United States Department of Labor
Employees' Compensation Appeals Board

M.E., Appellant	)	
and	)	**Docket No. 06-2068**
	)	**Issued: April 20, 2007**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF PRISONS, Marion, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 11, 2006 appellant, filed a timely appeal of a March 21, 2006 merit decision of an Office of Workers' Compensation Programs' hearing representative, finding that he had no more than an eight percent impairment of the left upper extremity, for which he received a schedule award. 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 has more than an eight percent impairment to the left upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On September 8, 2003 appellant, then a 41-year-old senior correctional officer, filed a traumatic injury claim. He alleged that on September 6, 2003 he hit the corner of a security cabinet door with his left shoulder and sustained a possible fracture of the left shoulder blade and swelling of the arm. Appellant stopped work on September 6, 2003. By letter dated October 30,

2003, the Office accepted appellant's claim for left shoulder tear. In a letter dated November 5, 2003, the Office subsequently authorized left shoulder arthroscopic surgery, which was performed on December 3, 2003 by Dr. William P. Thorpe, a Board-certified orthopedic surgeon, who indicated that the surgery consisted of partial excision anterior labrum, inferior labrum and posterior labrum, suture repair of labrum, lavage of humerus and glenoid, shaving of humerus and glenoid, debridement of humerus and glenoid, total synovectomy, repair of capsule, removal of cartilage loose body, bursectomy, division of C-A ligament and acromioplasty. Appellant's postoperative diagnosis included multi-directional anterior, inferior and posterior instability, rotator cuff tear with impingement, superior labial anterior posterior (SLAP) Type II lesion of the left shoulder.

In a February 19, 2004 treatment note, Dr. Thorpe reported that appellant's left shoulder had 150 degrees of flexion, 110 degrees of abduction, 65 degrees of external rotation and 70 degrees of internal rotation. Appellant complained of burning pain anteriorly but it was getting better. Dr. Thorpe reported no sign of muscle weakness, hypoesthesia in the long, ring and middle fingers of the left hand and a positive Tinel's sign at the elbow. He noted a history of the September 6, 2003 employment injury and opined that this injury was consistent with ulnar nerve compression. Dr. Thorpe recommended an electromyogram/nerve conduction study (EMG/NCS). A March 16, 2004 EMG/NCS was normal.

In an April 15, 2004 treatment note, Dr. Thorpe reported on physical examination that, appellant's arm moved freely and fully passively, there was some diffuse weakness and no sensory deficit. He noted the medical opinion of Dr. Paul B. Juergens, a pain management specialist, that appellant had diffuse hypesthesia and that he did not provide any explanation of his opinion. Dr. Thorpe opined that appellant had healed from his left shoulder surgery and recommended no use of the left arm as a permanent restriction.

On May 7, 2004 appellant underwent a functional capacity evaluation (FCE), which found that his subjective reports of pain and associated disability were considered reasonable and reliable. He could perform light physical work regarding his left upper extremity and activities with no limitations with regard to his right upper extremity.

In a May 13, 2004 treatment, Scott Peterson, a physician's assistant, stated that appellant complained of pain which he characterized as 7 on a scale of 0 to 10 where 0 was no pain and 10 was the worst pain imaginable. On physical examination, he reported some discoloration of the left palm and mild edema of the left knuckles. Appellant also experienced left shoulder pain and neuropathic pain of the left upper extremity, which Mr. Peterson suspected was of a sympathetic origin. Mr. Peterson stated that appellant had limited range of motion of the left upper extremity. He concluded that he agreed with the FCE work restrictions.

In a May 26, 2004 treatment note, Dr. Juergens indicated that, among other things, appellant complained of a burning sensation in his fingers and pain in his arm and shoulder that he characterized as 7 on a scale of 0 to 10. He reported his findings on physical examination and diagnosed complex regional pain syndrome (CRPS) of the left upper extremity. Dr. Juergens stated that appellant was also developing reflex sympathetic dystrophy (RSD) of the left upper extremity. Dr. Juergens' June 22, 2004 treatment note stated that, therapy had increased appellant's pain and he was having trouble with cognitive functions at work and handing people

the wrong equipment.[1] Appellant complained of pain, swelling, discoloration and temperature changes in his left upper extremity. On physical examination, Dr. Juergens reported pain of 10 on a scale of 0 to 10. Appellant's arm had significant modeling, his fingers were held in mild flexion and there was no allodynia to light touch or palpation. Dr. Juergens diagnosed CRPS I of the left upper extremity. He opined that, in the absence of a trial of sympathetic blocks or trial spinal cord stimulation, appellant was at maximum medical improvement. Dr. Juergens further opined that appellant sustained permanent loss of use of his left upper extremity in his present employment.

By letter dated July 15, 2004, the Office requested that Dr. Thorpe determine the extent of appellant's permanent impairment of the left upper extremity due to the September 6, 2003 employment-related injury based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).

By letter dated July 28, 2004, the Office referred appellant, along with a statement of accepted facts, the case record and a list of questions to be addressed, to Dr. Raymond A. Ritter, Jr., a Board-certified orthopedist, for a second opinion medical examination. It requested that Dr. Ritter provide his orthopedic diagnoses and address whether the diagnosed conditions were causally related to the accepted employment injury and whether appellant was totally disabled for work due to his conditions.

On August 2, 2004 the Office received Dr. Juergens' July 27, 2004 treatment note. Dr. Juergen stated that appellant complained of severe dysthetic pain of the left upper extremity with burning pain of the left fourth and fifth fingers and proximal forearm. On physical examination, he reported pain as 6 to 7 on a scale of 0 to 10. Dr. Juergens stated that appellant had 60 degrees of forward elevation, minimal backward elevation, 45 degrees of abduction, 60 degrees of internal rotation and 40 degrees of external rotation. He further stated that appellant had decreased strength of his left hand grip and left triceps' strength was four out of five. His shoulder abduction was three out of five and he had mild mottling discoloration of the left upper extremity. Dr. Juergens concluded that appellant sustained CRPS I of the left upper extremity.

On August 2, 2004 Dr. Thorpe reported that appellant sustained loss of function due to pain, discomfort, sensory alteration and RSD. He stated that appellant experienced increased pain with movement or use of his left upper extremity. Dr. Thorpe indicated that he had burning dysthetic pain in the anterior shoulder and severe pain in the fourth and fifth fingers. He provided the same range of motion measurements for appellant's left shoulder as set forth by Dr. Juergens in his July 27, 2004 treatment note.

On August 2, 2004 appellant filed a claim for a schedule award.

In a September 23, 2004 report, Dr. Ritter provided a history of appellant's September 6, 2003 employment-related injury and medical treatment. He noted appellant's complaint of severe pain and diminished sensation of the left upper extremity but not in a dermatomal

[1] The record reflects that effective June 8, 2004 appellant returned to limited-duty work on a full-time basis. He stopped work on June 24, 2004.

distribution. Dr. Ritter stated that the pain interfered with daily function to the point that appellant essentially had no use of the left shoulder because of the alleged discomfort. He reported weakness of the left upper extremity but no atrophy. Appellant had a weak grip and significant weakness of any ability to move his shoulder in abduction, extension or flexion. He also had marked restriction of motion as indicated in his range of motion chart. Dr. Ritter stated that appellant had symptoms of causalgia but there were no objective findings to verify such symptoms. He diagnosed chronic pain in the left shoulder causally related to the September 6, 2003 employment injury and resultant surgery, possible causalgia, depression and panic disorder. Dr. Ritter opined that appellant could not perform his regular work duties but that he could perform the duties of his June 2004 limited-duty job. He opined that it was impossible to provide an impairment rating based on the A.M.A., *Guides,* due to the complexity of appellant's symptoms. Dr. Ritter stated that he not only had restricted motion, but also his pain pattern had symptoms of significant pain that seemed to limit his activities, depression, anxiety, weakness and numbness. Based on a combination of the factors set forth in his report, Dr. Ritter determined that appellant had a 50 percent impairment of the left upper extremity.

The Office found a conflict in the medical opinion evidence between Drs. Juergens and Ritter as to whether appellant sustained a work-related injury and if so, whether he had any continuing residuals of his September 6, 2003 employment injury and whether he could perform the duties of his date-of-injury job. By letters dated March 10 and 16, 2005, the Office referred appellant, along with a statement of accepted facts, the case record and a list of questions to be addressed, to Dr. John J. Sheridan, a Board-certified orthopedic surgeon, for an impartial medical examination.

In an April 20, 2005 report, Dr. Sheridan provided a history of appellant's September 6, 2003 employment-related injury and medical treatment. On physical examination, he reported that light palpation around appellant's shoulder resulted in some grimacing, withdrawal and generalized expression of discomfort. He could only weakly initiate abduction, flexion and external rotation again with grimacing and posturing throughout his body. Dr. Sheridan stated that his attempts to assist with passive motion were also met with restriction, grimacing and expression of pain. He could not document any reproducible neurologic deficit in appellant's arm. Appellant had no alteration of heat, color or moisture in the left upper extremity. Based on his examination and medical evidence of record, Dr. Sheridan opined that appellant sustained a SLAP lesion of the left shoulder although there were numerous other abnormalities that were presumably identified at the time of surgery. Regarding whether the diagnosed condition was causally related to the September 6, 2003 employment injury, he stated that there was documentation of some type of contusion involving the left shoulder, but he seriously doubted the relationship of Dr. Thorpe's findings at the time of surgery to the mechanism of injury reported. Dr. Sheridan stated that appellant continued to complain of residuals related to the accepted employment injury but noted that there was very little objective evidence to support his complaints and restricted function. He opined that appellant could not return to his senior correctional officer position based on a review of his job requirements. Dr. Sheridan stated that any physical activity or encounter with hostile individuals would put him at medical risk. Appellant could return to a clerical job that did not require vigorous physical use of his left upper extremity which restricted pushing, pulling and overhead activities. In a work capacity

evaluation form dated March 31, 2005, Dr. Sheridan stated that appellant could perform limited-duty work eight hours per day with restrictions.[2]

On May 12, 2005 the Office requested that Dr. David Garelick, an Office medical adviser, review Dr. Juergens' July 27, 2004 findings and provide a permanent impairment rating for appellant's left upper extremity based on the A.M.A., *Guides*, as well as, the date he reached maximum medical improvement.

On May 16, 2005 Dr. Garelick reviewed appellant's medical records including, Dr. Juergens' July 27, 2004 findings. He stated that it was going to be very difficult, if not impossible, to provide an impairment rating based on the A.M.A., *Guides*. Dr. Garelick determined that appellant had a Class 4 severe impairment due to a pain disorder (A.M.A., *Guides* 575, Table 18-3). He stated that the only appropriate award at that time would be a five percent impairment of the left upper extremity for Grade 0 pain in the distribution of the suprascapular nerve. (A.M.A., *Guides* 482, 492, Tables 16-10, 16-15). Dr. Garelick found that appellant had an additional three percent impairment for pain (A.M.A., *Guides*, 574, Figure 18-1) because the pain-related impairment appeared to increase the burden of his condition substantially. He combined the five percent and three percent impairments for pain to determine that appellant had an eight percent impairment of the left upper extremity (A.M.A., *Guides* 604, Combined Values Chart). Dr. Garelick estimated that the date of maximum medical improvement occurred one year postoperatively, on December 3, 2004.

By decision dated June 27, 2005, the Office granted appellant a schedule award for an eight percent impairment of the left upper extremity based on Dr. Garelick's May 12, 2005 opinion. In a July 25, 2005 letter, appellant requested an oral hearing before an Office hearing representative.

In a decision dated March 21, 2006, an Office hearing representative affirmed the June 27, 2005 decision. He found that Dr. Garelick properly utilized the A.M.A., *Guides* in determining that appellant had an eight percent impairment of the left upper extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees Compensation Act[3] and its implementing regulation[4] set 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

[2] Appellant returned to limited-duty work as an assistant control room officer effective May 15, 2005.

[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).

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]

The standards for evaluation the permanent impairment of an extremity under the A.M.A., *Guides* are based on loss of range of motion, together with all factors that prevent a limb from functioning normally, such as pain, sensory deficit and loss of strength. All of the factors should be considered together in evaluating the degree of permanent impairment.[7] Chapter 16 of the fifth edition of the A.M.A., *Guides* provides a detailed grading scheme and procedure for determining impairments of the upper extremities due to pain, discomfort, loss of sensation or loss of strength.[8]

It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the protocols of the A.M.A., *Guides*, his opinion is of diminished probative value in establishing the degree of any permanent impairment. In such cases, the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[9]

ANALYSIS

The Office accepted that appellant sustained a left shoulder tear in the performance of duty on September 6, 2003. The Office found a conflict in the medical opinion evidence between Dr. Juergens, a treating physician, and Dr. Ritter, an Office referral physician, as to whether appellant sustained a work-related injury and if so, whether he had any continuing residuals of his September 6, 2003 employment injury. In a July 27, 2004 treatment note, Dr. Juergens opined that appellant sustained CRPS I of the left upper extremity. He reported his range of motion findings which included 60 degrees of forward elevation, minimal backward elevation, 45 degrees of abduction, 60 degrees of internal rotation and 40 degrees of external rotation. Dr. Juergens also reported decreased strength of the left hand grip, left triceps' strength that was four out of five, shoulder abduction that was three out of five and mild mottling discoloration of the left upper extremity. In a September 23, 2004 report, Dr. Ritter opined that appellant sustained employment-related chronic left shoulder pain, possible causalgia, depression and panic disorder. He opined that it was difficult to determine the extent of his permanent impairment based on the A.M.A., *Guides* due to the complexity of his symptoms, noting that he not only had restricted motion, but also his pain pattern had symptoms of significant pain that seemed to limit his activities, depression, anxiety, weakness and numbness. Dr. Ritter, however, opined that he sustained 50 percent impairment of the left upper extremity. He further opined that appellant could perform limited-duty work with restrictions.

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[6] *Supra* note 4.

[7] *See Paul A. Toms*, 28 ECAB 403 (1987).

[8] A.M.A., *Guides*, Chapter 16, The Upper Extremities, pp. 433-521 (5th ed. 2001).

[9] *See John L. McClanic*, 48 ECAB 552 (1997); *see also Paul R. Evans*, 44 ECAB 646, 651 (1993).

The Office properly referred appellant to Dr. Sheridan, selected as the impartial medical examiner, to resolve the conflict in the medical opinion evidence. In an April 25, 2005 report, he stated that appellant sustained a SLAP lesion of the left shoulder but doubted that it was employment related. Dr. Sheridan found that appellant's complaint of continuing residuals of his September 6, 2003 employment-related injury were not supported by objective evidence. He opined that appellant could not return to his date-of-injury position as a correctional officer because any physical activity or encounter with hostile individuals would put him at medical risk. Dr. Sheridan, however, opined that he could perform limited-duty work in a clerical position, eight hours per day with restrictions.[10]

On May 16, 2005 Dr. Garelick an Office medical adviser, reviewed appellant's medical records, including Dr. Juergens' July 27, 2004 findings. He stated that it was going to be very difficult, if not impossible, to determine the extent of permanent impairment of appellant's left upper extremity without providing any rationale for his opinion. Dr. Garelick determined that appellant had a Class 4 severe impairment due to a pain disorder (A.M.A., *Guides* 575, Table 18-3). He further determined that appellant had five percent impairment of the left upper extremity for Grade 0 pain in the distribution of the suprascapular nerve. (A.M.A., *Guides* 482, 492, Tables 16-10 and 16-15). Dr. Garelick found that he had an additional three percent impairment for pain (A.M.A., *Guides*, 574, Figure 18-1) because the pain-related impairment appeared to increase the burden of his condition substantially. However, according to section 18.3b, page 571 of the A.M.A., *Guides,* examiners should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ rating systems found in the other chapters.[11] Office procedures provide that Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain (Chapters 13, 16 and 17).[12] Thus, Dr. Garelick did not properly justify this additional allocation of three percent for appellant's pain. He utilized the Combined Values chart on page 604 of the A.M.A., *Guides* to determine that appellant had an eight percent impairment of the left upper extremity. However, as noted, appellant was not entitled to the three percent impairment under Chapter 18. Moreover, Dr. Garelick failed to apply the tables and figures of the A.M.A., *Guides* to Dr. Juergens' range of motion measurements for appellant's left upper extremity. Thus, the hearing representative's March 21, 2006 decision must be set aside and the case remanded to the Office. Upon remand, the Office will refer the case to an Office medical adviser to determine appellant's left upper extremity impairment by including the range of motion measurements provided by Dr. Juergens. Following this and any other development deemed necessary, the Office shall issue an appropriate decision regarding appellant's entitlement to a schedule award for permanent impairment of his left upper extremity.

[10] The Board notes that the Office did not ask Dr. Sheridan to determine whether appellant sustained any permanent impairment based on the A.M.A., *Guides* due to his September 6, 2003 employment-related injury and he did not offer an opinion regarding this issue.

[11] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); *Philip A. Norulak*, 55 ECAB 690 (2004).

[12] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

CONCLUSION

The Board finds that this case is not in posture for decision as to whether appellant has more than an eight percent impairment of the left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the March 21, 2006 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further proceedings consistent with this decision of the Board.

Issued: April 20, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board