

maximum medical improvement and the commencement date of his schedule award.¹ However, the Board set aside the Office's finding that he had a 15 percent impairment of the left arm and the rate of pay used to calculate his compensation.²

On remand, the Office granted appellant a schedule award for a 20 percent impairment of the left arm by decision dated February 5, 1981. On February 17, 1981 he appealed to the Board. In an order issued on March 20, 1981, the Board remanded the case to the Office, finding that it failed to use the proper pay rate to calculate his compensation.³

By decision dated February 9, 1983, the Office found that appellant did not have more than a 20 percent impairment of the left arm or entitlement to payment at a greater pay rate. On February 28, 1983 he requested an oral hearing before an Office hearing representative. By decision dated March 27, 1984, an Office hearing representative set aside the February 9, 1983 decision and remanded the case for further development to determine the extent of appellant's impairment.

The Office issued a decision dated September 5, 1985, finding that appellant did not have more than a 20 percent impairment of the left arm. It also determined that his other conditions, including permanent loss of use of the right arm, loss of range of motion of the neck, shingles, tension and anxiety contributing to burxison, lateral rotator cuff tear of the left arm, hypertension, pain, degenerative changes in the cervical spine, ability to walk and spinal injuries were not causally related to the September 18, 1968 accepted employment injury. On September 18, 1985 appellant appealed to the Board. In an order dated February 13, 1986, the Board remanded the case to the Office for proper assemblage of the case record as it did not contain relevant medical evidence. The Board instructed the Office to issue a *de novo* decision on the merits to preserve appellant's appeal rights.⁴

On March 20, 1986 the Office issued a decision which found no more than a 20 percent impairment of the left upper extremity. On April 9, 1986 he appealed to the Board. In an October 14, 1986 decision, the Board set aside the March 20, 1986 decision for further development of the medical evidence regarding the extent of appellant's impairment due to his orthopedic conditions.⁵

¹ On September 18, 1968 appellant, then a 38-year-old attorney-adviser, filed a claim alleging that on that date he strained, pulled and tore muscles and experienced headaches due to a work-related incident. He stated that, while he was on the telephone, he reached for a book and appellant's chair fell from underneath him and threw him backwards onto his left hip which was operated upon the previous year. The Office accepted appellant's claim for a strain of the neck, left shoulder and lower back, left rotator cuff tear and aggravation of a preexisting psychogenic condition.

² Docket No. 80-79 (issued March 3, 1980).

³ Docket No. 81-707 (issued March 20, 1981).

⁴ Docket No. 85-2049 (issued February 13, 1986).

⁵ Docket No. 86-1224 (issued October 14, 1986).

The Office issued a decision dated March 13, 1989 which granted appellant a schedule award for an additional 12 percent impairment of the left upper extremity, totaling a 32 percent impairment. By decision dated November 16, 1989, the Office found that he was not entitled to a schedule award for his right upper extremity. In a November 29, 1989 letter, appellant requested a review of the written record by an Office hearing representative. On April 5, 1990 a hearing representative found that the case was not in posture for decision and remanded the case for further development of whether appellant's orthopedic conditions were causally related to the September 18, 1968 employment injury and whether he was entitled to a schedule award for his right arm.

By decision dated August 7, 1991, the Office granted appellant a schedule award for a 28 percent impairment of the right upper extremity. In a March 1, 1992 letter, he requested reconsideration. By decision dated June 8, 1992, the Office denied modification of the August 7, 1991 decision. The Office noted that the schedule award for a 28 percent impairment of the right upper extremity was incorrect and instead he should have received an award for a 17 percent impairment. On June 22, 1992 appellant appealed to the Board. In a July 27, 1993 decision, the Board set aside the June 8, 1992 decision and remanded the case to the Office to determine whether appellant had any additional impairment of the right upper extremity due to pain, sensory deficit or weakness and the date he reached maximum medical improvement.⁶

In an August 11, 1994 decision, the Office granted appellant a schedule award for a 37 percent impairment of the right lower extremity.

On November 25, 2002 appellant filed a claim for an additional schedule award for his right and left upper extremities and his right lower extremity. He submitted a March 12, 2003 medical report of Dr. Mark D. Klaiman, a Board-certified physiatrist, which found that appellant experienced problems with his back and lower extremities. On physical examination, Dr. Klaiman reported range of motion findings regarding his lumbosacral spine and lower extremities. He reported muscle weakness of the right lower extremity at the hip as Grades 4+/5 and normal at the knee, ankle and foot. The left lower extremity demonstrated Grades 4-/5 weakness at the hip, 4/5 knee flexion and extension and 4 to 4+/5 in ankle plantar flexion and dorsiflexion. Deep tendon reflexes were absent at the knees and minimally present at both ankles. Dr. Klaiman stated that appellant had a slow antalgic gait with great difficulty achieving foot clearance on the left. He diagnosed left-sided radiculopathy and lumbar stenosis. Dr. Klaiman stated that appellant had not reached maximum medical improvement and that he required continued medical treatment. Based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*), he estimated that he had a 40 percent impairment of the whole person with regard to his lower extremities.

Dr. Klaiman submitted an April 23, 2003 medical report in which he stated that appellant's muscle weakness of both lower extremities was related to the diagnoses of lumbar stenosis and lumbar radiculopathy. He noted that appellant had developed disuse weakness due to chronic pain from these conditions. Utilizing the A.M.A., *Guides* 532, Table 17-8, Dr. Klaiman found that appellant's left lower extremity had a 47 percent impairment due to

⁶ Docket No. 92-1768 (issued July 27, 1993).

weakness at the hip, a 24 percent impairment due to weakness at the knee and a 14 percent impairment due to weakness at the ankle. Based on the Combined Values Chart, he found that appellant had a 66 percent impairment of the left lower extremity. Regarding the right lower extremity, Dr. Klaiman utilized the A.M.A., *Guides* 532, Table 17-8 to determine that appellant had a 27 percent impairment due to weakness at the hip, a 10 percent impairment due to weakness at the knee and a 14 percent impairment due to weakness at the ankle which constituted a 43 percent impairment of the right lower extremity.

Dr. Klaiman subsequently submitted a May 8, 2003 treatment note. On physical examination of appellant's left shoulder, he reported painful range of motion with 150 degrees of abduction and 60 degrees of internal rotation. Dr. Klaiman found that appellant had persistent myofascial neck symptoms and noted his treatment of these symptoms.

On July 22, 2003 an Office medical adviser reviewed the medical evidence and found that appellant reached maximum medical improvement on May 8, 2003. The Office medical adviser further found that "50" degrees of abduction constituted a 6 percent impairment based on the A.M.A., *Guides* 477, Figure 16-43 and that 60 degrees of internal rotation constituted a 2 percent impairment based on the A.M.A., *Guides* 479, Figure 16-46 totaling an 8 percent impairment of the left upper extremity. The Office medical adviser stated that the clinical information provided by Dr. Klaiman was insufficient to calculate an impairment rating for appellant's neck and that an electromyogram (EMG), nerve conduction velocity studies and a magnetic resonance imaging (MRI) scan would be helpful in calculating an impairment rating for the upper extremity. On August 22, 2003 the Office authorized appellant to undergo testing as recommended by the Office medical adviser.

By letter dated November 18, 2003, the Office referred appellant, together with the case record, a statement of accepted facts and a list of questions regarding his left shoulder to Dr. Michael S. Miller, Ph.D and a Board-certified neurologist, for a second opinion medical examination. He submitted a December 4, 2003 report which provided a history of appellant's employment-related injuries, medical treatment and family background. Findings on physical examination included decreased range of motion in the cervical spine and left shoulder and normal strength in the right upper extremity and both lower extremities. Dr. Miller noted that strength testing was difficult in the left upper extremity due to pain but it appeared to be essentially normal. He noted decreased range of motion about the left shoulder joint and that appellant could only abduct the arm 90 degrees. Prior to responding to the Office's questions, Dr. Miller indicated that he was only asked to address the status of appellant's left shoulder. He stated that appellant continued to have residuals of his September 18, 1968 employment injuries. Dr. Miller diagnosed frozen left shoulder and severe cervical spondylosis which were permanent conditions that precluded him from any gainful employment. He found that appellant had reached maximum medical improvement although the exact date was uncertain but it occurred prior to his evaluation. Dr. Miller opined that his impairment was related to his accepted employment injuries. Utilizing the A.M.A., *Guides* (4th ed. 1995) 58, Table 18, he determined that appellant had a 60 percent impairment of the left glenohumeral joint. In an accompanying work capacity evaluation dated December 4, 2003, Dr. Miller stated that he had a work-related medical problem and provided his physical restrictions. He stated that appellant could not work any hours.

On December 4, 2003 the Office requested that Dr. Miller submit an impairment rating based on the fifth edition of the A.M.A., *Guides*. On December 5, 2003 Dr. Miller responded that appellant had a 60 percent impairment of the left glenohumeral joint based on the A.M.A., *Guides* 499, Table 16-18. By letter dated December 22, 2003, the Office requested that he address specific questions regarding impairment to appellant's upper extremities and right lower extremity based on the fifth edition of the A.M.A., *Guides*.

The Office received Dr. Klaiman's treatment notes dated October 14 to December 16, 2003 regarding appellant's left upper extremity and neck symptoms. In a September 16, 2003 report, he reported abnormal EMG and nerve conduction velocity study results. Dr. Klaiman stated that the findings were suggestive of a chronic left-sided cervical root level lesion that most consistently involved C6. He also stated that there appeared to be evidence of a mild left-sided median nerve lesion that was most likely at the level of the wrist. On October 23, 2003 Dr. Klaiman stated that appellant's work-related condition had not resolved as he continued to experience symptoms related to his left upper extremity and lower back. He noted the results of recent cervical spine x-rays which found diffuse degenerative disc disease and spondylosis with neural foraminal narrowing at C5-6 and his EMG and nerve conduction velocity study results. Dr. Klaiman opined that appellant had chronic and permanent work-related residual impairments and that he would experience continuing and potentially worsening symptoms related to degenerative spine disease of the cervical and lumbosacral spines. He further opined that he would likely face additional disability in the future which would preclude him from working in any capacity. Dr. Klaiman stated that appellant was disabled due to his left hip and noted a history of osteomyelitis at a younger age and premature degenerative joint disease which required a total left hip replacement in 1967. He further stated that he had significant residual leg length discrepancy which required customized footwear and a history of carpal tunnel syndrome that was unrelated to his employment injuries.

In a January 21, 2004 response to the Office's request, Dr. Miller stated that appellant possibly reached maximum medical improvement in the late 1970s. He found that he had a 60 percent impairment of the left upper extremity which constituted a 36 percent impairment of the whole person based on the A.M.A., *Guides* 499, Table 16-18. Dr. Miller stated that the date was unknown as to when his lower extremity reached maximum medical improvement. Utilizing the A.M.A., *Guides* 546, Table 17-33, Dr. Miller also found that appellant had a 30 percent impairment of the left lower extremity and hip. He again noted that, when he saw appellant, he was only asked to assess impairment of his upper extremity.

On June 14, 2004 the Office medical adviser reviewed the case record, noting the importance of Dr. Klaiman's October 23, 2003 x-ray findings. Regarding the date appellant reached maximum medical improvement, the Office medical adviser referred to his July 22, 2003 opinion. Based on the A.M.A., *Guides* 424, Table 15-17, he determined that a C6 sensory deficit on the left constituted an eight percent impairment of the left upper extremity. The Office medical adviser stated that appellant reached maximum medical improvement on October 23, 2003, the date of Dr. Klaiman's report. With respect to his left upper extremity and left shoulder, the Office medical adviser reiterated that "50" degrees of glenohumeral abduction constituted a 6 percent impairment and that 60 degrees of internal rotation of the left shoulder merited a 2 percent impairment of the left upper extremity based on the tables of the A.M.A., *Guides*, totaling an 8 percent impairment of the left upper extremity. He stated that a new

calculation had to be added to his report for C6 left upper extremity radiculopathy, sensory deficit or pain which constituted an eight percent impairment. The Office medical adviser concluded that appellant had a 16 percent impairment of the left upper extremity based on the new calculations.

By decision dated June 24, 2004, the Office found the evidence of record insufficient to establish that appellant had more than a 32 percent impairment of the left upper extremity, a 28 percent impairment of the right upper extremity and a 37 percent impairment of the right lower extremity based on the Office medical adviser's opinion. On July 16, 2004 appellant appealed to the Board.

On March 9, 2005 the Board issued an order remanding case for proper assemblage of the case record as it did not contain relevant medical evidence. The Board also instructed the Office to issue an appropriate decision to protect appellant's appeal rights.⁷

By decision dated April 15, 2005, the Office found the evidence of record insufficient to establish that appellant had more than a 32 percent impairment of the left upper extremity, a 28 percent impairment of the right upper extremity and a 37 percent impairment of the right lower extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act⁸ and its implementing regulation⁹ sets forth the number of weeks of compensation to be paid for permanent loss or loss of use, of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.¹⁰ However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.¹¹

Before the A.M.A., *Guides* can be utilized, a description of appellant's impairment must be obtained from his physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, 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 descriptions of the impairment. This description must

⁷ Docket No. 04-1869 (issued March 9, 2005).

⁸ 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

⁹ 20 C.F.R. § 10.404.

¹⁰ 5 U.S.C. § 8107(c)(19).

¹¹ 20 C.F.R. § 10.404.

be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.¹²

ANALYSIS

The Office granted appellant a schedule award for a 32 percent impairment of the left upper extremity, a 28 percent impairment of the right upper extremity and a 37 percent impairment of the right lower extremity. He requested an additional schedule award for his upper extremities and right lower extremity. Dr. Klaiman, an attending physician, indicated in a May 8, 2003 treatment note, that appellant complained of increased left-sided neck and shoulder pain. He reported 150 degrees of abduction and 60 degrees of internal rotation on physical examination. Dr. Klaiman, however, did not address the relevant issue of whether appellant has any impairment of his left upper extremity due to the accepted September 18, 1968 employment injury, utilizing the appropriate edition of the A.M.A., *Guides*. Therefore, the Board finds that his treatment note is of diminished probative value regarding the impairment to appellant's left upper extremity.

In a March 12, 2003 medical report, Dr. Klaiman reported muscle weakness of 4+/5 at the right hip and 4-/5 at the left hip. He reported 4/5 left knee flexion and extension and 4 to 4+/5 left ankle plantar flexion and dorsiflexion. The right knee, ankle and foot had normal muscle strength. Dr. Klaiman diagnosed left-sided radiculopathy and lumbar stenosis and determined that appellant had a 40 percent impairment of the whole person based on the A.M.A., *Guides*. While the A.M.A., *Guides* provide for impairment to the individual member and to the whole person, the Act does not allow schedule awards for impairment to the whole person.¹³ Dr. Klaiman's impairment rating is insufficient to establish that appellant is entitled to a schedule award for an additional impairment.

Dr. Klaiman's April 23, 2003 report found that appellant had a 66 percent impairment of the left lower extremity based on the A.M.A., *Guides* 532, Table 17-8. Regarding the right lower extremity, he found that he had a 27 percent impairment due to weakness at the hip, a 10 percent impairment due to weakness of the knee and a 14 percent impairment due to weakness at the ankle which constituted a 43 percent impairment of the right lower extremity. Dr. Klaiman failed to explain the basis for changing his prior March 12, 2003 opinion that appellant had normal muscle strength in his right knee, ankle and foot. His report is insufficient to establish that appellant is entitled to a schedule award for an additional impairment of the right lower extremity.

Dr. Miller, an Office referral physician, reported decreased range of motion in the cervical spine and left shoulder and normal strength in the right upper extremity and both lower extremities. He also reported 90 degrees of abduction for the left shoulder. Dr. Miller opined that appellant continued to experience residuals of the September 18, 1968 employment injury and diagnosed frozen left shoulder and severe cervical spondylosis. He stated that these

¹² Robert B. Rozelle, 44 ECAB 616, 618 (1993).

¹³ Phyllis F. Cundiff, 52 ECAB 439 (2001); John Yera, 48 ECAB 243 (1996).

conditions were permanent and prevented him from obtaining any gainful employment. Utilizing the A.M.A., *Guides* 499, Table 16-18, Dr. Miller determined that appellant had a 60 percent impairment of the left glenohumeral joint which constitutes a 36 percent impairment of the whole person. As previously noted by the Board, the Act does not provide for impairment for the whole person.¹⁴ Moreover, Dr. Miller did not explain how he calculated a 60 percent impairment of the left upper extremity using Table 16-18, page 499 of the A.M.A., *Guides*. Therefore, his opinion is not sufficient to establish that appellant is entitled to a schedule award for an additional impairment of the left upper extremity.

An Office medical adviser reviewed the medical evidence of record, including Dr. Klaiman's May 8, 2003 findings and determined that "50" degrees of abduction constituted a 6 percent impairment based on the A.M.A., *Guides* 477, Figure 16-43 and that 60 degrees of internal rotation constituted a 2 percent impairment based on the A.M.A., *Guides* 479, Figure 16-46, totaling an 8 percent impairment of the left upper extremity.¹⁵ The Office medical adviser subsequently reviewed Dr. Klaiman's finding that appellant had a sensory deficit at C6 of the left upper extremity. Utilizing the A.M.A., *Guides* 424, Table 15-17, he determined that he had an eight percent impairment of the left upper extremity. The Office medical adviser added this impairment rating to his prior 8 percent impairment rating and found that appellant had a 16 percent impairment of the left upper extremity. As the Office medical adviser found that appellant does not have more than a 32 percent impairment of the left upper extremity for which he already received a schedule award, he is not entitled to a schedule award for an additional impairment of the left upper extremity.

CONCLUSION

Appellant has not provided any relevant medical evidence to establish that he has more than a 32 percent impairment of the left upper extremity, a 28 percent impairment of the right upper extremity and a 37 percent impairment of the right lower extremity, for which he received a schedule award. The Board, therefore, finds that appellant has not established that he is entitled to more than the schedule award granted by the Office.

¹⁴ *Id.*

¹⁵ The Board notes that the Office medical adviser used an incorrect value for abduction. Dr. Klaiman found that abduction was 150 degrees, which constitutes a 1 percent impairment of the left upper extremity based on the A.M.A., *Guides* 479, Figure 16-43.

ORDER

IT IS HEREBY ORDERED THAT the April 15, 2005 and June 24, 2004 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: February 13, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board