



Appellant underwent corrective surgery on October 10, 2002 and subsequent manipulation under anesthesia due to adhesive capsulitis. On July 2, 2003 he was released to return to full duty.

In a report dated July 2, 2003, appellant's physician, Dr. Thomas Harris, a treating physician, opined that his condition was permanent and stationary. He provided final diagnoses of status post third degree acromioclavicular joint separation, right shoulder; cervical radiculopathy; post-traumatic headache; status post partial tear, frayed labral tear and adhesive capsulitis, right shoulder. Applying the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,<sup>1</sup> Dr. Harris concluded that pursuant to Table 16-18, page 499, appellant had a 25 percent impairment of his right upper extremity secondary to his acromioplasty.

On August 21, 2003 appellant requested a schedule award. The case file was sent to the district medical adviser for a report on permanent functional loss of his right shoulder.

In a report dated December 15, 2003, the Office's orthopedic consultant, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, opined that appellant had an 11 percent total impairment to his right upper extremity. He did not perform an examination of appellant. Dr. Harris' report was based upon a review of the medical records, including imaging reports, the Office's decision and application of the fifth edition of the A.M.A., *Guides*. He concluded that appellant had a one percent impairment for loss of shoulder extension (Table 16-40, page 476), a two percent impairment for loss of shoulder internal rotation (Table 16-46, page 479) and a one percent impairment for loss of shoulder adduction (Table 16-43, page 477), resulting in a four percent total impairment for loss of motion. Dr. Harris then opined that he had a Grade 4 muscle strength (25 percent) (Table 16-11, page 484) of the suprascapular nerve/rotator cuff muscles (Table 16-15, page 492), resulting in a four percent impairment of his right upper extremity for residual rotator cuff weakness. Finally, he found that appellant had a Grade 3 pain/decreased sensation that interferes with some activity (60 percent) (Table 16-10, page 482) of the axillary nerve/deltoid muscles (Table 16-15, page 492), resulting in a three percent impairment of the right upper extremity for pain that interferes with some activity. Combining the totals, Dr. Harris found that he had an 11 percent impairment to his right upper extremity.

Based on Dr. Harris' report of January 6, 2004, the Office granted appellant a schedule award for an 11 percent impairment to his right upper extremity, finding that the date of maximum medical improvement was July 2, 2003.

On March 5, 2004 appellant requested reconsideration. In support of his request, he submitted a report dated January 15, 2004 from Dr. Michael R. Lenihan, a Board-certified orthopedic surgeon, who provided a detailed history of appellant's injury and treatment, as well as his findings upon examination. He indicated that his range of motion was forward flexion and abduction 175/180 of the right and left shoulder respectively; arms abducted 90 percent; elbow at 90 percent; extended rotation at 80/90; and internal rotation at 45/85 of the right and left shoulders respectively. Dr. Lenihan related that manual motor testing was 5/5 in all muscle groups tested in the upper extremities except with forward flexion, which was 5-/5 on the right and that sensation was intact to the bilateral upper extremities to light touch. He provided

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<sup>1</sup> A.M.A., *Guides* (5<sup>th</sup> ed. 2001).

diagnoses of status post right shoulder arthroscopy of the acromioclavicular joint secondary to Grade 3 acromioclavicular joint separation; resolved adhesive capsulitis; partial rotator cuff tear; C6 radiculopathy; and resolved post-traumatic headache. Dr. Lenihan noted subjective factors of disability as intermittent slight to moderate pain in the right shoulder; decreased motion; and decreased strength. He noted objective factors as significant scarring; operative findings; and EMG findings of mild cervical radiculopathy C6 distribution. Applying the fifth edition of the A.M.A., *Guides*. Dr. Lenihan concluded that appellant had a 26 percent impairment of the right upper extremity. Referring to Table 16.10, page 482, he found the severity of pain to be Grade 2, resulting in a pain deficit of .8. Multiplying the .8 pain deficit by the maximum impairment value of the acromioclavicular joint (.25), Dr. Lenihan arrived at a 20 percent right upper extremity impairment. Continuing to refer to Table 16.10, he determined that appellant also had a Grade 2 sensory deficit of .8, which when multiplied by the maximum upper extremity impairment in the C6 distribution (.25), yields a six percent upper extremity impairment.<sup>2</sup> Combining the two results, Dr. Lenihan concluded that appellant had a 26 percent total right upper extremity impairment.

Again, the case file was referred to the district medical adviser, who sought another opinion from the Office orthopedic consultant. Based upon his review of the records, on March 18, 2004 Dr. Harris opined that Dr. Lenihan had applied the A.M.A., *Guides* incorrectly, in that he awarded impairment for both pain which interferes with function as well as diminished sensation, a process which is disallowed as duplicative under the A.M.A., *Guides*. The orthopedic consultant also felt that because appellant had returned to full duties, his residual impairment was consistent with Grade 3 pain/decreased sensation which interferes with some activities, rather than the Grade 2 rating by Dr. Lenihan. Dr. Harris modified his recommendation upward to 13 percent, based upon Dr. Lenihan's documentation of residual weakness in the shoulder forward flexion which was somewhat greater than the mild rotator cuff weakness noted in the prior examination.

Based upon Dr. Harris' report, the Office modified the schedule award to 13 percent. On March 29, 2004 the Office granted appellant a schedule award for a 13 percent impairment of his right upper extremity, finding the date of maximum medical improvement to be February 28, 2004.<sup>3</sup>

On August 5, 2004 appellant again requested reconsideration. In support of his request, he submitted a July 20, 2004 report from Dr. Lenihan, who stated that he had misidentified a table in his January 15, 2004 report. He explained that appellant had sustained two distinct injuries to his right upper extremity, namely a severe injury to his acromioclavicular joint in the right shoulder and a peripheral nerve injury to C6 causing peripheral neuropathy. Dr. Lenihan contended that his disability should be rated applying Table 16-18 page 499, which describes the maximum impairment percent due to acromioclavicular joint disorder as 25 percent in the upper extremity. Referencing Table 16-10 and based upon appellant's restricted range of motion, loss

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<sup>2</sup> The Board notes that Dr. Lenihan's calculations are mathematically incorrect, however, they have no bearing on the ultimate disposition of this appeal.

<sup>3</sup> The March 29, 2004 schedule award reflects payment to appellant for an additional two percent over the January 6, 2004 schedule award previously paid.

of strength and inability to perform activities (such as using a shot gun, doing push-ups), Dr. Lenihan determined that he had between a 60 and 80 percent impairment as a result of the injury to the acromioclavicular joint. Multiplying the 80 percent impairment factor by the 25 percent maximum impairment, he concluded that appellant had a 20 percent impairment of his upper extremity. Dr. Lenihan reiterated his opinion that appellant had a Grade 2 impairment due to the C6 documented radiculopathy, resulting in a six percent additional impairment rating.

The case record was again forwarded to the district medical director, who requested another review by the Office's orthopedic consultant. In a report dated August 23, 2004, Dr. Harris opined that appellant was not entitled to a schedule award for peripheral nerve damage because the Office had not accepted peripheral nerve injury to C6 as a work-related condition. He further opined that he had not sustained a nerve injury to C6 resulting in peripheral neuropathy but rather that his injury was solely to his right shoulder acromioclavicular joint and concluded that appellant had a 13 percent impairment to his right upper extremity.

By decision dated October 5, 2004, the Office denied modification of its previous schedule award decisions based upon Dr. Harris' report.

On February 6, 2005 appellant again requested reconsideration. He related his inability to understand the Office's decision; that he had researched similar cases and found that claimants had received schedule awards between 23 and 31 percent; that the Office's consultant interpreted the evidence erroneously; and that he would like to be examined by another physician chosen by the Office.

By decision dated February 25, 2005, the Office denied modification of its schedule award. Stating that impairment attributable to peripheral neuropathy had not been accepted, the Office found that there was no basis to develop appellant's claim further or to modify its decision.

### **LEGAL PRECEDENT**

The schedule award provision of the Federal Employees' Compensation Act<sup>4</sup> and its implementing regulation<sup>5</sup> sets 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. The Act, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of the Office.<sup>6</sup> 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* has been

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<sup>4</sup> 5 U.S.C. §§ 8101 *et seq.*

<sup>5</sup> 20 C.F.R. § 10.404.

<sup>6</sup> *Linda R. Sherman*, 56 ECAB \_\_\_\_ (Docket No. 04-1510, issued October 14, 2004); *Daniel C. Goings*, 37 ECAB 781, 783-84 (1986).

adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.<sup>7</sup>

The Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.<sup>8</sup>

Section 8123(a) of the Act provides in part: “If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.”<sup>9</sup>

### ANALYSIS

The Board finds that this case is not in posture for decision on whether appellant is entitled to an additional schedule award for his right upper extremity. There is a conflict in medical opinion necessitating referral to an impartial medical specialist pursuant to 5 U.S.C. § 8123(a).

Appellant’s treating physician, Dr. Lenihan, opined that he had sustained two distinct injuries to his right upper extremity, namely a severe injury to his acromioclavicular joint in the right shoulder and a peripheral nerve injury to C6 causing peripheral neuropathy. He contended that appellant’s disability should be rated applying Table 16-18, page 499,<sup>10</sup> which describes the maximum impairment percent due to acromioclavicular joint disorder as 25 percent in the upper extremity. Referencing Table 16-10<sup>11</sup> and based upon his restricted range of motion, loss of strength and inability to perform activities (such as using a shot gun, doing push-ups), Dr. Lenihan determined that appellant had between a 60 and 80 percent impairment as a result of the injury to the acromioclavicular joint. Finding the severity of his pain to be Grade 2, Dr. Lenihan multiplied the 80 percent impairment factor by the 25 percent maximum impairment, concluding that he had a 20 percent impairment of his upper extremity due to the acromioclavicular joint condition. He then opined that appellant’s Grade 2 impairment due to the C6 documented radiculopathy resulted in a six percent additional impairment rating.

The Office’s orthopedic consultant, Dr. Harris, concluded that appellant had a 13 percent impairment to his right upper extremity. Noting that the only accepted condition was acromioclavicular joint separation, he allowed no rating for a peripheral nerve injury to C6.

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<sup>7</sup> *Ronald R. Kraynak*, 53 ECAB 130, 132 (2001).

<sup>8</sup> See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (March 1995).

<sup>9</sup> 5 U.S.C. § 8123(a).

<sup>10</sup> A.M.A., *Guides* at 499, Table 16-18.

<sup>11</sup> *Id.* at 482, Table 16-10.

Dr. Harris opined without examination that appellant's residual impairment was consistent with Grade 3 pain/decreased sensation which interferes with some activities, as opposed to Dr. Lenihan's Grade 2 rating, resulting in a reduction in the impairment factor under Table 16-10<sup>12</sup> to a maximum of 60 percent.

The Board notes that Dr. Lenihan's application of Tables 16-18 and 16-10 was inappropriate. Section 16.7 of the A.M.A., *Guides*<sup>13</sup> provides that the severity of conditions contributing to impairments of the upper extremity, such as joint disorders and loss of strength, is rated separately according to Tables 16-19 through 16-30 and then multiplied by the relative maximum value of the unit involved as specified in Table 16-18. Table 16-10 is not cited as a Table to be used in conjunction with Table 16-18. Moreover, Table 16-10 is to be used in determining impairment of the upper extremity due to sensory deficits or pain resulting from peripheral nerve disorders. Dr. Lenihan incorrectly used Table 16-10 to rate appellant's acromioclavicular joint disorder. The Board also notes that impairment of the upper extremity after arthroplasty of the clavicle is compensable pursuant to Table 16-27, page 506 and may be combined with decreased motion pursuant to the Combined Values Chart on page 604.<sup>14</sup> Neither Dr. Lenihan, nor Dr. Harris provided a rating for appellant's condition related to arthroscopy of his clavicle.

The physician for the Office and appellant's treating physician disagreed on the severity of pain attributable to his condition and method of analysis under the fifth edition of the A.M.A., *Guides*. To resolve this conflict in opinion, the Office shall refer him, together with the medical record and a statement of accepted facts, to an appropriate impartial medical specialist for a well-reasoned opinion on the extent of impairment of appellant's right upper extremity. The specialist should refer to the appropriate Tables in the fifth edition of the A.M.A., *Guides* outlined above in formulating his opinion as to the degree of his impairment. After such further development of the evidence as may be necessary, the Office shall issue an appropriate final decision on whether appellant is entitled to an additional schedule award.

### CONCLUSION

This case is not in posture for a decision on whether appellant's accepted employment injuries caused more than a 13 percent impairment to his left upper extremity. The Board finds that a conflict in medical opinion exists between the Office's orthopedic consultant and his physician. The Board will set aside the Office's January 6, March 29 and October 5, 2004 and February 25, 2005 decisions and remand the case for referral to an impartial medical specialist to resolve the conflict under section 8123(a) of the Act.

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<sup>12</sup> *Id.*

<sup>13</sup> A.M.A., *Guides* at 498.

<sup>14</sup> *Id.* at 498, section 16.7b.

**ORDER**

**IT IS HEREBY ORDERED THAT** the February 25, 2005 and October 5, March 29 and January 6, 2004 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further action consistent with this opinion.

Issued: August 8, 2005  
Washington, DC

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