United States Department of Labor
Employees' Compensation Appeals Board

DENNIS P. McCARTHY, Appellant	)	
and	)	**Docket No. 04-1804**
	)	**Issued: January 13, 2005**
DEPARTMENT OF THE TREASURY, U.S. CUSTOMS SERVICE, Jamaica, NY, Employer	)	

Appearances:
Dennis P. McCarthy, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On July 7, 2004 appellant filed an appeal from a merit decision of the Office of Workers' Compensation Programs dated May 4, 2004 which granted a schedule award for 10 percent impairment of the right upper extremity. Pursuant to 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 10 percent permanent impairment of his right upper extremity, for which he has received a schedule award.

FACTUAL HISTORY

On October 22, 2001 appellant, then a 48-year-old senior special agent, filed a traumatic injury claim alleging that on October 21, 2001 he sustained a right shoulder injury as he reached for a stairwell door to provide access to the World Trade Center Area 6 for New York fire department personnel. On January 18, 2002 the Office accepted that he sustained an

exacerbation of tendinitis of the right shoulder. A magnetic resonance imaging (MRI) scan demonstrated subchondral cystic degenerative changes of the humeral head, an old Hill-Sachs lesion, and persistent large effusion as well as biceps tenosynovitis. Appellant's symptoms persisted and his physician recommended arthroscopic surgery for impingement from an enlarged abnormal acromioclavicular joint.

On May 23, 2002 the Office authorized a right shoulder arthroscopy with biceps tenodesis and subacromial decompression. On July 18, 2002 appellant successfully underwent surgery.

On August 13, 2002 appellant was awarded compensation for the period August 11 to September 7, 2002. On November 16, 2002 he returned to work at the employing establishment on a full-time basis.

On February 21, 2003 appellant was noted as having mild greater tuberosity tenderness with a mildly positive impingement sign on the right and right shoulder stiffness.

By letter dated July 9, 2003, the Office advised appellant that he would be compensated for any permanent impairment in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, fifth edition, 2001, and requested that his treating physician, Dr. Jonathan B. Ticker, a Board-certified orthopedic surgeon, provide a report addressing the right upper extremity and identify all loss of function and weakness.

On July 30, 2003 Dr. Ticker noted that appellant had pain often at night and with use, that forward elevation was to 150 degrees (165 degrees on opposite side), backward elevation to 45 degrees (60 degrees on opposite), 120 degrees of abduction bilaterally, 30 degrees of adduction (60 degrees on opposite), 45 degrees of external rotation (60 degrees on opposite), and weakness on the rotator cuff. Dr. Ticker noted that date as the date of maximum improvement.

On August 25, 2003 the Office referred the case record with a statement of accepted facts to the Office medical adviser for calculation of the extent of appellant's permanent impairment. On September 1, 2003 the Office medical adviser calculated that appellant had 150 degrees of flexion which was a 2 percent impairment according to Table 16-40, page 476; 45 degrees of extension which was a 1 percent impairment according to Table 16-40, page 476; 120 degrees of abduction which was a 3 percent impairment according to Table 16-43, page 477; 30 degrees of adduction which was a 1 percent impairment according to Table 16-43, page 477; 30 degrees of internal rotation which was a 4 percent impairment according to Table 16-46, page 479; and 75 degrees which was a 0 percent impairment according to Table 16-46, page 479. He added the range of motion loss to find an 11 percent impairment and he noted the date of maximum medical improvement as July 30, 2003.

In a September 23, 2003 report, Dr. Ticker noted that appellant complained of crepitus with range of motion, persistent motion limitations and weakness of the upper extremity. Dr. Ticker provided new range of motion measurements, which were greater than the deficits noted before, stating that appellant had 140 degrees of forward flexion, 40 degrees of extension, abduction to 90 degrees, adduction to 20 degrees, internal rotation to 30 degrees and external

rotation to 40 degrees. He noted that appellant had 4+/5 weakness of the supraspinatus, 5-/5 weakness in external rotator strength, and internal rotation strength with discomfort. Dr. Ticker consulted the A.M.A., *Guides*, fourth edition, page 66, and stated that losses in range of motion is combined with other impairments to arrive at an impairment rating. He opined that appellant's loss of motion was a 14 percent impairment. Dr. Ticker then combined with impairment for crepitation secondary to degenerative changes, which was a 10 percent joint impairment, multiplied by the value for the glenohumeral joint, which was 60 percent, which equaled 6 percent impairment. He then added 6 percent with 14 percent to arrive at a 20 percent permanent impairment which was then added to further impairment for loss of strength. Dr. Ticker added an additional 10 percent as shown in Table 34 on page 65, and concluded that appellant had a total permanent impairment of his right upper extremity of 30 percent.

By letter dated January 12, 2004, the Office advised appellant that Dr. Ticker had used the fourth edition of the A.M.A., *Guides*, which was not current, and that the Office medical adviser stood by his 11 percent rating.

The Office found a conflict in medical opinion between Dr. Ticker and the Office medical adviser. It referred appellant, together with a statement of accepted facts, to Dr. Edmunde A.C. Stewart, a Board-certified orthopedic surgeon, for an impartial evaluation of the degree of permanent impairment.

By report dated March 23, 2004, Dr. Stewart reviewed appellant's factual and medical history, noted examination results and provided the following measurements: forward flexion of right compared to left was 150 to 155 degrees; extension was 45 to 50 degrees; abduction was 165 to 170 degrees; adduction was 40 to 40 degrees; internal rotation was 80 to 80 degrees; and external; rotation was 80 to 80 degrees. Dr. Stewart noted that, on passive manipulation of the right shoulder, no crepitus was noted, and appellant's right hand grasp and neurocirculatory status was satisfactory. He diagnosed status post right shoulder sprain, and status post corrective arthroscopic surgery of the right shoulder, and opined that appellant had made an excellent recovery from his conditions. Dr. Stewart opined that appellant's condition had improved since his assessment by Dr. Ticker and that he was performing his full duties as a law enforcement officer. He noted that, although there appeared to be a mild change in the right deltoid musculature, no additional 10 percent should be added to any perceived loss of strength. Referencing the A.M.A., *Guides*, fifth edition, pages 474 to 479, Dr. Stewart noted that forward flexion to 150 degrees was a 2 percent impairment, extension to 45 degrees was a 1 percent impairment, abduction to 165 was a 1 percent impairment, and adduction and rotation showed no losses. To this 4 percent impairment for range of motion losses, Dr. Stewart added an additional 6 percent for the mild deltoid atrophy and mild loss of power which resulted in a 10 percent permanent impairment of appellant's right upper extremity.

On April 5, 2004 the Office referred Dr. Stewart's report to an Office medical adviser. The Office medical adviser opined that Dr. Stewart gave a well-rationalized opinion in support of the 10 percent impairment found on examination.

On May 4, 2004 the Office granted appellant a schedule award for a 10 percent permanent impairment of his right upper extremity for the period July 20, 2003 to February 23, 2004 for a total of 31.2 weeks of compensation.

LEGAL PRECEDENT

Section 8107 provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[1] The schedule award provision of the Act[2] and its implementing regulation[3] 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,* fifth edition, 2001 has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*.[4] However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment. Chapter 18 of the A.M.A., *Guides* (fifth edition) provides a grading scheme and procedure for determining impairment of an affected body part due to pain, discomfort, or loss of sensation.[5] The element of pain may serve as the sole basis for determining the degree of impairment for schedule compensation purposes.[6]

Section 8123 provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint

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[1] 5 U.S.C. § 8107(a). It is thus the claimant's burden of establishing that he or she sustained a permanent impairment of a scheduled member or function as a result of her employment injury. *See Raymond E. Gwynn*, 35 ECAB 247 (1983) (addressing schedule awards for members of the body that sustained an employment-related permanent impairment); *Philip N.G. Barr*, 33 ECAB 948 (1982) (indicating that the Act provides that a schedule award be payable for a permanent impairment resulting from an employment injury).

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

[5] A.M.A., *Guides* at 565 (August 2002).

[6] *Paul A. Toms*, 38 ECAB 403 (1987); *Robin L. McClain*, 38 ECAB 398 (1987).

a third physician who shall make an examination.[7] In situations where there exists opposing medical reports of virtually equal weight and rationale, and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual and medical background, must be given special weight.[8]

ANALYSIS

The Board finds that a conflict of medical opinion arose between Dr. Ticker and an Office medical adviser. The Office properly referred appellant to Dr. Stewart, a Board-certified specialist for an examination.[9]

Dr. Stewart provided a thorough and complete medical report based on a proper factual and medical background, which included new measurements of appellant's upper extremity range of motion and an opinion on causal relationship. He remeasured appellant's ranges of motion and found that appellant's forward flexion of right compared to left was 150 to 155 degrees; extension was 45 to 50 degrees; abduction was 165 to 170 degrees; adduction was 40 to 40 degrees; internal rotation was 80 to 80 degrees; and external rotation was 80 to 80 degrees. He noted that, on passive manipulation of the right shoulder, no crepitus was noted, and appellant's right hand grasp and neurocirculatory status was satisfactory, and he diagnosed status post right shoulder sprain, and status post corrective arthroscopic surgery of the right shoulder, and opined that appellant had made an excellent recovery from his conditions. Dr. Stewart opined that appellant's condition had improved since his assessment by Dr. Ticker and noted that he was presently performing his full duties as a law enforcement officer, which would not be possible if he had a 30 percent permanent impairment. He noted that, although there appeared to be a mild change in the right deltoid musculature, no additional 10 percent should be added to any perceived loss of strength. Referencing the A.M.A., *Guides,* fifth edition, pages 474 to 479, Dr. Stewart noted that forward flexion to 150 degrees was 2 a percent impairment, extension to 45 degrees was a 1 percent impairment, abduction to 165 was a 1 percent impairment, and adduction and rotation showed no losses. To this 4 percent impairment for range of motion losses, Dr. Stewart added an additional 6 percent for the mild deltoid atrophy and mild loss of power which resulted in a 10 percent permanent impairment of appellant's right upper extremity.

On May 4, 2004 the Office granted appellant a schedule award for a 10 percent permanent impairment of his right upper extremity for the period July 20, 2003 to February 23, 2004 for a total of 31.2 weeks of compensation.

Dr. Stewart was an impartial medical examiner who rendered a complete and thorough opinion based on a proper factual and medical background, based upon the A.M.A., *Guides.* Dr. Stewart properly applied the A.M.A., *Guides* to the measurements found on examination. The Board finds that his report is entitled to special weight in establishing the degree of appellant's permanent impairment. The weight of the medical evidence of record is represented

[7] 5 U.S.C. § 8123(a).

[8] *Bertha J. Soule (Ralph G. Soule),* 48 ECAB 314 (1997).

by Dr. Stewart's well-rationalized report, and establishes that appellant has 10 percent impairment of the right upper extremity for which he received a schedule award. The medical evidence does not establish that appellant has more permanent impairment than that awarded.

CONCLUSION

The Board finds that appellant has not established that he has more than a 10 percent impairment of the right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 4, 2004 is hereby affirmed.

Issued: January 13, 2005
Washington, DC

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

[9] *See Leonard M. Burger*, 51 ECAB 369 (2000) (Office found conflict between appellant's treating physician and Office medical adviser on extent of contusion injury affects).