United States Department of Labor
Employees' Compensation Appeals Board

P.B., Appellant	)	
and	)	**Docket No. 06-1661**
	)	**Issued: February 9, 2007**
DEPARTMENT OF LABOR, EMPLOYMENT & TRAINING ADMINISTRATION, Washington, DC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 17, 2006 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated April 21, 2006. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than a 22 percent permanent impairment to his right upper extremity.

FACTUAL HISTORY

Appellant, a 53-year-old computer specialist, injured his left arm, right knee, right thigh and right shoulder on September 14, 2000 when he slipped and fell on a wet spot in the employing establishment cafeteria. He filed a claim for benefits on September 18, 2000, which the Office accepted for right shoulder strain.

On December 3, 2001 appellant filed a Form CA-7 claim for a schedule award based on a partial loss of use of his right shoulder.

The Office referred appellant to Dr. Francisco Ward, a Board-certified orthopedic surgeon, for a second opinion examination. In a report dated November 12, 2002, Dr. Ward found that appellant had a 45 percent right upper extremity impairment. He stated:

> "[Appellant] had full cervical range of motion. He had 65 degrees of abduction and forward flexion of the right shoulder. [Appellant] had a positive Apley reach test only reaching to the waistline with the right arm. He had 5 degrees of adduction with the right shoulder, 0 degrees of external rotation and 30 degrees of internal rotation. [Appellant] had crepitus markedly more severe in the right than in the left shoulder.
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> "The patient had very slight atrophy in the right posterior shoulder area and over the rhomboids on the right. The elbow and wrist exam[ination]s were essentially unremarkable.
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> "The patient's left forearm measured 31.5 centimeters (cm) and the right 30.75 cm. His left and right biceps were symmetric.
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> "The patient had 75 pounds of grip strength with the right using a Jamar Dynamometer in the third grip handle position and 140 pounds in the left. He had four plus five strength of the right rotator cuff with external rotation, 5/5 with internal rotation and he did not have the supraspinatous adequately checked due to pain and loss of range of motion.
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> "Assessment:
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> "[Appellant] is status post right humeral head fracture with likely traumatic arthritis, post-traumatic arthritis made worse after a fall in which the rotator cuff was pinched and further capsular adhesions degenerative changes occurred. The patient does have impairments to the use of his right arm; however, he is able to work his regular duty with minor adjustments such as supporting the right upper extremity.
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> "Using Figure 16-43 on page 477 [appellant] has five percent shoulder impairment for his amount of shoulder abduction. Using Figure 16-40 on page 476 he has eight percent impairment for his amount of forward flexion. [Appellant] has one percent shoulder impairment for loss of adduction and two percent impairment for loss of shoulder extension. Using Figure 16-46 on page 479 he had a four percent shoulder impairment for loss of internal rotation and two percent for loss of external rotation. [Appellant] had eight percent shoulder impairment for ankylosis due to loss of external rotation and six percent for ankylosis limiting internal rotation. Using Table 16-34 he had a 20 percent upper extremity impairment due to loss of grip strength. Using Table 16-16 reveals that

> [appellant] has less than eight objective signs of CRPS therefore there is no evidence of CRPS.
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> "Using the Combined Values Chart on page 604 [appellant] has a 45 percent impairment of the right shoulder and this utilizes the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (fifth edition) [the A.M.A., *Guides*]."

In a report dated November 30, 2002, the Office medical adviser informed Dr. Ward that his report was deficient because he did not report the range of motion in shoulder extension. He stated that "Using the range of motion that you reported and considering the pie charts, Figure 16-40, 16-43 and 16-46, the following ratings are applicable: abduction, 65 degrees, for an impairment of 6 percent; forward flexion, 65 degrees, for an impairment rating of 7.5 percent; adduction, 5 degrees, for a 1 percent impairment; external rotation, 0 degrees, for a 2 percent impairment; and internal rotation, 30 degrees, for a 4 percent impairment." The Office medical adviser further stated:

> "In reviewing your recommendation regarding the impairment rating, I do not understand how you could offer eight percent shoulder impairment for ankylosis due to loss of external rotation and six percent due to limited internal rotation when you did find in internal rotation that this individual was able to achieve 30 degrees."
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> The Office medical adviser explained:
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> "Strength assessment at the shoulder level cannot be done utilizing a loss of grip strength for a number of reasons. The A.M.A., *Guides* require that strength ratings for the shoulder be based on Table 16-35 and carried out according to the instructions in the column just below that Table as found on page 510.
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> "Please refer to page 508, section 16.8a 'Principles' where it indicates in the first column 'decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts (*e.g.*, thumb amputation) that prevent active application of maximum force in the region being evaluated.'"

The Office medical adviser also noted that "[a]nother reason that the strength index approach to the rating process would be precluded is found in section 16.8a 'Principles' wherein it states: 'Measurements of grip and pinch strength are used to evaluate power weaknesses relating to the structures in the hand, wrist, or forearm. Manual muscle testing of major groups is used for testing strength about the elbow and shoulder." The Office medical adviser concluded that "[t]he process whereby you have offered a rating for weakness cannot be accepted. Please provide manual strength assessments at the shoulder level in the planes that you believe are involved."

In a report dated February 6, 2003, Dr. Ward rejected the Office medical adviser's instructions and stated:

> "Please see section 1.8, page 13 of the A.M.A., *Guides*, which clearly states that, 'Impairment percentages derived from the A.M.A., *Guides* criteria should not be used as direct estimates of disability.' Impairment percentages estimate the extent of the impairment on whole person functioning. [Appellant's] measured internal rotation was an estimate but accurate impairment rating could not be calculated due to the marked loss of other shoulder motion capabilities. If you want to decrease the impairment from six percent to four percent that might appear technically more accurate if you were fixated on the Tables and Charts out of clinical context. His strength estimate was calculated using a Jamar Dynameter and appears to be an accurate reflection of true upper extremity strength/loss of strength in the primary functional capability of the upper extremity. As he cannot functionally use his involved shoulder I did not feel it necessary to base my strength assessment on muscle groups acting on the shoulder. His grip strength and elbow flexion/extension strength is a more accurate estimate in my professional opinion."

In a report dated February 24, 2003, the Office medical adviser reiterated his concerns regarding Dr. Ward's failure to rate the range of motion in shoulder extension. He stated that Dr. Ward's February 6, 2003 explanation was not in accordance with the instructions outlined at section 16.8(b), "Grip and Pinch Strength," pages 508-11. The medical adviser stated:

> "The mechanics of the Jamar testing necessary to even use grip strength testing if this were a forearm or hand condition were not complied with. Technically, Dr. Ward's explanation to indicate why the use of the strength loss index was done is not supportable even considering his own examination findings.
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> "If the muscles of the shoulder level were not testable (as Dr. Ward claims in the addendum) it is unfathomable as to how the biceps on the 'R and L' side could be indicated to be symmetric. The growth differences in the forearms may or may not be clinically significant. In any event those growth differences are not germane in considering the rating for weakness as the shoulder level.
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> "Using the strength loss that Dr. Ward did report in the November 12, 2002 report of Grade 4 strength in external rotation in conjunction with Table 16-35, a rating for reduction in strength in that plane of motion could be formed at 0 to 2 percent if the decrease in strength was no greater than 20 percent which is implied by 4/5.
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> "Using the [Grade 4] categorization by Dr. Ward, the strength rating would not be as high as 20 percent or as low as 0 percent."

The Office medical adviser concluded that appellant had a one percent impairment for weakness in that plane of motion. He further stated:

> "In the letter I sent to Dr. Ward dated November 30, 2002, the impairment percentage due to range of motion restrictions (absent any input regarding extension in the original and addendum report) is 20.5 percent. FECA Memorandum No. 49 would permit that rating to be rounded off at 21 percent.
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> "As I have explained the rating of weakness based on Dr. Ward's report is 1 percent.
>
> "Pain is considered in the serious range of motion restrictions, at page 20, section 2.5e pain. Thus, using the Combined Values Chart, pages 604-06, 21 percent combined with 1 percent yields 22 percent under the A.M.A., *Guides* (fifth edition)."

On February 28, 2003 the Office granted appellant a schedule award for a 22 percent permanent impairment of the right upper extremity for the period November 12, 2002 to March 6, 2004, for a total of 68.64 weeks of compensation.

By letter dated October 29, 2003, appellant requested reconsideration. He submitted an August 22, 2003 report from Dr. William J. Laudner, a Board-certified orthopedic surgeon, who stated:

> "According to the A.M.A., *Guides* for loss of motion, [appellant] had sustained an 18 percent impairment from Figures 16-40, 16-43, and 16-46. His weakness is a further 15 percent impairment from Table 16-35. [Appellant's] pain, dysfunction, and loss of endurance increases the total impairment in his shoulder to 50 percent. This is all due to his injury at work on September 14, 2000."

In a report dated November 14, 2003, the Office medical adviser found that Dr. Laudner did not set forth adequate findings to support his impairment rating. The Office medical adviser stated:

> "The range of motion is not indicated to have been measured with a dynamometer. If one could accept that 'pure abduction' was 40 degrees, it would not be possible to have made measurements in internal rotation and external rotation.
>
> "This being the case, the range of motion as reported appears to have been unlikely to have been technically, correctly assessed based on the requirements of the A.M.A., *Guides*.
>
> "It is not possible to pick a number, in this case 15 percent, for weakness, from Table 16-35.

"The weakness in the affected plane[s] must be manually evaluated as discussed on page 510. The physician did not do so.

"This doctor indicated 'his pain, dysfunction, and loss of endurance increased the total impairment in his shoulder to 50 percent.'

"Pain is inherently considered in the range of motion as discussed in section 2.5e 'Pain' page 20.

"If this is not sufficient to allow adequate consideration of pain, there are extensive instructions regarding pain as a consideration for a rating in Chapter 18. This physician did not consider any of the factors that are to be considered as discussed in Chapter 18.

"'Dysfunction' is a nebulous, indefinable term in context with a rating process. No weight for rating purposes can be ascribed to the term.

"Lack of endurance would be included in a properly considered consideration of weakness for pain; thus, no increase in a rating is ascribable to this term.

"Thus, the catch-all terms included in the sentence in which Dr. Laudner seeks to jump start this rating to 50 percent are likely to be duplicative.

"It appears that this physician also has no knowledge of the fact that ratings for range of motion, pain and weakness (as correctly determined from the A.M.A., *Guides*) must be combined, using the Combined Values Chart, pages 604-06 of the A.M.A., *Guides*.

"Thus, for these several reasons, the rating by Dr. Laudner in the August 22, 2003 report is not an acceptable basis to modify this claimant's previously processed schedule award."

By decision dated January 16, 2004, the Office found that the medical evidence was not sufficient to warrant modification of the February 28, 2003 schedule award decision.

By letter dated December 29, 2004, appellant requested reconsideration. In a December 3, 2004 report, Dr. H.S. Pabla, a Board-certified orthopedic surgeon, stated:

"Using the A.M.A., *Guides*, page 476, Figure 16-40 through 16-46, there is 8 percent impairment for loss of forward flexion, 6 percent impairment for loss of abduction, and 4 percent impairment for loss of internal rotation; hence, the total permanent impairment for loss of range of motion using the A.M.A., *Guides* is 21 percent. He has Grade 4 weakness of the right upper extremity due to strength deficit. Using page 510, Table 16-35, there is a 19 percent impairment for loss of flexion, extension, adduction and internal external rotation; hence, the total permanent partial impairment for the work-related injury of September 14, 2000 for the right shoulder is 40 percent."

In a report dated February 14, 2005, the Office medical adviser reiterated his concerns regarding appellant's failure to submit medical evidence sufficient to rate the loss of range of motion in the shoulder. He stated:

> "If [appellant] could not abduct the shoulder to 90 percent, it would not be possible to report a range of motion in internal rotation as Dr. Pabla did. Dr. Pabla reported that there was 'weakness of the shoulder abductor, flexor and external and internal rotators, Grade 4.' He then lumped a rating for weakness from Table 16-35 -- not specifically stating what the ratings were for weakness in each plane of motion.
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> "Moreover, a credibility issue arises in that according to the range of motion reported, external rotation was zero degrees. If this be the case, how did Dr. Pabla determine there was weakness in this plane?
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> "As I pointed out, the internal rotation measurement was not correctly accomplished. This being the case, a rating for weakness on this plane of motion is not technically correctly done.
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> "Even if the ratings for weakness and range of motion were correctly done (which they are not), the rating by Dr. Pabla is incorrect in that he added the ratings. The ratings for weakness and range of motion would for impairment rating purposes have to be combined, using the Combined Values Chart, pages 604-06.
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> "For these several reasons, the rating offered in Dr. Pabla's December 3, 2004 report cannot be used to revise the right upper extremity schedule award."

By decision dated March 28, 2005, the Office found that the medical evidence was not sufficient to warrant modification of the February 28, 2003 schedule award decision.

By letter dated February 22, 2006, appellant requested reconsideration. He submitted a May 27, 2005 report from Dr. James Snead, a Board-certified orthopedic surgeon, who stating findings on examination, discussed the loss of range of motion in the right shoulder and diagnosed right shoulder post-traumatic osteoarthritis but did not provide an impairment rating for the right shoulder. Appellant also submitted a January 26, 2006 report from Dr. James R. Kunec, Board-certified in orthopedic surgery, who stated:

> "I have used the A.M.A., *Guides* to evaluate loss of motion and find that [appellant] his 20 percent impairment based on Figures 16-40, 16-43 and 16-46 in the A.M.A., *Guides*. In addition, I believe that weakness in the shoulder may be rated from Table 16-35. Utilizing this table and based on strength deficit on the order of 30 to 50 percent, I believe that [appellant] has suffered an additional 15 percent impairment of the right shoulder based on these ratings. Finally, pain, dysfunction, and loss of endurance, at 5 percent increase the total impairment of

his shoulder to 40 percent. This impairment is based on his injury at work on September 14, 2000."

In a report dated March 20, 2006, the Office medical adviser noted that the reports from Drs. O'Donnell and Kunec were not a basis to revise the impairment rating for appellant's shoulder condition. He stated:

"Dr. Kunec did not report the range of motion of the shoulder in all applicable planes. There is set forth in Chapter 16 the requirements that must be met to offer a rating for shoulder weakness. Dr. Kunec met some of the requirements. [He] took the history that [appellant] reported weakness but did no examination to assess weakness. A rating for weakness using the A.M.A., *Guides* must be based on examination findings, not just a history of weakness.

"Thus in the absence of the specific findings of weakness on examination, a rating for weakness using Table 16-35 as is indicated in the report by Dr. Kunec is not verifiable.

"There is no basis to enhance the upper extremity impairment rating as Dr. Kunec did by offering an additional five percent rating for what he claimed was pain, dysfunction, and loss of endurance.

"Pain would be rated in the range of motion measurement.

"The terms dysfunction and lack of endurance are not ratable concepts using Chapter 16 of the A.M.A., *Guides*.

"Moreover, Dr. Kunec did not indicate the mechanism as to how he combined the ratings for the incompletely reported range of motion, weakness, and 'pains,' dysfunction and loss of endurance."

By decision dated April 21, 2006, the Office found that the medical evidence was not sufficient to support an increase in the impairment already awarded.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] sets forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[2] However, the Act does not specify the manner in which the percentage of loss of use of a member is to be determined. For consistent results and to ensure equal justice under the law to all claimants, the

[1] 5 U.S.C. §§ 8101-8193*; see* 5 U.S.C. § 8107(c).

[2] 5 U.S.C. § 8107(c)(19).

Office has adopted the A.M.A., *Guides* (fifth edition) as the standard to be used for evaluating schedule losses.[3]

ANALYSIS

The Office found appellant had a 22 percent impairment of the right upper extremity based on the Office medical adviser's November 30, 2002 report. The Office medical adviser utilized the report of Dr. Ward for loss of range of motion and applied the pie charts at Figure 16-40, 16-43 and 16-46, and calculated an overall 20.5 percent impairment.[4] This impairment rating was conducted in accordance with the procedure outlined at subsection 16.4(i), page 474. After attempting to obtain additional medical evidence based on weakness from Dr. Ward, the Office medical adviser determined that appellant rated an additional one percent impairment based on weakness.[5] The Office medical adviser took the fourth categorization finding for strength loss that Dr. Ward found in his November 12, 2002 report and applied it to Table 16-35. He noted that appellant's strength rating could not be as high as 20 percent or as low as 0 percent and determined that appellant had a 1 percent impairment for weakness in that plane of motion. Combining this figure with his previous 20.5 impairment rating, he found that appellant had a total 22 percent impairment.

Appellant subsequently requested reconsideration, seeking an increased award for impairment to his right upper extremity. In an August 3, 2003 report, Dr. Laudner stated that appellant had an 18 percent impairment due to loss of motion pursuant to Figures 16-40, 16-43, and 16-46, a 15 percent impairment based on weakness from Table 16-35, and 17 percent impairment for pain, dysfunction and loss of endurance for a total 50 percent impairment due to the September 14, 2000 work injury. The Office medical adviser found, however, that Dr. Laudner failed to discuss specific factors pertaining to appellant's impairment under the A.M.A., *Guides* or indicate how his findings conformed with the cited figures and tables of the A.M.A., *Guides*. The Office medical adviser stated that Dr. Laudner did not indicate whether his calculation of range of motion was measured with a dynamometer. He found that Dr. Laudner's range of motion impairment rating was not correctly assessed based on the requirements of the A.M.A., *Guides*.

With regard to Dr. Laudner's impairment based on weakness, the Office medical adviser found that it was not possible to pick a number, in this case 15 percent, for weakness, from Table 16-35. He stated that the weakness in the affected plane[s] must be manually evaluated as discussed on page 510, which Dr. Laudner did not do. The Office medical adviser concluded that Dr. Laudner failed to grasp that ratings for range of motion, pain and weakness must also be

[3] 20 C.F.R. § 10.404.

[4] As stated above, the Office medical adviser arrived at the 20.5 percent impairment rating based on the following calculations: abduction, 65 degrees, for an impairment of 6 percent; forward flexion, 65 degrees, for an impairment rating of 7.5 percent; adduction, 5 degrees, for a 1 percent impairment; external rotation, 0 degrees, for a 2 percent impairment; and internal rotation, 30 degrees, for a 4 percent impairment.

[5] As indicated above, the Office medical adviser discounted Dr. Wards' finding of growth differences in the biceps and forearms, stating that those growth differences were not germane in considering the rating for weakness at the shoulder level.

combined, using the Combined Values Chart at pages 604-06 of the A.M.A., *Guides*. He determined that Dr. Laudner's impairment rating was of diminished probative value. The Office medical adviser properly denied additional impairment based on pain, dysfunction and loss of endurance. He stated that pain was inherently considered in the range of motion as discussed in section 2.5e "Pain" page 20. The Office medical adviser further stated that pain could also be rated pursuant to the instructions outlined in Chapter 18, but noted that Dr. Laudner did not consider any of the factors set forth in Chapter 18. The Office medical adviser dismissed any impairment rating based on dysfunction, which he characterized as an inappropriate, indefinable basis for a rating impairment as any lack of endurance would be included within a consideration of weakness for pain.[6] The Office medical adviser properly found that Dr. Laudner's report was not sufficient to support an increase in appellant's schedule award because it was not made in conformance with the A.M.A., *Guides*. The Office medical adviser rated impairment at 22 percent of the upper extremity impairment in accordance with Figures 16-40, 16-43 and 16-46 and Table 35.

The Office medical adviser also found that Dr. Pabla's report was not sufficient to support an increase in appellant's impairment. Dr. Pabla stated that appellant had an eight percent impairment for loss of forward flexion, six percent impairment for loss of abduction, and four percent impairment for loss of internal rotation pursuant to page 476, Figure 16-40 through 16-46 of the A.M.A., *Guides*. This amounted to a total impairment for loss of range of motion of 21 percent. Dr. Pabla measured a Grade 4 weakness of the right upper extremity due to strength deficit pursuant to page 510, Table 16-35; this translated to a 19 percent impairment for loss of flexion, extension, adduction and internal external rotation, for a total 40 percent permanent impairment for the right shoulder. In reviewing Dr. Pabla's report, the Office medical adviser found that Dr. Pabla failed to follow the proper procedures required to calculate impairment based on loss of range of motion in shoulder. Citing Figure 16-44, page 478 of the A.M.A., *Guides*, he stated that, if appellant was unable to abduct the shoulder to 90 percent, it would not be possible to report the range of motion in internal rotation as noted by Dr. Pabla who reported weakness of the shoulder abductor, flexor and external and internal rotators, Grade 4, then combined these to make a rating for weakness from Table 16-35. The Office medical adviser properly rejected these ratings, finding that Dr. Pabla did not specifically indicate what the ratings were for weakness in each plane of motion.[7]

The Office medical adviser found that the reports submitted by Drs. Kunec and Snead were not sufficient to support an increase in appellant's permanent impairment. Dr. Kunec accorded a 20 percent impairment pursuant to Figures 16-40, 16-43 and 16-46 of the A.M.A., *Guides*. He rated appellant an additional 15 percent impairment of the right shoulder based on weakness of 30 to 50 percent pursuant to Table 16-35. Dr. Kunec found that appellant had a 5

[6] The Board has held that the amount payable under a schedule award does not take into account such factors as the effect of impairment on lifestyle activities, wage-earning capacity, sports, hobbies or other activities. *See Ruben Franco*, 54 ECAB 496 (2003).

[7] The Office medical adviser noted that, even if the ratings for weakness and range of motion were correctly done (which they are not), the rating by Dr. Pabla is incorrect in that he added the ratings. The ratings for weakness and range of motion would for impairment rating purposes have to be combined, using the Combined Values Chart, pages 604-06.

percent impairment based on pain, dysfunction, and loss of endurance, for a total 40 percent impairment of his right shoulder. The Office medical adviser indicated that Dr. Kunec did not report the range of motion of the shoulder in all applicable planes, as indicated by Chapter 16. While Dr. Kunec met some of these requirements, he made an impairment rating based on a history of weakness without performing an examination to assess weakness, as mandated by the A.M.A., *Guides*. The Office medical adviser rejected Dr. Kunec's impairment rating for pain, dysfunction, and loss of endurance on the same grounds that he rejected Dr. Laudner's rating based on these criteria. He noted that pain must be rated in the range of motion measurement pursuant to section 2.5e, "Pain" at page 20 of the A.M.A., *Guides*, he stated that the terms dysfunction and lack of endurance were not ratable concepts using Chapter 16 of the A.M.A., *Guides*; and found that Dr. Kunec did not indicate the means by which he combined the various impairment ratings. The Office medical adviser properly found that Dr. Snead's report lacked probative value, as he did not submit an impairment rating for the right shoulder.

The Board finds that the weight of the medical evidence establishes that appellant has no more than a 22 percent permanent impairment to his right upper extremity.

CONCLUSION

The Board finds that appellant has no more than a 22 percent impairment of the right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the April 21, 2006 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: February 9, 2007
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

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

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