United States Department of Labor
Employees' Compensation Appeals Board

A.V., Appellant	)	
and	)	**Docket No. 07-221**
	)	**Issued: May 21, 2007**
DEPARTMENT OF THE ARMY, DIRECTORATE OF PUBLIC WORKS, Fort Monmouth, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 31, 2006 appellant filed a timely appeal of the Office of Workers' Compensation Programs' May 16, 2006 merit decision affirming a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this appeal.

ISSUE

The issue is whether appellant has more than a 14 percent impairment of his left upper extremity, for which he received schedule awards.

FACTUAL HISTORY

On October 6, 2000 appellant, then a 53-year-old management specialist, injured his left shoulder while using a rowing machine. The Office accepted appellant's claim for left shoulder impingement syndrome and authorized left shoulder arthroscopy with decompression and coracoacromial release on July 19, 2001.

On March 26, 2002 appellant submitted a request for a schedule award. He submitted a December 26, 2001 report from Dr. David Weiss, a treating physician, who diagnosed post-traumatic acromioclavicular (ACV) arthropathy with impingement to the left shoulder; status post arthroscopic surgery with impingement release to the left shoulder; and status post apparent second degree burn to the left shoulder, which occurred during his surgical procedure. Range of motion examination of the left shoulder revealed forward elevation of 145/180 degrees; abduction of 120/180 degrees; cross-over adduction of 65/75 degrees; and external rotation of 80/90 degrees. Referencing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001),[1] Dr. Weiss concluded that appellant had a two percent deficit for left shoulder flexion (Figure 16-40, page 476) and a three percent deficit for left shoulder abduction (Figure 16-43, page 477). He found a 10 percent deficit for the resection arthroplasty (Table 16-27, page 506), for a combined impairment rating of 15 percent. Adding a three percent impairment for pain, Dr. Weiss concluded that appellant had a total left upper extremity impairment of 18 percent.

After reviewing his December 26, 2001 report, the district medical adviser agreed with Dr. Weiss' five percent assessment for range of motion deficit. However, he found that appellant's surgery did not fit the criteria for arthroplasty under the A.M.A., *Guides* and that, appellant's complaints of pain were too subjective to be ratable. The district medical adviser recommended that appellant receive a schedule award for a five percent impairment of his left upper extremity. He found that the date of maximum medical improvement (MMI) was December 26, 2001.

On May 29, 2002 the Office granted appellant a schedule award for a five percent permanent impairment of the left upper extremity. The period of the award was from December 26, 2001 to April 14, 2002.

On June 5, 2002 appellant, through his representative, requested an oral hearing. However, before a hearing could be held on the schedule award issue, appellant sustained a recurrence of disability.

On July 26, 2002 appellant filed a recurrence of disability as of May 30, 2002. He submitted an August 20, 2002 report from Dr. Mark Seckler, a Board-certified orthopedic surgeon, who indicated that a magnetic resonance imaging (MRI) scan and x-rays revealed a distal clavicular spur and a tear of the supraspinatus tendon. On September 12, 2002 the Office authorized arthroscopic surgery of the left shoulder. On October 18, 2002 appellant underwent arthroscopic surgery for repair of the left rotator cuff and resectioning of the distal clavicle and scar tissue. In a January 30, 2003 report, Dr. Seckler released appellant to full duty. He stated that appellant's range of motion was "almost 100 percent normal," but that he had a slight weakness to resisted external rotation.

On July 20, 2003 appellant submitted a request for an additional schedule award. He submitted a March 22, 2003 report from Dr. Weiss who opined that appellant had a total left upper extremity impairment of 27 percent. On examination, Dr. Weiss found tenderness over the tip of the acromion. Anterior cuff tenderness and focal ACV point tenderness was noted. Range

[1] A.M.A., *Guides*, 5th ed. (2000).

of motion testing revealed forward elevation of 90/180 degrees; abduction of 110/180 degrees; cross-over adduction of 35/75 degrees; and external rotation of 35/90 degrees. All ranges of motion were carried through with pain at the extremes. Internal rotation was abnormal at the sacrum. Hawkins impingement sign was positive. Manual muscle strength testing revealed reduced strength which he graded as follows: supraspinatus -- 3+/5; deltoid -- 4/5; triceps and biceps -- 4/5. Referring to the A.M.A., *Guides*, Dr. Weiss opined that appellant had a six percent range of motion deficit for flexion (Figure 16-42, page 476); a three percent range of motion deficit for abduction (Figure 16-43, page 477); a one percent range of motion deficit for external rotation (Figure 16-46, page 479); and a 15 percent deficit for left shoulder resection arthroplasty (2^{nd}) (Table 16-27, page 506). He opined that appellant had an additional five percent impairment for pain (Figure 18-1, page 574), for a total left upper extremity impairment of 27 percent. Dr. Weiss opined that the date of MMI was March 22, 2003.

An oral hearing was held on September 22, 2003. In a December 10, 2003 decision, an Office hearing representative affirmed the May 29, 2002 schedule award decision, finding that appellant had a five percent impairment of his left upper extremity. However, the case was remanded to the Office for further development of the medical evidence and a determination as to whether appellant's October 18, 2002 left shoulder arthroscopy caused additional impairment. The hearing representative noted that, although left rotator cuff tear was not an accepted condition, an impairment due to the approved surgery would be a basis for a schedule award.

In a report dated January 13, 2004, Dr. Seckler opined that the October 18, 2002 surgery did not worsen, but rather, improved appellant's condition. He found no signs of instability, other than a residual scar from prior surgery.

By decision dated April 2, 2004, the Office denied appellant's claim for an additional schedule award based on Dr. Seckler's report.

On April 14, 2004 appellant, through his representative, requested an oral hearing. By decision dated November 5, 2004, the Office of Hearings and Review vacated the April 2, 2004 decision and remanded the case for further development of the medical evidence. The hearing representative found that Dr. Seckler's opinion failed to establish that appellant had no residual impairment due to the October 18, 2002 surgery, in that he did not provide any range of motion measurements. The Office was instructed to refer appellant for a second opinion examination.

The Office referred appellant, together with a statement of accepted facts and the entire medical record, to Dr. Robert Dennis, a Board-certified orthopedic surgeon, for a second opinion examination and an opinion as to the degree of permanent impairment of appellant's left upper extremity. In a report dated February 18, 2005, Dr. Dennis reviewed appellant's medical history, indicating that he had undergone two surgeries. The first surgery was secondary to the October 6, 2000 work injury. The second surgery was a shoulder decompression due to an acceleration of a preexisting work-related condition which involved a repair of his rotator cuff and completion of a resection of the distal clavicle. Dr. Dennis noted that appellant had sustained a burn during his first surgery, which impaired his recovery and predisposed him to vulnerability. He stated that "the double surgery was accepted as an exacerbation of the original surgery." Examination of the left shoulder revealed slight diminution of strength of abduction. The left shoulder strength deficit was "a little less than five percent." Range of motion testing

revealed abduction of 160/180 degrees; adduction of 30/50 degrees; extension of 20/50 degrees; forward flexion of 150/180 degrees; internal rotation of 40/90 degrees; and external rotation of 50/90 degrees. Function of the triceps and biceps was intact. Dr. Dennis found tenderness on palpation in the subacromial bursa. All other aspects of the examination of the left upper extremity were within normal limits. Referring to the fifth edition of the A.M.A., *Guides*, Dr. Dennis concluded that appellant had a 3 percent deficit for forward flexion (140 degrees) (Figure 16-40, page 476);[2] a 2 percent deficit for backwards extension (20 degrees) (Figure 16-40, page 476); a 1 percent deficit for abduction (160 degrees) (Figure 16-43, page 477); a 1 percent deficit for adduction (30 degrees) (Figure 16-43, page 477); a 1 percent deficit for external rotation (50 degrees) (Table 16-46, page 479); and a 3 percent deficit for internal rotation (40 degrees) (Table 16-46, page 479). He found a 1 percent deficit for loss of strength secondary to deltoid adhesions to the skin ("extrapolated percentage of weakness 4/5") (Table 16-35, page 510). Referring to Table 16-27 at page 506, Dr. Dennis concluded that appellant had a 2 percent "extrapolated" deficit as a result of the "combination of the effects of the 2 surgeries," for a total functional impairment of 14 percent as of February 18, 2005, the date he reached MMI. Indicating that the first surgery was slightly incomplete (leaving too much bone), Dr. Dennis opined that a revision was necessary following an exacerbation of appellant's condition.

On March 10, 2005 the district medical adviser stated that appellant should be granted a schedule award for an additional 9 percent impairment of his left upper extremity, for a total impairment of 14 percent.

On March 21, 2005 the Office granted appellant an additional nine percent permanent impairment of his left upper extremity finding that appellant had reached MMI on February 18, 2005. The period of the award was from February 18 to September 2, 2005.

Appellant, through his representative, requested an oral hearing. At the February 24, 2006 hearing, appellant's representative argued that Dr. Dennis failed to explain his rationale for awarding two percent for the combined effects of appellant's two surgeries. The representative also contended that a conflict arose between Drs. Seckler and Dennis, requiring a referee examination.

By decision dated May 16, 2006, an Office hearing representative affirmed the March 21, 2005 decision, finding that the weight of the medical evidence was represented by Dr. Dennis' well-rationalized report. The hearing representative stated that Dr. Seckler's report was insufficient to create a conflict, as it did not provide findings of his examination of appellant and was not otherwise well rationalized. He further noted that Dr. Dennis had properly applied the fifth edition of the A.M.A., *Guides* in formulating his impairment rating.

[2] The Board notes that results of Dr. Dennis' range of motion testing revealed forward flexion of 150 degrees; however, his finding of a three percent deficit for forward flexion was based on 140 degrees.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulation[4] 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. 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.[5] 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.[6]

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the district medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the district medical adviser providing rationale for the percentage of impairment specified.[7]

It is well established that the period covered by a schedule award commences on the date that the employee reaches MMI from the residuals of the employment injury. The Board has defined MMI as meaning that the physical condition of the injured member of the body has stabilized and will not improve further. The Board has also noted a reluctance to find a date of MMI, which is retroactive to the award, as retroactive awards often result in payment of less compensation benefits. The Board, therefore, requires persuasive proof of MMI for the selection of a retroactive date of MMI.[8]

ANALYSIS

The Board finds that this case is not in posture for a decision. The medical evidence of record is insufficient for the Board to make a proper determination as to the extent of permanent impairment to appellant's left upper extremity.

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[3] 5 U.S.C. §§ 8101 *et seq.*

[4] 20 C.F.R. § 10.404.

[5] *Linda R. Sherman*, 56 ECAB ___ (Docket No. 04-1510, issued October 14, 2004); *Daniel C. Goings*, 37 ECAB 781, 783-84 (1986).

[6] *Ronald R. Kraynak*, 53 ECAB 130, 132 (2001).

[7] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (March 1995).

[8] *J.C.*, 58 ECAB ___ (Docket No. 06-1018, issued January 10, 2007). *See also James E. Earle*, 51 ECAB 567 (2000).

On May 29, 2002 appellant received a schedule award for a five percent impairment of his left upper extremity. He requested an oral hearing, but sustained a recurrence of disability before the hearing could be held. Following an authorized surgery on October 18, 2002 and his release to full duty on January 30, 2003 appellant submitted a request for an additional schedule award. On December 10, 2003 the Office's Branch of Hearings and Review affirmed the schedule award for a five percent impairment; however, the case was remanded for further development of the medical evidence on the issue of whether appellant was entitled to an increased schedule award by virtue of his second surgery. Relying on a January 13, 2004 report from Dr. Seckler, the Office denied appellant's request for an increased award on April 2, 2004. Properly finding that Dr. Seckler's report lacked probative value in that it contained no findings on examination on November 5, 2004 the Branch of Hearings and Review vacated the April 2, 2004 decision and remanded the case with instructions to refer appellant to a qualified physician for a second opinion examination. In a February 18, 2005 report, Dr. Dennis opined that appellant had a 14 percent impairment of his left upper extremity. Without explanation, the district medical adviser opined that appellant should be granted a schedule award for an additional nine percent impairment of his left upper extremity, based on Dr. Dennis' report. On March 21, 2005 the Office granted a schedule award for an additional nine percent impairment finding the date of MMI to be February 18, 2005. The Board finds, however, that Dr. Dennis' report is deficient and does not provide a proper basis for a schedule award determination.

Dr. Dennis' report appears inconsistent and based on inaccurate factual information. Referring to the A.M.A., *Guides*, he opined that appellant had a total left upper extremity impairment of 14 percent. Pursuant to Figure 16-40, Dr. Dennis found a 3 percent deficit for forward flexion of 140 degrees.[9] However, this determination is in conflict with the results of his physical examination, which revealed forward flexion of 150 degrees. The Board notes that Figure 16-40 provides for a 2 percent impairment rating for 150 degrees, versus a 3 percent rating for 140 degrees. It is impossible to determine the proper impairment rating based on the information provided. Dr. Dennis also found a 1 percent deficit for loss of strength secondary to deltoid adhesions to the skin ("extrapolated percentage of weakness 4/5") pursuant to Table 16-35 at page 510.[10] Table 16-35 provides impairment ratings for the upper extremity due to strength deficit from musculoskeletal disorders based on manual muscle testing. The minimum strength deficit for which a rating is provided is five percent. Dr. Dennis did not explain how he "extrapolated" a rating of one percent, in light of his finding that appellant's left shoulder strength deficit was "a little less than five percent." Referring to Table 16-27 at page 506, he opined that appellant had a two percent "extrapolated" deficit as a result of the "combination of the effects of the two surgeries."[11] However, without any explanation as to how he arrived at his rating, the Board is unable to properly assess his conclusion, particularly in view of the fact that Table 16-27 does not provide for a two percent impairment rating for resection arthroplasty.[12]

[9] A.M.A., *Guides* 476, Figure 16-40.

[10] *Id*. at 510, Table 16-35.

[11] *Id*. at 506, Table 16-27.

[12] Table 16-27 provides impairment ratings of the upper extremity after resection arthroplasty of specific bones or joints as follows: total shoulder -- 30 percent; distal clavicle (isolated); 10 -- percent; and proximal clavicle (isolated) -- 3 percent. *Id.*

Dr. Dennis' report is also based on an inaccurate factual background. He stated that "the double surgery was accepted as an exacerbation of the original surgery." While the Office approved the October 18, 2002 surgery, the record does not reflect that it was accepted as an exacerbation of the original surgery. It is impossible for the Board to determine from Dr. Dennis' report the degree of appellant's permanent disability or the date of MMI.

The district medical adviser did not address the physical findings made by Dr. Dennis and did not offer any reasoning for rating appellant's left upper extremity impairment. After reviewing his December 26, 2001 report, the district medical adviser agreed with Dr. Weiss' five percent assessment for range of motion deficit. However, he found that appellant's surgery did not fit the criteria for arthroplasty under the A.M.A., *Guides*. The district medical adviser has not explained why he now agrees that appellant should receive an impairment rating for resection arthroplasty.

The Board is unable to determine from the medical evidence of record the nature and extent of appellant's impairment. Dr. Weiss' December 26, 2001 report, concluding that appellant had a total left upper extremity impairment of 18 percent was based on an examination given prior to appellant's recurrence of disability. Although he opined that appellant had attained MMI at that time, Dr. Weiss was clearly incorrect. Accordingly, the findings and recommendations contained in his reports are not relevant to the degree of appellant's impairment following his recurrence. On July 20, 2003 Dr. Weiss' opined that appellant had a 27 percent left upper extremity impairment. However, he provided no rationale for awarding a 15 percent deficit for resection arthroplasty under Table 16-27 at page 506 or for granting an additional 5 percent for pain pursuant to Figure 18-1 at page 574. Dr. Weiss did not address the concerns of the district medical adviser who, following Dr. Weiss' December 26, 2001 report, found that appellant's surgery did not fit the criteria for arthroplasty under the A.M.A., *Guides* and that complaints of pain were too subjective to be ratable. Accordingly, this report is of diminished probative value. Dr. Seckler's reports do not constitute probative medical evidence. In a January 30, 2003 report, Dr. Seckler released appellant to full duty, stating that his range of motion was "almost 100 percent normal," but that appellant had a slight weakness to resisted external rotation. In a January 13, 2004 report, Dr. Seckler opined that appellant's October 18, 2002 surgery did not worsen, but rather improved appellant's condition. He found no signs of instability other than a residual scar from prior surgery. Neither report contains any findings on examination or an opinion as to the degree of appellant's impairment.

The Board finds that further development of the medical record is needed. On remand the Office should refer appellant to an appropriate medical specialist for an evaluation of permanent impairment, based on a proper application of the fifth edition of the A.M.A., *Guides* and a determination of the date of MMI. The Board notes that the period of the schedule award granted on May 29, 2002 and affirmed on December 10, 2003 was from December 26, 2001 to April 14, 2002. Although the district medical adviser had opined that the date of MMI was December 26, 2001, the Office did not make a specific finding in that regard. The Board notes that appellant had not reached MMI on December 26, 2001 in that he sustained a recurrence of disability and required subsequent surgery for his condition on October 18, 2002. On remand the Office should make a proper determination as to the date of MMI. Following such further development as the Office deems necessary, it should issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision and will be remanded for further development of the medical evidence.

ORDER

IT IS HEREBY ORDERED THAT the May 16, 2006 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision.

Issued: May 21, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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