United States Department of Labor
Employees' Compensation Appeals Board

ROGER H. SHECKELLS, Appellant	)	
and	)	**Docket No. 03-992**
	)	**Issued: December 10, 2003**
GENERAL SERVICES ADMINISTRATION, EDWARDS AIR FORCE BASE, CA, Employer	)	

Office of Solicitor, for the Director
Roger H. Sheckells, pro se,

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On March 4, 2003 appellant filed a timely appeal from the Office of Workers' Compensation Programs decision dated September 16, 2002, which awarded appellant an additional 8 percent schedule award for permanent impairment of the right upper extremity, augmenting a previous June 1, 2001 schedule award for a 26 percent permanent impairment of the right upper extremity, for a total of 34 percent. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has *de novo* jurisdiction over the merits of this case.[1]

[1] The record indicates that there was an overpayment in appellant's case in the amount of $1,473.85, which appellant repaid in full in June 2000. The record also contains an October 17, 2000 decision, determining appellant's loss of wage-earning capacity. The overpayment and loss of wage-earning capacity issues are not before the Board on the present appeal as there are no final decisions on these issues within one year of the date appellant filed his appeal with the Board. Following issuance of the September 16, 2002 decision, appellant submitted additional medical and factual evidence. The Board may not consider evidence for the first time on appeal that was not before the Office at the time it issued the final decision in the case. 20 C.F.R. § 501.2(c).

ISSUE

The issue on appeal is whether appellant sustained greater than a 34 percent impairment of the right upper extremity, for which he received schedule awards.

FACTUAL HISTORY

The Office accepted that on May 7, 1992 appellant, then a 38-year-old mobile equipment metal mechanic, sustained bicipital tendinitis of the right shoulder and a cervical strain while lifting 55-gallon drums. Appellant underwent right shoulder compression on February 8, 1993, debridement of the right shoulder on June 20, 1995, right shoulder arthroscopy on June 14, 1996 and closed manipulation on May 23, 1997.[2] When conservative treatment measures failed to produce functional improvement or pain relief, the Office authorized implantation of a spinal cord stimulator on December 14, 1998 with revisions on December 28, 1998 and February 1, 1999, performed by Dr. Jack M. Berger, an attending Board-certified anesthesiologist. The stimulator was removed due to infection on July 29, 1999 and reimplanted by Dr. Berger on November 8, 1999.

In a May 13, 1999 report, Dr. C. Thomas Vangness, Jr., an attending Board-certified orthopedic surgeon, found that appellant's condition was permanent and stationary. Dr. Vangness submitted periodic reports from September 1998 to July 19, 2000, noting appellant's right shoulder and neck problems.

In a March 29, 2000 report, Dr. Berger noted that appellant was working full time as an administrative assistant at the employing establishment, although he had intractable sympathetically independent right shoulder pain. Dr. Berger prescribed acupuncture from May 2000 to May 2002.[3]

On September 28, 2000 appellant claimed a schedule award.

In a September 29, 2000 report, Dr. Berger diagnosed neuropathic pain of the anterior right shoulder. He administered trigger point injections on September 29 and November 30, 2000.

In a March 21, 2001 report, Dr. Vangness found a full range of right shoulder motion except for a 10 degree loss in forward elevation. He also found marked weakness of the right shoulder musculature, with "very mild atrophy." He diagnosed a complex regional pain syndrome of the right shoulder.

[2] Appellant was off work from June 1995 through December 1, 1997. He performed light duty for four hours, then six hours per day beginning in December 1997 though July 1998. As of May 3, 2000, appellant worked full time as an administrative assistant at the employing establishment.

[3] In a January 31, 2002 report, Dr. Berger explained that acupuncture was a recognized adjunctive therapy that was effective in providing nonsedating pain relief and had proven efficacious in appellant's pain management.

By decision dated June 1, 2001, the Office issued appellant a schedule award for a 26 percent permanent impairment of the right upper extremity according to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*), based on Dr. Vangness' March 21, 2001 findings as interpreted by an Office medical adviser.[4]

Appellant disagreed with this decision and in a June 19, 2001 letter, requested an oral hearing before a representative of the Office's Branch of Hearings and Review, held December 12, 2001. Appellant asserted that he had greater than a 26 percent permanent impairment of the right upper extremity, as established by Dr. Berger's reports. He submitted additional medical evidence.

In a June 26, 2001 report, Dr. Berger noted that increasing right-sided neck symptoms related to weakness and atrophy of the right shoulder. He opined that appellant had at least a 50 percent impairment of the right upper extremity as opposed to the 26 percent impairment, for which appellant received a schedule award. Dr. Berger administered trigger point injections on August 14 and November 20, 2001, to alleviate appellant's intractable right shoulder pain.

In an October 31, 2001 report, Dr. Vangness noted that appellant was responding well to pain management with Dr. Berger. Dr. Vangness found mild impingement of forward flexion of the right shoulder and an otherwise full range of motion.

In a January 8, 2002 report, Dr. R. David Sibley, an attending Board-certified orthopedic surgeon, provided a history of injury and treatment, found chronic neck and right shoulder pain, severe atrophy of the right deltoid and rotator cuff muscles, suprascapular neuralgia, glenohumeral impingement, severely limited cervical range of motion and greatly decreased abduction of the right shoulder interfering with activities of daily living. Dr. Sibley noted that appellant continued to have intractable right shoulder pain despite the implanted stimulator. He stated that appellant sustained permanent impairment of the right upper extremity as follows: 15 percent due to pain; 20 percent due to loss of motion;[5] and 30 percent due to weakness.[6] Dr. Sibley commented that appellant's condition had plateaued but had not reached maximum medical improvement.

In a February 11, 2002 letter, Dr. Berger explained that appellant's right-sided neck pain was related to extensive bony and soft tissue damage as well as a nerve injury from the three right shoulder surgeries. Muscle weakness in the rotator cuff caused an unequal balance of the paracervical musculature, such that appellant had to assume awkward postures of the head and neck to get the maximum result from the implanted stimulator.

[4] The period of the award ran from November 3, 2000 to May 24, 2002.

[5] Dr. Sibley found 100 degrees forward elevation, 20 degrees backward elevation, 100 degrees abduction, 15 to 20 degrees adduction, 50 degrees internal rotation, 40 degrees external rotation and 20 degrees extension. He noted three out or five weakness of the deltoid and rotator cuff muscles.

[6] Dr. Sibley did not refer to any specific table, figure or edition of the A.M.A., *Guides* in his report.

By decision dated and finalized March 11, 2002, an Office hearing representative affirmed the June 1, 2001 schedule award finding a 26 percent impairment of the right upper extremity. The hearing representative noted that Dr. Berger's reports were too general to provide a precise description of appellant's impairments and that while Dr. Sibley provided many functional measurements, he did not refer to the A.M.A., *Guides* in calculating the offered percentages of impairment. The hearing representative, therefore, found that Dr. Vangness' opinion continued to represent the weight of the medical evidence.

Appellant disagreed with this decision and in a July 25, 2002 letter requested reconsideration. Appellant submitted additional medical evidence.

In a May 21, 2002 report, Dr. Sibley noted the Office's request that he utilize the A.M.A., *Guides* in calculating the percentage of permanent impairment, stating that he had reviewed "the A.M.A., guidelines for the shoulder and will be happy to comply with this request." Dr. Sibley asserted that appellant had a 75 to 85 percent impairment of the right upper extremity due to a 9-year history of chronic right shoulder and neck pain, "severe muscle atrophy" and "4 open right shoulder surgeries resulting in severe functional impairment." On examination Dr. Sibley found 100 degrees of right shoulder elevation, 100 degrees abduction and 35 degrees external rotation. He noted severe atrophy of the right shoulder musculature due to multiple surgeries with complications, resulting in severe weakness. Dr. Sibley stated that referring to the A.M.A., *Guides*, appellant had a 35 percent impairment of the right upper extremity due to pain, 10 percent due to loss of range of motion and 40 percent due to weakness and atrophy. He did not specify the edition, tables or figures relied upon in calculating these percentages.

In May 28 and July 16, 2002 reports, Dr. Berger diagnosed neuropathic pain of the right shoulder, reflex sympathetic dystrophy syndrome of the right upper extremity, myofascial cervical pain syndrome, suprascapular neuralgia and administered trigger point injections.

In an August 16, 2002 report, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon consulting to the Office, reviewed the medical record but did not examine appellant. Dr. Harris found that appellant had reached maximum medical improvement as of Dr. Sibley's May 21, 2002 examination. Dr. Harris noted that according to Dr. Sibley's May 21, 2002 report, appellant had 100 degrees of forward flexion of the right shoulder, 100 degrees abduction, 35 degrees external rotation and severe muscle atrophy and weakness. Dr. Harris also concurred with Dr. Sibley's diagnosis of complex regional pain syndrome. Referring to the fifth edition of the A.M.A., *Guides*, Dr. Harris determined that according to Figure 16-40, page 476,[7] 100 degrees of forward flexion of the right shoulder, a loss of 80 degrees of motion, equaled a 5 percent impairment of the upper extremity. According to Figure 16-43, page 477,[8] shoulder abduction of 100 degrees, representing a loss of 80 degrees of motion, equaled a 4 percent impairment of the upper extremity. Dr. Harris determined that 35 degrees external rotation, a loss of 55 degrees of the normal range of motion, equaled a 1 percent impairment of the upper

[7] Figure 16-40 at page 476 of the fifth edition of the A.M.A., *Guides* is entitled "[p]ie [c]hart of [u]pper [e]xtremity [m]otion [i]mpairments [d]ue to [l]ack of [f]lexion and [e]xtension of [s]houlder."

[8] Figure 16-43 at page 477 of the fifth edition of the A.M.A., *Guides* is entitled "[p]ie [c]hart of [u]pper [e]xtremity [m]otion [i]mpairments [d]ue to [l]ack of [a]bduction and [a]dduction of [s]houlder."

extremity according to Figure 16-46, page 479.[9] He totaled these percentages to arrive at a 10 percent impairment of the right upper extremity due to loss of motion. Regarding impairment due to weakness, Dr. Harris found that according to Table 16-35 at page 510,[10] moderate weakness of abduction, external rotation and flexion equaled 6, 3 and 12 percent impairments of the right upper extremity respectively, combined to equal a 19 percent impairment of the upper extremity. Regarding impairment due to pain or sensory changes, Dr. Harris found that according to Table 16-10, page 482[11] and Table 16-15 page 492,[12] appellant had a Grade 1 impairment due to pain or decreased sensation of the axillary nerve enervating the deltoid muscle preventing most activity was a 99 percent sensory deficit, resulting in a 5 percent impairment. Dr. Harris also found a Grade 1 impairment of the suprascapular nerve affecting the rotator cuff muscles, resulting in a five percent impairment according to the same tables. He then referred to the Combined Values Chart and found that the 10 percent impairment due to loss of range of motion, 19 percent impairments due to weakness and 10 percent impairment due to pain equaled a 34 percent impairment of the right upper extremity.

By decision dated September 16, 2002, the Office issued a schedule award for an additional 8 percent impairment of the right upper extremity, bringing to the total of the 2 schedule awards to 34 percent, based on Dr. Sibley's findings as interpreted by Dr. Harris.[13]

LEGAL PRECEDENT

The schedule award provisions of the Federal Employees' Compensation Act[14] and its implementing regulation[15] set forth the number of weeks of compensation payable to employees

---

[9] Figure 16-46 at page 479 of the fifth edition of the A.M.A., *Guides* is entitled "[p]ie [c]hart of [u]pper [e]xtremity [i]mpairments [d]ue to [l]ack of [i]nternal and [e]xternal [r]otation of [s]houlder."

[10] Table 16-35 at page 510 of the fifth edition of the A.M.A., *Guides* is entitled, "[i]mpairments of the [u]pper [e]xtremity [d]ue to [s]trength [d]eficit [f]rom [m]usculoskeletal [d]isorders [b]ased on [m]anual [m]uscle [t]esting of [i]ndividual [u]nits of [m]otion of the [s]houlder and [e]lbow."

[11] Table 16-10 at page 482 of the fifth edition of the A.M.A., *Guides* is entitled, "[d]etermining [i]mpairment of the [u]pper [e]xtremity [d]ue to [s]ensory [d]eficits or [p]ain [r]esulting [f]rom [p]eripheral [n]erve [d]isorders." A Grade 1 impairment, equivalent to an 81 to 99 percent sensory deficit, is described as "[d]eep cutaneous pain sensibility present; absent superficial pain and tactile sensibility (absent protective sensibility), with abnormal sensations or severe pain, that prevents most activity." Of the six grades listed, ranging from Grade 0 to 5, Grade 1 is the second most severe.

[12] Table 16-15 at page 492 of the fifth edition of the A.M.A., *Guides* is entitled "[m]aximum [u]pper [e]xtremity [i]mpairment [d]ue to [u]nilateral [s]ensory or [m]otor [d]eficits or to *[c]ombined* 100 [percent] [d]eficits of the [m]ajor [p]eripheral [n]erves." (Emphasis in the original.)

[13] The period of the award ran from September 8, 2002 to March 1, 2003, a period of 24.96 weeks. A September 12, 2002 file worksheet states that appellant's wage-loss compensation would be reinstated after expiration of the schedule award.

[14] 5 U.S.C. § 8107.

[15] 20 C.F.R. § 10.404 (1999).

sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. However, the Act does not specify how 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 and guidelines so that there are uniform standards applicable to all claimants. The Office has adopted the A.M.A., *Guides* as the appropriate standard for evaluating scheduled losses. As of February 21, 2001, the Office uses the fifth edition of the A.M.A., *Guides* to calculate new claims for a schedule award, or to recalculate prior schedule awards pursuant to an appeal, request for reconsideration, or decision of an Office hearing representative.[16]

The standards for evaluating the permanent impairment of an extremity can be found in Chapter 16 of the fifth edition of the A.M.A., *Guides*, which provides a detailed grading scheme and procedure for determining impairments of the upper extremities due to pain, discomfort, loss of sensation, or loss of strength.[17]

Before the A.M.A., *Guides* may be utilized, however, a description of appellant's impairment must be obtained from appellant's attending physician. The Federal (FECA) Procedure Manual provides that, in obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a "detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment."[18] This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its restrictions and limitations.[19]

ANALYSIS

In this case, appellant has the burden of proof to submit medical evidence establishing that he sustained greater than a 34 percent impairment of the right upper extremity according to the tables and grading schemes of the A.M.A., *Guides*.

Appellant submitted a June 26, 2001 report from Dr. Berger, an attending Board-certified orthopedic surgeon, stating that appellant had at least a 50 percent impairment of the right upper extremity. However, Dr. Berger did not refer to the A.M.A., *Guides* to support this percentage of impairment, or provide the clinical findings, on which his estimate of a 50 percent impairment

[16] *See* FECA Bulletin 01-05 (issued January 29, 2001) (awards calculated according to any previous edition should be evaluated according to the edition originally used; any recalculations of previous awards which result from hearings, reconsideration or appeals should, however, be based on the fifth edition of the A.M.A. *Guides* effective February 1, 2001).

[17] A.M.A. *Guides*, Chapter 16, "The Upper Extremities," pp. 433-521 (5th ed. 2001).

[18] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(c) (August 2002).

[19] *Noe L. Flores*, 49 ECAB 344 (1998).

was based. Therefore, Dr. Berger's opinion contains insufficient information, on which to base a schedule award.

Dr. Sibley, an attending Board-certified orthopedic surgeon, submitted a January 8, 2002 report finding a 15 percent impairment of the right upper extremity due to pain, 20 percent due to restricted motion and 30 percent due to weakness. However, Dr. Sibley did not refer to the A.M.A., *Guides* to support this percentage of impairment. Without reference to the A.M.A., *Guides*, Dr. Sibley's January 8, 2002 opinion is insufficient to establish the noted percentages of impairment.

In a May 21, 2002 report, Dr. Sibley noted that the Office's request that he perform a schedule award assessment and calculation using the tables and grading schemes of the A.M.A., *Guides*. Although Dr. Sibley stated that he was happy to comply with this request, Dr. Sibley again did not refer to any specific edition, page, table or figure of the A.M.A., *Guides*. Referring to an unspecified edition of the A.M.A., *Guides* in a general manner, he stated that appellant had a 35 percent impairment of the upper extremity due to pain, 10 percent due to restricted motion and 40 percent due to weakness and atrophy, for a total of 75 to 85 percent. However, Dr. Sibley did provide detailed measurements regarding range of right shoulder motion and clinical findings with rationale regarding pain and weakness.

As Dr. Sibley did not provide the requested schedule award calculation utilizing the A.M.A., *Guides*, but did provide sufficient clinical findings, on which to base a schedule award calculation, the Office referred the medical record to Dr. Harris, a Board-certified orthopedic surgeon, for performance of a schedule award calculation according to the fifth edition of the A.M.A. *Guides*. The Board finds that the Office's referral of the medical record to Dr. Harris was proper, as Dr. Sibley, appellant's attending physician, submitted a detailed description of appellant's impairments such that other physicians reviewing the report could clearly visualize the nature of those impairments.

Dr. Harris submitted an August 16, 2002 report, referring to the A.M.A., *Guides*' figures and tables addressing upper extremity impairment due to loss of flexion, extension, abduction, adduction and rotation, weakness, sensory deficits and pain. Dr. Harris applied these criteria to the entirety of Dr. Sibley's May 21, 2002 findings and determined that appellant had a 10 percent impairment of the right upper extremity due to restricted motion, 19 percent due to weakness and 10 percent due to pain. Utilizing the Combined Values Chart, Dr. Harris determined that these 3 impairments equaled a 34 percent impairment of the right upper extremity.

The Board finds that Dr. Harris properly reviewed Dr. Sibley's findings and accurately applied each measurement and clinical observation to the appropriate tables and figures of the A.M.A. *Guides*. Dr. Harris then performed accurate mathematical calculations in determining the 34 percent impairment according to the Combined Values Chart. Dr. Harris' opinion is thus of greater probative value than that of Dr. Sibley, who did not refer to the A.M.A., *Guides*. Also, Dr. Harris' opinion is of greater weight than that of Dr. Berger, as Dr. Berger did not provide detailed measurements and clinical findings sufficient to visualize the nature of appellant's impairments. Therefore, the Office properly relied on Dr. Harris' report in issuing the September 6, 2002 schedule award.

Thus, appellant has not met his burden of proof in establishing that he sustained greater than a 34 percent impairment of the right upper extremity, as he submitted insufficient probative medical evidence finding a greater percentage of impairment.

CONCLUSION

The Board finds that appellant has not established that he sustained greater than a 34 percent impairment of the right upper extremity, for which he received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 16, 2002 is hereby affirmed.

Issued: December 10, 2003
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

A. Peter Kanjorski
Alternate Member