

acromioplasty. He returned to work in a light-duty position on January 30, 1995. Dr. Richard L. Romeyn, Board-certified in sports medicine and orthopedic surgery, advised that appellant's restrictions were permanent. Appellant accepted a limited-duty/modified job offer on May 17, 1995 and continued in this position until he stopped work on April 30, 1998 to have a shoulder arthrodesis.

By decision dated July 28, 1995, the Office issued a schedule award for a 40 percent impairment of the right upper extremity.¹

On June 20, 1997 appellant filed a claim for a schedule award. In an August 19, 1997 report, Dr. Romeyn advised that appellant had an impairment of 75 to 100 percent of the right arm. He explained that appellant had a severe functional restriction of range of motion, secondary to antalgic, forward flexion of the shoulder of 10 degrees and active abduction of the shoulder of 15 degrees. He noted that external rotation of the shoulder was 15 degrees with appellant's elbows at his sides and advised that he could not position his elbow away from his side for external rotation to be measured in a more customary manner. Dr. Romeyn also advised that it was impossible to assess anterior laxity because the shoulder could not be positioned in abduction or external rotation and related that appellant complained of disabling pain with any attempt to position his hand in forward flexion, adduction or external rotation.

By decision dated November 5, 1997, the Office issued a schedule award for an additional five percent impairment of the right upper extremity.² On November 28, 1997 appellant requested a hearing. By decision dated March 11, 1998, the Office hearing representative affirmed the Office's November 5, 1997 decision.

Appellant subsequently underwent right shoulder arthrodesis and a right revision shoulder arthroplasty, which was authorized by the Office on March 31, 1998 and May 11, 1999.

On October 4, 1999 Dr. S.W. O'Driscoll, a Board-certified orthopedic surgeon, performed a revision of the right glenohumeral and acromioclavicular arthrodesis. He indicated that a bone graft was placed on the acromioclavicular and glenohumeral interfaces and a plate was laid along the scapular spine and the proximal humerus. He indicated that "the arm was positioned in 30 degrees of abduction, 30 degrees of forward flexion and 30 degrees of internal rotation." Dr. O'Driscoll noted that a plate was secured to the bone and the arthrodesis fixed with two 6.5 millimeter cancellous screws placed through the humeral head into the glenoid. He explained that appellant had good positioning of the shoulder with the screws in place.

On September 3, 2002 the Office scheduled appellant for a second opinion examination with Dr. Bruce W. Davey, a Board-certified orthopedic surgeon.

¹ In a June 6, 1995 report, Dr. Robert A. Wengler, a Board-certified orthopedic surgeon, advised that appellant had an impairment of 40 percent to the right arm. On July 12, 1995 an Office medical adviser indicated that he concurred with Dr. Wengler and opined that appellant had an impairment of 40 percent to the right arm.

² In a September 28, 1997 report, an Office medical adviser found that appellant had right arm impairment of 45 percent.

In a September 16, 2002 report, Dr. Davey, utilized the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) and noted appellant's history. He reported appellant's complaints of "daily aching pain in the shoulder and pain with any attempted use" and that it interfered with sleep. He noted that motion restriction was not applicable as appellant had a shoulder fusion. Dr. Davey examined appellant, noting a large scar and muscle atrophy in the left shoulder area. Appellant's fusion was at 0 degrees of abduction and 70 degrees of internal rotation but was "difficult to judge accurately due to the scapulothoracic motion." He explained that appellant was unable to get his hand to his mouth and could not use his arm to comb his hair or place the back of his hand in the small of his back and explained that appellant had "essentially no active motion of the glenohumeral joint and only minimal scapulothoracic motion." Under the A.M.A., *Guides*, he opined that appellant had a 49 percent permanent impairment of the shoulder. Dr. Davey referred to Figure 16-39 and noted that ankylosis of 0 degrees was equal to 80 percent of 30 or 24 percent.³ He referred to Figure 16.42 and stated that abduction of 0 degrees was worth 80 percent of 18 percent yielding 15 percent impairment.⁴ He referred to Figure 16-45 and indicated that rotation with ankylosis at 70 degrees was worth 80 percent of 12 percent or 10 percent.⁵ He added these impairments and arrived at 49 percent of the upper extremity. Dr. Davey referred to section 16.4i and opined that the impairment of the entire upper extremity would be 60 percent of this value.⁶ He indicated that appellant reached maximum medical improvement one year following his 1998 fusion.

In a report dated January 13, 2003, an Office medical adviser noted appellant's history of injury and treatment, which included reports from Drs. O'Driscoll and Davey.⁷ Appellant underwent a revision and shoulder fusion with autogenously bone graft and advised that appellant reached maximum medical improvement on October 4, 2000. Physical examination revealed complaints of intermittent discomfort in the right shoulder, "especially with use" and referred to Tables 16-15 and 16-10.⁸ Dr. David H. Garlicky noted that this would allow a three percent permanent impairment for a Grade 4 for pain in the distribution of the suprascapular nerve. The Office medical adviser also noted that appellant had a large scar and muscle atrophy and "significant scapulothoracic motion confounding the physical examination." He noted that Dr. O'Driscoll indicated in his October 4, 1999 operative report that the fusion was performed in 30 degrees of abduction, flexion and internal rotation. The Office medical adviser referred to Figure 16-43 and determined that 30 degrees of abduction was equal to 9 percent impairment.⁹ He referred to Figure 16-46 and determined that 45 degrees of internal rotation was equal to 6 percent impairment.¹⁰ The Office medical adviser referred to Figure 16-40 and determined that

³ A.M.A., *Guides* 475.

⁴ *Id.* at 477.

⁵ *Id.* at 478.

⁶ *Id.* at 474.

⁷ He also indicated that notations from physical therapists were available for review.

⁸ A.M.A., *Guides* 492 and 482.

⁹ *See supra* note 2.

¹⁰ A.M.A., *Guides* 479.

30 degrees of flexion was equal to 15 percent impairment.¹¹ He added these range of motion impairments which equaled 30 percent. The Office medical adviser combined the 30 percent with the 3 percent for pain and determined that appellant had 32 percent of the right upper extremity.¹² On March 31, 2003 the Office medical adviser explained that the 32 percent award was a total award.

By decision dated November 20, 2003, the Office denied appellant's claim for an additional schedule award. The Office found that the medical evidence was insufficient to establish that appellant was entitled to an additional impairment.

Appellant requested a review of the written record on December 15, 2003.

In a June 14, 2004 decision, the Office hearing representative found that there was a conflict in the medical evidence and remanded the case for an impartial medical examination. The Office hearing representative noted the medical reports provided conflicting findings. The Office hearing representative noted that Dr. Davey found that appellant had a complete loss of motion based upon his September 16, 2002 examination, whereas the Office medical adviser found up to 45 degrees of internal rotation and 30 degrees for abduction and flexion. He further noted that the differing findings of Dr. Davey and Dr. O'Driscoll could not be reconciled. He determined that the Office medical adviser did not explain why he had chosen to use one report over the other and that the case should be remanded for further development.

On August 6, 2004 the Office referred appellant, together with a statement of accepted facts and the medical record to Dr. Stephen F. Weiss, a Board-certified orthopedist, for an impartial medical evaluation to resolve the conflict in opinion between Dr. O'Driscoll, appellant's treating physician and Dr. Davey, the second opinion physician, regarding the impairment to the right upper extremity.

In a September 8, 2004 report, Dr. Weiss reviewed appellant's history of injury and treatment. He noted that appellant related that he had minimal use of the right upper extremity and wore a sling because it was too painful to walk with his arm at his right side and was unable to use his right arm to feed himself or operate a computer. Dr. Weiss conducted a physical examination and noted that for the right shoulder; appellant had 15 degrees of flexion and abduction, 0 degrees of extension, 45 degrees of internal rotation and advised that external rotation "lacks" 30 degrees. Dr. Weiss indicated that appellant lacked 15 degrees for adduction and had supraspinatus and infraspinatus atrophy, as well as scapular winging on the right side and prominence distal to the lateral border of the acromion, which felt like a screw head. He advised that appellant related that it was becoming more prominent and was "possibly a screw backing out." Appellant had edema of the hand and forearm, which was consistent with disuse and explained that the circumferences of the upper extremities were not measured. Dr. Weiss also advised that appellant had tenderness to palpation over the screw heads and along the incisional area at the mid-humerus. He utilized the A.M.A., *Guides* and opined that appellant had a 41 percent impairment of the right shoulder, which included 36 percent for lack of motion

¹¹ *Id.* at 476.

¹² *Id.* at 604.

and 5 percent for secondary scapular winging. He noted that appellant reached maximum medical improvement one year postsurgery.

In an October 8, 2004 report, the Office medical adviser reviewed the report of Dr. Weiss stating that it was “the most complete and recognizes the complexity of examination of the fused shoulder.” He noted that Dr. Weiss found 41 percent impairment, but had inadvertently added the findings for range of motion and winging instead of utilizing the Combined Values Chart. The Office medical adviser also explained that a fused scapular winging was to be expected from a fusion. He noted that appellant was entitled to five percent for Grade 1 pain in the distribution of the suprascapular nerve to her right shoulder as evidenced by atrophy of the rotator cuff muscles pursuant to Tables 16-10 and 16-15.¹³ Dr. Weiss referred to Figure 16-40 advised that appellant had 15 degrees of flexion, which equated to 13 percent and 0 degrees of extension, which equated to 3 percent.¹⁴ The Office medical adviser referred to Figure 16-43 and indicated that appellant had abduction which was ankylosed at 15 degrees and was entitled to an impairment of 10 percent and adduction, which lacked 15 degrees or 1 percent.¹⁵ He referred to Figure 16-46 and noted that appellant had internal rotation of 45 degrees, which was equal to 3 percent and external rotation, which lacked 30 degrees, of 2 percent.¹⁶ He added the values for these impairments and noted that they were equal to 32 percent. The Office medical adviser indicated that appellant was entitled to an award for an additional 3 percent impairment due to his pain related to an apparent nonunion. He explained that appellant was classified at Class 3 for pain and referred to Table 18-3.¹⁷ The Office medical adviser referred to the Combined Values Chart and advised that appellant was awarded 37 percent to the right upper extremity.¹⁸

By decision dated October 18, 2004, the Office denied appellant’s claim for an additional schedule award. The Office advised appellant that he had already been awarded more of a schedule award than his current permanent impairment.

On August 27, 2005 appellant requested reconsideration.

By decision dated December 7, 2005, the Office denied modification of the October 18, 2004 decision.

¹³ *Id.* at 482, 492.

¹⁴ *See supra* note 11.

¹⁵ *Supra* note 4.

¹⁶ *Supra* note 10.

¹⁷ A.M.A., *Guides* 575.

¹⁸ *See supra* note 12.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act¹⁹ sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.²⁰ The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.²¹ The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.²²

ANALYSIS

The Office determined that a conflict in medical opinion was created because there were conflicting findings in the medical reports between Dr. Davey, for the Office and Dr. O'Driscoll, for appellant. The Office noted that Dr. Davey found that appellant had a complete loss of motion, while Dr. O'Driscoll granted appellant up to 45 degrees of internal rotation and 30 degrees for abduction and flexion. The Office noted that the operating physician, Dr. O'Driscoll indicated that the fusion was performed at 30 degrees of abduction, flexion and internal rotation. The Office referred appellant to Dr. Stephen F. Weiss, a Board-certified orthopedic surgeon and impartial medical examiner, to resolve the conflict related to the differing findings for range of motion.

Section 8123(a) of the Act²³ provides, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.²⁴ In situations where there are 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 on a proper factual background, must be given special weight.²⁵

Dr. Weiss examined appellant, discussed the history of injury and reviewed the evidence of record. He determined that appellant had minimal use of the right upper extremity and noted that he used a sling as the pain did not allow appellant to walk with his arm at his right side and appellant was unable to use his right arm to feed himself or operate a computer. Dr. Weiss noted that for the right shoulder; appellant had 15 degrees of flexion and abduction, 0 degrees of

¹⁹ 5 U.S.C. §§ 8101-8193.

²⁰ 5 U.S.C. § 8107.

²¹ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

²² A.M.A., *Guides* (5th ed. 2001); 20 C.F.R. § 10.404.

²³ *See supra* note 19.

²⁴ 5 U.S.C. § 8123(a).

²⁵ *Barbara J. Warren*, 51 ECAB 413 (2000).

extension, 45 degrees of internal rotation and advised that external rotation “lacks” 30 degrees. He indicated that appellant lacked 15 degrees for adduction and noted that appellant had supraspinatus and infraspinatus atrophy, scapular winging and prominence distal to the lateral border of the acromion. Dr. Weiss also determined that appellant had edema of the hand and forearm, related to disuse and tenderness to palpation over the screw heads and along the incisional area at the mid-humerus. He utilized the A.M.A., *Guides* and opined that appellant had a 41 percent impairment of the right shoulder, which included 36 percent for lack of motion and 5 percent for secondary scapular winging. He noted that appellant reached maximum medical improvement one year postsurgery.

The Office medical adviser utilized the findings provided in Dr. Weiss’ report and applied the A.M.A., *Guides* to the physician’s findings.²⁶ He referenced Tables 16-10 and 16-15 and determined that appellant was entitled to an award of 5 percent for Grade 1 pain in the distribution of the suprascapular nerve to the right shoulder due to the atrophy of the rotator cuff muscles.²⁷ He referred to Figure 16-40 and noted that appellant had 15 degrees of flexion which was equal to an impairment of 13 percent and that 0 degrees of extension was equal to 3 percent.²⁸ The Office medical adviser referred to Figure 16-43 and indicated that appellant had abduction which was ankylosed at 15 degrees and was entitled to an impairment of 10 percent and adduction, which lacked 15 degrees or 1 percent.²⁹ He noted that appellant had internal rotation of 45 degrees and referred to Figure 16-46 and obtained impairment of 3 percent and for external rotation, appellant lacked 30 degrees and warranted an impairment of 2 percent.³⁰ He added the values for these impairments and noted that they were equal to 32 percent. The Office medical adviser also indicated that appellant was entitled to an award for an additional three percent impairment due to his pain related to an “apparent nonunion” and referred to Table 18-3.³¹ However, according to section 18.3(b) of the A.M.A., *Guides*, “examiners should not use this chapter to rate pain related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.”³² Office procedures provide that Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain (Chapters 13, 16 and 17).³³ Thus, he did not

²⁶ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.11(d) (April 1993) (an Office medical advisers may review schedule award cases following a referee medical examination); see also *Richard R. LeMay*, 56 ECAB ____ (Docket No. 04-1652, issued February 16, 2005) (an Office medical adviser may review the opinion of an impartial specialist in but the resolution of the conflict is the responsibility of the impartial medical specialist).

²⁷ See *supra* note 13.

²⁸ *Supra* note 11.

²⁹ *Supra* note 4.

³⁰ *Supra* note 10.

³¹ *Supra* note 17.

³² A.M.A., *Guides* (5th ed. 2001) 571, section 18.3b.

³³ See FECA Bulletin 01-05 (issued January 31, 2001). Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

properly justify this additional allocation of three percent for appellant's pain. The Office medical adviser referred to the Combined Values Chart and advised that appellant had 37 percent impairment to the right upper extremity.³⁴ However, as noted, appellant was not entitled to the three percent impairment under Chapter 18. The Board finds that appellant has no more than 35 percent for the right upper extremity.³⁵ The Board further notes that the Office medical adviser explained the discrepancies in the report of the impartial medical examiner. For example, he noted that Dr. Weiss provided appellant with 41 percent impairment, but had inadvertently added the findings for range of motion and winging instead of utilizing the Combined Values Chart. The Office medical adviser also explained that a fused scapular winging was to be expected from a fusion. Accordingly, the Board finds that the evidence supports that appellant has a 35 percent impairment of the right upper extremity. He has not established entitlement to a schedule award greater than the 45 percent previously awarded by the Office.

The Board finds that Dr. Weiss provided a detailed and well-rationalized report based on a proper factual background and thus his opinion is entitled to the special weight accorded an impartial medical examiner. His report, therefore, constitutes the weight of the medical opinion evidence and establishes that appellant does not have any additional impairment due his employment injury. The Board finds that no additional impairment is warranted.

Appellant did not submit evidence to support a greater schedule award. On appeal, appellant contends that he is entitled to greater than the 45 percent he was awarded and listed those items that in particular, were bothersome with regard to his injury. He referenced the August 19, 1997 report of his physician, Dr. Romeyn. Appellant also alleged that he did not think the Office referral physician's opinion should carry greater weight than that of his physician. However, as noted above, Dr. Weiss was selected to resolve a conflict and his opinion is entitled to special weight. The Board also notes that the report of Dr. Romeyn, did not contain any explanation to show how he arrived at his impairment calculations. It is well established that, when the attending physician fails to provide an estimate of impairment conforming with the protocols of the A.M.A., *Guides*, his opinion is of diminished probative value in establishing the degree of any permanent impairment. In such cases, the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.³⁶

CONCLUSION

The Board finds that appellant does not have more than a 45 percent impairment of his right upper extremity, for which he has already received a schedule award.

³⁴ *Supra* note 12.

³⁵ The 32 percent for range of motion combined with the 5 percent for pain equates to 35 percent in the Combined Values Chart on page 604 of the A.M.A., *Guides*.

³⁶ *See John L. McClanic*, 48 ECAB 552 (1997); *see also Paul R. Evans*, 44 ECAB 646, 651 (1993).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 7, 2005 is affirmed.

Issued: October 27, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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