United States Department of Labor
Employees' Compensation Appeals Board

J.G., Appellant	)	
and	)	**Docket No. 15-0467**
	)	**Issued: September 23, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Norwich, CT Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 22, 2014 appellant filed a timely appeal of an October 22, 2014 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 to consider the merits of the case.

ISSUE

The issue is whether appellant has more than 36 percent impairment of his left upper extremity and 2 percent impairment of his right upper extremity for which he has received schedule awards.

FACTUAL HISTORY

On May 1, 2009 appellant, then a 52-year-old letter carrier, filed a traumatic injury claim alleging that on April 29, 2009 he was attacked by two pit-bulls while delivering mail. He stated

[1] 5 U.S.C. § 8101 *et seq.*

that the attack dislocated his right shoulder, broke his left wrist, and inflicted puncture wounds. Appellant underwent surgical repair of 16 complex lacerations on the right forearm and 5 complex lacerations on his posterior neck on April 30, 2009. On April 30, 2009 an x-ray of the right shoulder demonstrated an anterior dislocation of the humeral head relative to the glenoid as well as a divot in the right humeral head that may be in contact with the inferior glenoid rim diagnosed as a large Hill-Sachs defect. Appellant's left wrist x-ray on April 30, 2009 demonstrated a nondisplaced radial styloid fracture with comminution and joint involvement.

OWCP accepted his claim on May 4, 2009 for right shoulder dislocation, left forearm fracture, multiple bilateral leg lacerations and multiple bilateral arm lacerations, and neck lacerations.

Appellant underwent a right shoulder magnetic resonance imaging (MRI) scan on May 27, 2009 which demonstrated a Hill-Sachs fracture with inferior and anterior glenoid labral tears as well as a tear of the infraspinatus tendon entering the subacromial subdeltoid bursa.

On June 18, 2009 OWCP accepted that appellant sustained a right rotator cuff tear due to his April 29, 2009 employment injury. On June 24, 2009 appellant underwent a right shoulder arthroscopy, labral repair, rotator cuff repair, and hemiarthroplasty.

On June 8, 2009 appellant filed a claim for a schedule award.

Appellant underwent an MRI scan of left wrist on August 26, 2009 which demonstrated a radial styloid fracture with arthritic changes and a likely scapholunate ligament tear and probable dorsal intercalated segment instability. A left wrist scaphoid excision, four corner wrist fusion with a bone graft, and posterior interosseous nerve neurectomy were performed.

On June 2, 2010 OWCP accepted that appellant sustained secondary renovascular hypertension as a result of his accepted employment.

Appellant underwent a computerized axial tomography (CAT) scan of his left wrist on May 27, 2010 which demonstrated significant arthritic changes with erosive changes between the lunate and capituate, lunate, harnate, and triquetrum. The CAT scan also demonstrated a possible unhealed fracture through the dorsal distal radius. A second surgical revision of the left wrist four corner fusion with iliac crest bone graft, and posterior interosseous nerve neurectomy was performed on June 28, 2010.

Dr. Tarik Kardestuncer, a Board-certified orthopedic surgeon, provided results on examination on June 7, 2011 and reported that appellant had significant motion limitation in the left wrist and some paresthesia and numbness on the dorsum of the left hand. Appellant also had numbness on the ulnar side of the right hand and wrist. Dr. Kardestuncer found 10 degrees of left wrist flexion and 20 degrees of wrist extension. He stated that appellant had 15 percent impairment of the left wrist and 3 percent impairment of the right hand.

Dr. Duffield Ashmead, a Board-certified plastic surgeon, provided examination results on October 3, 2011 and noted the history of injury. He reported that appellant had constant numbness on right forearm along the ulnar border. Appellant experienced hand numbness and tingling on the left with significant loss of range of motion of the left wrist. Dr. Ashmead listed

30 degrees of extension and 10 degrees of flexion as well as ulnar and radial deviation of 5 degrees each. He stated that appellant had sensory nerve involvement in the medial antebrachial cutaneous nerve of the right forearm[2] and found this was three percent impairment under the A.M.A., *Guides*. Dr. Ashmead found 20 percent impairment of the left upper extremity due to limited wrist arthrodesis with profound loss of wrist mobility.[3]

On November 29, 2011 Dr. Kardestuncer found that appellant's left wrist demonstrated 10 degrees of flexion and 30 degrees of extension.

By letter dated June 20, 2012, OWCP forwarded the record to OWCP's medical adviser for an impairment rating. On August 31, 2012 OWCP's medical adviser found that appellant had moderate sensory deficit of his right medial antebrachial cutaneous nerve, which he correlated to medial brachial cutaneous nerve with a class 1 impairment of two percent of the right forearm or right upper extremity.[4] He also noted that this rating corresponded with a mild impairment of the peripheral nerve with retained protective sensation and some pain.[5] The medical adviser stated that a history of right shoulder joint dislocation with no residual findings following surgical treatment resulted in no impairment.[6] He evaluated the surgical fusion of appellant's wrist bones due to nonoptimal positioning[7] based on range of motion.[8] The medical adviser found 30 degrees of left wrist extension was 3 percent impairment, 10 degrees of flexion was 9 percent impairment, 5 degrees of radial deviation was 12 percent impairment and 5 degrees of ulnar deviation was also 12 percent impairment, totaling 36 percent impairment of the left upper extremity. OWCP's medical adviser stated that Dr. Ashmead had not provided sufficient rationale for his impairment rating in accordance with the A.M.A., *Guides*.

By decision dated October 22, 2014, OWCP granted appellant a schedule award for 36 percent impairment of his left wrist/upper extremity due to range of motion and 2 percent impairment for the right forearm/right upper extremity due to nerve deficit.

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

[2] A.M.A., *Guides*, 432, Figure 15-8.

[3] *Id.* at 473, Table 15-32.

[4] *Id.* at 437, Table 15-21.

[5] *Id.* at 429, Table 15-18.

[6] *Id.* at 403, Table 15-5.

[7] *Id.* at 397, Table 15-3.

[8] *Id.* at 473, Table 15-32.

[9] 5 U.S.C. §§ 8101-8193, 8107.

[10] 20 C.F.R. § 10.404.

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

ANALYSIS

OWCP accepted multiple injuries as the result of a dog attack on April 29, 2009 including right shoulder dislocation, left forearm fracture, multiple bilateral leg lacerations, multiple bilateral arm lacerations, neck lacerations, right rotator cuff tear, and secondary renovascular hypertension.

The A.M.A., *Guides* generally provide for impairment values of the upper extremities to be calculated using the diagnosis-based impairment method.[12] On June 24, 2009 appellant underwent a right shoulder arthroscopy, labral repair, rotator cuff repair, and hemiarthroplasty.

Appellant was later evaluated by Dr. Ashmead on October 2, 2011. Utilizing the A.M.A. *Guides*, he opined "that given all factors considered" appellant's condition would support a 3 percent impairment to the right upper extremity referable to sensory losses, and a 20 percent permanent impairment to the left upper extremity on the basis of limited arthrodesis with a profound loss of wrist mobility.

Subsequently, on August 31, 2012 OWCP's medical adviser reviewed the findings of Dr. Ashmead. OWCP's medical adviser found a moderate sensory deficit and assigned a default CDX as class 1 impairment of the right extremity corresponding to a two percent impairment of the right upper extremity. This corresponded with page 429, Table 15-18 a "mild" impairment of the peripheral nerve. With respect to the left, he found that, according to page 403, Table 15-5 for a history of shoulder joint dislocation with no residual finding, with surgical treatment he assigned a class 0 with no residual impairment. For a surgical fusion for the bones involved using page 397, Table 15-3 he referred to page 47, Table 15-32. Doing so, he found that 30 degrees of wrist extension corresponds to 3 percent impairment, 10 degrees of flexion corresponds to 9 percent impairment, 5 degrees of ulnar deviation to 12 percent impairment, and 5 degrees of radial deviation to 12 percent, equaling a sum of 36 percent impairment to the left upper extremity.

OWCP's medical adviser indicated that Dr. Ashmead had not provided a rationale in the A.M.A., *Guides* for his impairment assignment.

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[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); and Part 3 -- Medical, *Schedule Awards,* Chapter 3.700, Exhibit 1 (January 2010).

[12] A.M.A., *Guides*, 385, Chapter 15.1, Principles of Assessment.

The Board finds that OWCP's medical adviser represents the weight of the medical evidence. It is appellant's burden of proof to establish an increased schedule award.[13] The evidence of record given the absence of rationale by appellant's treating physician does not establish more than 36 percent impairment to his left upper extremity and a 2 percent impairment of his right upper extremity.

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.[14]

CONCLUSION

The Board finds that appellant has not established more than 36 percent impairment to his left upper extremity and a 2 percent impairment of his right upper extremity for which he received a schedule award for permanent impairment to his right lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the October 22, 2014 decision of the Office of Workers' Compensation Programs is affirmed.[15]

Issued: September 23, 2016
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[13] *Edward W. Spohr*, 54 ECAB 806, 810 (2003).

[14] *See Linda T. Brown*, 51 ECAB 115 (1999).

[15] James A. Haynes, Alternate Judge, participated in the original decision but was no longer a member of the Board effective November 16, 2015.