

rotation and T4 of internal rotation bilaterally. Dr. Morrison also noted that appellant could perform normal activities of daily living and was doing his normal job duties with occasional to intermittent shoulder discomfort which became moderate with heavy activity at or above the shoulder, rapid fatigability and intermittent pain at night. He diagnosed chronic subacromial impingement syndrome with rotator cuff tendinitis of the right shoulder and internal derangement of the right acromioclavicular joint, both substantially resolved. Dr. Morrison provided permanent restrictions to appellant's physical activity and opined that, due to his shoulder condition, his strength was decreased approximately 20 to 25 percent above the shoulder level.¹ On July 8, 2004 appellant filed a schedule award claim.

In a January 5, 2005 report, an Office medical consultant, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, noted his review of the medical record including Dr. Morrison's June 22, 2004 report. Dr. Harris noted that appellant had reached permanent and stationary status and maximum medical improvement had been reached on June 22, 2004, the date of Dr. Morrison's examination. Dr. Harris noted that appellant had some residual pain in his right shoulder but that examination demonstrated a full range of motion without muscle weakness, atrophy or instability which would preclude an impairment rating on those grounds. He stated that, pursuant to the fifth edition of the A.M.A., *Guides*,² Table 16-10, appellant had a Grade 4, sensory deficit or pain with decreased sensation that was forgotten with activity in the axillary nerve/deltoid muscle region. This grade allowed a sensory deficit of 25 percent. Under Table 16-15, the maximum impairment for axillary sensory deficit was five percent. Therefore appellant had a one percent right upper extremity impairment for pain, forgotten with activity.

By decision dated September 23, 2005, appellant was granted a schedule award for a one percent impairment of the right upper extremity, a total of 3.12 weeks of compensation to run from June 22 to July 13, 2004.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act³ and section 10.404 of the implementing federal regulation⁴ schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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

¹ Dr. Morrison did not address the American Medical Association, *Guides to the Evaluation of Permanent Impairment* in providing his analysis.

² A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404.

A.M.A., *Guides*⁵ has been adopted by the Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.⁶

Chapter 16 provides the framework for assessing upper extremity impairments,⁷ and section 16.5b of the A.M.A., *Guides* describes the methods for evaluating upper extremity impairments due to peripheral nerve disorders. It provides that the severity of the sensory deficit is classified according to Tables 16-10a. Under Table 16-15 the values for maximum impairment for affected nerves are provided. Under Table 16-19 the grade of severity for sensory deficit is then to be multiplied by the maximum upper extremity impairment value for the nerve involved. This results in the upper extremity impairment for sensory loss.

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*. However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.⁸

Office procedures further provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment.⁹

ANALYSIS

The Board finds that appellant has a two percent impairment of the right upper extremity. The Office medical adviser reviewed a June 22, 2004 report submitted by Dr. Morrison, appellant's attending orthopedic surgeon. He found that maximum medical improvement had been reached on June 22, 2004, the date of Dr. Morrison's examination, and advised that demonstrated a full range of motion without muscle weakness, atrophy or instability, precluded an impairment rating on these grounds. However, he noted that Dr. Morrison also indicated that appellant had residual, intermittent pain which entitled him to a one percent impairment pursuant to the A.M.A., *Guides*.

⁵ A.M.A., *Guides*, *supra* note 2.

⁶ See *Joseph Lawrence, Jr.*, *supra* note 2; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

⁷ A.M.A., *Guides*, *supra* note 2 at 433-521.

⁸ *Robert V. Disalvatore*, 54 ECAB 351 (2003).

⁹ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(d) (August 2002).

The Board finds that the Office medical adviser properly analyzed appellant's sensory deficit in accordance with section 16.5b of the A.M.A., *Guides*.¹⁰ Under Table 16-10,¹¹ appellant had Grade 4 pain for decreased sensation that is forgotten with activity which allows a maximum 25 percent impairment deficit. Under Table 16-15, he identified the axillary nerve and found that the A.M.A., *Guides* provide a maximum five percent impairment.¹² The Office medical adviser multiplied the 5 percent maximum impairment by the 25 percent sensory grade to find a 1 percent right upper extremity impairment for pain, forgotten with activity.¹³

The Board notes that Dr. Morrison also stated that appellant's shoulder forward flexion was 170 degrees. Figure 16-40 of the A.M.A., *Guides*, at page 476 allows a one percent impairment for loss of forward flexion.¹⁴ Section 16.5b of the A.M.A., *Guides* provides that when multiple impairments of the extremity are present, they are to be combined.¹⁵ The one percent impairment for a sensory deficit, when combined with the one percent for loss of range of motion, totals a two percent right upper extremity impairment.¹⁶

Although Dr. Morrison indicated that appellant had a 20 to 25 percent loss of strength, he provided no impairment estimate. As Dr. Morrison's report is insufficient to establish an impairment due to loss of strength.¹⁷

CONCLUSION

The Board finds that appellant has established that he is entitled to a two percent impairment of the right upper extremity.

¹⁰ A.M.A., *Guides*, *supra* note 2 at 81.

¹¹ *Id.* at 482.

¹² *Id.* at 492.

¹³ The policy of the Office is to round the calculated percentage of impairment to the nearest whole point. *Marco A. Padilla*, 51 ECAB 202 (1999).

¹⁴ A.M.A., *Guides*, *supra* note 2 at 476.

¹⁵ *Id.* at 481.

¹⁶ *Id.* at 604.

¹⁷ *See Lela M. Shaw*, 51 ECAB 372 (2000).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 23, 2005 be affirmed, as modified.

Issued: February 6, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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