United States Department of Labor
Employees' Compensation Appeals Board

PATRICIA J. PENNEY-GUZMAN, Appellant **and** **DEPARTMENT OF HEALTH & HUMAN SERVICES, SOCIAL SECURITY ADMINISTRATION, San Bernardino, CA, Employer**	)	**Docket No. 04-1052** **Issued: September 30, 2004**

Appearances:
Patricia J. Penney-Guzman, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
WILLIE T.C. THOMAS, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On March 12, 2004 appellant filed a timely appeal from the February 26, 2004 nonmerit decision of the Office of Workers' Compensation Programs, which denied a reconsideration of her claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review this decision. The Board also has jurisdiction to review the Office's April 8 and July 22, 2003 merit decisions on appellant's entitlement to a schedule award.[1]

ISSUES

The issues are: (1) whether appellant has more than a seven percent impairment of her right upper extremity due to the accepted work injury of June 13, 2001; and (2) whether the Office properly denied reopening appellant's case for a review of the merits of her claim.

[1] Appellant does not appeal the Office's May 12, 2003 decision denying her claim that she sustained a recurrence of disability on or about September 3, 2002 as a result of her accepted employment injury. Thus, the Board has not addressed it on this appeal.

FACTUAL HISTORY

On or about June 13, 2001, appellant, then a 47-year-old senior technician, sustained an injury to her right arm as a result of pulling drawers and lifting files at work. The Office accepted her claim for right shoulder tendinitis and lateral epicondylitis of the right elbow.[2] On July 25, 2002 appellant filed a claim for a schedule award.

The Office referred appellant, together with a statement of accepted facts, to Dr. Laurence Meltzer, a Board-certified orthopedic surgeon, for an evaluation of permanent impairment. In a report dated November 29, 2002, Dr. Meltzer reviewed the statement of accepted facts, related appellant's history and described his findings on physical examination, which he conducted on November 26, 2002. He evaluated appellant's right shoulder and elbow conditions as follows:

> "Regarding this patient's shoulder, I do not find any pathology at this time. She has normal range of motion. She has no tenderness, and all the tests of her shoulder are negative.
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> "Regarding the patient's right elbow, I feel the symptoms are very minimal. She does have some discomfort with gripping and I feel this could easily be treated with one, possibly two or three, injections. [Eighty] percent of patients who have epicondylitis, particularly this mild, should recover eventually with injections. It would be suggested that she wear a tennis elbow band while working, however."

On November 27, 2002 Dr. Meltzer completed evaluation forms provided by the Office. With respect to the right shoulder, he indicated that appellant had no symptoms of pain or discomfort and had no atrophy or weakness. All measured ranges of motion matched the indicated normal values. Asked for the date of maximum medical improvement, he wrote: "See report -- No findings on this exam[ination]." With respect to the right elbow, Dr. Meltzer indicated that appellant had mild elbow pain that interfered minimally with lifting. There was no atrophy or weakness, and all measured ranges of motion matched the indicated normal values. Asked for the date of maximum medical improvement, he wrote: "Still has slight discomfort."

On March 5, 2003 an orthopedic consultant to the Office, Dr. Arthur S. Harris, reviewed Dr. Meltzer's findings and reported that appellant had a four percent permanent impairment of the right upper extremity due to loss of shoulder extension and shoulder pain that interfered with some activity. He also reported that appellant had a three percent permanent impairment of the right upper extremity due to elbow pain that interfered with some activity. Dr. Harris concluded that appellant had a seven percent total permanent impairment of the right upper extremity as a result of the accepted work injury of June 13, 2001. He stated that the date of maximum medical

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[2] In a separate claim, File No. 13-1163260, the Office accepted an aggravation of osteoarthritis in the metacarpophalangeal joint of the right thumb and authorized surgery. Appellant received compensation for this injury, including a schedule award for a 17 percent permanent impairment of her right arm due to the accepted thumb condition. The current appeal under File No. 13-2031790 relates to different joints and a different schedule award.

improvement was November 26, 2002, "when the claimant was seen for evaluation by Dr. Meltzer."

On April 8, 2003 the Office issued a schedule award for a seven percent permanent impairment of the right upper extremity. In a decision dated July 22, 2003, an Office hearing representative reviewed the written record and affirmed the April 8, 2003 schedule award.

On December 2, 2003 appellant requested reconsideration based upon the fact that pinch strength measurements were not considered. In support thereof she submitted an August 8, 2003 medical report from Dr. Charles S. Lane, a Board-certified orthopedic surgeon specializing in surgery of the hand and upper extremity. Dr. Lane evaluated appellant's right thumb and noted the "separate work-related injury to her right elbow, which occurred in 2001."

In a decision dated February 26, 2004, the Office denied reconsideration. The Office found that appellant's right thumb or hand condition, and the medical evidence she submitted pertaining thereto, were misdirected and irrelevant to the April 8 and July 22, 2003 decisions relating to the accepted work injury of June 13, 2001.

LEGAL PRECEDENT -- ISSUE 1

Section 8107 of the Federal Employees' Compensation Act[3] 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*.[4]

ANALYSIS -- ISSUE 1

On his November 27, 2002 evaluation form and in his November 29, 2002 narrative report, Dr. Meltzer indicated that appellant's right shoulder had normal range of motion, no pain, no discomfort, no atrophy and no weakness. Yet, when Dr. Harris reviewed Dr. Meltzer's findings, he determined that appellant had a four percent impairment of the right upper extremity due to loss of motion and shoulder pain. The Board has carefully reviewed this apparent discrepancy and finds that clarification is required on several points.

First, in his narrative report on November 29, 2002, Dr. Meltzer noted clinical findings with respect to five ranges of shoulder motion: (1) abduction (180/180 degrees); (2) flexion (180/180 degrees); (3) external rotation (90/90 degrees); (4) internal rotation (90/90 degrees); and (5) extension (30/30 degrees). This is one range of motion short of the clinical findings required to evaluate shoulder impairment properly under the A.M.A., *Guides*. Dr. Meltzer did not report a range of motion for adduction in his narrative report, and Dr. Harris, who based his rating on the clinical findings contained in that report, made no mention of the omission. It

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[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (2003). Effective February 1, 2001 the Office began using the A.M.A., *Guides* (5th ed. 2001).

appears, therefore, that the Office issued its April 8, 2003 schedule award without a sufficiently described clinical picture of appellant's right shoulder condition.[5]

Second, in his November 29, 2002 narrative report, Dr. Meltzer reported that range of motion for shoulder extension was 30 degrees out of a possible 30 degrees. According to the A.M.A., *Guides*, however, normal extension is to 50 degrees.[6] So, although it is clear that Dr. Meltzer meant to convey full or normal extension, Dr. Harris took his narrative report to mean a 20 degree loss of motion, even though Dr. Meltzer reported extension to a normal 50 degrees on the Office's evaluation form. Adding to the confusion is the evaluation form itself. The normal values appearing on that form do not all correspond to the normal values given by the A.M.A., *Guides*. Normal range of motion for abduction is 180 degrees, according to the A.M.A., *Guides*,[7] but is 170 degrees according to the Office's evaluation form. Normal range of motion for adduction is 50 degrees, according to the A.M.A., *Guides*,[8] but is 40 degrees according to the form. Normal range of motion for internal rotation is 90 degrees, according to the A.M.A., *Guides*,[9] but is 80 degrees according to the form. When Dr. Meltzer indicated on the form that all ranges of motion were normal, the measurements he recorded for abduction, adduction and internal rotation all fell short of the normal values given by the A.M.A., *Guides* and therefore might be used to calculate an impairment of the right shoulder where Dr. Meltzer found none. The Office must seek clarification from Dr. Meltzer of all the relevant goniometric findings he obtained on November 26, 2002.

Third, on November 29, 2002 Dr. Meltzer diagnosed complaint of rotator cuff tendinitis, right shoulder, "not demonstrable on this examination." He found no pathology, normal range of motion, no tenderness and negative results on all shoulder tests. He reported: "I feel her shoulder, again, has recovered." On the November 27, 2002 evaluation form, he indicated that appellant had no symptoms of shoulder pain or discomfort. Nonetheless, Dr. Harris determined that appellant had a three percent permanent impairment of the right upper extremity due to shoulder pain that interfered with some activity. It appears that Dr. Harris based this rating solely on appellant's complaint of pain and not on the clinical findings obtained on physical examination of the joint. Dr. Harris followed the grading scheme and procedure set forth in Table 16-10 of the A.M.A., *Guides* for determining impairment of the upper extremity due to sensory deficit or pain resulting from peripheral nerve disorders.[10] He identified the involved

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[5] In obtaining medical evidence required for a schedule award, the evaluation must include a "detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment." Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Cases*, Chapter 2.808.6.c (March 1995). This description must be sufficiently detailed so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations. *Renee M. Straubinger*, 51 ECAB 667, 669 (2000).

[6] A.M.A., *Guides* 475.

[7] *Id*. at 476.

[8] *Id.*

[9] *Id*. at 478.

[10] *Id*. at 482, Table 16-10.

nerve as the axillary nerve/deltoid muscle, with a maximum impairment value of 5 percent for sensory deficit or pain. He graded appellant's pain as Grade 3, "Distorted superficial tactile sensibility (diminished light touch and two-point discrimination), with some abnormal sensations or slight pain, that interferes with some activities." Dr. Harris then multiplied the 5 percent maximum impairment value of the axillary nerve by the maximum sensory deficit under Grade 3, 60 percent, and arrived at an impairment rating of 3 percent for pain that interfered with function. The A.M.A., *Guides* warn:

> "Table 16-10 provides a classification for determining impairment of the upper extremity due to a sensory deficit or pain resulting from a nerve disorder. This table is to be used for pain that is due to *nerve injury* or disease that has been documented with objective physical findings or electrodiagnostic abnormalities. *It is not to be used for pain in the distribution of a nerve that has not been injured* except in diagnosed cases of complex regional pain syndromes."[11] (Emphasis in the original.)

Because Dr. Meltzer reported no objective findings to document nerve injury or disease, because he did not report distorted superficial tactile sensibility or diminished light touch and two-point discrimination, because he did not report electrodiagnostic abnormalities or diagnose a complex regional pain syndrome, it does not appear that Dr. Harris based his impairment rating for shoulder pain on a proper application of the A.M.A., *Guides*.

In addition to these points, clarification is required with respect to the right elbow. Dr. Harris reported that the date of maximum medical improvement was November 26, 2002, noting only that this was "when the claimant was seen for evaluation by Dr. Meltzer." But Dr. Meltzer emphasized that appellant's right elbow symptoms were very minimal and could easily be treated with one, possibly two or three, injections. He explained that 80 percent of patients who have epicondylitis, particularly such mild epicondylitis, should recover eventually with injections. As there is no indication that appellant refuses ever to have such treatment, a substantial question is presented whether she has reached maximum medical improvement (MMI) from her accepted right elbow condition.

The A.M.A., *Guides* explains that an impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized:

> "It is understood that an individual's condition is dynamic. Maximal medical improvement refers to a date from which further recovery or deterioration is not anticipated, although over time there may be some expected change. Once an impairment has reached MMI, a permanent impairment rating may be performed."[12]

Dr. Meltzer examined appellant on November 26, 2002 but gave no date for maximum medical improvement regarding appellant's right elbow. Instead, he reported that she would be

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[11] *Id*. at 482.

[12] *Id*. at 19.

expected not only to improve but to recover with treatment. This is inconsistent with Dr. Harris' report, which presumes that recovery is not anticipated and that appellant's right elbow condition is unlikely to change substantially in the next year even with treatment.[13] The Office should seek clarification from Dr. Meltzer regarding the issue of maximum medical improvement.

CONCLUSION

The Board finds that this case is not in posture for decision. The Board will remand the case for further development of the medical evidence and an appropriate final decision on appellant's entitlement to a schedule award for her accepted employment injury on June 13, 2001.[14]

ORDER

IT IS HEREBY ORDERED THAT the July 22 and April 8, 2003 decisions of the Office of Workers' Compensation Programs are set aside. The case is remanded for further action consistent with this opinion.

Issued: September 30, 2004
Washington, DC

Colleen Duffy Kiko
Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

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[13] *See id*. at 601 (Defining "maximal medical improvement" as follows: "A condition or state that is well stabilized and unlikely to change substantially in the next year, with or without medical treatment. Over time, there may be some change; however, further recovery or deterioration is not anticipated.")

[14] Because the Board is remanding this case for further development and a merit review of the schedule award issue, the second issue in this case, whether the Office properly denied reconsideration of the merits of appellant's claim, is moot.