

of 23 percent. The period of the second award ran from October 29, 2001 to April 21, 2002, or 24.96 weeks of compensation. An Office hearing representative affirmed the schedule award in an April 11, 2003 decision.

Appellant requested reconsideration and submitted the June 12, 2003 note from Dr. Ronald D. Carter, a Board-certified orthopedic surgeon, who provided an impairment rating of 35 percent to the right upper extremity based on loss of strength and range of motion deficits. Dr. Carter listed the following impairments for loss of range of motion of the shoulder: 7 percent for abduction, 5 percent for flexion, 2 percent for extension, 1 percent for external rotation and 2 percent for internal rotation, for a total of 17 percent. He also listed the following impairments due to loss of strength: 1 percent in extension, 4 percent in flexion, 6 percent in abduction, 3 percent in external rotation, 2 percent in internal rotation and 2 percent in adduction, for a total of 18 percent. Dr. Carter added the strength and motion deficits to total 35 percent impairment.

On July 21, 2003 Dr. Daniel D. Zimmerman, an Office medical adviser, reviewed the medical evidence and noted that Dr. Carter did not provide the measurement in degrees for loss of range of motion affecting appellant's right shoulder. Moreover, no citation was provided by Dr. Carter to the tables applied in rating loss of strength of the right arm and that the total impairment rating of 35 percent was not made with reference to the Combined Values Chart. The medical adviser stated that Dr. Carter did not provide a history or findings on physical examination such that the impairment rating did not conform to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (fifth edition). He concluded that the rating by Dr. Carter was not sufficient to establish greater impairment.

In an August 14, 2003 decision, the Office found that appellant did not have more than 23 percent impairment of his right arm.

On December 11, 2003 appellant requested reconsideration of his claim. In a September 24, 2003 report, Dr. Garth S. Russell, a Board-certified orthopedic surgeon, reviewed the history of injury, noting that diagnostic testing had revealed a rotator cuff tear of the right shoulder and the presence of carpal tunnel syndrome on the right. Appellant underwent surgery on November 2, 1994 for the carpal tunnel condition and on December 1, 1994 for repair of the rotator cuff tear. Following his return to work, he noted gradual weakness and pain in his right shoulder and diagnostic testing revealed progressive degenerative changes in the right acromioclavicular and glenohumeral joints. Dr. Russell noted marked atrophy over the biceps tendon of the right arm, with the long head ruptured and a small mass retracted in the mid-biceps area. Range of motion of the right shoulder included: 30 degrees of abduction, 50 degrees internal rotation, 25 degrees external rotation, 100 degrees flexion and 25 degrees extension. On an attached worksheet, Dr. Russell noted 2 percent impairment for elbow loss of strength and 35 percent impairment for shoulder loss of motion or a total impairment of 37 percent.

On January 19, 2004 Dr. Zimmerman reviewed Dr. Russell's report and opined that he did not properly apply the A.M.A., *Guides*. He noted that Dr. Russell did not report whether the range of motion findings had been measured with a goniometer. Referencing Figure 16-44, page

478, Dr. Zimmerman advised that the purported findings for external rotation and internal rotation were not credible. He stated:

“Moreover, I have done a very large number of shoulder examinations. I have never found, even in an individual with a through and through tear of the rotator cuff, unrepaired, and an unrepaired biceps tendon, that there is weakness in every plane of motion which appears to be the assertion of Dr. Russell in the work sheet that he signed.

“This is not credible. There are [six] tendons insertions about the shoulder. Residuals of a rotator cuff tear would not affect the strength of *all* 6 tendon insertions except, perhaps, by pain inhibition which Dr. Russell did not consider in the report of September 24, 2003 (Pain generally is considered in ROM.)” (Emphasis in the original.)

The Office medical adviser concluded that Dr. Russell’s strength ratings were not acceptable under the criteria at Table 16-35 and section 16.8c “Manual Muscle Testing.”

In an August 14, 2003 decision, the Office denied appellant’s request for an additional schedule award, finding no greater than 23 percent impairment of the right arm.

On September 10, 2004 appellant requested reconsideration and contended that he had sustained a left shoulder condition as a consequence of his right shoulder injury. In a May 10, 2004 report, Dr. Brent Koprivicia, Board-certified in preventive and emergency medicine, reviewed appellant’s history of injury and medical treatment. He diagnosed a work-related right shoulder, wrist and hand injury, right carpal tunnel syndrome, degenerative right acromioclavicular joint disease and recurrent massive rotator cuff tear. Dr. Koprivicia also diagnosed a left shoulder injury which occurred as a consequence of compensatory overuse due to the right shoulder injury. He rated appellant’s impairment as 46 percent to the right upper extremity.

Using Table 16-34, page 509, of the A.M.A., *Guides*, Dr. Koprivicia determined that appellant had a 20 percent impairment based on 38 percent grip strength loss and 33 percent pinch strength loss. He noted that this impairment was due to the right carpal tunnel syndrome. With respect to right shoulder impairment, appellant had a 20 percent strength deficit of elbow flexion and forearm supination associated with the biceps weakness. Dr. Koprivicia referred to Table 16-35, page 510, to find 5 percent impairment for flexor weakness, 4 percent for forearm supinator weakness and 6 percent impairment for weakness of abduction, which represented “a 50 percent strength deficit” or a 3 percent upper extremity impairment. He found two percent impairment based on a Grade 4 weakness for right shoulder flexor weakness. Dr. Koprivicia rated loss of motion in the right shoulder under Figures 16-40, 16-43 and 16-46, as 6 percent impairment for flexion and 0 percent impairment for extension; percent impairment for abduction and 1 percent impairment for adduction; 2 percent impairment for external rotation and 3 percent impairment for internal rotation, for a total loss of 17 percent. He found a total 32 percent impairment at the level of the shoulder based on loss of strength and range of motion. Dr. Koprivicia combined the 20 percent carpal tunnel impairment with the 32 percent right shoulder impairment to find a total 46 percent right upper extremity impairment.

On October 6, 2004 Dr. Zimmerman noted that the report of Dr. Koprivicia placed extensive weight on strength deficits which were associated with severe pain. Therefore, the reported results were based on pain inhibition rather than on definitive muscular deficit. The Office medical adviser noted that a rating for pain was already incorporated into the range of motion values such that Dr. Koprivicia essentially doubled the weighting for pain. Moreover, he stated that there was insufficient medical documentation to permit acceptance of a consequential left shoulder injury. The Office medical adviser concluded that Dr. Koprivicia's report was not sufficient to establish greater impairment of the right shoulder.

In an October 19, 2004 decision, the Office again denied appellant's claim for an additional schedule award.

In an October 31, 2004 report, Dr. Koprivicia noted his disagreement with the opinion of Dr. Zimmerman. He stated that appellant had objective evidence of atrophy of the rotator cuff on clinical examination which objectively supported weakness, not merely based on limitation due to pain. An arthrogram obtained on May 24, 2001 showed a recurrent full thickness rotator cuff tear that was not surgically corrected and which supported weakness on a structural basis. Dr. Koprivicia noted that Dr. Carter had also suggested an increased impairment based on strength deficit.

On October 12, 2005 appellant requested reconsideration and submitted a January 4, 2005 note from Dr. Carter who diagnosed left carpal tunnel syndrome and a partial tear of the rotator cuff of the left shoulder.

On January 2, 2006 Dr. Zimmerman contrasted the range of motion losses as reported, noting that those of Dr. Carter were substantially better than those obtained by Dr. Koprivicia. He stated that Dr. Koprivicia did not provide the girth measurements to support his finding of atrophy. Moreover, the strength impairment percentages provided by Dr. Koprivicia did not correlate with the weakness percentages set forth at Table 16-35 and were not similar to those reported by Dr. Carter. Dr. Zimmerman noted that manual strength testing was volitional and dependent upon the cooperation of the individual being evaluated and inhibited by pain.

By decision dated January 4, 2006, the Office denied appellant's request for an increased schedule award.

On April 27, 2006 appellant requested reconsideration and submitted an April 5, 2006 note from Dr. Carter together with a November 28, 2005 functional capacity evaluation (FCE). The FCE reported the work demand level as sedentary and listed several validity results as invalid for the left and right grip strength. Three range of motion trials for the right shoulder found: 75, 75 and 74 degrees flexion; 46, 47 and 44 degrees extension; 61, 59 and 64 degrees abduction; 57, 57 and 53 degrees internal rotation and 22, 23 and 19 degrees external rotation. Dr. Carter addressed the FCE results but did not provide any impairment rating for the right shoulder.

On May 8, 2006 the Office medical adviser noted that the additional medical evidence did not permit consideration of an increased impairment rating.

By decision dated August 14, 2006, the Office denied appellant's request for an additional schedule award.

On October 20, 2006 appellant requested reconsideration. In an August 21, 2006 report, Dr. Koprivicia stated that the Office medical adviser excluded consideration of strength deficits and reiterated that appellant had objective weakness related to the tear of his biceps muscle. He noted that appellant was unable to lift any resistance overhead, which suggested a Grade 3 weakness addressed in his prior report. The FCE revealed 13 of 16 valid measurements in terms of measuring shoulder strength, consistent with the 30 to 50 percent range for strength deficit found at Table 16-35. Dr. Koprivicia reiterated that appellant had severe impairment greater than the 23 percent already awarded.

On December 17, 2006 Dr. Zimmerman noted that Dr. Koprivicia provided no impairment rating or information sufficient to permit use of Table 16-35.

By decision dated January 23, 2007, the Office denied appellant's request for an additional schedule award.

On March 20, 2007 appellant requested reconsideration. He submitted a CA-7 claim for an increased schedule award.

On April 6, 2007 the Office denied appellant's request for reconsideration without further merit review.

Appellant again requested reconsideration on September 17, 2007. He submitted the September 5, 2007 report of Dr. Allen J. Parmet, Board-certified in occupational medicine. Dr. Parmet diagnosed right rotator cuff tear with recurrence and residual atrophy, supraspinatus and infraspinatus, unrepaired right biceps tear with atrophy, right carpal tunnel syndrome and right frozen shoulder due to rotator cuff tear and biceps tear. Range of motion for the right shoulder included 80 degrees abduction, 40 degrees adduction, 120 degrees flexion, 50 degrees extension, 20 degrees external rotation and 50 degrees internal rotation. Dr. Parmet found 4/5 motor strength bilaterally of the shoulder and upper arm musculature and found osteoarthritic changes in the hands. He found a 4 percent impairment of the hand based on abnormal thumb motion, a 7 percent impairment of the hand based on second digit abnormal motion, an 8 percent hand impairment based on abnormal motion of the third digit, a 3 percent hand impairment due to abnormal fourth digit motion and a 10 percent hand impairment based on fifth digit motion impairment. This converted to 32 percent impairment of the hand or 29 percent upper extremity impairment using Table 16-2. At the elbow, Dr. Parmet stated that there was abnormal motion causing five percent impairment. He found 12 percent shoulder impairment based on abnormal motion which, when combined with the hand and elbow, yield 41 percent impairment of the upper extremity using the Combined Values Chart. Dr. Parmet stated that appellant had a good outcome from his carpal tunnel surgery and noted that the A.M.A., *Guides*, recommended an impairment rating not to exceed five percent. He advised that appellant had "very significant

muscular loss and atrophy of the shoulder” due to his shoulder surgery and unrepaired biceps and rotator cuff tears. In addressing the FCE, Dr. Parmet stated:

“Clearly, the examination should be accepted with significant strength deficits and, in fact, [appellant] has, in reality, no functional use of his right upper extremity above shoulder level and can only raise his arm above shoulder level through a small portion of the normal arc. Therefore, I would assign an additional 10 percent strength loss to the shoulder. The summary of these impairments, using the combined values table, therefore is 50 percent of the right upper extremity permanent partial impairment. Given the severity of the frozen shoulder, this value actually underestimates the limitations imposed on [appellant] by that condition alone and does not encompass any factor of pain which could be rendered in accordance with Chapter 18 of the A[.]M[.]A[.] *Guides to the Evaluation of Permanent Impairment*....”

On November 19, 2007 Dr. Zimmerman noted that the only accepted condition was to the right shoulder and that the Office had not accepted any condition involving other locations of the right upper extremity. As to loss of range of motion, he applied the findings of Dr. Parmet to the A.M.A., *Guides*, noting that 120 degrees of flexion was 4 percent impairment; 80 degrees of abduction was 5 percent impairment; 50 degrees internal rotation was 2 percent impairment; 20 degrees external rotation was 1 percent impairment; 50 degrees extension was 0 (zero) percent impairment and 40 degrees adduction was 0 percent impairment, or a total 12 percent right upper extremity impairment. Dr. Zimmerman noted that Dr. Parmet referred to Table 16-35, but did not provide grades for any plane of motion as directed at page 510. As Dr. Parmet’s loss of strength impairment rating failed to conform to the A.M.A., *Guides*, it did not support an increased schedule award.

In a December 13, 2007 decision, the Office denied appellant’s claim for an additional schedule award for his right upper extremity.

LEGAL PRECEDENT

The schedule award provision of the Act¹ and its implementing regulations 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.² 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 Office as the appropriate standard for evaluating schedule losses.³

¹ 5 U.S.C. § 8107.

² 20 C.F.R. § 10.404.

³ *Id.*; see *Billy B. Scoles*, 57 ECAB 258 (2005).

In rating impairment of the upper extremity, Chapter 16 of the A.M.A., *Guides* states that strength measurements are functional tests largely influenced by subjective factors that are difficult to control.⁴ Therefore, the A.M.A., *Guides* do not assign a large role to such measurements. Section 16.8a provides that, in a rare case, an examiner may rate loss of strength should it represent an impairing factor not adequately considered by other methods. An example of this situation is loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. However, the A.M.A., *Guides* reiterate that impairment ratings based on objective anatomic findings take precedence as decreased strength cannot be rated in the presence of decreased motion or painful conditions that prevent effective application of maximal force in the region being evaluated.⁵

ANALYSIS

The Office accepted appellant's claim for aggravation of a rotator cuff tear of the right shoulder and a rupture of the long head of the right biceps muscle. Appellant was granted previous schedule awards in 1999 and 2002 for a total 23 percent impairment of his right upper extremity. The Board finds that the case is not in posture decision as to whether he has greater impairment.

Initially, the Board notes that much of the medical evidence submitted by appellant does not conform to the protocols of the A.M.A., *Guides*. In addition to loss of range of motion findings, each examining physician also rated impairment due to loss of strength. None of their reports, however, adequately address the principle stated at section 16.8 that: "[d]ecreased strength *cannot* be rated in the presence of decreased motion" or other painful conditions. (Emphasis in the original.)

Dr. Carter provided an impairment rating of 35 percent which was derived from a 17 percent loss of range of motion and 18 percent loss of strength. His June 13, 2003 note does not provide any physical findings or measurements in degrees of range of motion. Dr. Carter did not address why, under the circumstances of this case, any impairment for strength deficit was appropriate. The method he used to determine the loss of strength ratings is not readily apparent as he failed to provide any reference to the tables or figures found at Chapter 16. Moreover, it appears that Dr. Carter added the 17 percent range of motion loss to the 18 percent loss of strength. This further reduces the probative value to his impairment rating. These defects were not cured in the additional notes he submitted to the record.

Dr. Russell provided loss of range of motion findings but did not correlate them to the charts at Figure 16-40, Figure 16-43 and Figure 16-46. Rather, he utilized a chart at Figure 16-1a. Moreover, his report is unclear as to the extent of any loss due to adduction or abduction. Dr. Russell stated that appellant abducted actively to 30 degrees which represents seven percent

⁴ A.M.A., *Guides* 507, § 16.8.

⁵ *Id.* at 508.

impairment;⁶ internal rotation was to 50 degrees which represents two percent impairment;⁷ external rotation of 25 degrees represents eight percent impairment;⁸ 100 degrees of flexion represents five percent impairment;⁹ and 25 degrees of extension represents two percent impairment.¹⁰ He did not provide any finding regarding adduction and stated that there “was no active abduction or external rotation with resistance.” However, as noted, Dr. Russell listed 30 degrees of active abduction. This renders appellant’s range of motion impairment rating of diminished probative value as it appears incomplete and the physician was unclear on how the impairment estimates he listed under the chart at Figure 16-1b were derived.¹¹ Moreover, having found decreased motion of the shoulder, Dr. Russell did not address the admonition found at section 16.8a when he also rated decreased strength.¹²

Dr. Koprivicia rated impairment to appellant’s right upper extremity as 46 percent based upon loss of motion and strength of the right wrist, elbow, forearm and shoulder. He found 70 degrees of active abduction which represents 5 percent impairment; 30 degrees of adduction which represents 1 percent impairment; 90 degrees of flexion which represents 6 percent impairment; 50 degrees of extension which represents 0 percent impairment; 45 degrees internal rotation which represents 3 percent impairment; and 10 degrees external rotation which represents 2 percent impairment, or a total 17 percent impairment. Dr. Koprivicia stated that he rated impairment for the right shoulder girdle, based on biceps weakness, supraspinatus weakness and evidence of a recurrent tear of the rotator cuff. He noted that, even though there was decreased motion present, “the manual muscle testing of the specific muscle groups was possible with effective application and demonstration of maximal force capabilities clinically.” Dr. Koprivicia stated that the principles section under 16.8a “does not apply in this clinical situation.” He went on to rate impairment due to loss of strength under Table 16-35. The Board finds, however, that Dr. Koprivicia did not provide a cogent explanation for departing from the principles section of 16.8a, noting only that they did “not apply” and he was able to make clinical measurements. He did not adequately address why such ratings were made in the presence of decreased motion and other painful conditions. Dr. Koprivicia also rated 20 percent impairment based on 38 percent grip strength loss and 33 percent pinch strength loss due to carpal tunnel syndrome. He did not address the section of the A.M.A., *Guides* pertaining to compression neuropathies or to the specific provision at page 495 addressing the three scenarios

⁶ *Id.* at 477, Figure 16-43.

⁷ *Id.* at 479, Figure 16-46.

⁸ *Id.*

⁹ Figure 16-40 at 476.

¹⁰ *Id.*

¹¹ As noted by Dr. Zimmerman, the A.M.A., *Guides* state that active motion takes precedence and that actual measured goniometer readings or linear measurements are recorded. A.M.A., *Guides* 451.

¹² Section 16.8a provides an example for measuring loss of strength due to a severe muscle tear that leaves a palpable muscle defect. Dr. Russell noted a small mass retracted in the mid-biceps area but did not otherwise address how this factored into his loss of strength estimate.

by which carpal tunnel may be rated.¹³ This, in turn, further reduces the probative value of Dr. Russell's opinion. His additional reports of record did not further clarify his reasons for departing from the principles articulated in the A.M.A., *Guides*.

Dr. Parmet provided an impairment rating of 50 percent to the right upper extremity. He found 12 percent impairment based on loss of range of motion to the shoulder which, when combined with loss of range of motion of the elbow (5 percent) and digits of the hand (converted to 29 percent impairment of the upper extremity), totaled 41 percent impairment under the Combined Values Chart. Dr. Parmet went on to address carpal tunnel, noting that the A.M.A., *Guides* recommended an impairment not to exceed five percent at page 495. Addressing the loss of strength to appellant's right shoulder, Dr. Parmet stated that appellant had no function use of his right upper extremity above shoulder level for which he would assign an additional 10 percent loss.¹⁴ Dr. Parmet did not address which tables from Chapter 16 were applied in making the loss of strength impairment estimate and, as noted, failed to comment on the provisions of section 16.8a.

In turn, the reports of Dr. Zimmerman, the Office medical adviser, are also of diminished probative value. In reviewing the range of motion examination of Dr. Russell, he stated that the purported findings for external rotation and internal rotation were not credible. Dr. Russell found external rotation to 25 degrees and internal rotation to 50 degrees which, under Figure 16-46, represent impairments of eight percent and two percent. It is not readily apparent to the Board how these values were found not to be credible by the medical adviser. Similarly, in the material at section 16.8a, the principles provide an example of a situation where "loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect" may be rated separately. The evidence reflects that appellant has such a muscle tear to his biceps, as Dr. Russell noted a small mass retracted in the mid-biceps area. In reviewing the report of Dr. Parmet, the medical adviser noted that the only accepted condition in this claim was for the right shoulder. However, the Office also accepted the ruptured right biceps tear of the forearm. In light of this, it is not readily apparent that an impairment rating involving the forearm or elbow should be excluded from consideration. In addition, it is well established under Board case precedent that, in determining the extent of impairment for purposes of a schedule award, preexisting impairment to the scheduled member is to be included.¹⁵ Dr. Zimmerman improperly isolated consideration of the medical evidence to appellant's right shoulder range of motion without adequately addressing whether any preexisting impairment was established by the medical evidence of record.

For these reasons, the Board will remand the case to the Office for referral of appellant to an appropriate medical specialist for examination and opinion on the nature and extent of permanent impairment to his right upper extremity. The Office should prepare a statement of

¹³ The A.M.A., *Guides* provide that sensory deficits (pain) and/or motor deficits (weakness) are to be evaluated according to the method described in section 16.b. Moreover, in compression neuropathies, additional impairment values are not given for decreased strength. Page 494.

¹⁴ Dr. Parmet commented that he did not give consideration to any sensory impairment under Chapter 18, noting that he would leave it to the Office medical adviser to add any rating for pain.

¹⁵ See *Michael C. Milner*, 53 ECAB 446 (2002); *Lela M. Shaw*, 51 ECAB 372 (2000).

accepted facts and inquire whether, under the circumstances, loss of strength should be rated in the presence of loss of range of motion and whether there is any preexisting impairment affecting the member that should also be considered. After such other development as the Office deems necessary, it shall issue a merit decision on appellant's entitlement to an increased schedule award.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the December 13, 2007 schedule award decision of the Office of Workers' Compensation Programs be set aside. The case is remanded for further action in conformance with this decision of the Board.

Issued: June 23, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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