

On February 25, 2003 the Office authorized right shoulder open anterior acromioplasty repair. Dr. Stephen L. Hershey, a Board-certified orthopedic surgeon, performed the surgery on May 12, 2003 and recorded preoperative and postoperative diagnoses of right shoulder rotator cuff tear. On June 2, 2003 appellant accepted a light-duty position with the employing establishment.

Appellant requested a schedule award on December 7, 2005. In a July 7, 2005 report, Dr. Nicholas Diamond, an osteopath, reviewed appellant's medical history and stated that he presented with subjective complaints of right shoulder pain and an intermittent "pins and needles sensation" in his right hand. He also reported that appellant rated his pain level at 4/10. Upon physical examination, Dr. Diamond noted a well-healed surgical scar over the anterior aspect of the right shoulder, with tenderness in the acromioclavicular joint, anterior cuff and bicipital groove. He measured appellant's right shoulder range of motion and noted 165 degrees of flexion and 130 degrees of abduction. Dr. Diamond found that appellant otherwise exhibited full range of motion but experienced some pain with internal rotation. He diagnosed right shoulder massive rotator cuff tear, status post right shoulder open rotator cuff repair and status post right shoulder acromioplasty. He based his impairment rating on the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed.). He calculated 10 percent impairment for right shoulder resection acromioplasty, based on Table 16-27,¹ 1 percent impairment for loss of flexion, based on Figure 16-40² and 2 percent impairment for loss of abduction, based on Figure 16-43³ of the A.M.A., *Guides*, for a combined impairment rating of 13 percent of the right upper extremity. He then added an additional 3 percent for "pain-related impairment," under Table 18-1, of the A.M.A., *Guides* for a total of 16 percent impairment of the right upper extremity.

On February 2, 2006 Dr. Morley Slutsky, Board-certified in preventative medicine and an Office medical consultant, reviewed Dr. Diamond's impairment rating. He concluded that appellant had 13 percent impairment of the right arm. Dr. Slutsky agreed with Dr. Diamond that appellant had three percent impairment attributable to loss of range of motion. He noted that appellant's right shoulder acromioplasty "is not a ratable impairment per Table 16-27, page 506; however, Dr. Diamond applied 10 percent upper extremity impairment for this operation. Dr. Slutsky agreed with Dr. Diamond's assignment of 10 percent impairment for the acromioplasty and explained that "a distal clavicle resection is ratable at 10 percent upper extremity impairment per this table and I feel the acromioplasty is equally impairing as the distal clavicle resection." However, he disagreed with Dr. Diamond's inclusion of three percent impairment for pain under Table 18-1. Dr. Slutsky explained:

"Dr. Diamond indicated that '[r]ange of motion is restricted and painful.' This means that [appellant's] reduced shoulder range of motion is partly due to pain and, therefore, pain was already addressed in the impairment for loss of right shoulder range of motion. Thus, the organ system rating methods used above (for

¹ A.M.A., *Guides*, 5th ed., 506, Table 16-27.

² *Id.* at 476, Figure 16-40.

³ *Id.* at 477, Figure 16-43.

loss of range of motion and acromioplasty) take into account pain and I do not feel an additional three percent needs to be added.”

Dr. Slutsky found that appellant reached maximum medical improvement on July 7, 2005, the date of Dr. Diamond’s examination.

By decision dated February 7, 2006, the Office granted appellant a schedule award for 13 percent impairment of the right upper extremity.

After issuance of the Office’s decision, appellant provided a January 16, 2006 report from Dr. Hershey who agreed with Dr. Diamond’s finding that appellant had 13 percent impairment of the right upper extremity.

On February 10, 2006 appellant requested an oral hearing which was held on June 12, 2006. He submitted a March 30, 2006 report from Dr. Diamond who noted that appellant reported his pain level as 4/10 and characterized it as daily and constant in nature, interfering with the activities of daily living and awakening him at night. Dr. Diamond explained:

“According to the A.M.A., *Guides*, (5th ed.), page 574, [F]igure 18-1, it is noted that, ‘if pain-related impairment appears to increase the burden of the individual’s condition slightly, the examiner can increase the percentage up to three percent. No formal assessment of pain-related impairment is required.’ It is my opinion, due to [appellant’s] constant and daily right shoulder pain, along with his restrictions in activities of daily living, that [appellant] is entitled to a 3 percent pain-related impairment, in addition, bringing the total right upper extremity impairment to 16 percent.”

By decision dated July 25, 2006, the hearing representative affirmed the February 7, 2006 schedule award.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees’ Compensation Act⁴ and its implementing regulation⁵ 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 regulation as the appropriate standard for evaluating schedule losses.⁶

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404 (1999).

⁶ See *id.*; Linda R. Sherman, 56 ECAB ____ (Docket No. 04-1510, issued October 14, 2004).

ANALYSIS

The Board finds that the Office properly rated appellant's right upper extremity impairment at 13 percent. The Office medical consultant, Dr. Slutsky, used Dr. Diamond's range of motion measurements which recorded 165 degrees of flexion and 130 degrees of abduction. Pursuant to the A.M.A., *Guides*, Figure 16-40 on page 476, a measurement of 165 degrees of flexion corresponds to one percent impairment based on range of motion deficit.⁷ Pursuant to Figure 16-43 on page 477 of the A.M.A., *Guides*, a measurement of 130 degrees of abduction yields 2 percent impairment based on range of motion deficit.⁸ Accordingly, appellant's impairment based on range of motion deficit is three percent. Both Dr. Slutsky and Dr. Diamond agreed upon this rating for loss of shoulder motion.

Dr. Diamond also awarded appellant 10 percent impairment for his right shoulder acromioplasty and repair. He based this rating on Table 16-27 on page 506 of the A.M.A., *Guides*.⁹ Section 16.7(b) of the A.M.A., *Guides* notes that in the presence of decreased motion a rater may combine impairment values for loss of range of motion and arthroplasty.¹⁰ Table 16-27 provides for impairment ratings for total shoulder arthroplasty, distal clavicle arthroplasty and proximal clavicle arthroplasty of both the implant and resection varieties.¹¹ Pursuant to Table 16-27, a distal clavicle arthroplasty resection corresponds to 10 percent impairment of the right arm.¹² Dr. Slutsky agreed with Dr. Diamond that appellant's right shoulder open acromioplasty and repair was equally as impairing as a distal clavicle arthroplasty. Under the Combined Values Chart at page 604 of the A.M.A., *Guides*, 10 percent combined with 3 percent yields 13 percent.

Dr. Slutsky did not concur with Dr. Diamond's recommendation of an additional three percent impairment based on pain under Chapter 18 of the A.M.A., *Guides*. The Office properly relied upon his recommendation and excluded the three percent pain-related impairment. Dr. Slutsky noted that appellant's reduced shoulder range of motion was partly due to pain such that pain was already addressed in the impairment for loss of right shoulder range of motion and no additional rating was warranted. Furthermore, the A.M.A., *Guides* specifically provide that "examiners should not use [Chapter 18] to rate pain-related impairment for any condition that can be adequately rated on the basis of the body and organ impairment rating systems given in other chapters of the A.M.A., *Guides*."¹³ The Board has also recognized that physicians should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately

⁷ A.M.A., *Guides* 476, Figure 16-40.

⁸ *Id.* at 477, Figure 16-43.

⁹ *Id.* at 506, Table 16-27.

¹⁰ *Id.* at 505.

¹¹ *Id.* at 506, Table 16-27.

¹² *Id.*

¹³ *Id.* at 571. See also Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); *Linda Beale*, 57 ECAB ____ (Docket No. 05-1536, issued February 15, 2006).

rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.¹⁴

The Board finds that Dr. Diamond did not sufficiently explain why the objective ratings system in Chapter 16, The Upper Extremities, of the A.M.A., *Guides* was inadequate to rate appellant's impairment due to pain. Dr. Diamond noted that the A.M.A., *Guides* do not require a "formal assessment" of pain-related impairment.¹⁵ The A.M.A., *Guides* do, however, require that a physician explain why objective ratings are not adequate to measure impairment and why additional impairment for pain is appropriate or necessary.¹⁶ In his March 30, 2006 report, Dr. Diamond stated that he believed pain-related impairment was appropriate because appellant had characterized his pain as constant and reported that it interfered with the activities of daily living. However, Dr. Diamond did not identify specific activities or provide detailed reasoning concerning why appellant's pain impairment was not adequately rated under Chapter 16, based on the ratings allowed for surgery and loss of range of motion.¹⁷ Moreover, the Board notes that Dr. Hershey, in concurring with Dr. Diamond's impairment rating, did not offer any additional rationale or reasoning for why appellant's pain impairment was not adequately rated under Chapter 16 of the A.M.A., *Guides*. Accordingly, the Board finds that the Office properly excluded pain-related impairment, as it appears that Dr. Diamond based his impairment rating for shoulder pain on an improper application of the A.M.A., *Guides*.

The Board finds that the Office properly found that appellant had 13 percent impairment of the right arm for which he was granted a schedule award.

CONCLUSION

The Board finds that appellant did not meet his burden of proof in establishing that he was entitled to greater than 13 percent impairment of the right upper extremity, for which he received a schedule award.

¹⁴ See *Frantz Ghassan*, 57 ECAB ____ (Docket No. 05-1947, issued February 2, 2006) (appellant's physician improperly attributed three percent left leg impairment to Chapter 18 of the A.M.A., *Guides* but the physician did not explain why this pain-related impairment could not be adequately rated by applying Chapter 17 of the A.M.A., *Guides*).

¹⁵ See A.M.A., *Guides* 574, Figure 18-1.

¹⁶ *Id.* at 570-71.

¹⁷ The principles of assessment at Chapter 16.1 note that the impairment ratings developed and retained in this chapter were developed to reflect the degree of impairment and its impact on the ability of the individual to perform activities of daily living. The rationale provided by Dr. Diamond for applying Table 18-1 is already reflected in the tables applicable under Chapter 16. *Id.* at 434.

ORDER

IT IS HEREBY ORDERED THAT the July 25, 2006 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 21, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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