

Appellant came under the treatment of Dr. Charles D. Hummer, III, a Board-certified orthopedic surgeon, who treated appellant from March 22 to October 7, 2004 for his right rotator cuff tear. A March 19, 2004 magnetic resonance imaging (MRI) scan of the right shoulder revealed a large full thickness tear of the rotator cuff with tendon retraction. On April 2, 2004 Dr. Hummer performed a right shoulder diagnostic arthroscopy followed by an open rotator cuff repair for massive tear, with complete reconstruction and diagnosed right complete supraspinatus and partial anterior infrapinatus avulsion tear of the rotator cuff. In reports dated April 8 to October 7, 2004, he noted that appellant continued with physical therapy and experienced markedly improved range of motion and could return to work full time on August 12, 2004. On October 7, 2004 Dr. Hummer noted full active range of motion of the right shoulder, essentially normal rotator cuff strength, impingement sign was negative, no audible or palpable subacromial crepitus and the motor, sensory and reflex examination was normal. He recommended that appellant continue full-time work and follow-up as needed.

On October 25, 2004 appellant filed a claim for a schedule award.

In a letter dated November 12, 2004, the Office asked that appellant have his physician evaluate the extent of permanent impairment of the left and right arm pursuant to the A.M.A., *Guides*.¹

Appellant submitted a report dated January 27, 2005, from Dr. George L. Rodriguez, a Board-certified orthopedic surgeon, who diagnosed rotator cuff tear and ulnar nerve injury at the elbow. Dr. Rodriguez noted that appellant reached maximum medical improvement on October 2, 2004 and determined that he had 19 percent impairment of the right arm under the A.M.A., *Guides*. He noted findings upon physical examination of external rotation of 70 degrees for 0 percent impairment;² internal rotation was 30 degrees for 4 percent impairment;³ and no abnormalities in range of motion for flexion,⁴ extension⁵ and adduction.⁶ Dr. Rodriguez noted a 25 percent deficit in shoulder strength for flexion for 6 percent impairment;⁷ a 25 percent deficit in shoulder strength for abduction for 3 percent impairment;⁸ a 25 percent deficit in shoulder strength for internal rotation for 2 percent impairment;⁹ a 50 percent deficit in shoulder strength

¹ The American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).

² *Id.* at 479, Figure 16-46.

³ *Id.*

⁴ *Id.* at 476, Figure 16-40.

⁵ *Id.*

⁶ *Id.* at 477, Table 16-43.

⁷ *Id.* at 510, Figure 16-35.

⁸ *Id.*

⁹ *Id.*

for external rotation for 3 percent impairment;¹⁰ and a sensory nerve impairment for the ulnar nerve, a Grade 4 or a 25 percent deficit, for a 2 percent impairment.¹¹ Appellant also submitted a May 5, 2005 MRI scan of the right shoulder that noted recurrent supraspinatus tear, small glenohumeral joint effusion, acromioclavicular degenerative disease and proximal biceps tendon synovitis.

The Office referred Dr. Rodriguez' report to an Office medical adviser. In a June 1, 2005 report, the Office medical adviser advised that appellant had four percent permanent impairment of the right arm under the A.M.A., *Guides*. He found that appellant reached maximum medical improvement on January 27, 2005. The Office medical adviser calculated that external rotation was 70 degrees for 0 percent impairment;¹² and internal rotation was 30 degrees for 4 percent impairment.¹³ He noted that section 16.8a on page 508 of the A.M.A., *Guides*, provided that when calculating a schedule award for the right shoulder, decreased strength cannot be rated in the presence of decreased motion. The medical adviser further noted that appellant was not entitled to a schedule award for the ulnar nerve because the Office did not accept this condition as work related.

In a decision dated June 21, 2005, the Office granted appellant a schedule award for four percent permanent impairment of the right upper extremity. The period of the schedule award was from January 27 to April 24, 2005.

On November 28, 2005 appellant requested a review of the written record. He submitted reports from Dr. Rodriguez dated April 26 to September 15, 2005, who noted a history of appellant's injury and diagnosed rotator cuff tears and ulnar nerve injury at the elbow caused by appellant's fall at work on March 16, 2004. Dr. Rodriguez recommended physical therapy and advised that appellant could return to work subject to restrictions. In a report dated October 10, 2005, he disagreed with the medical adviser's findings and opined that appellant had 16 percent permanent impairment of the right arm under the A.M.A., *Guides*. Dr. Rodriguez noted that since range of motion was rated for internal rotation a strength deficit would not be rated for this motion. However, he noted that since range of motion was not rated for external rotation, flexion or abduction, a strength deficit could be rated for these motions. Dr. Rodriguez noted that internal rotation was 30 degrees for 4 percent impairment;¹⁴ a deficit in shoulder strength for flexion was a Grade 4 or 25 percent for 6 percent impairment;¹⁵ a deficit in shoulder strength for abduction was a Grade 4 or 25 percent for 3 percent impairment;¹⁶ and a deficit in shoulder

¹⁰ *Id.*

¹¹ *Id.* at 482, 492, Table 16-10, 16-15.

¹² *See supra* note 2.

¹³ *Id.*

¹⁴ *See supra* note 2.

¹⁵ *See supra* note 7.

¹⁶ *Id.*

strength in external rotation was a Grade 3 or 50 percent for 3 percent impairment.¹⁷ An x-ray of the right shoulder dated July 13, 2005, revealed no significant abnormality.

In a September 9, 2005 report, an Office medical adviser opined that appellant sustained a 10 percent permanent impairment of the right arm. He noted that the only limitation of range of motion was internal rotation of 30 degrees for a 4 percent permanent impairment of the right upper extremity in accordance with Figure 16-46, page 479 of the A.M.A., *Guides*. The medical adviser disagreed with Dr. Rodriguez calculation for shoulder strength impairment which was based upon Table 16-35, page 510 of the A.M.A., *Guides*. He noted that section 16.8, page 508 of the A.M.A., *Guides*, provides that impairment due to loss of strength could be combined with other impairment only if based on unrelated or pathomechanical causes; otherwise, impairment ratings based upon objective anatomic findings take precedence. Additionally, Table 16-2, page 526, of the A.M.A., *Guides*, provides that where range of motion analysis is used muscle strength cannot be utilized. The medical adviser modified his impairment rating and noted that appellant would be entitled to a 10 percent impairment of the right upper extremity based upon Table 16-27, Distal Clavicle Resection, page 506, of the A.M.A., *Guides*.

Appellant submitted an MRI scan of the right shoulder dated January 10, 2006, which revealed status post rotator cuff repair with a recurrent supraspinatus tear present, acromioclavicular joint degenerative disease and a small glenohumeral joint effusion.

In a decision dated March 2, 2006, the hearing representative set aside June 21, 2005 schedule award and remanded the matter for further development. The hearing representative noted that Dr. Rodriguez provided an additional impairment of 12 percent for shoulder strength impairment due to flexion and requested the medical adviser determine whether appellant had additional impairment of 12 percent based on loss of shoulder strength.

In reports dated January 3 to March 28, 2006, Dr. Rodriguez noted appellant's continued complaints and diagnosed rotator cuff tear of the right shoulder and brachial plexitis of the right shoulder.

The Office referred Dr. Rodriguez' report's and the case record to an Office medical adviser. In a report dated August 27, 2006, the Office medical adviser advised that appellant sustained 14 percent permanent impairment of the right arm. He calculated that appellant had a 10 percent impairment of the right upper extremity based upon the distal clavicle resection,¹⁸ and 4 percent impairment for the range of motion deficit for internal rotation of 30 degrees.¹⁹ The Office medical adviser noted that in accordance with section 16-7B arthroplasty, page 505 of the A.M.A., *Guides*, decreased range of motion can be combined with arthroplasty impairment, which would provide a 14 percent permanent impairment of the right arm. He opined that Dr. Rodriguez' calculation which combined range of motion findings with loss of strength deficits was not in compliance with the A.M.A., *Guides*.

¹⁷ *Id.*

¹⁸ *Id.* at 506, Table 16-27.

¹⁹ *See supra* note 2.

By decision dated September 12, 2006, the Office granted appellant a schedule award of 14 percent permanent impairment of the right upper extremity. As appellant was previously paid a schedule award of 4 percent impairment for the right upper extremity he would receive compensation for the additional 10 percent permanent impairment. The period of award was from April 25 to November 29, 2005.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act²⁰ and its implementing regulation²¹ set 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. However, the Act does not specify the manner in which 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 so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.²²

The A.M.A., *Guides* standards for evaluating the impairment of extremities are based primarily on loss of range of motion.²³ However, all factors that, prevent a member from functioning normally, including pain or discomfort, should be considered, together with loss of motion, in evaluating the degree of permanent impairment.²⁴

ANALYSIS

On appeal, appellant contends that he has greater impairment than the 14 percent determined by the Office.

Dr. Rodriguez determined that appellant had 16 percent permanent impairment of the right arm. However, he did not adequately explain how his rating complied with the A.M.A., *Guides*. In an October 10, 2005 report, Dr. Rodriguez noted that since deficits in range of motion were not rated for external rotation, flexion or abduction, deficits in strength could be rated for these motions. He noted that internal rotation was 30 degrees for 4 percent impairment;²⁵ a deficit in shoulder strength for flexion was a Grade 4 or 25 percent for 6 percent impairment;²⁶ a deficit in shoulder strength for abduction was a Grade 4 or 25 percent for

²⁰ 5 U.S.C. § 8107.

²¹ 20 C.F.R. § 10.404 (1999).

²² *Michele Tousley*, 57 ECAB ____ (Docket No. 05-1156, issued October 12, 2005).

²³ See *William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

²⁴ See *Paul A. Toms*, 28 ECAB 403 (1987).

²⁵ See *supra* note 2.

²⁶ See *supra* note 7.

3 percent impairment;²⁷ and a deficit in shoulder strength in external rotation was a Grade 3 or 50 percent for 3 percent impairment.²⁸ The A.M.A., *Guides*, provide that, regarding strength evaluations under section 16.8, decreased strength cannot be rated in the presence of decreased motion.²⁹ Consequently, impairment attributable to decreased strength under section 16.8 cannot be combined with impairment for decreased motion. The Board finds that Dr. Rodriguez did not properly follow the A.M.A., *Guides* and finds that his opinion is of diminished probative value.³⁰

The Office medical adviser, on August 27, 2006, properly applied the A.M.A., *Guides* to the information provided in Dr. Rodriguez' October 10, 2005 report. He correctly determined that appellant had 10 percent impairment of the right arm based upon the distal clavicle resection;³¹ and 4 percent impairment for the range of motion deficit for internal rotation of 30 degrees.³² The Office medical adviser noted that in accordance with section 16-7b, arthroplasty, at page 505 of the A.M.A., *Guides*, decreased range of motion can be combined with arthroplasty impairment, which allowed a 14 percent permanent impairment of the right arm. The Board finds that appellant has no more than a 14 percent permanent impairment of the right upper extremity. The medical adviser properly set forth calculations in conformance with the A.M.A., *Guides*. The evidence establishes that appellant has a 14 percent permanent impairment of the right arm.

On appeal appellant contends that the medical adviser incorrectly excluded appellant's ulnar nerve condition from the schedule award calculation. He indicated that a preexisting impairment to the limb or organ must be included in the impairment rating regardless of whether the injury was work related. Appellant contends that his schedule award should be increased to include preexisting impairments of the ulnar nerve and cites the holding in *Walter R. Malena*,³³ where the Office was required to incorporate all preexisting impairments to the scheduled member in making a schedule award determination.

Although preexisting impairments of the body are to be included, in determining the amount of a schedule award,³⁴ the medical evidence in this case fails to establish any preexisting impairments of appellant's ulnar nerve. Dr. Hummer, in his initial report of March 22, 2004, noted a history of an auxiliary load injury to his elbow and shoulder on March 16, 2004. He noted that appellant had very mild achy pain intermittently in the right shoulder for several years but had no acute injury and no limitation of range of motion prior to this injury. Dr. Hummer

²⁷ *Id.*

²⁸ *Id.*

²⁹ See A.M.A., *Guides* at section 16.8a, pg 508.

³⁰ See *Paul R. Evans, Jr.*, 44 ECAB 646 (1993); *John Constantin*, 39 ECAB 1090 (1988) (medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

³¹ See *supra* note 18.

³² See *supra* note 2.

³³ 46 ECAB 983 (1995).

³⁴ *Id.*

referred to appellant's examination of the right elbow revealing pain free range of motion and made no mention of a ulnar nerve diagnosis, preexisting or otherwise. In a January 27, 2005 impairment evaluation, Dr. Rodriguez noted a history of an impact injury to appellant's elbow and shoulder on March 16, 2004, but stated that appellant "otherwise denies any prior or subsequent injuries to his right shoulder." Dr. Rodriguez rated appellant for sensory nerve impairment involving the ulnar nerve but he did not indicate that any ulnar nerve impairment was preexisting. Instead, he asserted that the "Ulnar Nerve Injury at Elbow -- Right" was "caused by initial fall" on March 16, 2004. However, an ulnar nerve injury was not accepted by the Office and the physician failed to provide a reasoned opinion regarding the causal relationship between appellant's right ulnar nerve injury and the March 16, 2004 injury.³⁵

Therefore, the Board finds that appellant was not entitled to a schedule award for preexisting impairment to the ulnar nerve as no preexisting impairment has been established.

CONCLUSION

The Board finds that appellant sustained a 14 percent permanent impairment of the right upper extremity.

ORDER

IT IS HEREBY ORDERED that the September 12, 2006 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 8, 2007
Washington, DC

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

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

³⁵ *Jaja K. Asaramo*, 55 ECAB 200 (2004) (where an employee claims that a condition not accepted or approved by the Office was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury).