United States Department of Labor
Employees' Compensation Appeals Board

ANDREW E. ZARZOSA, Appellant	)	
	)	**Docket No. 05-528**
and	)	**Issued: June 15, 2005**
	)	
DEPARTMENT OF THE NAVY, NAVAL FACILITIES ENGINEERING COMMAND, San Diego, CA, Employer	)	

Appearances:
Ross W. Kirk, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On January 3, 2005 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated September 8, 2004. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than a 30 percent permanent impairment of the left upper extremity and more than a 25 percent permanent impairment of the right upper extremity for which he received a schedule award.

FACTUAL HISTORY

On July 11, 2000 appellant, then a 54-year-old motor vehicle operator, filed an occupational disease claim alleging that he developed degenerative joint disease of the cervical

spine as a result of performing repetitive duties at work.[1] Appellant became aware of his condition on March 17, 2000. After initially denying appellant's claim, on December 19, 2000, the Office accepted that appellant sustained an aggravation of degenerative joint disease of the cervical spine. Appellant returned to work part-time light duty in August 2000 and retired on November 15, 2002.

Appellant submitted various medical records from Dr. John W. Alchemy, a Board-certified orthopedic surgeon, dated June 20 to August 2, 2000 who noted appellant's history of 15 years of heavy work with his upper extremities and opined that this work was of sufficient force to cause aggravation of degenerative joint changes and nerve outlets at multiple levels from C5 to C7. He diagnosed multilevel degenerative joint disease of the cervical spine with cervical impingement and recommended epidural steroid injections to control the pain. On September 1, 2000 the physician noted full range of motion of the cervical spine and hand grip of 4/5 bilaterally. Appellant was returned to limited duty four hours per day on August 4, 2000. Other reports from Dr. Alchemy from October 31, 2000 to April 3, 2001 noted appellant's condition had worsened and the trigger point injections were only minimally successful in relieving pain. In his note of January 23, 2001, the physician noted that appellant was permanent and stationary and recommended six additional weeks of physical therapy and selective nerve blocks.

In claim number 13-1201669, the Office referred Dr. Alchemy's report and the case record to the Office's medical adviser who, in a report dated December 3, 2000, in accordance with the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,*[2] (A.M.A., *Guides*), advised that appellant had a 24 percent permanent impairment for both the left upper extremity and the right upper extremity. Dr. Alchemy noted that appellant reached maximum medical improvement on July 3, 2000.

In an operative report dated March 20, 2001, Dr. Michael D. McBeth, a Board-certified orthopedist, noted performing a C5-6 cervical epidural steroid injection. He diagnosed cervical degenerative disc disease and cervical facet arthropathy with right and left upper extremity radiculopathy. On June 15, 2001 the physician noted performing a left C3-4, C4-5 and C5-6 zygapophyseal joint median branch block and diagnosed a left neck and upper shoulder pain, possibly cervical facet arthropathy and cervical degenerative disc disease.

Appellant came under the treatment of Dr. Peter Low, Board-certified in preventative medicine, who reported treating appellant from June 19, 2001 to January 28, 2003 for multilevel cervical degenerative joint disease and cervical impingement. He noted that appellant's condition was permanent and stationary. The physician advised that appellant continued to experience persistent neck pain but continued to work light duty four hours per day. In a November 19, 2002 report, he noted that left shoulder x-rays revealed a partial thickness tear of

[1] Appellant filed a separate claim, number 13-1201669, which was accepted for bilateral epicondylitis, carpal tunnel syndrome and forearm tenosynovitis. Appellant was granted a schedule award for 25 percent permanent impairment of the left upper extremity and 30 percent impairment for the right upper extremity. On July 27, 2004 the Board remanded the claim number 13-2007568, for consolidation with claim number 13-1201669. Docket No. 04-1058 (issued July 11, 2000).

[2] A.M.A., *Guides* (fourth edition 1993).

the supraspinatus tendon. The physician diagnosed left shoulder tendinitis with partial thickness rotator cuff tear and right shoulder tendonisis and impingement. A magnetic resonance imaging (MRI) scan of the left shoulder dated January 23, 2003 revealed thickening of the tendon on the articular surface, consistent with a partial thickness tear. The MRI scan of the right shoulder revealed no abnormalities. In an operative report dated February 28, 2003, Dr. John Murphy, a Board-certified orthopedist, noted performing arthroscopic subacromial decompression with debridement of bursal and glenoid side of the rotator cuff, debridement of partial thickness rotator cuff and complaining of distal clavicle left shoulder. He diagnosed a partial thickness rotator cuff tear of the left shoulder with impingement syndrome.

On October 8, 2003 appellant filed a claim for a schedule award. Appellant submitted a final report of the primary treating physician Dr. Low dated September 8, 2003, which provided a comprehensive summary of appellant's treatment. He noted that appellant experienced shoulder pain three to four times a day that was "real sharp pain, but generally it is worse with moving." Dr. Low noted findings upon physical examination of abduction on the left of 95 degrees, on the right of 105 degrees, forward flexion on the left of 165 degrees, and on the right of 170 degrees, internal rotation on the left of 40 degrees and on the right of 50 degrees, external rotation of 50 degrees on the left and 60 degrees on the right and extension was 30 degrees on the left and the right. He diagnosed left shoulder impingement with partial thickness rotator cuff tear, status post arthroscopic decompression and debridement, right shoulder impingement, and multilevel cervical degenerative joint disease at C4-5 and C5-7. Dr. Low opined that appellant sustained an injury to his neck and both shoulders secondary to years of forceful pushing, pulling, repetitive overhead lifting and reaching while working at the employing establishment. He noted that appellant reached maximum medical improvement and was permanent and stationary. Dr. Low advised that appellant could return to work under permanent work restrictions.

On November 12, 2003 Dr. Low's report and the case record were referred to Dr. Leonard A. Simpson, an orthopedic surgeon and Office's medical adviser. In a report dated November 15, 2003, he determined that appellant sustained an additional six percent impairment of the left upper extremity and one percent impairment of the right upper extremity in accordance with the fifth edition of the of the A.M.A., *Guides.*[3] He calculated that the right shoulder pain was a Grade 3 impairment of the axillary nerve, pain or altered sensation that may interfere with activities, or a 60 percent sensory deficit which has an impairment value of 5 percent upper extremity impairment due to unilateral or sensory deficits of the axillary nerve for a 3 percent impairment of the right upper extremity.[4] With regard to the left upper extremity, pain was greater and would be a maximal Grade 2, with abnormal sensations or moderate pain that prevents activities, or between a 61 and 80 percent sensory deficit. This examiner recommended a 70 percent motor deficit of the axillary nerve which has an impairment value of 5 percent upper extremity impairment due to unilateral or sensory deficits of the axillary nerve for a 3.5 percent impairment of the left upper extremity, rounded up to 4 percent.[5] He further

[3] A.M.A., *Guides* (fifth edition 2001).

[4] Table 16-10, 16-15, page 482, 492 (A.M.A., *Guides*).

[5] *Id.*

noted that range of motion for forward flexion on the right was 170 degrees for a 1 percent impairment,[6] 155 degrees on the left for a 1 percent impairment,[7] abduction on the right was 105 degrees for a 3.5 percent impairment,[8] and on the left 95 degrees for a 4 percent impairment,[9] internal rotation on the right was 50 degrees for a 2 percent impairment,[10] and on the left 40 degrees for a 3 percent impairment,[11] external rotation on the right was 60 degrees for a 0 percent impairment,[12] and on the left 50 degrees for a 1 percent impairment,[13] extension was 30 degrees on each side for a 0 percent impairment.[14] Regarding impairment due to weakness, Dr. Simpson found that according to Table 16-35 at page 510, shoulder girdle strength was decreased on the right measuring 4/5, for a 17 percent impairment due to strength deficit on the right.[15] He further noted that the left shoulder girdle strength was decreased to 3-4/5 for a 19 percent impairment due to strength deficit on the left.[16] The medical adviser noted that the Combined Values Chart for the right upper extremity provided a 3 percent impairment for pain factors combined with a 7 percent impairment for loss of motion, combined with a 17 percent loss of strength for a 25 percent impairment of the right upper extremity. Similarly, for the left upper extremity the 4 percent impairment for pain factors combined with the 9 percent for limitation of motion, combined with the 19 percent for decreased strength for a 30 percent impairment of the left upper extremity. He noted that maximum medical improvement was reached on September 8, 2003.

In a decision dated December 16, 2003, the Office granted appellant an additional schedule award for six percent permanent impairment of the left upper extremity and one percent permanent impairment of the right upper extremity. The period of the schedule award was from September 8, 2003 to February 7, 2004. The Office noted that the schedule award was in addition to the 24 percent for each extremity previously awarded under appellant's other claim number 13-1201669.

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[6] Figure 16-40, page 476 (A.M.A., *Guides*).

[7] *Id.*

[8] Figure 16-43, page 477 (A.M.A., *Guides*).

[9] *Id.*

[10] Figure 16-46, page 479 (A.M.A., *Guides*).

[11] *Id.*

[12] *Id.*

[13] *Id.*

[14] Figure 16-40, page 476 (A.M.A., *Guides*).

[15] Table 16-35, page 510 (A.M.A., *Guides*) is entitled, "Impairments of the Upper Extremity Due to Strength Deficit from Musculoskeletal Disorders Based on Manual Muscle Testing of Individual Units of Motion of the Shoulder and Elbow."

[16] *Id.*

In a letter dated January 10, 2004, appellant requested reconsideration. In a decision dated February 6, 2004, the Office denied appellant's request for a merit review on the grounds that the evidence submitted was insufficient to warrant review of the prior decision.

On March 6, 2004 appellant appealed to the Board. In an order dated July 27, 2004, the Board remanded the case to the Office to combine case file numbers 13-2007568 and 13-1201669 and directed the Office to issue a merit decision on appellant's claim for compensation.[17]

By a decision dated September 8, 2004, the Office granted appellant a schedule award for six percent permanent impairment of the left upper extremity and a one percent impairment of the right upper extremity. The Office noted that the total impairment due to both accepted injuries on the left upper extremity was 30 percent impairment less the 24 percent impairment previously paid in claim number 13-1201669. With regard to the right upper extremity the Office noted that the total impairment due to both injuries on the right upper extremity was 25 percent impairment less the 24 percent impairment previously paid in claim number 13-1201669. The period of the award was from September 3, 2003 to February 7, 2004.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[18] and its implementing regulation[19] sets 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.

ANALYSIS

Appellant's attending physician, Dr. Low completed a report on September 8, 2003 noting appellant's history of injury and medical history. He noted that appellant experienced shoulder pain three to four times a day that was "real sharp pain, but generally it is worse with moving." Dr. Low noted findings upon physical examination of abduction on the left of 95 degrees, on the right of 105 degrees, forward flexion on the left of 165 degrees, and on the right of 170 degrees, internal rotation on the left of 40 degrees and on the right of 50 degrees, external rotation of 50 degrees on the left and 60 degrees on the right and extension was 30 degrees on the left and the right. He diagnosed left shoulder impingement with partial thickness rotator cuff tear, status post arthroscopic decompression and debridement, right shoulder impingement, and multilevel cervical degenerative joint disease at C4-5 and C5-7. Dr. Low opined that appellant

[17] Docket No. 04-1058 (issued July 27, 2004).

[18] 5 U.S.C. § 8107.

[19] 20 C.F.R. § 10.404 (1999).

sustained an injury to his neck and both shoulders secondary to years of forceful pushing, pulling, repetitive overhead lifting and reaching while working at the employing establishment. He noted that appellant reached maximum medical improvement and was permanent and stationary.

The Board has carefully reviewed the Office medical adviser's report dated November 15, 2003, and finds this report deficient. While the physician found a 25 percent impairment of the right upper extremity and a 30 percent impairment for the left upper extremity he did not adequately explain how his determination was reached in accordance with the relevant standards of the A.M.A., *Guides*.[20] The doctor calculated that, based on the fifth edition of the of the A.M.A., *Guides,*[21] right shoulder pain was a Grade 3 impairment of the axillary nerve, pain or altered sensation that may interfere with activities, or a maximum of 60 percent sensory deficit which has an impairment value of 5 percent upper extremity impairment due to unilateral or sensory deficits of the axillary nerve multiplied together for a 3 percent impairment of the right upper extremity.[22] With regard to the left upper extremity, pain was greater and would be a maximal Grade 2, with abnormal sensations or moderate pain that prevents activities, or between a 61 and 80 percent sensory deficit. Dr. Simpson recommended a 70 percent motor deficit of the axillary nerve which has an impairment value of 5 percent upper extremity impairment due to unilateral or sensory deficits of the axillary nerve multiplied together for a 3.5 percent impairment of the left upper extremity, rounded up to 4 percent.[23] He further noted that range of motion for forward flexion on the right was 170 degrees for a 1 percent impairment,[24] 165 degrees on the left for a 1 percent impairment,[25] abduction on the right was 105 degrees for a 3.5 percent impairment,[26] and on the left 95 degrees for a 4 percent impairment,[27] internal rotation on the right was 50 degrees for a 2 percent impairment,[28] and on the left 40 degrees for a 3 percent impairment,[29] external rotation on the right was 60 degrees for a 0 percent impairment,[30] and on the left 50 degrees for a 1 percent impairment.[31] However, Dr. Simpson incorrectly noted that extension for both the left and right shoulder was measured at 30 degrees for 0 percent

[20] *See Tonya R. Bell,* 43 ECAB 845, 849 (1992).

[21] A.M.A., *Guides* (fifth edition 2001).

[22] Table 16-10, 16-15, page 482, 485 (A.M.A., *Guides*).

[23] *Id.*

[24] Figure 16-40, page 476 (A.M.A., *Guides*).

[25] *Id.*

[26] Figure 16-43, page 477 (A.M.A., *Guides*).

[27] *Id.*

[28] Figure 16-46, page 479 (A.M.A., *Guides*).

[29] *Id.*

[30] *Id.*

[31] *Id.*

impairment, as this figure does not conform with the A.M.A., *Guides* which provides for a 1 percent impairment rating for 30 degrees of extension.[32] This revised calculation would provide appellant with a greater impairment rating than that which was previously granted.

With regard to decreased strength and weakness, Dr. Simpson found that, according to Table 16-35, of section 16.8c, at page 510, shoulder girdle strength was decreased on the right measuring 4/5, for a 17 percent impairment due to strength deficit on the right. The physician further noted that on the left shoulder girdle strength was decreased to 3-4/5 for a 19 percent impairment due to strength deficit on the left.[33] However, the A.M.A., *Guides*, provide that, regarding strength evaluations under section 16.8, decreased strength cannot be rated in the presence of decreased motion.[34] Consequently, impairment attributable for decreased strength under section 16.8 cannot be combined with impairment for decreased motion.

In view of these errors in determining impairment under the A.M.A., *Guides*, the Office should further develop the medical evidence as appropriate to determine the extent of appellant's impairment of the right and left upper extremity.[35]

The Board has held that proceedings under the Act are not adversary in nature nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. It has the obligation to see that justice is done. Accordingly, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[36]

The Board will remand the case for further development. Following this the Office shall issue an appropriate decision on appellant's schedule award claim.[37]

CONCLUSION

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

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[32] Figure 16-40, page 476 (A.M.A., *Guides*).

[33] *Id.*

[34] *See* A.M.A., *Guides* at section 16.8a, p. 508. This provision also states that motor weakness associated with disorders of the peripheral nerve system and various degenerative neuromuscular conditions are evaluated according to guidelines described in section 16.5.

[35] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[36] *John W. Butler,* 39 ECAB 852 (1988).

[37] With his appeal appellant submitted additional evidence. However, the Board may not consider new evidence on appeal; *see* 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the September 8, 2004 decision of the Office of Workers' Compensation Programs is set aside and remanded for further proceedings consistent with this decision of the Board.

Issued: June 15, 2005
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member