

work on August 5, 1997. The Office accepted appellant's claim for work-related internal derangement of the left shoulder with rotator cuff repair on August 26, 1997.¹

The record reflects that appellant was treated by Dr. James Schippa, an orthopedic surgeon, who also performed a right shoulder rotator cuff repair and resection of the distal clavicle on August 29, 1997 and prescribed physical therapy.

Appellant returned to full-time light duty on January 26, 1998.

On February 18, 1998 the Office referred appellant to Dr. Ronald L. Silver, a Board-certified orthopedic surgeon for a second opinion examination. In a February 25, 1998 report, Dr. Silver noted appellant's history of injury and treatment which included a distal clavicle resection and a single metallic anchor in her acromion where her deltoid was repaired. He noted a severe rotator cuff impingement and adhesive capsulitis, which were causally related to her employment injury on July 29, 1997. Dr. Silver advised arthroscopic subacromial decompression to decompress the shoulder with manipulation under anesthesia followed by the use of a home continuous passive motion machine and aggressive physical therapy. Appellant subsequently contacted the Office and indicated that she would like Dr. Silver to perform the surgery and become her treating physician.

The Office authorized the arthroscopic surgery which Dr. Silver performed on March 23, 1998. Appellant returned to limited duty on May 15, 1998 and was released to full duty on August 3, 1998. However, prior to her release, appellant stopped work on July 10, 1998 due to a psychological condition, which she alleged resulted from the addictive pain medication.

In a July 29, 1998 report, Dr. Silver discharged appellant with regard to her left shoulder and advised that she could begin normal work activities on August 3, 1998.

In an August 9, 2000 report, Dr. Silver provided range of motion measurements for appellant. He advised that, regarding her range of motion, it was full with the exception of overhead motion at 150 degrees of forward flexion and lateral abduction. Dr. Silver provided lifting restrictions of 10 pounds or less, and no lifting above the shoulder. In a February 28, 2001 report, Dr. Silver advised that her range of motion for appellant's left shoulder was limited to 140 to 150 degrees of forward flexion and 130 degrees of lateral abduction. He advised that her internal rotation was to the belt line, and that she had a slightly positive impingement sign and negative drop arm test. Dr. Silver opined that appellant was at maximum medical improvement and placed appellant on permanent restrictions with no work above the left shoulder level. He opined that appellant had a 10 percent permanent impairment of the left arm and could return to work on April 16, 2001.

On April 17, 2001 appellant filed a schedule award claim.

In a November 26, 2001 report, the Office medical adviser reviewed appellant's history of injury and treatment, which included treatment for a right shoulder rotator cuff repair and

¹ Appellant resigned effective December 1999.

resection of the distal clavicle on August 29, 1997 and indicated that appellant developed postoperative arthrofibrosis, which necessitated a subacromial decompression and manipulation under anesthesia, on March 23, 1998. He determined that appellant was entitled to an award of 10 percent for her distal clavicle resection pursuant to Table 16-27.² The Office medical adviser noted that appellant had continued intermittent discomfort in the left shoulder, especially with overhead activity and allowed a two percent permanent impairment for Grade 3 pain in the distribution of the subscapular nerve according to Table 16-15 and Table 16-10.³ Regarding range of motion, the Office medical adviser indicated it was limited, with abduction of 130 degrees for 2 percent pursuant to Figure 16-43,⁴ 40 degrees of internal rotation for 3 percent pursuant to Figure 16-46,⁵ and flexion of 150 degrees for 2 percent pursuant to Figure 16-40.⁶ The Office medical adviser utilized the Combined Values Chart⁷ and determined that appellant was entitled to an impairment of 18 percent of the left upper extremity.

Accordingly, on January 8, 2002, the Office granted appellant a schedule award for an 18 percent permanent impairment of the left upper extremity. The award covered a period of 56.16 weeks from March 23, 1999 to April 19, 2000.

In a September 17, 2003 report, Dr. Silver opined that appellant's shoulder condition had deteriorated. He indicated that she had 90 degrees of flexion and 60 degrees of lateral abduction, and internal rotation was at the belt line, with significant weakness and that appellant had reached maximum medical improvement and was permanently disabled. In an October 23, 2003 report, Dr. Silver advised that appellant's pain was so severe in her shoulder that with such limited motion and weakness, she would be unable to do any type of work.

On September 24, 2003 appellant requested an additional schedule award.

The Office developed appellant's claim⁸ and by decision dated September 30, 2003, expanded appellant's claim to include depression, during the period of withdrawal of medication as a result of the work-related physical condition, which ceased on February 1, 2000.⁹

² The American Medical Association, *Guides to the Evaluation of Permanent Impairment* at 506, Table 16-27.

³ *Id.* at 492, Table 16-15, 482, Table 16-10.

⁴ *Id.* at 477, Figure 16-43.

⁵ *Id.* at 479, Figure 16-46.

⁶ *Id.* at 477, Figure 16-40.

⁷ *Id.* at 604.

⁸ This included development regarding an emotional component to appellant's condition. As part of this development, appellant appealed a November 16, 2001 decision. In a March 28, 2003 order, the Board granted the Director's motion to remand for further development regarding disability and the emotional component of appellant's claim. Docket No. 02-422 (issued March 28, 2003).

⁹ The Office modified a prior decision dated May 21, 2001 to reflect that the case was accepted for depression ceasing on February 1, 2000.

Dr. Silver's report and the case record were referred to the Office medical adviser, who in a report dated December 15, 2003, utilized the fifth edition of the A.M.A., *Guides*. The Office medical adviser indicated that appellant was previously awarded a permanent impairment of 18 percent to the left upper extremity. He noted that her condition had deteriorated requiring revision surgery, including a revision anterior acromioplasty on October 21, 2002 and a debridement of a "partial thickness bursal sided rotator cuff tear." The Office medical adviser reviewed the updated reports from Dr. Silver and a functional capacity evaluation and opined that appellant's range of motion had decreased since his last report. He indicated that, for flexion, appellant had 90 degrees which pursuant to Figure 16-40¹⁰ was equal to an impairment of 6 percent. The Office medical adviser advised that abduction of 60 degrees was equal to an impairment of 6 percent pursuant to Figure 16-43.¹¹ He also determined that internal rotation of 30 degrees was equal to an impairment of 4 percent.¹² The Office medical adviser determined that these three measurements when combined, were equal to 16 percent. He combined the 10 percent for the distal clavicle resection, and the 2 percent for pain, with the 16 percent for motion, and utilizing the Combined Values Chart on page 604,¹³ determined that the new impairment was 26 percent to the left upper extremity with maximum medical improvement on September 17, 2003.

Accordingly, on January 22, 2004, the Office granted appellant a schedule award for an additional eight percent permanent impairment of the left upper extremity. The award covered a period of 24.96 weeks from September 17, 2003 to January 24, 2004.

On January 22, 2004 the Office requested clarification regarding whether the 26 percent award was in addition to or a total percentage of her previous awards. In a January 26, 2004 clarification, the Office medical adviser repeated his calculations and advised that appellant was entitled to a total (not additional) left upper extremity impairment of 26 percent.

By letter dated March 17, 2004, appellant requested reconsideration.

In a March 10, 2004 report, Dr. Silver advised that appellant's shoulder had worsened and that she was disabled with regard to her arm. He indicated that appellant was permanently disabled and that the percentage provided by the Office was too low as appellant could not use her arm above her shoulder level for any activity and that use of the arm below the shoulder level was quite difficult for her because of severe weakness and pain. Dr. Silver opined that the arm could not be used for any productive work activity. He also indicated that additional surgery might be able to improve appellant's condition.

In a letter dated April 22, 2004, appellant requested that the Office authorize a consultation with Dr. Tyson Cobb, a Board-certified orthopedic surgeon, for an assessment of permanent impairment as Dr. Silver was not able to provide a rating.

¹⁰ A.M.A., *Guides* at 476, Figure 16-40.

¹¹ *Id.* at 477, Figure 16-43.

¹² *Id.* at 479, Figure 16-46.

¹³ *Id.* at 604.

By letter dated April 26, 2004, the Office advised appellant that a one time consultation was being authorized with Dr. Cobb.

In a June 9, 2004 report, Dr. Cobb noted the history of the employment injury that required surgical decompression, a subsequent rotator cuff repair, decompression of her shoulder and postoperative therapy. He noted that appellant had continued arm pain with numbness and tingling in her left-hand digits and a stabbing sensation across the top of her shoulder and neck. Dr. Cobb conducted a physical examination and noted that, for the left thumb, two-point discrimination measured in millimeters (mm) was 15 on the radial, 12 on the ulnar; for the index 12 on the radial and 12 on the ulnar; for the middle finger, 12 on the radial and 18 on the ulnar side. He also indicated that the discrimination for the ring finger was 8 mm on the radial and 12 on the ulnar with 8 for the little finger, noting this was “somewhat inconsistent,” and observed that appellant could manipulate small objects without any difficulty. Regarding Jamar manual muscle testing of the upper extremity, which he noted was in pounds, Dr. Cobb advised that at stages I-V the measurements for the left were 10/10/5/5/5 and key pinch was 0 on the left and that there was a loss of a normal bell-shaped curve and surmised that this could be due to a less than maximal effort. He also indicated that the left upper extremity examination showed no evidence of intrinsic or extrinsic atrophy, that appellant had full range of motion of the fingers, wrist and elbow. Dr. Cobb determined that the circumference of the biceps at 5 inches proximal to the lateral epicondyle is 14 inches on both left and right biceps. Regarding rotation of the shoulder, Dr. Cobb determined that appellant had 30 degrees of external rotation, 30 degrees of internal rotation, abduction of 60 degrees, adduction of 25 degrees, flexion of 60 degrees and extension of 3 degrees on active motion. He also noted that passively, appellant resisted any attempts to exceed the active range and that the grip strengths that were measured were invalid as they did not fit into the bell-shaped curve. Regarding sensory examination, the physician indicated that two-point discrimination was also invalid as it did not fit into an anatomical pattern. Dr. Cobb advised that appellant reached maximum medical improvement on October 1, 2002. He referred to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001), and opined that appellant was entitled to a permanent impairment of 23 percent of the upper extremity. He explained that this was based on section 16.4i pertaining to shoulder motion impairment starting on page 474.¹⁴ Dr. Cobb indicated that flexion of 70 degrees was equal to an impairment of 7 percent pursuant to Figure 16-40 and extension of 3 degrees was equal to 3 percent.¹⁵ He noted that abduction of 60 degrees equated to 6 percent and that adduction of 25 degrees equated to 1 percent when rounding up to the next highest value.¹⁶ Dr. Cobb also determined that for internal rotation of 30 degrees this would equate to 4 percent and external rotation of 30 degrees would equate to 1 percent.¹⁷ He further determined that pursuant to page 479¹⁸ for an abnormal shoulder motion, rotation was equal to 5 percent and flexion-extension was equal to 11 percent and abduction-adduction was equal to 7 percent.

¹⁴ *Id.* at 474, Section 16.4i.

¹⁵ *Id.* at 476, Figure 16.40.

¹⁶ *Id.* at 477, Figure 16.43.

¹⁷ *Id.* at 479, Figure 16.46.

¹⁸ *Id.* at 479.

In a June 28, 2004 report, an Office medical adviser noted that on August 29, 1997 appellant underwent an open rotator cuff repair and distal clavicle resection and that on March 23, 1998 she underwent arthroscopic subacromial decompression and manipulation. He indicated that appellant received an award of 18 percent to the left upper extremity. The Office medical adviser also noted that she subsequently had a third arthroscopic subacromial decompression and debridement of the rotator cuff and that she received an additional 8 percent for her left upper extremity impairment for a total award of 26 percent impairment of the left upper extremity. He also noted Dr. Cobb's recommendation of a 23 percent left upper extremity impairment was 3 percent less than already awarded. In addition, he explained that while the shoulder range of motion measured by Dr. Cobb was less than measured previously, Dr. Cobb found inconsistencies with regard to appellant's grip strength and sensory examinations. He explained that the results were not credible due to inconsistencies throughout many components of the examination and explained that no additional permanent partial impairment could be awarded for the decreased range of shoulder motion, "as the patient was most likely not putting forth a full effort." The Office medical adviser further related that, when range of motion was measured passively, appellant resisted any attempts to exceed the motion attained actively and explained that this was "atypical as passive motion almost always exceeds active motion." He opined that appellant's impairment remained at 26 percent of the left arm.

By decision dated July 7, 2004, the Office denied modification of the January 22, 2004 decision. The Office found that the evidence presented by Dr. Cobb was less than the percentage provided by the Office medical adviser, and thus did not establish any percentage greater than was already paid.

By letter dated July 19, 2004, appellant requested reconsideration. In her request, appellant indicated that she should have received an award of 28 percent and explained that there were some discrepancies between Dr. Cobb's report and the Office medical adviser's report, and that Dr. Cobb would be submitting a revised report. Appellant also indicated that she should receive additional compensation or that a third opinion should be obtained to resolve the conflict. She enclosed a copy of page three of Dr. Cobb's report.

By decision dated August 3, 2004, the Office denied appellant's reconsideration request without reviewing the case on the merits. The Office found that the medical evidence was already of record and was insufficient to warrant merit review.

LEGAL PRECEDENT -- ISSUE 1

Section 8107 of the Federal Employees' Compensation Act¹⁹ sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.²⁰ The Act, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the

¹⁹ 5 U.S.C. §§ 8101-8193.

²⁰ 5 U.S.C. § 8107.

use of uniform standards applicable to all claimants.²¹ The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.²²

ANALYSIS -- ISSUE 1

The Office accepted appellant's claim for work-related internal derangement of the left shoulder and authorized appropriate surgery for her condition.

In a December 15, 2003 report, the Office medical adviser utilized Dr. Silver's findings in his September 17 and October 23, 2003 reports to calculate appellant's impairment. He explained that appellant's condition had worsened such that she underwent a revision anterior acromioplasty on October 21, 2002 and a debridement of a "partial thickness bursal-sided rotator cuff tear." Regarding range of motion, for flexion, appellant had 90 degrees which pursuant to Figure 16-40²³ was equal to an impairment of 6 percent and that abduction of 60 degrees was also equal to an impairment of 6 percent pursuant to Figure 16-43.²⁴ The Office medical adviser determined that internal rotation of 30 degrees was equal to an impairment of 4 percent.²⁵ He added these three range of motion measurements to equal 16 percent. The Office medical adviser combined the 10 percent for the distal clavicle resection, with the 16 percent for motion, and utilizing the Combined Values Chart on page 604,²⁶ determined that the new impairment was 24 percent. He combined the 2 percent for pain²⁷ and determined that appellant was entitled to 26 percent of the left upper extremity with maximum medical improvement on September 17, 2003. The Board finds that the Office medical adviser's determination was properly applied the A.M.A., *Guides* to the findings provided by Dr. Silver.

In support of her claim for an increase in her schedule award, appellant submitted a September 17, 2003 report from Dr. Silver who opined that appellant's shoulder had worsened and that she was permanently disabled. However, he failed to provide calculations or specific findings that could be utilized to support increased impairment under the A.M.A., *Guides*.

In a June 9, 2004 report, Dr. Cobb noted examining appellant and utilizing the A.M.A., *Guides*. However, Dr. Cobb concluded that, based on the A.M.A., *Guides*, appellant had 23 percent impairment of the left arm, 3 percent less than already awarded by the Office.

²¹ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

²² A.M.A., *Guides* (5th ed. 2001); 20 C.F.R. § 10.404; *Linda R. Sherman*, 56 ECAB ____ (Docket No. 04-1510, issued October 14, 2004).

²³ *Id.* at 476, Figure 16-40.

²⁴ *Id.* at 477, Figure 16-43.

²⁵ *Id.* at 479, Figure 16-46.

²⁶ *Id.* at 604

²⁷ The medical adviser referenced his November 26, 2001, report in which he allowed a two percent permanent partial impairment for Grade 3 pain in the distribution of the subscapular nerve according to Table 16-15 and Table 16-10 of the A.M.A., *Guides*. See A.M.A., *Guides* at pages 482, 492.

Additionally, Dr. Cobb questioned the validity of some of the testing that he performed. An Office medical adviser concurred that some of appellant's test results as noted by Dr. Cobb were invalid. The medical adviser found no other basis in Dr. Cobb's report to support an increased impairment rating. The Board finds that Dr. Cobb's report does not provide a basis for any increased impairment.

On appeal, appellant alleged that the Office medical adviser's report was not sufficient to carry the weight, or in the alternative, should have created a conflict. However, the Board notes that the medical adviser properly applied the A.M.A., *Guides* to medical evidence to arrive at his impairment calculations. There is no evidence of record from any of appellant's physicians, in conformance with the A.M.A., *Guides*, that supports a higher degree of impairment.

LEGAL PRECEDENT -- ISSUE 2

Section 10.606(b)(2) of Title 20 of the Code of Federal Regulations provides that a claimant may obtain review of the merits of the claim by either: (1) showing that the Office erroneously applied or interpreted a specific point of law; (2) advancing a relevant legal argument not previously considered by the Office; or (3) submitting relevant and pertinent new evidence not previously considered by the Office.²⁸ Section 10.608(b) provides that, when an application for review of the merits of a claim does not meet at least one of the three requirements enumerated under section 10.606(b)(2), the Office will deny the application for reconsideration without reopening the case for a review on the merits.²⁹ When reviewing an Office decision denying a merit review, the function of the Board is to determine whether the Office properly applied the standards set forth at section 10.606(b)(2) to the claimant's application for reconsideration and any evidence submitted in support thereof.³⁰

ANALYSIS -- ISSUE 2

By letter dated July 19, 2004, appellant requested reconsideration. She alleged that she should have received an award of 28 percent and also alleged that there were discrepancies between Dr. Cobb's and the Office medical adviser's reports and that Dr. Cobb would be submitting a revised report. Appellant indicated that she should receive additional compensation or that a third opinion should be obtained to resolve the conflict. However, as noted, the evidence does not suggest a conflict, as the Office previously awarded appellant a greater percentage of impairment than that supported by Dr. Cobb. Therefore, appellant's July 19, 2004 request for reconsideration neither alleged nor demonstrated that the Office erroneously applied or interpreted a specific point of law, nor advanced a relevant legal argument not previously considered by the Office. Consequently, appellant is not entitled to a review of the merits of her claim based on the first and second above-noted requirements under section 10.606(b)(2).

²⁸ 20 C.F.R. § 10.606(b)(2) (2003).

²⁹ 20 C.F.R. § 10.608(b) (2003).

³⁰ *Annette Louise*, 54 ECAB ____ (Docket No. 03-335, issued August 26, 2003).

With respect to the third requirement, submitting relevant and pertinent new evidence not previously considered by the Office, appellant did not submit any new evidence with her request for reconsideration. Although, appellant submitted page three of Dr. Cobb's June 9, 2004 report, this report was previously submitted. The Board has held that the submission of evidence or argument which repeats or duplicates that already in the case record does not constitute a basis for reopening a case.³¹ Accordingly, appellant is not entitled to a review of the merits of her claim based on the third requirement under section 10.606(b)(2).

As appellant is not entitled to a review of the merits of her claim pursuant to any of the three requirements under section 10.606(b)(2), the Board finds that the Office properly refused to reopen appellant's case for further review of the merits of her claim pursuant to 5 U.S.C. § 8128(a).

CONCLUSION

The Board finds that the Office properly concluded that the medical evidence of record did not support a permanent impairment of more than 26 percent entitling appellant to a greater schedule award. The Board further finds that the Office properly refused to reopen appellant's claim for a review on the merits.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated August 3, July 7 and January 22, 2004 are hereby affirmed.

Issued: July 11, 2005
Washington, DC

Alec J. Koromilas
Chairman

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

³¹ *Edward W. Malaniak*, 51 ECAB 279 (2000); *Donald E. Ewals*, 51 ECAB 428 (2000); *Denis M. Dupor*, 51 ECAB 482 (2000); *Helen E. Paglinawan*, 51 ECAB 591 (2000).