United States Department of Labor
Employees' Compensation Appeals Board

E.R., Appellant	)	
	)	**Docket No. 08-2522**
and	)	**Issued: July 20, 2009**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Duluth, GA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
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 September 22, 2008 appellant filed a timely appeal from a July 28, 2008 schedule award of the Office of Workers' Compensation Programs. 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 four percent impairment of the right upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On March 27, 2002 appellant, then a 47-year-old mail handler, injured his right arm and back as a result of pulling, bending and twisting while lifting heavy trays of mail. The Office

accepted appellant's claim for right rotator cuff tear and lumbosacral strain. Appellant did not stop work.[1]

Appellant was treated by Dr. Todd E. Kinnebrew, a Board-certified orthopedic surgeon. On March 22, 2002 Dr. Kinnebrew noted appellant's history was significant for right shoulder surgery two years prior. He diagnosed lumbar radiculopathy, lumbar strain, and shoulder strain and returned appellant to limited-duty work.

Appellant came under the treatment of Dr. John I. Foster, III, a Board-certified orthopedic surgeon, from May 17, 2002 to July 19, 2005, for right shoulder pain and weakness. Dr. Foster noted appellant sustained a right rotator cuff tear in July 2000 and underwent surgical repair. On June 26, 2002 he diagnosed recurrent right rotator cuff tear sustained on March 20, 2002 while lifting a tray at work and advised that this was employment related. In reports dated May 19 to July 19, 2005, Dr. Foster treated appellant for persistent right shoulder pain. He noted findings of positive impingement sign and positive Phalen's sign on the right and diagnosed right rotator cuff tear, left rotator cuff tendinitis, and right carpal tunnel syndrome. An electromyogram (EMG) dated October 8, 2002 revealed left sensory neuropathy of the median nerve at the wrist with mild carpal tunnel syndrome. An EMG on June 1, 2005 revealed mild to moderate right carpal tunnel syndrome. Appellant underwent a magnetic resonance imaging (MRI) scan of the right shoulder on May 31, 2005 which revealed a large retracted rotator cuff tear of the distal supraspinatus and infraspinatus tendons and attenuation of the distal torn margin of the supraspinatus and infraspinatus tendons.

On May 11, 2007 appellant filed a claim for a schedule award. In a March 6, 2007 report, Dr. Eric D. Solomon, an osteopath, treated appellant for a right shoulder girdle injury and back pain secondary to work activities. He noted findings upon physical examination of the right shoulder of no crepitation or effusions, range of motion was intact, muscle strength deficit on shoulder girdle rotation was "4/5," there was no atrophy, reflexes were symmetric, there was right shoulder girdle pain, burning and numbness, lower extremity pain, burning and radiating symptoms including mild sensory deficit of the right lower extremity with provocative sensory disturbances of the right carpal distribution. Dr. Solomon diagnosed lumbar radiculopathy, lumbar disc disease with degenerative changes and herniation, cervical spondylosis, rotator cuff tear, status post surgical repair and carpal tunnel syndrome. He found that appellant had 29 percent whole person impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment.* Dr. Solomon noted a 40 percent impairment of abduction, internal and external rotation, and calculated 11 percent impairment for the upper extremity pursuant to Table 16-35 of the A.M.A., *Guides.* He further noted carpal tunnel syndrome sensory involvement of 25 percent, pursuant to Table 16-15, for 10 percent upper extremity impairment. Dr. Solomon calculated 20 percent upper extremity impairment or 12 percent whole person impairment. He also attributed whole person impairment to appellant's lumbar and cervical spine.

[1] Appellant filed a claim for a right shoulder injury on April 17, 2000 that was accepted for a sprain of shoulder and upper arm, file number xxxxxx862. He also filed a claim for a low back injury occurring on October 9, 2001 that was accepted for lumbosacral strain, file number xxxxxx044. These claims are not before the Board.

The Office referred the medical evidence to an Office medical adviser. In a report dated May 23, 2007, the Office medical adviser found that Dr. Solomon's whole person impairment rating did not conform to the A.M.A., *Guides*. Dr. Solomon noted an 11 percent impairment of the upper extremity; however, he failed to provide objective findings such as range of motion measurements. The Office medical adviser noted that he rated carpal tunnel syndrome at 10 percent impairment; however, appellant's claim was not accepted for carpal tunnel syndrome. Moreover, Dr. Solomon rated appellant's lumbar and cervical spine but noted that the Office did not recognize such impairment for schedule award purposes. The Office medical adviser recommended Dr. Solomon provide objective findings for the right shoulder.

By a letter dated May 24, 2007, the Office requested that appellant have Dr. Solomon provide objective findings on examination of the right shoulder pursuant to the A.M.A., *Guides.* It advised appellant that schedule awards for permanent impairment were not based on whole person impairment, only on impairment to a particular extremity.

In a report dated May 22, 2008, Dr. Solomon noted upper extremity impairment was calculated secondary to weakness. He noted findings of weakness in the planes of motion and measured strength as "4/5." Dr. Solomon used Table 16-35 to calculate impairment based on specific strength deficits. He calculated impairments of the shoulder girdle as 11 percent impairment of the upper extremity. Dr. Solomon advised that range of motion of the right shoulder was normal with 180 degrees of flexion, 50 degrees of extension, 90 degrees of internal rotation and 90 degrees of external rotation.

The Office referred Dr. Solomon's report to an Office medical adviser. In a July 2, 2008 report, the Office medical adviser noted that Dr. Solomon measured full range of motion of the right shoulder with 20 percent weakness on abduction and internal and external rotation. Pursuant to Table 16-35 of the A.M.A., *Guides*, appellant had four percent impairment of the right arm. The Office medical adviser indicated that these findings were based on subjective examination and not supported by objective evidence including an EMG, nerve conduction testing or findings of atrophy of the right shoulder girdle musculature. He noted that Dr. Solomon noted pain on the right shoulder with testing that would further alter his findings of weakness pursuant to section 16.8a, page 508, of the A.M.A., *Guides*. The Office medical adviser opined that appellant reached maximum medical improvement on March 5, 2007.

By decision dated July 28, 2008, the Office granted appellant a schedule award for four percent permanent impairment of the right upper extremity. The period of the award was from March 5 to May 31, 2007.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] set 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 regulations as the appropriate standard for evaluating schedule losses.

No schedule award is payable for a member, function or organ of the body not specified in the Act or in the implementing regulations.[4] As neither the Act nor its regulations provide for the payment of a schedule award for the permanent loss of use of the back or the body as a whole, no claimant is entitled to such a schedule award.[5] The Board notes that section 8101(19) specifically excludes the back from the definition of "organ."[6] However, a claimant may be entitled to a schedule award for permanent impairment to an upper or lower extremity even though the cause of the impairment originated in the neck, shoulders or spine.[7]

ANALYSIS

On appeal, appellant contends that he has more than four percent impairment of the right upper extremity. Further, he noted that as the Office medical adviser "did not actually perform a physical examination of appellant, he was not in a position to dispute the physical findings of Dr. Solomon." The Office accepted appellant's claim for right rotator cuff tear and lumbosacral strain. As noted above, however, the Act does not provide for a schedule award based on impairment to the back or spine. Appellant may only receive a schedule award for impairment to the upper extremities if such impairment is established as being due to his accepted rotator cuff tear.

In reports dated March 6, 2007 and May 22, 2008, Dr. Solomon rated 29 percent whole person impairment due to strength deficit. The Board has carefully reviewed Dr. Solomon's reports and notes that he did not provide an adequate evaluation of appellant's right shoulder impairment in accordance with the A.M.A., *Guides*. Dr. Solomon noted "40 percent impairment of abduction, internal and external rotation which totals 3 percent plus 3 percent plus 5 percent" for 11 percent impairment of the upper extremity pursuant to Table 16-35 of the A.M.A.,

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[5] *See Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[6] 5 U.S.C. § 8101(19).

[7] *Thomas J. Engelhart*, *supra* note 5.

Guides.[8] The A.M.A., *Guides*, however, provide at page 509 that strength deficits measured by manual muscle testing should only rarely be included in the calculation of upper extremity impairment as such testing is subject to the individual's control.[9] Dr. Solomon stated that appellant reported right shoulder girdle pain, burning and numbness and lower extremity pain, burning and radiating symptoms, including mild sensory deficit of the right lower extremity and provocative sensory disturbances in the right carpal tunnel distribution; however, he did not set forth findings clearly describing whether appellant had permanent impairment due to pain or sensory loss with respect to his accepted conditions according to the specific tables provided under Chapter 16.[10] The A.M.A., *Guides* contain specific procedures for evaluating sensory loss in the upper extremities and Dr. Solomon did not address these procedures.[11] Dr. Solomon referred to carpal tunnel syndrome sensory deficit of 25 percent, Grade 4, pursuant to Table 16-15. He calculated 10 percent upper extremity impairment under Table 16-15, noting the maximum allowed for sensory deficit of the median nerve was 39 percent. However, the Office did not accept appellant's claim for carpal tunnel syndrome and Dr. Solomon's report failed to provide a rationalized opinion which establishes that the carpal tunnel syndrome was either causally related to appellant's work injury[12] or that it preexisted appellant's work injury.[13]

Dr. Solomon further referenced Tables 15-3 and 15-15 of the A.M.A., *Guides* which pertains to impairment for a lumbar and cervical spine injury.[14] However, as noted above, neither the Act nor its regulations provide for the payment of a schedule award for whole body impairment or for impairment to the back or cervical spine. Dr. Solomon did not otherwise address how these findings caused permanent impairment to a schedule member of the body.

In a May 22, 2008 note, Dr. Solomon referred to his prior report, reiterating that upper extremity impairment was calculated secondary to weakness pursuant to Table 16-35 of the *Guides*. He noted impairment of the shoulder girdle was 11 percent impairment of the upper

[8] The Board notes that Table 16-35 lists a maximum of 3 percent for 30 to 50 percent strength deficit for internal and external rotation and 4 to 6 percent for abduction.

[9] The A.M.A., *Guides* provides that loss of strength may be rated separately if such a deficit has not been considered adequately by other rating methods. An example of this situation would be loss of strength caused by a severe muscle tear that healed leaving "a palpable muscle defect." If the rating physician determines that loss of strength should be rated separately in an extremity that presents other impairments, "the impairment due to loss of strength could be combined with the other impairments, only if based on unrelated etiologic or pathomechanical causes. *Otherwise, the impairment ratings based on objective anatomic findings take precedence*." (Emphasis in the original). The A.M.A., *Guides* further provides that decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximum force. A.M.A., *Guides* 508, section 16.8a.

[10] *See* A.M.A., *Guides* 480-97.

[11] *Id.*

[12] For conditions not accepted by the Office as being employment related, it is the employee's burden to provide rationalized medical evidence sufficient to establish causal relation, not the Office's burden to disprove such relationship. *Alice J. Tysinger*, 51 ECAB 638 (2000).

[13] *See Carol A. Smart*, 57 ECAB 340 (2006).

[14] A.M.A., *Guides* 385, 392, Table 15-3, 15-15.

extremity; however, he did fully not explain how he calculated this amount pursuant to the Table 16-35 of the A.M.A., *Guides*.[15] Additionally, as noted above, the A.M.A., *Guides* specifically provides that strength deficits measured by manual muscle testing should only rarely be included in the calculation of upper extremity impairment and Dr. Solomon provided no explanation as to why appellant's strength deficit was not adequately considered by other methods in the A.M.A., *Guides*.[16] The report offered no basis on which to attribute impairment under the A.M.A., *Guides*.

In a report dated July 2, 2008, the Office medical adviser provided an analysis of permanent impairment under Table 16-13 similar to that contained in Dr. Solomon's report. He determined that pursuant to Table 16-35 of the A.M.A., *Guides* appellant had four percent impairment of the right arm.[17] However, there was no explanation as to why appellant's strength deficit could not adequately be considered by the other methods outlined in Chapter 16.[18]

Proceedings under the Act are not adversarial in nature nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, it shares responsibility in the development of the evidence. Once it has begun an investigation of a claim, it must pursue the evidence as far as reasonably possible. The Office has an obligation to see that justice is done.[19]

The case will be remanded to the Office for referral of appellant and the case record to an appropriate specialist and an opinion on the extent of impairment of his right arm, to be followed by an appropriate decision. Furthermore, as the record indicates that appellant has another accepted claim pertaining to the right shoulder, file number xxxxxx862, this claim should be combined with the present claim to allow the medical specialist to review all relevant evidence regarding appellant's right upper extremity.[20]

CONCLUSION

The Board finds the case not in posture for decision.

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[15] For example, in rating impairment due to loss of strength, Dr. Solomon did not address whether there was complete active range of motion against gravity without resistance or with resistance.

[16] *Richard A. Neidert*, 57 ECAB 474 (2006) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

[17] The Office medical adviser allowed two percent each for internal and external rotation without addressing abduction.

[18] A.M.A. *Guides* 508, 16.8a, Principles.

[19] *A.A.*, 59 ECAB ___ (Docket No. 08-951, issued September 22, 2008).

[20] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *File Maintenance and Management*, Chapter 2.400.8(c) (February 2000) (advises that claims should be doubled where a new injury case is reported for an employee who previously filed an injury claim for a similar condition or the same part of the body).

ORDER

IT IS HEREBY ORDERED THAT the July 28, 2008 decision of the Office of Workers' Compensation Programs is set aside and remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: July 20, 2009
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