

not initially stop work.² The Office accepted appellant's claim for left shoulder rotator cuff tear. It authorized left shoulder arthroscopic surgery, which he underwent on January 24, 2006 and which was performed by Dr. David A. Detrisac, a Board-certified orthopedic surgeon and treating physician. Appellant was totally disabled through May 12, 2006 and returned to work full time in a rehabilitation position as an express mail clerk. He received appropriate compensation benefits.

In an August 17, 2006 report, Dr. Detrisac noted that appellant was six months status post left shoulder arthroscopic rotator cuff repair and arthroscopic acromioplasty. He indicated that appellant had occasional complaints of left shoulder pain. Dr. Detrisac noted that the surgical incisions were healed. He determined that, for range of motion of the left shoulder, appellant had 145 degrees of flexion when upright, 145 degrees of abduction, 50 degrees of external rotation and internal rotation to T12.

On July 18, 2007 Dr. Detrisac noted that it was one and a half years since appellant's rotator cuff repair. He examined appellant's range of motion for the left shoulder and noted findings which included 150 degrees of flexion to 150 degrees of abduction. Dr. Detrisac also noted 50 degrees of external rotation and internal rotation to T12. He noted that appellant had good strength of flexion and abduction and normal strength to internal and external rotation.

On July 20, 2008 appellant requested a schedule award. He submitted a June 19, 2008 report from Dr. John W. Ellis, a Board-certified family practitioner, who noted appellant's history of injury and treatment and examined him. Dr. Ellis utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*) and determined that, for the left shoulder, appellant was entitled to receive an impairment of 14 percent to the left upper extremity. For range of motion of the left shoulder, he referred to Figures 16-38 to 46, pages 475-479,³ and advised that appellant had 13 percent impairment. Dr. Ellis' findings included flexion of 112 degrees for five percent impairment, extension of 46 degrees for one percent impairment, abduction of 102 degrees for four percent impairment, internal rotation of 61 degrees for two percent impairment and external rotation of 57 degrees for one percent impairment. He also referred to Tables 16-10a and 16-11 at pages 482-484⁴ and advised that appellant had an impairment of one percent for the brachial plexus according to Table 16-14.⁵ Dr. Ellis referred to the Combined Values Chart and opined that appellant was entitled to an impairment of 14 percent to the left upper extremity. He indicated that appellant reached maximum medical improvement on September 8, 2006, one year after surgery on his left shoulder.

² The record reflects that he was assigned to full-time limited-duty work until January 23, 2006.

³ A.M.A., *Guides* (5th ed. 2001).

⁴ *Id.*

⁵ *Id.* at 490.

By letter dated July 29, 2008, the Office requested that appellant's treating physician, Dr. Detrisac, provide an impairment rating based on the A.M.A., *Guides*.⁶

In an August 27, 2008 treatment note, Dr. Detrisac noted that it was now two years and seven months since appellant's left shoulder arthroscopic rotator cuff repair and arthroscopic acromioplasty. He advised that appellant complained of left shoulder pain, after heavy activity and exercise and/or at night. Dr. Detrisac indicated that appellant continued to have work restrictions. Regarding the left shoulder, he provided range of motion measurements which included 135 degrees of flexion when appellant was upright, 130 degrees of abduction, 50 degrees of external rotation and internal rotation to T12. On manual testing of the left shoulder, Dr. Detrisac indicated that there was good strength of the flexion, abduction, external rotation and internal rotation. In a separate report also dated August 27, 2008, he noted examining appellant on that date. Dr. Detrisac advised that appellant had reached maximum medical improvement on July 24, 2006, six months after surgery. He provided measurements for range of motion for the left shoulder which included: 135 degrees of flexion, 130 degrees of abduction; and 50 degrees of external rotation and 30 degrees of internal rotation. Dr. Detrisac noted diminished shoulder strength with only good strength of flexion, abduction, external rotation and internal rotation, but found no sensory losses or atrophy. He opined that appellant had left upper extremity impairment of 12 percent based on 2 percent flexion, 2 percent abduction, 6 percent external rotation and 2 percent internal rotation.

On September 26, 2008 the Office requested that the Office medical adviser review the range of motion measurements provided by Dr. Detrisac and provide an impairment rating.

In a September 29, 2008 report, the Office medical adviser utilized the A.M.A., *Guides*, and provided an impairment rating. He referred to Figures 16-40, 16-43 and 16-46⁷ and noted findings for the left shoulder, which included: appellant had forward flexion of 135 degrees, for three percent impairment; abduction of 130 degrees, for two percent impairment; internal rotation of 30 degrees, for four percent impairment and external rotation of 50 degrees, for one percent impairment. The Office medical adviser explained that appellant reached maximum medical improvement on July 24, 2006, which was approximately six months after his rotator cuff repair. He indicated that appellant had an impairment of 10 percent to the left upper extremity. The Office medical adviser noted that his calculation differed from that of Dr. Detrisac because it appeared that Dr. Detrisac inadvertently switched the calculations when reading Figure 16-46.⁸ He noted that Dr. Detrisac awarded the deficit for internal rotation when reading the external rotation value and vice versa. The Office medical adviser opined that appellant had an impairment of 10 percent to the left upper extremity.

⁶ Appellant, who lives in Lansing, Michigan, previously asked that the Office authorize Dr. Ellis, who practices in Oklahoma City, Oklahoma, to be his treating physician. On August 1, 2008 the Office denied this request to change treating physicians, noting that Dr. Ellis was located more than 1,000 miles from appellant's home.

⁷ A.M.A., *Guides* 476, 477, 479.

⁸ *Id.*

On October 21, 2008 the Office granted appellant a schedule award for 10 percent impairment of the left upper extremity. The award covered a period of 31.2 weeks from July 24, 2006 to February 27, 2007.

On January 14, 2009 appellant's representative requested reconsideration and submitted additional medical evidence. He indicated that the Office did not properly consider the measurements provided by Dr. Ellis.

In a December 19, 2008 report, Dr. Ellis noted that when he examined appellant on June 19, 2008 he conducted a thorough examination and evaluation, which included range of motion measurements for his shoulder. He provided the worksheet for his calculations. They included findings for the left shoulder, which included: appellant had forward flexion of 112 degrees, for five percent impairment; extension of 46 degrees for one percent impairment, abduction of 102 degrees, for four percent impairment; internal rotation of 61 degrees, for two percent impairment and external rotation of 57 degrees, for one percent impairment. Dr. Ellis also provided findings for the brachial plexus and referred to Table 16-14.⁹ He indicated that appellant had an impairment of one percent. Dr. Ellis opined that appellant had 14 percent impairment of the left arm.

In a report dated February 10, 2009, the Office medical adviser noted that he had reviewed appellant's history of injury and treatment. He indicated that appellant reached maximum improvement on July 24, 2006, which was approximately six months after his rotator cuff repair. The Office medical adviser repeated that appellant's impairment for the left upper extremity was equal to 10 percent. He noted that he had utilized the results from the treating physician, Dr. Detrisac, from August 27, 2008. The Office medical adviser explained that he selected the results from Dr. Detrisac, as opposed to those of Dr. Ellis, because he had "consistently documented significantly better abduction and flexion of the left shoulder compared to that of Dr. Ellis." He adviser noted that Dr. Detrisac's examinations were relatively consistent over several visits and were never as poor as was documented in Dr. Ellis' examination. The Office medical adviser also noted that Dr. Ellis gave appellant a brachial plexus rating, but in the setting of overlying cervical pathology, it was unlikely that any neurological symptoms were related to the shoulder diagnosis. He reiterated that the proper impairment was 10 percent to the left upper extremity.

By decision dated February 23, 2009, the Office denied modification of its previous decision.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act¹⁰ sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.¹¹ The Act, however, does not specify the manner by which the

⁹ *Id.* at 490.

¹⁰ 5 U.S.C. §§ 8101-8193.

¹¹ *Id.* at § 8107.

percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.¹² The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.¹³

ANALYSIS

In the present case, appellant's claim was accepted for left shoulder rotator cuff tear and arthroscopic surgery. The record contains reports from appellant's treating physician, Dr. Detrisac, and also Dr. Ellis who performed an impairment evaluation of appellant. These physicians submitted reports with differing impairment ratings.

In a report dated June 19, 2008, Dr. Ellis, indicated that appellant had impairment of 14 percent to the left upper extremity and reached maximum medical improvement on September 8, 2006, a year after his left shoulder surgery. He utilized the A.M.A., *Guides* and provided range of motion measurements for the left shoulder. Dr. Ellis referred to Figures 16-38 to 46, pages 475-79 of the A.M.A., *Guides*. He noted that appellant had flexion of 112 degrees for 5 percent impairment, extension of 46 degrees for one percent impairment, abduction of 102 degrees for four percent impairment, internal rotation of 61 degrees for two percent impairment and external rotation of 57 degrees for one percent impairment. These measurements were added to equal 13 percent impairment. While Dr. Ellis advised that appellant had an impairment of one percent for the brachial plexus according to Table 16-14, and Tables 16-10a and 16-11 at pages 482-484 of the A.M.A., *Guides*, he did not explain how he determined that this additional impairment was appropriate. Medical conclusions unsupported by rationale are of little probative value.¹⁴

While Dr. Ellis explained how he arrived at the findings for the left shoulder (with the exception of the brachial plexus findings), the Board notes that his range of motion findings were slightly higher than those presented by the treating physician, Dr. Detrisac. The Board notes that on three separate occasions, Dr. Detrisac measured appellant's range of motion and presented consistent findings. In his most recent report dated August 27, 2008, Dr. Detrisac provided measurements for range of motion for the left shoulder which included; 135 degrees of flexion, 130 degrees of abduction, 50 degrees of external rotation and 30 degrees of internal rotation. He also explained there were no sensory losses or atrophy. The Office medical adviser explained the reasons he chose to use the findings presented by Dr. Detrisac, the attending physician, over Dr. Ellis. The Board finds that the medical adviser properly explained why the opinion and consistent findings of Dr. Detrisac provided a more accurate basis on which to determine appellant's permanent impairment. Dr. Detrisac is an orthopedic surgeon and appellant's treating physician who performed appellant's surgery and examined him on several occasions

¹² *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

¹³ A.M.A., *Guides* (5th ed. 2001); 20 C.F.R. § 10.404.

¹⁴ *S.S.*, 59 ECAB ___ (Docket No. 07-579, issued January 14, 2008); *see Mary E. Marshall*, 56 ECAB 420 (2005) (medical reports that do not contain rationale on causal relationship have little probative value).

over several years while Dr. Ellis is a general practitioner and examined appellant once for purposes of an impairment evaluation.¹⁵

The Board finds that the Office medical adviser, using Dr. Detrisac's findings, properly rated the impairment to appellant's left shoulder. Applying Figures 16-40, 16-43 and 16-46 of the fifth edition of the A.M.A., *Guides*¹⁶ to Dr. Detrisac findings on examination of August 27, 2008, the Office medical adviser properly assigned 3 percent impairment for 135 degrees of flexion, 2 percent for 130 degrees of abduction, 1 percent for 50 degrees of external rotation and 4 percent for 30 degrees of internal rotation, and added these values for a total of 10 percent impairment for loss of motion to the left upper extremity. Although Dr. Detrisac indicated that appellant was entitled to an impairment of 12 percent to the left upper extremity, the Board finds the minor calculation error in Dr. Detrisac's report in the values for internal and external rotation explained the difference. The Board also finds no evidence to suggest a brachial plexus rating as there were no neurological symptoms present, consistent with findings reported by Dr. Detrisac.

Accordingly, the Board finds that appellant has no more than 10 percent permanent impairment of the left upper extremity.

On appeal, appellant's representative argues that additional development of the record is required in regard to the brachial plexus; however, as noted above, the Office medical adviser explained that there were no findings to support such a rating, and appellant's treating physician also provided no support for such a rating. Dr. Ellis did not explain how he determined that this rating was determined pursuant to the A.M.A., *Guides* or how it was due to the accepted condition. Thus, appellant's contention is without merit.

CONCLUSION

The Board finds that appellant has no more than 10 percent permanent impairment of the left upper extremity, for which he received a schedule award.

¹⁵ Office procedures also contemplate that the attending physician should make the impairment evaluation whenever possible. See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(c) (August 2002).

¹⁶ A.M.A., *Guides* 476, 477, 479.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 23, 2009 is affirmed.

Issued: December 8, 2009
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