improvement on September 9, 2002.

In an August 12, 2004 decision, the Office granted appellant a schedule award for an additional 25 percent impairment of the right upper extremity.[4] The date of maximum medical

[2] A.M.A., *Guides* 477, Figure 16-43.

[3] A.M.A., *Guides* 484, Table 16-11.

[4] The record reflects that appellant previously received an award of 15 percent to the right upper extremity on April 21, 1997.

improvement was September 9, 2002 and the award covered a period of 78 weeks from September 9, 2002 to March 7, 2004. The Office also advised appellant that, since she had already received compensation for lost wages for the period of the award, September 9, 2002 through March 7, 2004, it was not possible to receive compensation for lost wages due to a disability and compensation for a schedule award for the same period.

LEGAL PRECEDENT -- ISSUE 1

Section 8107 of the Federal Employees' Compensation Act[5] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[6] The Act however does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[7] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[8]

It is well established that the period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the employment injury.[9] The issue of maximum medical improvement was extensively treated by the Board in its two decisions in *Marie J. Born*.[10] In *Born*, the Board reviewed the well-settled rule that the period covered by a schedule award commences on the date that the employee reaches maximum medical improvement and explained that maximum medical improvement "means that the physical condition of the injured member of the body has stabilized and will not improve further." The Board also noted a reluctance to find a date of maximum medical improvement, which is retroactive to the award, as retroactive awards often result in payment of less compensation. The Board, therefore, requires persuasive proof of maximum medical improvement for selection of a retroactive date of maximum medical improvement.[11]

ANALYSIS -- ISSUE 1

In support of her claim for a schedule award, appellant submitted reports from Drs. Chin and Bazan. Dr. Chin, in his September 9, 2002 report, advised that appellant's impairments were permanent and would worsen with time. This report was used as the date of maximum medical improvement. Maximum medical improvement is based on the probative medical evidence of

[5] 5 U.S.C. §§ 8101-8193.

[6] 5 U.S.C. § 8107.

[7] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[8] A.M.A., *Guides* (5th ed. 2001); 20 C.F.R. § 10.404.

[9] *Yolanda Librera, (Michael Librera)*, 37 ECAB 388, 392 (1986).

[10] 27 ECAB 623 (1976); *petition for recon. denied*, 28 ECAB 89 (1976).

[11] *Id*. *See also James E. Earle*, 51 ECAB 567 (2000).

record and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[12] The Board finds that the evidence establishes that appellant reached maximum medical improvement by September 9, 2002, the date of Dr. Chin's report, which was based upon a comprehensive examination of appellant. Dr. Chin gave no indication that appellant's condition was not stable and, in fact, when Dr. Bazan examined appellant, about two months later, he did not indicate any impairment greater than that reported by Dr. Chin.

The Board notes that, while both Drs. Chin and Bazan advised that appellant had a 90 percent loss of function of the right upper extremity, neither physician explained how their calculations were derived or provided a report that conformed with the protocols of the A.M.A., *Guides*. The Board precedent is well settled however that when an attending physician's report gives an estimate of impairment, but does not indicate that the estimate is based upon the application of the A.M.A., *Guides* or improperly applies the A.M.A., *Guides*, the Office is correct to follow the advice of its medical adviser or consultant where he or she has properly utilized the A.M.A., *Guides*.[13]

The Office medical adviser utilized the A.M.A., *Guides* and reviewed the findings contained in Drs. Chin and Bazan's reports and determined that appellant was entitled to an impairment of 40 percent to the right upper extremity. In his July 1, 2004 report, the Office medical adviser explained that, for shoulder range of motion, abduction of 100 degrees was equal to 4 percent,[14] forward flexion of 130 degrees was equal 3 percent[15] and internal rotation of 30 degrees was equal to 4 percent.[16] Regarding external rotation of 70 degrees, he referred to Figure 16-46 and determined that this was equal to 0 percent.[17] The Office medical adviser noted that extension of 30 degrees was equal to 1 percent[18] and adduction of 30 degrees was equal to 1 percent.[19] He added these figures, which were equal to 13 percent. The Office medical adviser also indicated that appellant had elbow flexion of 130 degrees. The Board notes that, pursuant to the A.M.A., *Guides* at Figure 16-34, this would equate to 1 percent.[20] The Office medical adviser also indicated that appellant had supination of 80 degrees and the Board

[12] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3(a) (June 2003); *see Mark A. Holloway*, 55 ECAB ___ (Docket No. 03-2144, issued February 13, 2004).

[13] *See Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980).

[14] *Supra* note 2.

[15] *Id*.

[16] A.M.A., *Guides* 479, Figure 16-46.

[17] *Id*.

[18] A.M.A., *Guides*, 476, Figure 16-40.

[19] *Supra* note 2.

[20] A.M.A., *Guides* 472, Figure 16-34.

notes that, according to Figure 16-36, this equates to 0 percent.[21] He added the 1 percent for elbow flexion to the 13 percent figure shoulder range of motion and determined that this was equivalent to a 14 percent range of motion impairment. The Office medical adviser also noted that for the brachial plexus, the maximum upper extremity impairment for motor deficits at C5, C6, C7 and C8 was 100 percent.[22] The Office medical adviser noted that the average motor deficit was 3/5. According to Table 16-11, this would mean that a complete active range of motion against gravity only, with no resistance, was equal to a range of 26 to 50 percent motor deficit. The physician selected a 30 percent grade within this range[23] He explained that 100 percent multiplied by 30 percent was equivalent to a 30 percent motor deficit. The Board notes that the A.M.A., *Guides* suggest that the severity of motor deficit is multiplied by the maximum upper extremity motor deficit.[24] He multiplied the figure of 100 percent, for the affected nerves, by 30 percent and derived a 30 percent motor deficit. The Office medical adviser indicated that no figures were given for sensory estimates, opined that the total right upper extremity impairment was 40 percent, after combining 30 percent for motor deficit with 14 percent for lost range of motion[25] and advised that appellant reached maximum medical improvement on September 9, 2002. The Office relied upon the Office medical adviser's opinion in awarding a 25 percent additional impairment to appellant's right upper extremity. Appellant did not submit any other evidence to support a greater schedule award.

LEGAL PRECEDENT -- ISSUE 2

It is well established that a claimant is not entitled to dual workers' compensation benefits for the same injury.[26] A claimant may not receive compensation for temporary total disability or compensation based on loss of wage-earning capacity and a schedule award covering the same period of time.[27]

ANALYSIS -- ISSUE 2

In this case, appellant received a schedule award for the period from September 9, 2002 to March 7, 2004. The Board notes; however, that appellant had already received compensation for lost wages for the period from September 9, 2002 to March 7, 2004. As noted above, a claimant is not entitled to dual workers' compensation benefits for the same injury.[28] An

[21] A.M.A., *Guides*, 473, Figure 16-36.

[22] A.M.A., *Guides* 490, Table 16-14.

[23] *Supra* note 3.

[24] A.M.A., *Guides* 494.

[25] A.M.A., *Guides* 604.

[26] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[27] *See William Taylor*, 50 ECAB 234 (1999); *Eugenia L. Smith*, 41 ECAB 409, 412 (1990).

[28] *Supra* note 25. *See also James E. Earle*, 51 ECAB 567 (2000).

employee cannot concurrently receive compensation under a schedule award and wage-loss compensation for disability for work.[29]

As indicated in the analysis of the first issue, maximum medical improvement was reached by September 9, 2002. Since appellant cannot receive both a schedule award payment and compensation for wage loss covering the same period, appellant is not entitled to any additional compensation for the period covered by the schedule award from September 9, 2002 to March 7, 2004. The Board finds that appellant received the amount of benefits that she was entitled to receive and the Office properly denied payment of the schedule award during this period.

CONCLUSION

The Board finds that appellant does not have more than a 40 percent impairment of her right upper extremity. The Board also finds that appellant is not entitled to dual workers' compensation benefits for total disability and a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 12, 2004 is affirmed.

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

[29] *Id. See also* A. Larson, *The Law of Workers' Compensation* § 92.02 (2005) (the normal rule is that, since a person can be no more than totally disabled at a given point, he or she cannot be awarded both total permanent and partial benefits for the same injurious episode).