United States Department of Labor
Employees' Compensation Appeals Board

D.A., Appellant	)	
	)	**Docket No. 08-216**
and	)	**Issued: May 1, 2008**
	)	
U.S. POSTAL SERVICE, POST OFFICE, New Castle, DE, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 30, 2007 appellant filed a timely appeal from a November 22, 2006 decision of the Office of Workers' Compensation Programs, adjudicating his claim for a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than a 16 percent impairment of his left upper extremity for which he received a schedule award.

FACTUAL HISTORY

On February 19, 1997 appellant, then a 39-year-old letter carrier, filed an occupational disease claim for injuries to his left shoulder and arm due to carrying a heavy mail satchel. The Office accepted his claim for left shoulder tendinitis. On July 17, 1997 appellant underwent arthroscopic surgery. On October 26, 2004 he filed a claim for a schedule award.

In a June 29, 2004 report, Dr. David Weiss, an orthopedic surgeon, found that appellant had a combined 24 percent impairment of his left upper extremity under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*).[1] This included 10 percent for a left shoulder resection arthroplasty, based on Table 16-27 at page 506, 9 percent and 4 percent, respectively, for motor deficits of the left deltoid muscle[2] and supraspinatus muscle[3] (25 percent for a Grade 4 motor deficit multiplied by 35 percent for the axillary nerve equals 8.75 percent, rounded to 9 percent; 25 percent impairment for a Grade 4 motor deficit multiplied by 16 percent for the suprascapular nerve equals 4 percent), based on Table 16-11 at page 484 and Table 16-15 at page 492, and 3 percent for pain, based on Table 18-1 at page 574. Dr. Weiss stated:

> "[Appellant] is noted to complain of intermittent left shoulder pain and stiffness which waxes and wanes.… He notes changes in weather will exacerbate his shoulder … symptoms.
>
> "[Appellant] notes difficulty with overhead reaching and overhead lifting. He notes difficulty with grasping objects. [Appellant] notes difficulty with pushing and pulling.
>
> "[Appellant] states his pain level on a scale of 0 to 10 is 5-6/10 involving the left shoulder…."
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> * * *
>
> "Examination of the left shoulder reveals well[-]healed portal arthroscopy scars noted. There is focal acromioclavicular point tenderness noted. Range of motion reveals forward elevation (flexion) of 160/180 degrees, abduction of 170/180 degrees, cross over adduction of 75/75 degrees, external rotation of 90/90 degrees. Posterior reach (internal rotation) is to T6. Circumduction is positive for crepitance within the acromioclavicular joint. Hawkin's impingement sign is positive. O'Brien's test is negative. Drop test is negative.
>
> "Motor strength testing of the upper extremities reveals the supraspinatus [muscle] is graded at 4+/5 on the left, the deltoid is graded at 4/5 on the left, and the biceps and triceps are graded 5/5 on the left.
>
> "Upper arm circumferential measurements reveal 32.5 cm [centimeters] on the right versus 31 cm on the left."

On June 13, 2005 Dr. Arnold T. Berman, a district medical director, found that appellant had a 12 percent impairment of his left upper extremity, based on the findings in the report of

[1] A.M.A., *Guides* (5th ed. 2001).

[2] The deltoid muscle is innervated by the axillary nerve. A.M.A., *Guides* 485 and 487, Table 16-12a and Figure 16-47.

[3] The supraspinatus muscle is innervated by the suprascapular nerve. A.M.A., *Guides* 485, Table 16-12a.

Dr. Weiss. This included 10 percent for left shoulder arthroplasty and resection, based on Table 16-27 at page 506 of the A.M.A., *Guides*, and 2 percent for pain, based on Figure 18-1 at page 574.[4] Based on section 16.8a at page 508 of the A.M.A., *Guides*, appellant was not entitled to additional impairment due to weakness.

On February 28, 2006 the Office granted appellant a schedule award from June 29, 2004 to March 18, 2005, or 37.44 weeks, for a 12 percent impairment of his left upper extremity.[5]

On March 8, 2006 appellant requested a hearing that was held on June 12, 2006. By decision dated July 25, 2006, an Office hearing representative remanded the case for further development of the medical evidence. He directed the Office to refer appellant for a second opinion medical examination regarding his left upper extremity impairment.

In a September 15, 2000 report, Dr. Kevin F. Hanley, a Board-certified orthopedic surgeon and an Office referral physician, reviewed appellant's medical history and provided findings on physical examination. He stated:

> "Physical examination at this time shows a healthy, pleasant cooperative gentleman in no acute distress. Examination of the left shoulder shows measurements recorded with the goniometer. Abduction is 145 [degrees], forward flexion is 150, extension is 60, adduction is 50, internal rotation is 60 and external rotation is 100. [Appellant] has tenderness over the distal clavicle and there is indeed a gap suggesting a prior distal clavicle resection. External rotation strength is 5/5. Internal rotation strength is 5/5. Abduction strength is 5/5."
>
> * * *
>
> "[Appellant's] rating is the following using the A.M.A., *Guides*, 5th [e]dition: Table 16-27, page 506 is the arthroplasty table. It shows that a distal clavicle resection is a 10 percent impairment of the upper extremity. Range of motion is rated using [F]igure 16-40 on page 476 where he gets two percent impairment for flexion of 150 degrees and zero percent impairment for extension of zero, Figure 16-43 on page 477 where he gets two percent impairment for loss of abduction. No impairment for loss of adduction. Finally, Figure 16-46 on page 479 gives a two percent impairment for internal rotation loss and no impairment for external rotation loss. Utilizing the Combined Values [Chart], this combines to 16 percent impairment of the left upper extremity on the basis of this examination. No additional impairment is offered as a consequence of pain as I do not believe that his pain constitutes an increased burden that is not appropriately rated already."

In an October 5, 2006 memorandum, Dr. Berman concurred with Dr. Hanley's impairment rating.

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[4] Dr. Berman noted that appellant had minor complaints of pain.

[5] The Federal Employees' Compensation Act provides for 312 weeks of compensation for 100 percent loss or loss of use of an upper extremity. 5 U.S.C. § 8107(c)(1). Multiplying 312 weeks by 12 percent equals 37.44 weeks of compensation.

By decision dated November 22, 2006, the Office granted appellant a schedule award for an additional four percent impairment from March 19 to June 14, 2005, or 12.48 weeks.[6]

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[7] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[8]

ANALYSIS

As to appellant's distal clavicle resection arthroplasty of his left shoulder, Table 16-27 at page 506 of the A.M.A., *Guides* provides 10 percent impairment of the upper extremity. In this impairment evaluation method, all of the medical examiners agree.

Dr. Hanley also found that appellant had impairment due to decreased range of motion of his left shoulder. This included two percent for 150 degrees of flexion, based on Figure 16-40 on page 476 of the A.M.A., *Guides*, two percent for 145 degrees of abduction, based on Figure 16-43 at page 477, and two percent for 60 degrees of internal rotation, based on Figure 16-46 at page 479. There was no impairment due to extension, adduction or external rotation.

Regarding impairment due to pain, Dr. Weiss and Dr. Berman did not adequately support their rating estimates. They listed a three percent and two percent pain-related impairment, respectively, based on Chapter 18 of the A.M.A., *Guides.* The A.M.A., *Guides* warns that examiners should not use Chapter 18 to rate pain-related impairment for any condition that can be adequately rated on the basis of the body and organ impairment rating systems given in other chapters.[9] Moreover, as the A.M.A., *Guides* explains: "The impairment ratings in the body organ system chapters make allowance for expected accompanying pain."[10] Dr. Weiss and Dr. Berman did not adequately explain why appellant's condition could not be rated in other chapters of the A.M.A., *Guides* or how his condition falls within one of the several situations identified under Chapter 18.3a.[11] Dr. Hanley found that appellant had no additional impairment

[6] Subsequent to the November 22, 2006 Office decision, appellant submitted additional evidence. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

[9] A.M.A., *Guides* 571.

[10] *Id*. at 20.

[11] *Id*. at 570-71.

due to pain because it did not constitute an increased burden that was not appropriately rated by other evaluation methods.

Dr. Weiss found additional impairment due to motor deficit. He noted that appellant had difficulty with overhead reaching and lifting, grasping objects and pushing and pulling. Dr. Weiss calculated nine percent and four percent impairment, respectively, for a Grade 4 motor deficit of the left deltoid muscle and supraspinatus muscle based on Table 16-11 at page 484 and Table 16-15 at page 492.[12] In his report, Dr. Hanley did not address the issue of whether appellant had any impairment due to motor deficit. The Board finds that this case requires further medical development on the issue of the extent of impairment to appellant's left upper extremity.

CONCLUSION

The Board finds that the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 22, 2006 be set aside. The case is remanded for further development consistent with this decision of the Board.

Issued: May 1, 2008
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[12] Dr. Berman opined that, based on section 16.8a at page 508, appellant was not entitled to additional impairment due to motor deficit. Section 16.8a states that loss of strength should not be rated separately if other evaluation methods adequately consider this impairing factor. However, section 16.8 pertains to "Strength Evaluation" which is a different type of impairment evaluation than motor deficit evaluation which is addressed in section 16.5, "Impairment of the Upper Extremities Due to Peripheral Nerve Disorders." Section 16.8 states at page 508: "Motor weakness associated with disorders of the peripheral nerve system and various degenerative neuromuscular conditions are evaluated according to guidelines described in [s]ection 16.5…." Furthermore, pursuant to Table 17-2 at page 526 motor deficit caused by peripheral nerve injury may not be combined with muscle atrophy or muscle strength ratings, but can be combined with diagnosis based and range of motion ratings.