United States Department of Labor
Employees' Compensation Appeals Board

D.N., Appellant	)	
and	)	**Docket No. 07-195**
	)	**Issued: June 11, 2007**
DEPARTMENT OF THE NAVY, NAVSEA CRANE, Crane, IN, 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
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On October 30, 2006 appellant filed a timely appeal from a September 26, 2006 schedule award decision of the Office of Workers' Compensation Programs granting one percent impairment for the left upper extremity and two percent impairment for the right upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award.

ISSUE

The issue is whether appellant has more than one percent impairment for the left upper extremity and two percent impairment for the right upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On February 20, 2003 appellant, then a 55-year-old police officer, sustained injury to his left shoulder and sustained back and chest strains when he slipped on ice while entering his motor vehicle. He stopped work on February 20, 2003 and returned to work on

February 24, 2003. On January 3, 2004 appellant injured his right shoulder. On January 16, 2004 he filed a recurrence of disability claim for which a new left shoulder injury was accepted. The Office combined the files pertaining to the left and right shoulder conditions. It accepted impingement of the right shoulder, left rotator cuff strain and tear and left scapula contusion.

Appellant submitted several reports from his treating physicians. Dr. Harlen C. Hunter, an osteopath, performed a left shoulder arthroscopy on July 26, 2004 and found a "slight inferior dipping of the acromion," but no evidence of a rotator cuff tear. He performed a right shoulder arthroscopy on September 8, 2004 and reported that appellant's range of motion was "free at this time." In an October 12, 2004 report, Dr. Hunter noted that appellant had reduced active range of motion due to 90 degrees of abduction in the right shoulder.

In a December 1, 2004 report, Dr. Earl J. Craig, a Board-certified physiatrist, diagnosed right rotator cuff tear and impingement and noted that appellant's right shoulder range of motion was limited but his strength was generally normal. On December 10, 2004 he repeated his diagnosis and noted that appellant's left shoulder range of motion was also limited. Dr. Craig referred appellant to Dr. R. Kent Moseman, a Board-certified orthopedic surgeon. In a January 6, 2005 report, Dr. Moseman referenced an October 29, 2004 magnetic resonance imaging (MRI) scan report and diagnosed "residual AC [acromioclavicular] joint pain versus continued impingement from partial rotator cuff tear." In a February 3, 2005 follow-up report, he noted that appellant continued to have pain with abduction and forward flexion. On April 12, 2005 Dr. Moseman performed a right shoulder arthroscopy with subacromial decompression and mending open repair.

Appellant subsequently requested schedule awards for permanent impairment to both upper extremities In an August 15, 2005 report, Dr. Moseman indicated that appellant had reached a "quiescent state" in his left shoulder. On examination, he measured full overhead flexion and abduction and "external rotation of about 65 or 70." Dr. Moseman opined: "[Appellant] has no impairment based upon loss of movement or deformity, but based on the fact that he does have a defect in his rotator cuff, I think that he would have approximately a two percent impairment of the whole person." He explained that he employed a diagnosis based evaluation method and took appellant's successful left shoulder surgery into consideration.

In a September 12, 2005 report, Dr. Moseman addressed appellant's right shoulder, noting that he had reached a quiescent state and was permanently restricted from using his right arm in overhead lifting of loads weighing greater than 20 pounds. He opined: "As far as a permanent impairment otherwise, he would have approximately a four percent impairment of the whole person based more upon a diagnosis-related evaluation. There is no specific category for distal rotator cuff tear, but by comparing it with other diagnoses, I believe that this is fair."

On November 22, 2005 the Office referred appellant with a statement of accepted facts to Dr. James B. Rickert, a Board-certified orthopedic surgeon, for a second opinion evaluation. Dr. Rickert examined appellant and prepared an impairment rating on December 12, 2005 based upon the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[1] Upon examination, he measured full range of motion in appellant's left

[1] A.M.A., *Guides* (5th ed. 2001).

shoulder, save for 160 degrees of forward flexion. Dr. Rickert also noted 160 degrees of forward flexion and 160 degrees of abduction in appellant's right shoulder, with full range of motion in all other aspects. Appellant exhibited normal strength. He concluded:

> "For the left shoulder, using Figure 16-43, [appellant] has a one percent impairment of the left shoulder. Using Table 16-40 for the right shoulder, [appellant] has a one percent impairment of the right shoulder. Using Figure 16-43 for the right shoulder, again [appellant] does have a one percent impairment of the right shoulder. Using Table 16-11, [appellant] has a five percent impairment of the right shoulder. Therefore, for the right shoulder, [appellant] has a seven percent impairment of the upper extremity, which correlates with a four percent impairment of the whole person. For the left shoulder, [appellant] has a one percent impairment of the upper extremity, which correlates with a one percent impairment of the whole person. Added together, [appellant] therefore has a five percent impairment of the whole person."

In a November 29, 2005 report, Dr. Moseman advised that, based on Table 16-35, page 510 of the A.M.A., *Guides*, for the right shoulder appellant had "five percent impairment of shoulder flexion for loss of power and a three percent impairment of the upper extremity for loss of abduction power, which gives a total of eight percent of the upper extremity, which translates to a four percent impairment of the whole person." For the left shoulder, he stated that appellant had "about a two percent impairment of flexion power and a two percent impairment of abduction, which would be a total of four percent impairment of the upper extremity or two percent impairment of the whole person."

On September 13, 2006 an Office medical adviser reviewed the medical evidence and rated impairment under the A.M.A., *Guides* based on Figure 16-40[2] for the left arm and Figures 16-40[3] and 16-43[4] for the right arm. He determined that appellant had a one percent impairment of the left upper extremity, based on a measurement of 160 degrees of forward flexion with otherwise full range of motion. The medical adviser found that appellant had a two percent impairment of the right upper extremity; one percent based on 160 degrees of forward flexion and one percent based on 160 degrees of abduction with otherwise full range of motion. The medical adviser explained that his calculations were based on appellant's demonstrated range of motion deficits. He elaborated: "My value differs from that of Dr. Rickert for the right upper extremity because Dr. Rickert factors weakness into his calculations. While the claimant does have weakness, the fifth edition of the A.M.A., *Guides* states that strength deficits are not to be taken into consideration in the setting of decreased range of motion." The medical adviser also noted that appellant reached maximum medical improvement as of September 12, 2005.

By decision dated September 26, 2006, the Office granted schedule awards for one percent impairment of the left arm and two percent impairment of the right arm.

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[2] *Id*. at 476, Figure 16-40.

[3] *Id.*

[4] *Id*. at 477, Figure 16-43.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulation[6] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to 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 A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[7]

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.[8] Section 16.4 provides that in evaluating abnormal motion both active and passive motion measurements are necessary to evaluate the joint motion under the appropriate charts and these should be added to obtain the total motion impairment.[9] A schedule award is not payable for impairment to the whole person.[10]

ANALYSIS

In support of his schedule award request, appellant submitted several reports from Dr. Moseman who discussed appellant's limited range of motion but stated that his impairment estimate was a "diagnosis based evaluation." Dr. Moseman opined that appellant had two percent whole person impairment with regard to his left shoulder and four percent whole person impairment with regard to his right shoulder. As noted, the Office does not issue schedule awards based on a whole person impairment rating.[11] Dr. Moseman did not adequately explain how his impairment ratings comported with the A.M.A., *Guides*.[12] On August 15, 2005 he provided a measurement of "about 65 or 70" for external rotation and stated that appellant had "full overhead flexion and abduction." Dr. Moseman did not explain how such measurements led him to find, under the A.M.A., *Guides*, that appellant had ratable permanent impairment. His September 12, 2005 report has similar deficiencies with regard to the right arm. Dr. Moseman did not explain how appellant had any ratable impairment pursuant to the A.M.A., *Guides*.

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[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999).

[7] *Id.*; *see, e.g., Rose V. Ford*, 55 ECAB 449 (2004).

[8] A.M.A., *Guides*, 433-521.

[9] *Id.* at 451-452.

[10] *See Gordon G. McNeill*, 42 ECAB 140, 145 (1990).

[11] *See id.*

[12] An estimate of permanent impairment is irrelevant and of diminished probative value where it is not based on the A.M.A., *Guides*. *James R. Hill*, 57 ECAB ___ (Docket No. 05-1899, issued May 12, 2006).

Dr. Moseman's November 29, 2005 impairment rating is also of reduced probative value as it was improperly based upon loss of strength. He calculated eight percent impairment of the right shoulder and four percent impairment of the left shoulder based on Table 16-35, page 510, of the A.M.A., *Guides*, which measures shoulder strength deficit.[13] The A.M.A., *Guides*, section 16.8, state that "because strength measurements are influenced by subjective factors that are difficult to control and the [A.M.A.,] *Guides* for the most part is based on anatomic impairment, the [A.M.A.,] *Guides* does not assign a large role to such measurements."[14] The A.M.A, *Guides* provide that: "If the examiner judges that loss of strength should be rated separately in an extremity that presents other impairments, the impairment due to loss of strength could be combined with the other impairments, only if based on unrelated etiologic or pathomechanical causes."[15] (Emphasis omitted). Ratings based on objective anatomic findings generally take precedence and the A.M.A., *Guides* caution that decreased strength cannot be rated in the presence of decreased motion.[16] The Board finds that Dr. Moseman did not provide sufficient explanation to warrant combining strength deficit and loss of range of motion in appellant's impairment rating. Dr. Moseman did not identify any unrelated etiologic or pathomechanical cause or explain why range of motion or other methods for rating impairment were inadequate. He did not explain why the use of Table 16-35 would be appropriate in this case, before employing loss of strength as a method for rating impairment. The Board finds that Dr. Moseman's impairment ratings are of reduced probative value because he did not properly rate impairment in accordance with the A.M.A., *Guides*.

Dr. Rickert rated five percent impairment of the right shoulder based on weakness, using Table 16-11 of the A.M.A., *Guides*.[17] The A.M.A., *Guides* indicates that loss of strength should only be rated in rare cases where the loss of strength represents an impairing factor that has not been considered adequately by other methods.[18] As noted, the impairment due to loss of strength may be combined with other impairments only if based on unrelated etiologic or pathomechanical causes and generally, decreased strength should not be rated in the presence of decreased motion that prevents effective application of maximal force in the evaluated region.[19] Dr. Rickert did not identify an unrelated etiologic or pathomechanical cause for appellant's muscle strength deficit or explain why range of motion and other methods for rating impairment were inadequate. The Board finds that Dr. Rickert's impairment ratings are of diminished probative value.

The Office medical adviser based his calculations on Dr. Rickert's measurements and properly applied the fifth edition of the A.M.A., *Guides*, Figures 16-40 and 16-43, on pages 476

[13] A.M.A., *Guides*, 510, Table 16-35.

[14] *Id*. at 507.

[15] *Id*. at 508.

[16] *Id*.

[17] *See id*. at 484, Table 16-11.

[18] *Id.* at 508.

[19] *Id.*

and 477.[20] As noted above, the medical adviser properly discounted Dr. Rickert's assessment of impairment due to weakness. With regard to appellant's left shoulder, the medical adviser noted that Dr. Rickert measured full range of motion, save for 160 degrees of flexion. Figure 16-40[21] establishes that upper extremity impairment based on 160 degrees of shoulder flexion is one percent.[22] As Dr. Rickert measured full range of motion based on extension, abduction and adduction, no additional impairment is present.[23] Therefore, appellant's left arm impairment due to loss of range of motion is one percent. The Board finds that the Office medical adviser properly calculated appellant's left shoulder impairment at one percent. With regard to appellant's right shoulder, the medical adviser noted that Dr. Rickert measured full range of motion save for 160 degrees of flexion and 160 degrees of abduction. As noted, Figure 16-40 establishes that upper extremity impairment based on 160 degrees of shoulder flexion is one percent.[24] Figure 16-43, located on page 477, measures upper extremity impairment based on abduction and adduction.[25] According to Figure 16-43, a measurement of 160 degrees of abduction represents one percent impairment of the upper extremity.[26] Dr. Rickert measured full range of motion with regard to extension and adduction. Accordingly, no additional impairment is present.[27] The Board finds that the Office medical adviser properly calculated appellant's right arm impairment at two percent; one percent for loss of flexion and one percent for loss of abduction.

CONCLUSION

The Board finds that appellant has not established greater than one percent impairment of the left upper extremity and two percent impairment of the right upper extremity.

[20] *Id*. at 476-477, Figures 16-40, 16-43.

[21] The Board notes that Dr. Rickert stated that he used Figure 16-43 to determine appellant's left shoulder impairment rating based on flexion. However, Figure 16-43 measures shoulder impairment based on abduction and adduction. Figure 16-40 measures shoulder impairment based on flexion and extension. Accordingly, the Board assumes that Dr. Rickert's statement that he calculated appellant's shoulder impairment based on flexion from Figure 16-43 is a typographical error.

[22] A.M.A., *Guides*, 476, Figure 16-40.

[23] *See id*. at 476-477, Figures 16-40, 16-43.

[24] *Id*. at 476, Figure 16-40.

[25] *Id*. at 477, Figure 16-43.

[26] *Id.*

[27] *See supra* note 15.

ORDER

IT IS HEREBY ORDERED THAT the September 26, 2006 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 11, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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