United States Department of Labor
Employees' Compensation Appeals Board

C.J., Appellant	)	
and	)	**Docket No. 08-90**
	)	**Issued: May 7, 2008**
U.S. POSTAL SERVICE, GREENVILLE STATION, Wilmington, DE, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 1, 2007 appellant filed a timely appeal from schedule award decisions of the Office of Workers' Compensation Programs dated October 24, 2006 and June 26, 2007. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determinations in this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish that she has more than a 16 percent impairment of the right upper extremity and a 15 percent impairment of the left upper extremity, for which she received schedule awards.

FACTUAL HISTORY

On January 17, 2002 the Office accepted that appellant, then a 37-year-old letter carrier, sustained an employment-related lateral epicondylitis and tendinitis of the left upper extremity. Appellant underwent an authorized acromioplasty with distal clavicle excision of the left upper extremity on April 30, 2002 and returned to limited duty on September 3, 2002. On April 22,

2004 she filed an occupational disease claim for a right shoulder injury, and on February 9, 2005 the Office accepted that she sustained an employment-related sprain/strain of the right upper arm and shoulder. Appellant underwent acromioplasty with distal clavicle excision of the right upper extremity on July 15, 2005.

Appellant submitted an April 18, 2005 report in which Dr. David Weiss, an osteopath, reviewed her medical history and noted her complaint of bilateral shoulder pain and stiffness on a daily basis that waxed and waned. He advised that maximum medical improvement was reached on April 18, 2005. Left shoulder examination demonstrated forward elevation of 170 degrees and abduction of 165 degrees. Dr. Weiss also provided manual muscle strength testing results and diagnosed cumulative and repetitive trauma disorder, acromioclavicular arthropathy with impingement to the left shoulder, chronic rotator cuff tendinitis to the left shoulder, status post arthroscopic surgery with acromioplasty and distal clavicular excision to the left shoulder, impingement syndrome to the right shoulder, and chronic rotator cuff tendinitis to the right shoulder. He advised that in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*)[1] appellant had a seven percent right upper extremity impairment due to loss of shoulder motion and pain. Regarding the left shoulder, under Figures 16-40 and 16-43 of the A.M.A., *Guides*, appellant had one percent impairment for 170 degrees of shoulder flexion and one percent impairment for 165 degrees of abduction. Dr. Weiss also found 15 percent impairment for left shoulder resection acromioplasty and distal clavical excision under Table 16-27, and a pain-related impairment of 3 percent under Figure 18-1, to total a 20 percent left upper extremity impairment.

On March 25, 2006 appellant submitted a schedule award claim and a January 24, 2006 report in which Dr. Weiss noted her complaint of daily right shoulder pain that waxed and waned and advised that maximum medical improvement was reached on January 24, 2006. Dr. Weiss provided examination findings for the right shoulder that included forward elevation of 170 degrees and manual muscle strength testing that he rated as supraspinatus at 4/5 and deltoid at 4/5. He additionally diagnosed acromioclavicular arthropathy with impingement to the right shoulder and status post arthroscopic surgery with acromioplasty and right distal clavicular excision to the right shoulder. Dr. Weiss advised that, under Table 16-27 of the A.M.A., *Guides*, appellant had a 15 percent impairment for right shoulder resection acromioplasty and distal clavical excision, and that under Tables 16-11 and 16-15 she had a 4 percent motor strength deficit of the right supraspinatus and a 9 percent motor strength deficit of the right deltoid plus a pain-related impairment of 3 percent under Figure 18-1, which he combined to yield a 29 percent right upper extremity impairment.

The Office referred Dr. Weiss' January 24, 2006 report to an Office medical adviser, Dr. Morley Slutsky, Board-certified in occupational medicine, for review to determine an impairment rating of appellant's right upper extremity. In a report dated September 9, 2006, Dr. Slutsky opined that maximum medical improvement was reached on January 24, 2006 and found that, in accordance with Figure 16-40 of the A.M.A., *Guides*, appellant was entitled to a 1 percent impairment for 170 degrees of flexion, that under Table 16-35 she was entitled to a 6

[1] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

percent impairment for strength deficit for abduction, and under Table 16-27 a 10 percent impairment for a distal clavicle resection, which combined to equal a 16 percent right upper extremity impairment. By decision dated October 24, 2006, appellant was granted a schedule award for a 16 percent impairment of the right upper extremity, to run from January 24, 2006 to January 8, 2007.

On June 4, 2007 appellant submitted a schedule award claim for her left shoulder, and resubmitted Dr. Weiss' April 18, 2005 report. The Office referred Dr. Weiss' April 18, 2005 report to an Office medical adviser, Dr. Arnold T. Berman, Board-certified in orthopedic surgery, for review regarding appellant's left upper extremity. In a report dated June 13, 2007, Dr. Berman noted his review of Dr. Weiss' April 2005 report including his physical findings of 170 degrees of flexion and 165 degrees of abduction. He advised that maximum medical improvement was reached on April 18, 2005 and that, in accordance with Table 16-27 of the A.M.A., *Guides*, appellant would be entitled to 10 percent impairment for the left arthroplasty with distal clavicle resection, a 1 percent impairment under Figure 16-40 for 170 degrees of flexion, a 1 percent impairment for 165 degrees of abduction, and under Figure 18-1, a 3 percent impairment for pain, stating that appellant had continued pain. Dr. Berman combined these values to reach a 15 percent impairment of the left upper extremity. By decision dated June 26, 2007, appellant was granted a schedule award for a 15 percent impairment of the left upper extremity, to run from January 9 to December 2, 2007.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulations,[3] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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*[4] has been adopted by the Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5]

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[6] Office procedures provide that to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred ("date of maximum medical improvement"), describes the impairment in sufficient

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] A.M.A., *Guides*, *supra* note 1.

[5] *See Joseph Lawrence, Jr.*, *supra* note 1; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[6] *Tammy L. Meehan*, 53 ECAB 229 (2001).

detail to include, 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, and the percentage of impairment should be computed in accordance with the fifth edition of the A.M.A., *Guides*. The procedures further provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for opinion concerning the nature and percentage of impairment, and the Office medical adviser should provide rationale for the percentage of impairment specified.[7]

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the figures and tables found in the A.M.A., *Guides*. However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.[8]

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.[9] Section 16.4 provides that in evaluating abnormal motion both active and passive motion measurements are necessary to evaluate the joint motion under the appropriate charts, and these should be added to obtain the total motion impairment.[10] Section 16.8a provides that in a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods, the loss of strength may be rated separately. An example of such situation would be loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated.[11] Section 16.4 provides that in evaluating abnormal motion both active and passive motion measurements are necessary to evaluate the joint motion under the appropriate charts, and these should be added to obtain the total motion impairment.[12] Section 16.5b provides that, when multiple impairments of the extremity are present, these are to be combined.[13] Section 18.3b provides that pain-related impairment should not be used if the condition can be adequately rated under another section of the A.M.A., *Guides*. Office procedures provide that, if the conventional impairment adequately encompasses the burden

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6(b-d) (August 2002).

[8] *Robert V. Disalvatore*, 54 ECAB 351 (2003).

[9] A.M.A., *Guides*, *supra* note 1 at 433-521.

[10] *Id.* at 451-52.

[11] *Id*. at 508.

[12] *Id.* at 451-52.

[13] *Id*. at 481.

produced by pain, the formal impairment rating is determined by the appropriate section of the A.M.A., *Guides*. Section 18.3d, however, provides guidance on how a pain-related impairment should be rated, noting that an award of up to three percent whole person impairment may be granted if pain increases the burden of the employee's condition.[14] While the A.M.A., *Guides*, provides for impairment to the individual member and to the whole person, the Act does not provide for permanent impairment for the whole person.[15]

ANALYSIS

The Board finds this case is not in posture for decision as none of the medical reports used to determine the schedule awards in this case comports with the A.M.A., *Guides*. The Office referred Dr. Weiss' April 18, 2005 and January 24, 2006 reports to Drs. Slutsky and Berman to determine impairment ratings for appellant's right and left upper extremities respectively.[16] In both his reports, Dr. Weiss found that appellant was entitled to 15 percent impairment under Table 16-27 based on a shoulder resection arthroplasty and distal clavicle resection. However, as found by both Office medical advisers, Table 16-27 provides that 10 percent impairment is found with a shoulder resection arthroplasty and distal clavicle resection.[17]

Dr. Berman utilized Dr. Weiss' January 24, 2006 report for appellant's left upper extremity, and noted that appellant's adduction, internal rotation and external rotation were reported as normal. He agreed with Dr. Weiss that, under Figure 16-40, loss of left shoulder motion of forward elevation (flexion) of 170 degrees yielded one percent impairment,[18] and under Figure 16-43, abduction of 165 degrees also yielded one percent impairment.[19] Dr. Berman properly added each unit of motion to determine that appellant had a total two percent impairment of the left upper extremity for loss of shoulder motion. But both Dr. Weiss and Dr. Berman awarded an additional three percent for pain under Chapter 18 of the A.M.A., *Guides*. Examiners should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.[20] In this case, neither appellant's physician, Dr. Weiss, nor the Office medical adviser, Dr. Berman, explained why appellant's left shoulder condition could not be adequately rated under Chapter 16 relevant to upper extremity impairments.[21]

---

[14] *Id*. at 573, 588; *see Richard B. Myles*, 54 ECAB 379 (2003).

[15] *See Janae J. Triplette*, 54 ECAB 792 (2003).

[16] The Board notes that Dr. Weiss also provided an impairment rating for appellant's right upper extremity in his April 18, 2005 report. This was, however, prior to her right shoulder surgery on July 15, 2005. Dr. Weiss' January 24, 2006 report is therefore more probative regarding an impairment rating for appellant's right upper extremity.

[17] A.M.A., *Guides*, *supra* note 1 at 506.

[18] *Id*. at 476.

[19] *Id*. at 477.

[20] *Supra* note 14.

[21] *See P.C.*, 58 ECAB ____ (Docket No. 07-410, issued May 31, 2007).

Regarding the right upper extremity, Dr. Weiss also reported that appellant had abnormal flexion of 170 degrees but did not include this in his impairment rating. He also reported that he performed manual muscle strength testing and reported that on the right supraspinatus musculature was graded at 4/5 and deltoid at 4+/5 and advised that, under Tables 16-11 and 16-15 of the A.M.A., *Guides*, appellant was entitled to motor impairments of four percent for the supraspinatus strength deficit and nine percent for the deltoid deficit. Section 16.5b of the A.M.A., *Guides* provides that Table 16-11 is not to be used for rating weakness that is not due to a diagnosed injury of a specific nerve or nerves.[22] Dr. Weiss merely advised that strength testing for these muscles was 4/5 and did not identify a specific nerve injury. Dr. Slutsky, an Office medical adviser, stated that both the deltoid and supraspinatus muscles aided in abduction and found that, under Table 16-35 of the A.M.A., *Guides*, appellant would be entitled to a six percent strength deficit. Section 16.8c of the A.M.A., *Guides*, however, provides that results of strength testing should be reproducible on different occasions or by two or more trained observers.[23] There is no evidence of record to show that this was done. Furthermore, section 16.7 of the A.M.A., *Guides* provides that the criteria for arthroplasty impairment should be used only when the other criteria have not adequately encompassed the extent of appellant's impairment. The evaluator must apply proper judgment to avoid any duplication of impairment ratings,[24] and section 16.8a provides that decreased strength cannot be rated in the presence of decreased motion.[25]

The Office procedure manual provides 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 which should be computed in accordance with the fifth edition of the A.M.A., *Guides*. The Office medical adviser should provide rationale for the percentage of impairment specified, especially when more than one evaluation of the impairment is present. If the impairment has not been correctly described or the percentage is not reasonable, a new or supplemental evaluation should be obtained.[26] In this case, Dr. Weiss did not use Tables 16-11, 16-15 or 16-27 properly. Neither he nor Dr. Berman explained why appellant's pain could not be adequately rated on the basis of the impairment systems described in Chapter 16, and Dr. Slutsky did not explain why application of Table 16-35 was justified. The Board will therefore set aside the Office's October 24, 2006 and June 26, 2007 schedule awards and remand the case for further development. In addition to determining whether appellant is entitled to an impairment due to loss of strength on manual muscle testing and pain, the Office should determine whether motion impairments, derived separately, should be combined with strength impairments and impairment for resection arthroplasty under Table 16-27. After such further development as may be necessary, the Office shall issue an appropriate final decision on appellant's claim for schedule awards for her right and left upper extremities.

[22] A.M.A., *Guides*, *supra* note 1 at 484 and 492.

[23] *Id*. at 509.

[24] *Id*. at 499.

[25] *Id*. at 508.

[26] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedules Awards & Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

CONCLUSION

The Board finds that this case is not in posture for decision because further development of the medical evidence is warranted to determine the permanent impairment of appellant's upper extremities resulting from her employment injuries.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated June 26, 2007 and October 24, 2006 are set aside and the case is remanded to the Office for proceedings consistent with this opinion of the Board.

Issued: May 7, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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