United States Department of Labor
Employees' Compensation Appeals Board

ROBERT C. MOBERG, Appellant	)	
and	)	**Docket No. 06-147**
	)	**Issued: April 14, 2006**
DEPARTMENT OF THE NAVY, MARE ISLAND NAVAL SHIPYARD, Vallejo, CA, Employer	)	

Appearances:
Robert C. Moberg, 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

JURISDICTION

On October 31, 2005 appellant filed a timely appeal from the October 20, 2005 merit decision of the Office of Workers' Compensation Programs, which denied an increased schedule award for his right upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review this schedule award issue.

ISSUE

The issue is whether appellant is entitled to an increased schedule award for his right upper extremity.

FACTUAL HISTORY

On May 18, 1984 appellant, then a 41-year-old sheet metal mechanic, sustained an injury in the performance of duty while using a wrench. The bolt he was working on snapped in half, causing him to fall on his right side. The Office accepted his claim for contusion of the right elbow with epicondylitis.

On September 1, 1986 appellant filed a claim alleging that his right shoulder condition was a result of his federal employment. He first experienced pain in his right shoulder while spinning metal on August 13, 1983. The pain became progressively worse over the next three years. The Office accepted this claim for bicipital tendinitis of the right shoulder and approved his April 8, 1987 surgery for excision of the distal end of the right clavicle.

On January 19, 1990 the Office issued a schedule award for a 15 percent permanent impairment of the right upper extremity. On August 8, 1991 the Office issued a schedule award for an additional three percent impairment of the right upper extremity due to elbow pain.

The Office expanded acceptance of appellant's claim to include right shoulder impingement. On January 10, 1996 appellant underwent a subacromial decompression of the right shoulder, which the Office authorized. On November 11, 2004 he underwent a right shoulder arthroscopic rotator cuff repair and subacromial decompression, which the Office also authorized.

On July 19, 2005 appellant filed a claim for an increased schedule award. He submitted a May 24, 2005 evaluation by his orthopedic surgeon, Dr. Kent E. Yinger, who reported that appellant had a 13 percent permanent impairment of the right upper extremity due to loss of shoulder motion and an 18 percent permanent impairment due to loss of shoulder strength. He indicated no impairment due to the right elbow.[1]

The Office referred appellant, together with a statement of accepted facts, to Dr. Alan B. Kimelman, a specialist in physical medicine and rehabilitation, for a second opinion. Dr. Kimelman examined appellant on August 30, 2005 and reported his findings. He offered no impairment rating.

On September 21, 2005 an orthopedic consultant, Dr. Arthur S. Harris, reviewed appellant's medical records, including the findings reported by Dr. Yinger and Dr. Kimelman. Using Dr. Kimelman's report, he determined that appellant had a 15 percent permanent impairment of his right upper extremity due to loss of shoulder motion and loss of shoulder strength.

In a decision dated October 20, 2005, the Office denied appellant's claim for an increased schedule award. The Office explained that he previously received a schedule award for an 18 percent permanent impairment of his right upper extremity and that the medical evidence did not support an increase in the impairment already compensated.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[2] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body.

[1] Epicondylitis is not given a permanent rating unless there is some other factor to consider, such as surgery that causes a permanent loss of grip strength. American Medical Association, *Guides to the Evaluation of Permanent Impairment* 505 (A.M.A., *Guides*) (5th ed. 2001).

[2] 5 U.S.C. § 8107.

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 A.M.A., *Guides*.[3]

ANALYSIS

The Office denied appellant's claim for an increased schedule award based on the review and calculation performed by Dr. Harris, an orthopedic consultant. He based his calculation of permanent impairment on the August 30, 2005 findings reported by Dr. Kimelman, the Office referral physiatrist. The Board notes, however, that Dr. Yinger, appellant's orthopedic surgeon, evaluated appellant only three months earlier on May 24, 2005. While Dr. Harris noted these findings, he gave no rationale for selecting Dr. Kimelman's report as the basis for his calculation. In such cases the Board has held that the Office must provide an explanation for selecting one report over another or refer the claimant for another evaluation.[4] Here, there are more substantive reasons to set aside the Office's decision.

Dr. Yinger examined appellant's right shoulder on May 24, 2005 and reported findings of 120 degrees flexion, 30 degrees extension, 130 degrees abduction, 20 degrees adduction, 30 degrees internal rotation and 50 degrees external rotation. Using Figures 16-40 through 16-46, pages 476 to 479, of the A.M.A., *Guides*, these findings represent upper extremity impairments of 4, 1, 2, 1, 4 and 1 percent respectively, for a 13 percent impairment due to loss of motion.

Dr. Kimelman examined appellant's right shoulder on August 30, 2005. His findings were 120 degrees flexion, 50 degrees extension, 110 degrees abduction, 25 degrees adduction, 60 degrees internal rotation and 80 degrees external rotation. Using the same figures in the A.M.A., *Guides*, these findings represent upper extremity impairments of 4, 0, 3, 1, 2 and 0 percent respectively, for a 10 percent impairment due to loss of motion.

Repeated examinations, even by the same physician, need not yield identical findings, but the results should be consistent. The A.M.A., *Guides* state:

> "As with any biological measurements, some variability and normal fluctuations are inherent in permanent impairment ratings. Two measurements made by the same examiner using the [A.M.A.,] *Guides* that involve an individual or an individual's functions would be consistent if they fall within 10 percent per each other. Measurements should also be consistent between two trained observers or by one observer on two separate occasions, *assuming the individual's condition is*

[3] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001 the Office began using the A.M.A., *Guides* (5th ed. 2001).

[4] *Irving Brichke*, 32 ECAB 1044 (1981) (setting aside the schedule award for right leg impairment and remanding the case where the Office medical adviser provided no rationale for selecting one evaluation of the four that were conducted within a span of five months); *John C. Messick*, 25 ECAB 333 (1974) (when several audiograms are in the case record and all are made within approximately two years of each other and are submitted by more than one physician, the Office should give an explanation for selecting one audiogram over the others).

stable. Repeating measurements may decrease error and result in a measurement that is closer to average function."[5]

Dr. Kimelman examined appellant only three months after Dr. Yinger, yet he recorded ranges of motion that appeared significantly improved. Extension increased by 67 percent in those few months. Internal rotation doubled. External rotation increased by 60 percent. These three measures reduced Dr. Yinger's rating for loss of motion by four percent.[6]

The A.M.A., *Guides* explains that 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 [maximum medical improvement], a permanent impairment rating may be performed."[7]

The apparent improvement in appellant's right shoulder motion over a three-month period raises a question of whether his medical condition was static and well stabilized by August 30, 2005. Dr. Harris noted this improvement, reporting that appellant's rating was now less than the 18 percent previously awarded and that his condition was "somewhat improved" since Dr. Yinger's examination on May 24, 2005. But he offered no rationale, in light of this improvement, to show that appellant had reached maximum medical improvement.

The estimates given for loss of strength also raise a question of maximum medical improvement. Dr. Yinger reported a right upper extremity impairment of 18 percent due to strength deficit from musculoskeletal disorders based on manual muscle testing. Using the same table in the A.M.A., *Guides*,[8] Dr. Kimelman reported an impairment of only six percent. Apart from the significant discrepancy in these estimates, the A.M.A., *Guides* provides that when evaluating strength the examiner must have good reason to believe the individual has reached maximum medical improvement and that the condition is permanent:

> "Maximum strength is usually not regained for at least a year after an injury or surgical procedure. Because impairment is evaluated when the individual has reached [maximum medical improvement], strength can only be applied as a measure when a year or more has passed since the time of injury or surgery."

Appellant's most recent surgery, an authorized right shoulder arthroscopic rotator cuff repair and subacromial decompression, was performed on November 11, 2004, less than a year

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[5] A.M.A., *Guides* 20 (emphasis added).

[6] A 15 percent worsening in abduction increased appellant's rating by one percent. A 25 percent improvement in adduction had no effect.

[7] A.M.A., *Guides* 19.

[8] *Id*. at 510 (Table 16-35).

before the impairment ratings given by Dr. Yinger and Dr. Kimelman. Dr. Harris did not explain how a rating of permanent impairment was appropriate under these circumstances.

Further, Dr. Harris did not justify a separate rating for loss of strength. The A.M.A., *Guides* states that it is a rare case where loss of strength must be rated separately because it is not considered adequately by other methods.[9] Dr. Harris did not explain why this was one of those rare cases.

Lastly, the Board notes that the Office authorized appellant's April 8, 1987 surgery for excision of the distal end of the right clavicle. The A.M.A., *Guides* provides that a resection arthroplasty of the distal clavicle is a 10 percent impairment of the upper extremity.[10] If other impairment evaluation criteria have not adequately encompassed the extent of appellant's impairment and there are no overlapping pathomechanics, this diagnosis-based estimate is combined with separately derived motion impairments.[11] Even using Dr. Kimelman's lower rating for loss of motion, such a combination would support a 19 percent impairment of appellant's right upper extremity. Dr. Harris did not address whether this method of evaluation was appropriate.

The Board finds that further development of the medical evidence is warranted. The Office medical consultant provided no reason for selecting Dr. Kimelman's report as the basis for his calculations. Also, his report does not adequately address the issue of maximum medical improvement, whether loss of strength must be rated separately and whether loss of motion should be combined with a diagnosis-based estimate for resection arthroplasty. The Board will set aside the Office's October 20, 2005 decision and remand the case for further development and an appropriate final decision on appellant's claim for an increased schedule award for his right upper extremity.

CONCLUSION

The Board finds that this case is not in posture for decision. Further, development of the medical evidence is warranted.

[9] If the examiner judges 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. Further, decreased strength cannot be rated in the presence of decreased motion or painful conditions that prevent effective application of maximal force in the region being evaluated. *Id*. at 508.

[10] *Id*. at 506 (Table 16-27).

[11] *Id*. at 505, 499.

ORDER

IT IS HEREBY ORDERED THAT the October 20, 2005 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: April 14, 2006
Washington, DC

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

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