U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of WILLIAM E. BRITT and U.S. POSTAL SERVICE,
CINCINNATI BULK MAIL CENTER, Cincinnati, OH

Docket No. 99-2357; Submitted on the Record;
Issued March 14, 2001

DECISION and ORDER

Before MICHAEL J. WALSH, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

The issue is whether appellant has more than a 20 percent permanent impairment of the left arm.

On April 17, 1981 appellant, then a 34-year-old mailhandler picked up a heavy package to rewrap and had his left arm jerked down. He indicated that he had pain in his left side and back.[1] The Office accepted appellant's claim for back strain, left shoulder strain and adhesive capsulitis of the left shoulder. In a January 3, 1991 decision, the Office issued a schedule award for a 19 percent permanent impairment of the left arm.

Appellant subsequently requested an increased schedule award. In a February 2, 1998 decision, the Office issued a schedule award for an additional one percent permanent impairment of the left arm. Appellant requested a review of the written record by an Office hearing representative. In a February 27, 1999 decision, the Office hearing representative affirmed the Office's February 2, 1998 decision. In an April 1, 1999 letter, appellant requested reconsideration of the Office's decisions. In an April 28, 1999 decision, the Office denied appellant's request for reconsideration on the grounds that the evidence submitted was repetitious and, therefore, insufficient to warrant review of the prior decisions.

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

[1] Appellant previously filed a claim for a lung condition which he attributed to exposure to dust at work. He underwent surgery for removal of the left lung. The Office of Workers' Compensation Programs accepted appellant's claim and in a January 21, 1988 decision, appellant received a schedule award for 100 percent loss of the left lung.

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use, of members or functions of the body listed in the schedule. However, neither the Act nor its regulations specify the manner in which the percentage loss of a member shall be determined. For consistent results and to ensure equal justice to all claimants, the Board has authorized the use of a single set of tables in evaluating schedule losses, so that there may be uniform standards applicable to all claimants seeking schedule awards. The American Medical Association, *Guides to the Evaluation of Permanent Impairment*[4] has been adopted by the Office as a standard for evaluating schedule losses and the Board has concurred in such adoption.[5]

In a June 4, 1981 report, Dr. Robert H. Jebsen, a Board-certified physiatrist, indicated that appellant had undergone a thoracotomy and pneumonectomy on the left side on June 26, 1980. He stated that appellant was relatively asymptomatic until the April 17, 1981 employment injury when he developed sudden sharp pain in the area of the thoracotomy scar while trying to lift a heavy box. Dr. Jebsen reported that the pain had since spread to the entire scapular area and upper trapezius area. On examination, appellant reported pain over the upper lateral chest, scapular area and upper trapezius. He reported that appellant had a normal range of motion of the left shoulder. Dr. Jebsen diagnosed probable tearing of adhesions in the area of the scar with secondary postural strain in the upper part of the left shoulder.

In a July 28, 1981 report, Dr. Jebsen indicated that appellant had no pain at rest in the shoulder but had pain in pushing his mower. He reported that examination showed normal scapulothoracic mobility and normal range of motion in the left shoulder and neck. Dr. Jebsen found no pain with resisted muscle activity except with pushing forward with the left arm. He noted that this use primarily involved the serratus anterior muscle which attached to the medial scapula.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. Stuart M. Brooks, for an examination and second opinion. In his April 9, 1982 report, Dr. Brooks primarily addressed whether appellant's pulmonary condition was related to his employment. He indicated, however, that appellant had a right midbiceps circumference of 13 7/8 inches and a left midbiceps circumference of 12 5/8 inches. Dr. Brooks reported appellant had abduction in the left shoulder to 90 degrees with mild pain and significant pain in additional abduction. He noted appellant had forward flexion of 45 degrees and backward elevation of 15 degrees. Dr. Brooks found a noticeable decrease in strength but reported was grossly intact in the neurological examination. He concluded that the pain and decreased mobility in appellant's left arm was probably a result of the thoracotomy. Dr. Brooks reported appellant had an obvious decrease in size and strength of the left arm. He commented that the

[2] 5 U.S.C. § 8107(c).

[3] 20 C.F.R. § 10.304.

[4] (4th ed., 1993).

[5] *Thomas P. Gauthier*, 34 ECAB 1060, 1063 (1983).

decreased range of motion of the left arm was probably due to a "frozen shoulder syndrome" from surgery with muscle atrophy from decreased use.

In a February 16, 1983 report, Dr. Jebsen reported some limitation in appellant's range of motion in the left shoulder. In reports of July 7 and August 3, 1983, he indicated that appellant had a virtually normal range of motion of the shoulder but discomfort with heavy use of the shoulder.

In a February 5, 1984 report, Dr. Richard J. Watson, a Board-certified physiatrist, indicated that appellant complained of diffuse discomfort in the left shoulder which was made markedly worse by any heavy use. Dr. Watson reported that appellant's strength was normal and noted no atrophy. He stated that appellant had a reduced range of motion, with a loss of 20 degrees of external rotation, 10 degrees of internal rotation. Dr. Watson found appellant could abduct his arm 120 degrees. He stated appellant could not do any work over his head and could not lift more than 10 pounds. In a December 12, 1984 note, Dr. Watson reported that an electromyogram (EMG) showed no nerve damage in the left arm. He again reported that appellant's range of motion of the left shoulder was markedly decreased.

The Office referred appellant to Dr. Ernest H. Meese, a Board-certified thoracic surgeon, for an examination. In an April 23, 1985 report, Dr. Meese discussed appellant's employment injury and stated that he had progressive pain and paresthesia in the left arm and shoulder with abnormal contractions and fasciulations in the muscle around the shoulder over which he had no control. He noted appellant had pain extending down the ulnar distribution to the ring finger. Dr. Meese reported appellant had marked difficulty in trying to abduct his arm over his head. He indicates appellant's ranges of motion in the left shoulder were 75 degrees internal rotation, 80 degrees external rotation and 120 degrees of abduction with marked pain at the extreme of each motion. Dr. Meese found normal strength and no muscle atrophy. He related appellant's condition to the employment injury and possible aggravation of the original chest incision, which may have caused weakness of the latissimus and trapezius muscles.

In a January 13, 1987 report to the employing establishment, Dr. E.H. Schweitzer, a Board-certified orthopedic surgeon, stated that appellant's left shoulder was grossly atrophic for muscle wasting. Dr. Schweitzer reported appellant had 10 degrees of internal rotation, 35 degrees of external rotation and 90 degrees of abduction. He commented that these findings represented a significant limitation of motion in the shoulder which was going to limit function and cause pain. Dr. Schweitzer diagnosed appellant's condition as a frozen shoulder.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. James H. LeVan, a Board-certified orthopedic surgeon, for an examination and second opinion. In an August 29, 1988 report, Dr. LeVan stated that appellant could only abduct his shoulder to 110 degrees. He related that an EMG performed at his direction was normal.

In an August 1, 1989 report, Dr. Watson stated appellant had ranges of motion in the left shoulder of 85 degrees abduction, 90 degrees forward flexion, a loss of 50 degrees of internal rotation and a loss of 30 degrees of external rotation. He noted that deep tendon reflexes were difficult to obtain.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. Stephen D. Heis. In a June 21, 1990 report, Dr. Heis stated that appellant had constant pain, which radiated over his left shoulder and down into the posterior aspect of his arm. He indicated appellant had reached maximum medical improvement. Dr. Heis noted appellant had 160 degrees of flexion in the right shoulder which he related to age. He stated that in the left shoulder appellant had 90 degrees of abduction and forward flexion before pain restricted his motion. Dr. Heis indicated appellant had 80 degrees of external rotation, 30 degrees of internal rotation, full adduction and backward elevation to 20 degrees. He reported pain on palpation over the superior aspect of the thoracotomy scar. Dr. Heis concluded that appellant had a 6 percent permanent impairment for forward elevation, 2 percent for backward elevation, 7 percent for abduction, 0 percent for adduction, 2 percent for external rotation and 2 percent for internal rotation for a total permanent impairment of 19 percent.

In an October 15, 1990 memorandum, the Office medical adviser indicated that appellant had a 1 percent permanent impairment for 160 degrees of forward flexion, a 4 percent permanent impairment for 90 degrees of abduction, a 6 percent permanent impairment for 90 degrees of flexion, a 1 percent permanent impairment for 30 degrees of internal rotation, no impairment for external rotation, no impairment for adduction and a 2 percent permanent impairment for backward elevation. He stated that appellant had a five percent permanent impairment for pain and tenderness in his scar. The Office medical adviser added the impairment figures and concluded that appellant had a 19 percent permanent impairment of the left arm.

In an October 13, 1994 report, Dr. Watson indicated that he had trouble eliciting any reflexes on the left side. He noted appellant still had pain and stiffness in the left shoulder. Dr. Watson reported appellant could abduct 90 degrees and forward flex a little more than that. He reported appellant had lost 45 degrees of internal and external rotation.

The Office asked appellant to submit an additional report from Dr. Watson. In an October 29, 1997 report, Dr. Watson stated appellant was still having difficulty with his shoulder with an aching pain. He indicated appellant could abduct to 80 degrees and forward flex to the same degree. Dr. Watson reported appellant had lost 50 degrees of internal rotation and 45 degrees of external rotation. He estimated that appellant had a permanent impairment of 26 percent.

In a December 16, 1997 memorandum, the Office medical adviser indicated that appellant had a 7 percent permanent impairment for 80 degrees of flexion, a 5 percent permanent impairment for 80 degrees of abduction, a 3 percent permanent impairment for a loss of 40 degrees of internal rotation and a 1 percent permanent impairment for a loss of 50 degrees of external rotation. The medical adviser listed no permanent impairment for shoulder extension because Dr. Watson had not given a range of motion for extension. He estimated that appellant had approximately five percent permanent impairment for pain. Dr. Watson noted that sensory deficits and strength deficits were not mentioned so he assumed appellant had no permanent impairment for those reasons. The Office medical adviser used the Combined Values Chart to conclude appellant had a 20 percent permanent impairment, 1 percent more than he had received previously.

The Office medical adviser properly used the A.M.A., *Guides*, including the Combined Value Chart, to calculate appellant's permanent impairment due to loss of motion and pain as

reported by Dr. Watson in his October 29, 1997 report. However, the original schedule award had included a 2 percent permanent impairment due to a range of motion of only 20 degrees in elevation. While Dr. Watson did not report appellant's range of motion in elevation of the left shoulder, the Office medical adviser could not assume there was no loss of motion in elevation when the original schedule award was based in part, on such a loss of motion. Also, Dr. Watson had previously reported appellant had difficulty in eliciting tendon reflexes in the left arm. The Office medical adviser did not discuss this finding in evaluating appellant's permanent impairment or contrast such a finding with the normal EMG tests previously reported. The record also contains differing findings on whether appellant has atrophy of the left shoulder. The Office medical adviser did not address whether appellant currently has any atrophy of the left shoulder.

The case will be remanded for further development. On remand, the Office should refer appellant, together with a statement of accepted facts and the case record, to an appropriate physician for an examination. The specialist should present a full report on appellant's left shoulder condition, taking into account all factors that would contribute to an evaluation of the permanent impairment of appellant's left arm. After further development as it many find necessary, the Office should issue a *de novo* decision.

The decisions of the Office of Workers' Compensation Programs, dated April 18 and February 27, 1999, are hereby set aside and the case remanded for further action as set forth in this decision.

Dated, Washington, DC
March 14, 2001

Michael J. Walsh
Chairman

Willie T.C. Thomas
Member

Michael E. Groom
Alternate Member