U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JON C. SETINA and DEPARTMENT OF THE TREASURY, BUREAU OF THE MINT, Denver, Colo.

Docket No. 96-1473; Submitted on the Record;
Issued July 29, 1998

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS, BRADLEY T. KNOTT

The issue is whether appellant sustained any permanent impairment of his right lower extremity or left upper extremity causally related to his federal employment which entitled him to a schedule award.

On November 3, 1989 appellant, then a 48-year-old maintenance mechanic, sustained tendinitis of the right Achilles tendon of the right leg in the performance of duty.

On June 22, 1990 appellant sustained a lumbosacral sprain and left rotator cuff tear in the performance of duty.

On March 13, 1991 appellant underwent surgery of the left shoulder to repair a torn rotator cuff.

In a report dated May 14, 1992, Dr. Donald S. Harder, a Board-certified orthopedic surgeon, related that appellant was complaining of pain in the low back, left shoulder, rotator cuff and rupture right Achilles tendon. He provided a history of appellant's condition and findings on examination. He stated:

> "Examination of the left shoulder reveals he has 170 degrees of forward flexion and 160 degrees of abduction. With the shoulder abducted, internal rotation is 80 degrees. External rotation is 90 degrees. He does has some crepitation on making a circumductive movement. He has some pain and weakness on abduction and forward flexion against resistance. There is some tenderness present over the rotator cuff area. Some tenderness is present over the biceps tendon.
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> " He ambulates slowly with a slight limp favoring the right ankle. [Appellant] is able to walk on his tip-toes on the right. There is a surgical scar over the right Achilles tendon. On palpation the tendon is tender, widened and somewhat

nodular and fibrous. The calf measurements are 17¼ inch on the right and 17 inches on the left. When viewed from behind, the muscular definition of the left calf muscle is more than on the right yet the right calf appears larger. There is no evidence of edema as such. The deep tendon reflexes of the lower extremities are brisk, 2+ at the ankle and 3+ at the knees."

Dr. Harder diagnosed a disc injury of the lumbosacral spine with disc protrusion but without herniation, a rotator cuff injury of the left shoulder postoperative status, and an Achilles tendon rupture, partial, with fibrous union. He indicated that appellant had reached maximum medical improvement.

In a report dated August 11, 1992, Dr. John K. Davis, III, a Board-certified orthopedic surgeon, stated that appellant had a 10 percent permanent impairment of the left upper extremity due to pain and weakness, a 10 percent permanent impairment of the right lower extremity due to pain and weakness, and a 10 percent permanent impairment of the right lower extremity due to decreased strength. He indicated that appellant had full range of motion of the left upper extremity.

By letter dated February 3, 1994, the Office of Workers' Compensation Programs referred appellant, along with a statement of accepted facts and copies of all the medical record, to Dr. David Madison, a Board-certified neurologist, to determine whether appellant had any permanent impairment causally related to his employment injury.

In a report dated February 22, 1994, Dr. Madison provided a history of appellant's condition and findings on examination. He related that appellant had pain radiating into his right lower extremity with a sore right Achilles tendon and pain with motion of the ankle. Dr. Madison also related that appellant experienced some left shoulder pain with various activities but that this was not a major problem. He stated:

"Examination of the upper extremities reveals no clear-cut weakness. Coordination too is within normal limits. The muscle stretch reflexes on the left are hyperactive in comparison to those on the right. Range of motion at the left shoulder is slightly decreased but not to any significant degree. There is some pain with abduction, internal and external rotation, etc.

"Examination of the lower extremities reveals no clear-cut weakness. Again, there is hyperreflexia on the left. Plantar responses, however, are flexor bilaterally."

Dr. Madison stated that appellant was probably at maximum medical improvement with regard to his left shoulder injury and he did not believe there was any significant limitation with regard to appellant's left shoulder. He stated that loss of sensation and loss of strength were not a problem for appellant but that chronic pain and discomfort were disabling.

In notes dated June 30, 1994, Dr. W.G. Davis, an orthopedic surgeon and an Office medical adviser, stated that Dr. Madison did not report any findings in either leg to support neurological deficit from spinal nerve root and therefore there was no basis in which to propose a

permanent impairment for a schedule award. Dr. Davis did not comment on Dr. Madison's findings regarding appellant's accepted left upper extremity condition.

By decision dated February 18, 1995, the Office stated that the evidence of record did not establish that appellant had any permanent impairment of his left upper extremity or right lower extremity entitling him to a schedule award.

By letter dated February 7, 1996, appellant requested reconsideration of the denial of his claim for a schedule award and submitted additional medical evidence.

In a report dated July 19, 1995, Dr. Harder related that appellant still had some discomfort in his shoulder and pain in his Achilles tendon. He stated:

> "Examination of the left shoulder reveals ... [f]orward flexion is 160 degrees, abduction 140 degrees, internal rotation with the shoulder abducted is 70 degrees, and external rotation is 90 degrees. A mild crepitation is present on movement. He has some reduced strength on abduction and on flexion against resistance.
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> "Examination of the right calf reveals that the circumstance is 17½ inches. The left calf measures 17 inches in circumference. There is some tenderness at the musculotendinous junction. [Appellant] walks with a limp favoring the right. I did ask him to walk on his tiptoes which he states that he cannot do because of pain. Straight leg raising was normal. The neurovascular status is intact."

In a report dated February 23, 1996, Dr. Davis related that appellant complained that he did not have the strength in his right leg that he once had but that he had no numbness or tingling and that, with regard to the left shoulder, he was not having a great deal of pain in the shoulder with normal use. Dr. Davis related that appellant had some residual pain in the left shoulder with abduction or flexion but that he felt that he did not have any limitation of motion and basically that his shoulder was doing fairly well. He stated:

> "On examination today, [appellant] walks in a normal heel/toe fashion without a limp or without ambulatory aids. He can heel walk without difficulty, but cannot toe walk more than a few steps with regard to the right foot. He has full ankle and subtalar [range of motion] on the affected right lower extremity, but does have a palpable nodular tenosynovitis at the proximal tendon just distal to the musculotendinous junction. He has 5-/5 plantarflexor strength on initially testing, but fatigues rather easily. He has a mild calf atrophy, as compared to the left lower extremity. He has well healed surgical incisions with no apparent skin disorder.
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> "With regards to the left upper extremity, he has negative impingement testing. He has a full [range of motion] in all planes. He does have a slightly painful arc of abduction from 95 to 105 degrees. With strength testing, he has no residual subacromial crepitance. His skin incision is well healed. He has no apparent deltoid atrophy as compared to the opposite extremity. Neurologically, both the

left upper extremity and right lower extremity show no sensory deficit. His reflexes are brisk and symmetrical. There are no pathologic reflexes elicited.

"[Diagnosis is] [r]esidual chronic nodular tenosynovitis, right tendo-Achilles, minimal residual pain, left upper extremity from rotator cuff repair.

"While his residual impairment is real, it is difficult to rate this in terms of the strict criteria as outlined by the A.M.A., *Guides.* [Appellant] does have what I believe is real pain and loss of strength in the right lower extremity as a result of his chronic nodular tenosynovitis only partially cured by surgery. He also has mild residual pain and slight weakness in the left upper extremity as a result of his rotator cuff repair. Therefore, I stand by my previous 10 [percent] impairment rating of the right lower extremity and 10 [percent] rating of the left upper extremity on the basis of residual pain, mild atrophy, mild loss of strength and mild residual tendon scarring. I find no evidence of any neurologic compromise of either the upper or lower extremity."

By decision dated March 21, 1996, the Office denied modification of its February 18, 1995 schedule award decision.

The Board finds that this case is not in posture for a decision on the issue of whether appellant has a permanent impairment of the right lower extremity or left upper extremity causally related to his November 3, 1989 and June 22, 1990 employment injuries.

An employee seeking compensation under the Federal Employees' Compensation Act[1] has the burden of establishing the essential elements of his claim by the weight of the reliable, probative, and substantial evidence,[2] including that he sustained an injury in the performance of duty as alleged and that his disability, if any, was causally related to the employment injury.[3]

Section 8107 of the Act provides that if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[4] Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants the Office has adopted the A.M.A., *Guides* as a standard for evaluating schedule losses and the Board has concurred in such adoption.[5]

[1] 5 U.S.C. §§ 8101-8193.

[2] *Donna L. Miller*, 40 ECAB 492, 494 (1989); *Nathanial Milton*, 37 ECAB 712, 722 (1986).

[3] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[4] 5 U.S.C. § 8107(a).

[5] *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989); *Charles Dionne*, 38 ECAB 306, 308 (1986).

Before the A.M.A., *Guides* may be utilized, however, a description of appellant's impairment must be obtained from appellant's attending physician. The Federal (FECA) Procedure Manual provides that in obtaining medical evidence required for a schedule award the evaluation made by the attending physician must include a "detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive motion of the affected member of function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment."[6] This description must be in sufficient detail so that the claims examiner and other reviewing the file will be able to clearly visualize the impairment with its restrictions and limitations.[7]

The Federal [FECA] Procedure Manual states:

> "[pain and loss of strength] ... should be explicitly considered along with the impairment measured by the A.M.A., *Guides* and correlated as closely as possible with the factors set forth there. This approach, combined with thorough rationale from the [District medical adviser] as to the percentage of loss chosen, has been supported by [the Board] in decisions concerning schedule award determinations for factors not defined in the *Guides*... Whenever pain, discomfort, or loss of sensation is present due to nerve injury or nerve dysfunction...the evaluating physician should include these factors in arriving at a percentage of impairment."[8]

In this case, in a report dated May 14, 1992, Dr. Harder, a Board-certified orthopedic surgeon, included in his findings on examination appellant's complaints of pain in his left upper extremity and right lower extremity as well as some weakness in his left upper extremity on abduction and forward flexion against resistance. In a report dated July 19, 1995, Dr. Harder related that appellant still had some discomfort in his shoulder and pain in his Achilles tendon. Although he did not provide an opinion as to permanent impairment based upon the A.M.A., *Guides*, Dr. Harder did find that appellant had some permanent residual pain from his employment injuries.

In a report dated August 11, 1992, Dr. Davis, a Board-certified orthopedic surgeon, stated that appellant had a 10 percent permanent impairment of the left upper extremity due to pain and weakness, a 10 percent permanent impairment of the right lower extremity due to pain and weakness, and a 10 percent permanent impairment of the right lower extremity due to decreased strength. Although he did not explain his opinion as to permanent impairment based upon the A.M.A., *Guides*, he did opine that appellant had some permanent impairment due to pain and weakness.

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[6] Federal (FECA) Procedure Manual, Part -- 2 Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(c) (March 1995); *see John H. Smith*, 41 ECAB 444, 448 (1990).

[7] *Alvin C. Lewis*, 36 ECAB 595, 596 (1985).

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

In a report dated February 22, 1994, Dr. Madison, a Board-certified neurologist and Office referral physician, provided a history of appellant's condition and findings on examination. He related that appellant had pain radiating into his right lower extremity with a sore right Achilles tendon and pain with motion of the ankle. Dr. Madison also related that appellant experienced some left shoulder pain with various activities. Although he did not provide an opinion on impairment based on the A.M.A, *Guides*, his report indicates that appellant had permanent residual pain due to his employment injuries.

In a report dated February 23, 1996, Dr. Davis related that appellant complained that he did not have the strength in his right leg that he once had but that he had no numbness or tingling. He related that appellant had some residual pain in the left shoulder with abduction or flexion. Dr. Davis stated that appellant had real pain and loss of strength in the right lower extremity only partially cured by surgery as well as mild residual pain and slight weakness in the left upper extremity as a result of his rotator cuff repair. Dr. Davis stated, "I stand by my previous 10 [percent] impairment rating of the right lower extremity and 10 [percent] rating of the left upper extremity on the basis of residual pain, mild atrophy, mild loss of strength and mild residual tendon scarring. Although Dr. Davis did not specifically address whether appellant had any permanent impairment due to pain in the left upper extremity or right lower extremity, he did report such residual pain and this should have considered by the Office in its determination as to appellant's entitlement to a schedule award.

The Office stated in its March 21, 1996 decision that the medical evidence contained no "measurable impairment ... with which pain can be considered." The Board has stated, "The element of pain may serve as the sole basis for determining the degree of impairment for schedule award purposes.[9] However, the Office failed to determine whether appellant had any permanent impairment due to pain.

On remand, the Office should refer appellant and the case record to an appropriate medical specialist for a reasoned opinion as to whether appellant has any permanent impairment of the left upper extremity or right lower extremity causally related to his November 3, 1989 and June 22, 1990 employment injuries, and, if so, for calculation of the percentage of such impairment in accordance with the A.M.A., *Guides*.

The decision of the Office of Workers' Compensation Programs dated March 21, 1996 is set aside and the case is remanded for further action consistent with this decision of the Board, to be followed by a *de novo* decision.

Dated, Washington, D.C.
July 29, 1998

David S. Gerson
Member

[9] *Jack L. Lemond*, 33 ECAB 15, 18 (1981); *see also Cynthia M. Judd*, 42 ECAB 246, 251 (1990).

Willie T.C. Thomas
Alternate Member

Bradley T. Knott
Alternate Member