United States Department of Labor
Employees' Compensation Appeals Board

P.G., Appellant	)	
and	)	**Docket No. 06-778**
	)	**Issued: August 16, 2006**
U.S. POSTAL SERVICE, MADISON POST OFFICE, Madison, CT, Employer	)	

Appearances:
Joseph Marotti, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On February 14, 2006 appellant, through her attorney, filed a timely appeal from the January 5, 2006 merit decision of the Office of Workers' Compensation Programs, affirming a schedule award for a 12 percent impairment of the left upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award case.

ISSUE

The issue is whether appellant established that she has more than a 12 percent impairment of the left upper extremity for which she received a schedule award.

FACTUAL HISTORY

On February 7, 1998 appellant, then a 47-year-old rural carrier associate, filed a traumatic injury claim alleging that on that date she hurt her left shoulder when she fell on icy steps while delivering certified mail. By letter dated October 15, 1998, the Office accepted her claim for contusions of the left shoulder and left foot. On October 28, 2002 the Office accepted that appellant sustained a recurrence of disability on May 16, 2001 causally related to the February 7, 1998 employment injuries. The Office subsequently authorized arthroscopic subacromial

decompression, open excision of the left acromioclavicular joint, distal clavical which was performed on January 14, 2003 by Dr. Steven M. Luster, a Board-certified orthopedic surgeon. It also authorized physical therapy from October 28, 2002 to January 28, 2003.

On March 6, 2004 the Office authorized left shoulder arthroscopy which was performed on February 17, 2004 by Dr. John Daigneault, an attending Board-certified orthopedic surgeon. The Office accepted appellant's claim for impingement syndrome of the left shoulder. On July 2, 2004 she returned to limited-duty work six hours a day, six days a week alternating with five days a week. On July 8, 2004 appellant's work schedule was decreased to six hours a day, four days a week due to increased symptoms. Dr. Daigneault released her to return to limited-duty work six hours a day, five days a week on August 17, 2004.

On March 3, 2005 appellant filed a claim for a schedule award.[1] In a February 7, 2005 report, Dr. Daigneault indicated that she was doing well one year after revision acromioplasty distal clavicle excision and anterior stabilization. Appellant had clearly improved compared to her preoperative status but, she was not totally asymptomatic. Dr. Daigneault stated that she had some soreness over the left shoulder with more vigorous use of the left arm, but this did not affect her ability to work. Appellant denied any sense of shoulder instability. On physical examination Dr. Daigneault reported well-healed surgical wounds without signs of infection. Appellant held her arm in a normal position. There was no winging of the scapula. There was mild tenderness over the anterior and posterior joint lines. With regard to range of motion, Dr. Daigneault reported active elevation to 170 degrees, external rotation to 90 degrees and internal rotation to 70 degrees with end range tenderness. Strength was 5/5 except 5- in external rotation and scaption. He stated that impingement signs were trace positive and the glenohumeral joint appeared to be stable. Elbow range of motion and strength were normal. Neovascularization was intact in the left upper extremity including, motor, sensory, radial pulse and deep tendon reflexes. Dr. Daigneault noted that appellant had been able to continue her regular-duty work with no restrictions. He opined that she had reached maximum medical improvement at that time. Based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*), Dr. Daigneault determined that appellant had a 16 percent impairment of the left upper extremity based on her distal clavicle excision and residual losses for range of motion and strength.

By letter dated June 16, 2005, the Office requested that Dr. Daigneault provide, among other things, the date appellant reached maximum medical improvement and determine the extent of her impairment based on the tables in the fifth edition of the A.M.A., *Guides*.

On July 3, 2005 an Office medical adviser reviewed appellant's medical records, including Dr. Daigneault's findings. He noted a September 23, 2003 magnetic resonance imaging (MRI) scan which demonstrated a full thickness tear of the left rotator cuff and no demonstrable injury to the left labrum or the glenohumeral ligament.[2] The Office medical adviser also noted Dr. Luster's May 20, 2003 treatment note which indicated that appellant was

[1] On March 15, 2005 the Office indicated that appellant returned to full-duty work on January 14, 2005.

[2] The Board notes that contrary to the Office medical adviser's finding, the September 23, 2003 MRI scan indicated that "a full thickness rotator cuff tear is not visualized."

status post subacromial decompression and distal clavicle excision. A January 11, 2005 treatment note from her physical therapist reported 170 degrees of flexion, 90 degrees of external lateral rotation and 88 degrees of external medial rotation. Utilizing the A.M.A., *Guides* 479, Figure 16-46, the Office medical adviser determined that both ranges of motion were not associated with any impairment of the left upper extremity. He determined that appellant had a 10 percent impairment for the left distal clavicle arthroplasty based on the A.M.A., *Guides* 506, Table 16-27. The Office medical adviser assigned an additional 2 percent impairment for pain based on her complaint of increased pain with passive movement due to stiffness and some capsular tightness remaining in flexion, totaling a 12 percent impairment of the left upper extremity. He concluded that she reached maximum medical improvement no later than February 7, 2005.

By decision dated August 22, 2005, the Office granted appellant a schedule award for a 12 percent impairment of the left upper extremity based on the Office medical adviser's opinion.

On September 6, 2005 Dr. Daigneault stated that appellant reached maximum medical improvement as of February 7, 2005 and that she had subjective complaints of pain and stiffness. Dr. Daigneault submitted copies of a figure and tables of the A.M.A., *Guides* that he utilized in determining the extent of impairment of appellant's left upper extremity. According to the A.M.A., *Guides* 479, Figure 16-46, he determined that 70 degrees of internal rotation constituted a 1 percent impairment. Based on the A.M.A., *Guides* 476, Figure 16-40, Dr. Daigneault found that 170 degrees of flexion constituted a 1 percent impairment. He calculated a two percent impairment for abduction and adduction utilizing the A.M.A., *Guides* 477, Figure 16-43. Dr. Daigneault found that appellant had a 10 percent impairment for distal clavicle arthroplasty based on the A.M.A., *Guides* 506, Table 16-27. He also found that a slight weakness in abduction and external rotation each resulted in a two percent impairment based on the A.M.A., *Guides* 510, Table 16-35, totaling a four percent impairment due to weakness about the left shoulder. Dr. Daigneault added his 2 percent, 4 percent and 10 percent impairment ratings to calculate a 16 percent impairment of the left upper extremity.

In a September 26, 2005 report, Dr. Daigneault contended that the Office medical adviser misquoted Figure 16-46 of the A.M.A., *Guides*. He stated that the previously submitted tables demonstrated that appellant's range of motion findings constituted impairments of the left upper extremity. Dr. Daigneault disputed the Office medical adviser's finding that appellant had a two percent impairment for pain. He noted that the A.M.A., *Guides* clearly stated on numerous occasions that pain was subjective and that objective measurements should be used to provide ratings when possible. Dr. Daigneault stated that appellant was assigned impairment for the objective loss of rotator cuff strength which was not included in the Office medical adviser's assessment while her final visit clearly stated that she had residual shoulder weakness. He explained that he had tried to avoid including subjective measurements in the determination of appellant's impairment. Objective criteria were used for his assessment and they had been clearly and accurately calculated.

By letter dated October 14, 2005, appellant requested reconsideration of the Office's August 22, 2005 decision.

On November 20, 2005 the Office medical adviser reviewed the medical records and determined that appellant had a 10 percent impairment of the left upper extremity for distal clavicle resection arthroplasty based on the A.M.A., *Guides* 506, Table 16-27. The Office medical adviser noted the difference between the January 11, 2005 physical therapy report and Dr. Daigneault's February 7, 2005 report with regard to range of motion findings. He stated that internal rotation was previously reported as 88 degrees which did not constitute impairment while Dr. Daigneault's finding of 70 degrees constituted a 1 percent impairment of the left upper extremity based on the A.M.A., *Guides* 479, Figure 16-46. The Office medical adviser further stated that Dr. Daigneault was correct in finding that flexion of 170 degrees constituted a 1 percent impairment of the left upper extremity based on the A.M.A., *Guides* 476, Figure 16-40. He disputed Dr. Daigneault's finding that appellant had an additional two percent impairment based on the A.M.A., *Guides* 477, Figure 16-43, because he did not report the range of motion measurements for abduction or adduction. Further, the Office medical adviser stated that no additional impairment should be calculated for weakness based on the first paragraph of page 508 of the A.M.A., *Guides*. He explained that the most recent report did not indicate that the shoulder "soreness" appellant experienced was limiting her ability to work and that she had apparently improved since a January 11, 2005 evaluation. The Office medical adviser combined the impairment values to determine that she had a 12 percent impairment of the left upper extremity. He concluded that appellant reached maximum medical improvement on February 7, 2005.

By decision dated January 5, 2006, the Office denied modification of the August 25, 2005 decision. It found that the Office medical adviser's November 20, 2005 opinion that appellant had a 12 percent impairment of the left upper extremity constituted the weight of the medical opinion evidence.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulation[4] sets forth the number of weeks of compensation to be paid for permanent loss or loss of use, of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[5] However, neither the Act, nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[6]

Before the A.M.A., *Guides* can be utilized, a description of appellant's impairment must be obtained from her physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment,

[3] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[4] 20 C.F.R. § 10.404.

[5] 5 U.S.C. § 8107(c)(19).

[6] *See supra* note 4.

including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[7]

ANALYSIS

On appeal appellant contends that she has more than a 12 percent impairment of the left upper extremity based on the findings of Dr. Daigneault. In a February 7, 2005 medical report, he found that she had active elevation to 170 degrees, which is the equivalent of a 1 percent impairment (A.M.A., *Guides* 476, Figure 16-40), external rotation to 90 degrees, which is the equivalent of a 0 percent impairment (A.M.A., *Guides* 479, Figure 16-46) and internal rotation to 70 degrees, which is the equivalent of a 1 percent impairment (A.M.A., *Guides* 479, Figure 16-46). Dr. Daigneault also found that her strength was 5/5 except 5- in external rotation and scaption. He determined that appellant had a 16 percent impairment of the left upper extremity based on the A.M.A., *Guides*. Although Dr. Daigneault determined that she sustained a 16 percent impairment of the left upper extremity, the Board finds that he failed to provide a fully-rationalized medical opinion on the issue of permanent impairment. He did not adequately explain how he reached his impairment rating in accordance with the relevant standards of the A.M.A., *Guides*.[8] The Board notes that he did not properly explain how he calculated the impairment rating using specific figures and tables of the A.M.A., *Guides* as requested by the Office. Such explanation was especially important since, when adding the impairment values of active elevation (one percent), external rotation (zero percent) and internal rotation (one percent) they only resulted in two percent impairment of the left upper extremity based on loss of range of motion.

On September 6, 2005 Dr. Daigneault found that appellant reached maximum medical improvement on February 7, 2005. Utilizing the A.M.A., *Guides* 479, Figure 16-46, he determined that 70 degrees of internal rotation constituted a 1 percent impairment. Based on the A.M.A., *Guides* 476, Figure 16-40, Dr. Daigneault found that 170 degrees of flexion constituted a 1 percent impairment. He allowed a two percent impairment for abduction and adduction according to the A.M.A., *Guides* 477, Figure 16-43. Appellant sustained a 10 percent impairment for distal clavicle arthroplasty based on the A.M.A., *Guides* 506, Table 16-27. Dr. Daigneault calculated a two percent impairment each for a slight weakness in abduction and external rotation resulting in a four percent impairment of the left upper extremity due to weakness about the shoulder based on the A.M.A., *Guides* 510, Table 16-35. He apparently calculated a 16 percent impairment of the left upper extremity by adding the 2 percent, 4 percent and 10 percent impairment values. The Board finds that Dr. Daigneault failed to fully explain his impairment rating. He failed to identify the range of motion calculations for abduction and adduction to support his finding that appellant had a two percent impairment. Further, the A.M.A., *Guides* provide that decreased strength cannot be rated in the presence of decreased

[7] *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

[8] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

motion or painful conditions[9] and that strength deficits measured by manual muscle testing should only rarely be included in the calculation of upper extremity impairment.[10] Therefore, appellant is not entitled to a schedule award for impairment due to loss of range of motion and loss of muscle strength as determined by manual muscle testing. The Board notes that appellant did not submit any other medical evidence establishing that she has more than a 12 percent impairment of the left upper extremity.

An Office medical adviser reviewed Dr. Daigneault's findings under the provisions of the A.M.A., *Guides*. He agreed that appellant had a 10 percent impairment of the left upper extremity for distal clavicle resection arthroplasty based on the A.M.A., *Guides* 506, Table 16-27. The Office medical adviser noted that 70 degrees of internal rotation constituted a 1 percent impairment of the left upper extremity based on the A.M.A., *Guides* 479, Figure 16-46 and flexion of 170 degrees constituted a 1 percent impairment of the left upper extremity based on the A.M.A., *Guides* 476, Figure 16-40. He noted that Dr. Daigneault did not provide any range of motion measurements for abduction or adduction and, thus, appellant was not entitled to an additional two percent impairment. The Office medical adviser stated that no additional impairment should be calculated for weakness based on the first paragraph of page 508 of the A.M.A., *Guides* as the most recent report did not indicate that the shoulder "soreness" appellant experienced was limiting her ability to work and that she had apparently improved since a January 11, 2005 evaluation. He added the 1 percent impairment resulting from internal rotation and 1 percent impairment for loss of flexion. The Office medical adviser then combined the 2 percent impairment for loss of range of motion with the 10 percent impairment for total distal clavicle resection arthroplasty to find a 12 percent impairment of the left upper extremity.

Board precedent is well settled that, when an attending physician provides an estimate of impairment but does not explain how the estimate is based upon the application of the A.M.A., *Guides* or improperly applies the A.M.A., *Guides*, the Office may follow the advice of its medical adviser or consultant where he or she has properly utilized the A.M.A., *Guides*.[11] The Office medical adviser provided a reasoned opinion that appellant had a 12 percent impairment based on the proper tables and figures of the A.M.A., *Guides*. The Board finds that the weight of the medical evidence with regard to the degree of impairment to the left upper extremity is represented by the Office medical adviser's opinion.

CONCLUSION

The Board finds that appellant has failed to establish that she has more than a 12 percent impairment of the left upper extremity for which she received a schedule award.

---

[9] A.M.A., *Guides* 508 and 526, Table 17-2; *Patricia J. Horney*, 56 ECAB ____ (Docket No. 04-2013, issued January 14, 2005). The A.M.A., *Guides* further note that motor weakness associated with disorders of the peripheral nerve system are evaluated in accordance with Chapter 16.5. A.M.A., *Guides*, 508, 480. This is not the evaluation method utilized by Dr. Daigneault.

[10] *Cerita J. Slusher*, 56 ECAB ___ (Docket No. 04-1584, issued May 10, 2005).

[11] *See Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980).

ORDER

IT IS HEREBY ORDERED THAT the January 5, 2006 and August 25, 2005 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: August 16, 2006
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

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