United States Department of Labor
Employees' Compensation Appeals Board

P.N., Appellant	)	
and	)	**Docket No. 09-1178**
	)	**Issued: February 17, 2010**
DEPARTMENT OF TRANSPORTATION, FEDERAL MOTOR CARRIER SAFETY ADMINISTRATION, Albany, NY, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 31, 2009 appellant filed a timely appeal from a January 15, 2009 merit decision of the Office of Workers' Compensation Programs denying an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award issue.

ISSUE

The issue is whether appellant has more than a 10 percent permanent impairment of the right upper extremity for which she received a schedule award.

FACTUAL HISTORY

On November 14, 2005 appellant, then a 49-year-old field office supervisor, sustained injury to her right shoulder, right arm and the right side of her neck in the performance of duty. The Office accepted the claim for neck sprain/strain and right shoulder sprain/strain. On May 4, 2006 Dr. Leonard E. Goldstock, a Board-certified orthopedic surgeon, performed an authorized

right shoulder arthroscopy with debridement of the undersurface of the rotator cuff and superior glenoid labrum tear and an acromioplasty with mini open full thickness rotator cuff repair.

In a report dated February 6, 2007, Dr. Goldstock found that appellant was doing "remarkably well" after her surgery with little to no pain and full functional range of motion. He related that she would be assessed for an impairment rating one year from her May 2006 surgery. Dr. Goldstock noted that he did not have experience rating impairments under federal law but that under the state law appellant had a 15 percent permanent shoulder impairment. He discharged her from care.

On July 23, 2007 appellant filed a claim for a schedule award. On January 25, 2008 an Office medical adviser discussed appellant's June 7, 2006 arthroscopic acromioplasty and rotator cuff repair.[1] He noted that the record contained no range of motion measurements subsequent to the surgery. The Office medical adviser determined that, under the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001) (A.M.A., *Guides*), appellant had a 10 percent right upper extremity impairment due to a distal clavicle resection arthroplasty.[2] He opined that she reached maximum medical improvement on June 7, 2007.

By decision dated March 11, 2008, the Office granted appellant a schedule award for a 10 percent impairment of the right upper extremity. The period of the award ran for 31.20 weeks from June 7, 2007 to January 11, 2008.

On September 10, 2008 appellant requested reconsideration. She advised that she sought medical treatment because she had continued pain, loss of strength and decreased range of motion in her right arm, shoulder and neck. Appellant related that when she traveled for her work she experienced difficulty carrying luggage and using her right arm.

On August 12, 2008 Dr. Goldstock recommended that appellant have an impairment evaluation. In an August 13, 2008 report, Dr. Robert Mantica, a Board-certified orthopedic surgeon, diagnosed a resolved aggravation of cervical spondylosis due to her November 2005 work injury and possible carpal tunnel syndrome unrelated to her employment injury. On examination of the right shoulder, he measured 160 degrees flexion, 35 degrees extension, 140 degrees abduction, 10 degrees adduction, 45 degrees passive internal rotation and 45 degrees external rotation. Dr. Mantica stated:

> "With regard to her right shoulder, there is muscle atrophy noted in the deltoid. There is also a loss of range of motion and there is pain on extremes of range of motion. For this decreased range of motion, pain and muscular atrophy, the patient has a mild permanent impairment."

[1] The Office medical adviser initially provided a report on November 10, 2007, however, in that report, he reviewed the record and made findings relevant to another claimant.

[2] A.M.A., *Guides* at 506, Table 16-27.

He concluded that appellant had a 12 percent impairment to her right upper extremity due to her November 14, 2005 work injury.

In a report dated October 13, 2008, Dr. Goldstock asserted that a rotator cuff tear constituted a 15 percent impairment under the guidelines of workers' compensation.[3] He found an additional 15 percent impairment for loss of internal rotation, or a total right shoulder impairment of 30 percent.

On December 23, 2008 an Office medical adviser reviewed the medical record. He disagreed with Dr. Goldstock's impairment rating, noting that under the A.M.A., *Guides* a rotator cuff tear was not ratable and the maximum impairment for a loss of internal rotation was five percent. The Office medical adviser concluded that Dr. Goldstock's report did not support an additional impairment.

On January 13, 2009 another Office medical adviser reviewed Dr. Mantica's opinion. He noted that Dr. Mantica did not reference the A.M.A., *Guides* in finding a 12 percent upper extremity impairment. The Office medical adviser found that, under the A.M.A., *Guides*, flexion of 160 degrees constituted a one percent impairment[4] extension of 35 degrees constituted a one percent impairment,[5] adduction of 10 degrees constituted a one percent impairment,[6] abduction of 140 degrees constituted a two percent impairment[7] and external rotation of 45 degrees constituted a one percent impairment,[8] or a total impairment due to loss of range of motion of six percent. He did not determine appellant's impairment due to loss of internal rotation as Dr. Mantica used passive range of motion for internal rotation. The Office medical adviser recommended that the Office obtain clarification from Dr. Mantica regarding why he used passive rather than active range of motion for internal rotation.

By decision dated January 15, 2009, the Office denied modification of its March 11, 2008 decision. It noted that the Office medical adviser found that she had a 6 percent impairment of the right upper extremity and that she had already received a schedule award for a 10 percent impairment.

[3] On September 5, 2008 appellant filed a claim for an increased schedule award. On September 24, 2008 the Office requested that Dr. Goldstock provide an impairment evaluation in accordance with the fifth edition of the A.M.A., *Guides*. The Office enclosed forms from the A.M.A., *Guides* for completion. By letter dated September 24, 2008, appellant again requested reconsideration. On September 30, 2008 the Office found that it should not have issued its September 24, 2008 letter as appellant was requesting reconsideration of its prior decision rather than an increased schedule award.

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

[5] *Id*.

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

[7] *Id*.

[8] *Id*. at 479, Figure 16-46.

On appeal appellant contends that she has more than a 10 percent right upper extremity impairment based on the opinions of Drs. Goldstock and Mantica. She described her difficulties performing activities of daily living due to right arm pain and requested that the Office send her for an impairment evaluation.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[9] and its implementing federal regulations,[10] 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 for all claimants, the Office has adopted the A.M.A, *Guides* as the uniform standard applicable to all claimants.[11] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[12]

ANALYSIS

The Office accepted that appellant sustained neck and right shoulder strains/sprains due to a November 14, 2005 employment injury. Appellant underwent an authorized acromioplasty and full thickness rotator cuff repair. On July 23, 2007 she filed a claim for a schedule award.

In a report dated February 6, 2007, Dr. Goldstock opined that appellant had a 15 percent permanent impairment of the right shoulder. He did not, however, reference the appropriate tables and pages of the A.M.A., *Guides* in reaching his conclusion. Thus, his report is of diminished probative value.[13]

On January 25, 2008 an Office medical adviser reviewed Dr. Goldstock's February 6, 2007 report. Citing Table 16-27 on pages 506 of the A.M.A., *Guides*, he found that appellant had a 10 percent impairment of the right upper extremity due to her distal clavicle resection arthroplasty. Based on the Office medical adviser's January 25, 2008 report, the Office granted her a schedule award for a 10 percent right upper extremity impairment.

In a report dated August 13, 2008, Dr. Mantica measured range of motion of the right shoulder of 160 degrees flexion, 35 degrees extension, 140 degrees abduction, 10 degrees adduction, 45 degrees internal rotation and 45 degrees external rotation. He concluded, without any reference to the A.M.A., *Guides*, that appellant had a 12 percent permanent impairment of

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] *Id*. at § 10.404(a).

[12] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003). As of May 1, 2009, the sixth edition will be used. FECA Bulletin No. 09-03 (issued March 15, 2008).

[13] *See I.F.*, 60 ECAB ___ (Docket No. 08-2321, issued May 21, 2009).

the right upper extremity. As Dr. Mantica did not explain the protocols used in making the impairment determination, his opinion is insufficient to establish permanent impairment.[14]

On October 13, 2008 Dr. Goldstock found that appellant had a 15 percent impairment due to her rotator cuff tear and a 15 percent impairment due to loss of range of motion for internal rotation. He did not, however, refer to specific tables and pages of the A.M.A., *Guides* in reaching his conclusion. Dr. Goldstock's report does not conform to the A.M.A., *Guides*; thus, it is of diminished probative value.[15]

On January 13, 2009 an Office medical adviser reviewed Dr. Mantica's opinion. He determined that 160 degrees of flexion yielded a one percent impairment,[16] 35 degrees of extension yielded a one percent impairment,[17] 10 degrees adduction yielded a one percent impairment,[18] 140 degrees abduction yielded a two percent impairment,[19] and 45 degrees external rotation yielded a one percent impairment.[20] The Office medical adviser added the impairment findings and concluded that appellant had a six percent impairment due to loss of range of motion. He did not include any impairment due to loss of internal rotation in his calculations as Dr. Mantica measured passive rather than active range of motion. The Office medical adviser recommended that the Office obtain clarification from Dr. Mantica regarding his internal rotation measurement.

Based on the Office medical adviser's report, the Office found that appellant had no more than the 10 percent permanent impairment of the right upper extremity previously awarded for her resection arthroscopy. However, under the A.M.A., *Guides*, an impairment due to a resection arthroscopy and an impairment due to loss of range of motion are combined using the Combined Values Chart.[21] Consequently, appellant's right upper extremity impairment under the A.M.A., *Guides* may include her impairment due to loss of range of motion and the impairment from her resection arthroscopy. Moreover, the Office did not, as recommended by the Office medical adviser, obtain clarification from Dr. Mantica regarding his internal rotation measurements. The case will be remanded to the Office for a supplemental report from Dr. Mantica explaining his internal rotation measurement and a redetermination of the extent of

[14] *See Carl J. Cleary*, 57 ECAB 563 (2006) (an opinion which is not based upon the standards adopted by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of permanent impairment).

[15] *Mary L. Henninger*, 52 ECAB 408 (2001).

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

[17] *Id*.

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

[19] *Id*.

[20] *Id*. at 479, Figure 16-46.

[21] *Id*. at 505. The Combined Values Chart is designed to account for the effects of multiple impairments with a summary value.

appellant's permanent impairment. Following this and any further development as deemed necessary, the Office should issue a *de novo* decision.

On appeal appellant describes the effect her right arm pain has on her activities of daily living. Factors such as employability or limitations on daily activities, however, have no bearing on the rating of impairment under a schedule award.[22]

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 15, 2009 is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: February 17, 2010
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[22] *Kimberly M. Held*, 56 ECAB 670 (2005).