United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	**Docket No. 09-1323**
	)	**Issued: February 3, 2010**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, Linthicum, MD, Employer	)	

Appearances:
Appellant, pro se[1]
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 April 24, 2009 appellant filed a timely appeal from the December 4, 2008 merit decision of the Office of Workers' Compensation Programs, which denied an increased schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant has more than a 14 percent impairment of his left upper extremity.

[1] No individual may appear as a Representative in a proceeding before the Board without first filing with the Clerk a written authorization signed by appellant to be represented. 20 C.F.R. § 501.9(3)(b). The attorney who submitted appellant's appeal request form did not attach an authorization of representation. On April 29, 2009 the Clerk of the Board allowed the attorney 30 days to file an authorization, but the attorney simply resubmitted the appeal request form. Because this attorney has failed to file with the Clerk the authorization of representation required by the Board's *Rules of Procedure*, the Board may not recognize him as representing appellant. An appeal request form signed by appellant having been filed, however, the appeal may move forward in a *pro se* status.

FACTUAL HISTORY

On November 6, 2005 appellant, then a 35-year-old transportation security screener, sustained an injury in the performance of duty when he helped unload a cart and lifted a bag to place on the rollers. The Office accepted his claim for "left, sprain and strain of other specified sites of shoulder and upper arm." Diagnosed with a left shoulder subacromial impingement, rule out rotator cuff tear and degenerative acromioclavicular joint, appellant underwent a mini open partial acromioplasty, rotator cuff tear repair and distal clavicle resection on August 15, 2006. He returned to work as a program assistant on November 12, 2006 and was released from medical care on November 27, 2006.

On February 7, 2007 Dr. Sheldon D. Milner, a Board-certified internist, related appellant's history and complaints. He described findings on physical examination of the left shoulder, including 70 degrees flexion, 45 degrees extension, 90 degrees abduction, 30 degrees adduction and 80 degrees internal and external rotation. Manual muscle testing revealed 2/5 strength compared to the right. Dr. Milner concluded that appellant had a 60 percent impairment of the left shoulder.

On August 22, 2007 appellant filed a claim for a schedule award. To clarify the extent of the injury-related impairment, the Office referred him, together with the medical file and a statement of accepted facts, to Dr. Robert A. Smith, a Board-certified orthopedic surgeon.

On October 12, 2007 Dr. Smith related appellant's history and complaints. On physical examination, he measured 110 degrees flexion, 35 degrees extension, 110 degrees abduction, 40 degrees adduction and 60 degrees internal and external rotation. Manual muscle testing revealed weakness in the shoulder that appeared to be related to pain rather than frank muscle weakness, as there was no atrophy. Neurologic examination of the left upper extremity was normal. Dr. Smith determined that appellant had an 11 percent impairment of the left upper extremity due to loss of motion. He found it reasonable to add an additional three percent for complaints of chronic pain and crepitation.

On November 13, 2007 an Office medical adviser rejected Dr. Milner's estimate because he used the wrong guidelines and did not explain how he arrived at his rating. He confirmed that Dr. Smith's measurements showed an 11 percent impairment of the left upper extremity due to loss of shoulder motion. The medical adviser allowed an additional three percent for pain.

On January 17, 2008 the Office issued a schedule award for a 14 percent impairment of appellant's left upper extremity.

Appellant submitted an April 30, 2008 evaluation from Dr. Kenneth R. Lippman, a Board-certified orthopedic surgeon, who related appellant's history and complaints. On physical examination, Dr. Lippman noted some mild loss of bulk in the supraspinatus and infraspinatus region posteriorly. He found 90 degrees flexion with significant pain, 20 degrees extension with less pain, 80 degrees abduction with significant pain and 10 degrees adduction. It was difficult to place the arm in 90 degrees abduction to test external and internal rotation. With complex internal rotation maneuvers, appellant could reach L3 on the left compared to T8 on the right. With complex external rotation maneuvers, he could reach the lateral margin of the occiput on

the left compared to T2 on the rights. Strength testing showed breakaway weakness and associated pain complaints, which he graded at 1/2 weakness of forward flexion and external rotation. Motor testing was clouded by pain, interfering with a full objective examination. Dr. Smith calculated that appellant had a 17.5 percent impairment of the left upper extremity due to loss of shoulder motion. He found a 15 percent impairment due to loss of motor function in the suprascapular and axillary nerve distributions. Dr. Smith combined these figures for a total impairment of 29.5 percent.

On October 30, 2008 the Office medical adviser reviewed Dr. Lippman's evaluation. He noted there was no evidence in Dr. Smith's or Dr. Lippman's examination of any loss of sensation or motor strength as a result of suprascapular nerve impairment. The medical adviser rejected Dr. Lippman's rating of 15 percent based on suprascapular nerve injury. He added: "The motion impairment calculation that I used was based upon multiple prior examinations and I believe that the weight of the medical evidence has been previously presented by multiple other physicians in regard to range of motion." The Office medical adviser therefore found no basis to change appellant's previous rating of 14 percent.

In a decision dated December 4, 2008, the Office denied an increased schedule award.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[2] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

As with any biological measurements, some variability and normal fluctuations are inherent in permanent impairment ratings. Two measurements made by the same examiner using the A.M.A., *Guides* that involve an individual or an individual's functions would be consistent if they fall within 10 percent of each other. Measurements should also be consistent between two trained observers or by one observer on two separate occasions, assuming the individual's condition is stable.[4]

ANALYSIS

The Office issued a schedule award for a 14 percent impairment of appellant's left upper extremity based on the October 12, 2007 evaluation by Dr. Smith, an orthopedic surgeon and Office referral physician, whose goniometric findings supported an 11 percent impairment due to loss of shoulder motion. Flexion of 110 degrees is a five percent impairment and extension of 35

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] A.M.A., *Guides* 20 (5th ed. 2001).

is a one percent impairment.[5] Abduction of 110 degrees is a three percent impairment and adduction of 40 degrees is no impairment.[6] Internal rotation of 60 degrees is a two percent impairment and external rotation of 60 degrees is no impairment.[7]

Following Dr. Smith's evaluation, Dr. Lippman, an orthopedic surgeon, reported a 14 percent impairment of the left upper extremity due to loss of shoulder motion. Flexion of 90 degrees is a six percent impairment and extension of 20 is a two percent impairment. Abduction of 80 degrees is a five percent impairment and adduction of 10 degrees is a one percent impairment.[8] The Office medical adviser believed that the weight of the medical evidence was previously presented by multiple other physicians in regard to range of motion, but he did not adequately explain this observation. He gave no rationale for discounting Dr. Lippman's clinical findings on range of motion, which were the most recent clinical findings in the record and which showed greater impairment of the left upper extremity.

The Board finds that further development is warranted. The Board will set aside the Office's December 4, 2008 decision denying an increased schedule award and remand the case for clarification from an Office medical adviser, who shall review the range of motion findings reported by Dr. Milner, Dr. Smith and Dr. Lippman and address whether the measurements are reasonably consistent, whether appellant's shoulder condition is stable or whether a appellant has impairment for the excision of his distal clavicle on August 15, 2006. In the presence of decreased motion, motion impairments are derived separately and may be combined with arthroplasty impairment.[9] Table 16-27, page 506 of the A.M.A., *Guides* states that a resection arthroplasty of the distal clavicle is a 10 percent impairment of the upper extremity.

Dr. Smith found it reasonable to add an additional three percent for complaints of chronic pain and crepitation and the Office awarded such. However, the pie charts for impairment due to lack of shoulder motion and the table for impairment due to arthroplasty already account for any accompanying pain.[10] Chapter 18, which pertains to pain-related impairment, should not be redundant of or inconsistent with principles of impairment rating described in other chapters. If an examining physician determines that an individual has pain-related impairment, he or she will have the additional task of deciding whether or not that impairment has already been adequately

[5] *Id*. at 476 (Table 16-40).

[6] *Id*. at 477 (Table 16-43).

[7] *Id*. at 479 (Table 16-46). Because the relative upper extremity value of each shoulder functional unit has been taken into consideration in the impairment pie charts, the impairment values contributed by each unit of motion are added to determine the impairment of the upper extremity due to abnormal shoulder motion. *Id*. at 479.

[8] *Id*. at 477 (Table 16-43). Because of difficulty-placing appellant's arm in 90 degrees abduction to test external and internal rotation, Dr. Lippman's clinical findings do not properly support an impairment rating for those shoulder functions under Figure 16-46, page 479 of the A.M.A., *Guides*.

[9] *Id*. at 505

[10] *Id*. at 20 (the impairment ratings in the body organ system chapters make allowance for any accompanying pain).

incorporated into the rating the person has received on the basis of other chapters of the A.M.A., *Guides*.[11]

Neither Dr. Smith nor the Office medical adviser explained why the impairment ratings for shoulder motion (or the impairment rating for arthroplasty) do not adequately encompass appellant's pain.[12] In the absence of rationale, no rating for pain-related impairment is supported.

Dr. Milner offered an impairment rating of 60 percent, but he did not refer to the fifth edition of the A.M.A., *Guides* and did not explain how he calculated this rating.[13] Dr. Lippman offered a 15 percent rating for loss of motor function in the suprascapular and axillary nerve distributions, but he did not explain how this was consistent with appellant's "breakaway" weakness on examination or Dr. Smith's observation that weakness in the shoulder appeared to be related to pain rather than frank muscle weakness. He also did not show how he applied Table 16-15, page 492 and Table 16-11, page 484, to arrive at his rating of 15 percent. For these reasons, the Board finds that the Office properly discounted these ratings.

After obtaining clarification from an Office medical adviser and after such further development of the evidence as may be necessary, the Office shall issue an appropriate final decision on appellant's entitlement to an increased schedule award.

CONCLUSION

The Board finds that this case is not in posture for decision. Further, development is warranted.

[11] *Id*. at 570.

[12] The A.M.A., *Guides* notes that crepitation is an inconsistent finding that depends on such factors as forces on joint surfaces and synovial fluid viscosity. *Id*. at 544 (arthritis impairments in the lower extremities).

[13] Manual muscle testing is subject to an individual's conscious or unconscious control and individuals whose performance is inhibited by pain or fear of pain may not be good candidates for this testing. *Id*. at 509.

ORDER

IT IS HEREBY ORDERED THAT the December 4, 2008 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: February 3, 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