United States Department of Labor
Employees' Compensation Appeals Board

TAMMIE L. BESS, Appellant	)	
and	)	**Docket No. 04-547**
	)	**Issued: August 6, 2004**
U.S. POSTAL SERVICE, POST OFFICE, Salt Lake City, UT, Employer	)	

Appearances:
Tammie L. Bess, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On December 22, 2003 appellant filed a timely appeal from the Office of Workers' Compensation Programs' decision dated November 21, 2003. The Board has jurisdiction to review the case on the merits pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2).

ISSUE

The issue is whether appellant has greater than a 15 percent permanent impairment to her right upper extremity for which she received a schedule award.

FACTUAL HISTORY

The Office accepted appellant's claim for right rotator cuff tear and surgical repair of the tear on May 26, 2001 resulting from an injury at work on February 4, 1999. Appellant also underwent surgery on July 11, 1996 consisting of a Bankart repair for anterior-inferior stability of the right shoulder and on March 2, 2000 consisting of an arthroscopy and repair of her rotator cuff.

In a report dated August 8, 2000, appellant's treating physician, Dr. Dennis H. Gordon, a Board-certified orthopedic surgeon with a specialty in adult reconstruction orthopedics, found that appellant had an impairment of 1 percent for forward flexion of 160 degrees, 0 percent for extension of 30, 1 percent for abduction of 160 degrees, 0 percent for adduction of 40 degrees, 2 percent for internal rotation of 60 degrees and 0 percent for external rotation of 70 degrees. He found that using the "[American Medical Association,] *Guides to the Evaluation of Permanent Impairment*, Table 12," appellant had active abduction and extension against gravity with some resistance as well as weakness in external rotation against resistance. Dr. Gordon found that appellant had a 10 percent upper extremity impairment for loss of strength characterized by loss of the ability to maintain abducted and forward extended positions as well as to perform repetitive activities. He stated that using the Combined Values Chart, appellant had a 14 percent impairment to her right upper extremity.

In a report dated August 25, 2000, the district medical adviser agreed that, based on Dr. Gordon's findings, appellant had a 14 percent impairment to her right upper extremity. By decision dated September 12, 2000, the Office granted appellant a schedule award for a 14 percent permanent impairment of use of the right arm.

In a report dated March 11, 2002, Dr. Gordon indicated that appellant's restrictions in range of motion persisted and determined that she had an impairment of 2 percent for abduction of 140 degrees, 0 percent for adduction to 40 degrees, 3 percent for flexion to 130 degrees, 1 percent for extension to 40 degrees, 1 percent for external rotation of 50 degrees and 2 percent for internal rotation limited to 60 degrees. Using the A.M.A., *Guides* (5th ed. 2001), Figures 16-38 to 16-46 on pages 475-79, he stated that appellant demonstrated residual weakness in her right upper extremity which was consistent with extensive injuries that she sustained to the rotator cuff. Using Section 16.8c on pages 509-10, entitled "Manual Muscle Testing," he multiplied a 60 percent relative value for the shoulder times a 10 percent strength deficit value to equal a 6 percent impairment due to strength loss. He added the various percentages of impairment for loss of motion and strength and found that appellant had a 15 percent impairment to her right upper extremity.

A note dated February 23, 2002 from Dr. Gordon's office indicated that the impairment rating in his March 11, 2002 report, *i.e.*, 15 percent, was in addition to the impairment rating in his August 8, 2000 report, *i.e.*, 14 percent. In a report dated June 5, 2002, Dr. Gordon further described appellant's rotator cuff injury, and stated that under the Utah Guide of the Utah Labor Commission, appellant had a 6 percent impairment for a large full thickness rotator cuff tear. In a note dated June 18, 2002, the district medical adviser stated that he did not see where there was both a 15 percent and a 14 percent impairment to the right upper extremity and a second opinion was needed.

On the Office form, CA-203, ACPS Schedule Award Payment, signed July 23, 2002, the Office noted that appellant was previously paid a schedule award for a 14 percent impairment to the right upper extremity and was entitled to an additional 1 percent impairment to the right upper extremity. By decision dated July 23, 2002, the Office granted appellant a schedule award for an additional one percent permanent impairment to her right upper extremity.

By letter dated July 28, 2002, appellant requested an oral hearing before an Office hearing representative which was held on May 7, 2003. At the hearing, appellant testified that Dr. Gordon indicated that his impairment rating of 15 percent which was obtained pursuant to the A.M.A., *Guides* (5th ed. 2001) in his March 11, 2002 report was in addition to his earlier impairment rating of 14 percent. Appellant stated that she had two separate shoulder injuries, and her impairment was significantly greater than a mere one percent increase after the second surgery. She testified that she was unable to work or return to school because she could not "lift."

Appellant submitted a report from Dr. Gordon dated May 23, 2003. In his report, Dr. Gordon emphasized he was using the A.M.A., *Guides* (5th ed. 2001), not the Utah Guide. He stated that, pursuant to Figure 16-4 on page 476, appellant had an impairment of 3 percent for 130 degrees of flexion and 1 percent for extension of 40 degrees. Dr. Gordon indicated that, pursuant to Table 16-43 on page 477, she had an impairment of 2 percent for abduction of 140 degrees and 0 percent for adduction of 40 degrees and that, pursuant to Figure 16-46 on page 479, she had an impairment of 1 percent for external rotation of 40 degrees and 2 percent for internal rotation of 60 degrees. He concluded that appellant had a nine percent impairment for restricted range of motion.

He stated that according to Figure 16-7 on page 447 appellant had an element of bone and joint deformities. Dr. Gordon stated that appellant demonstrated no joint swelling but had evidence of atrophy of the shoulder girdle muscles on the right compared with the left. He stated that she had evidence of impingement-type shoulder pain with rotation of the shoulder with associated crepitus and grating. Dr. Gordon noted that appellant had Class II humeral head subluxation and humeral head forward with anterior posterior motion in 90 degrees of abduction. Referring to section 16.7a on page 504, entitled "Bone and Joint Deformities," he noted that the value of instability may be combined with impairments due to decreased motion, and noted that appellant had occult instability of the shoulder with impingement and crepitus in the subacromial region with range of motion. Pursuant to Figure 16-26 on page 466, he stated that appellant had a 6 percent impairment to the right upper extremity.

Further, Dr. Gordon referenced section 16.8 on page 507, entitled "Strength Evaluation," where strength of the shoulder and elbow are rated based on manual testing. Using Figure 16-35 on page 473, he found that appellant had an impairment of 6 percent for shoulder flexion of 4/5, 0 percent for extension of 5/5, 3 percent for abduction of 4/5, 0 percent for adduction of 5/5, 2 percent for internal rotation of 4/5, and 2 percent for external rotation of 4/5. Dr. Gordon stated that this resulted in a 19 percent impairment of the right upper extremity due to motor weakness as well as shoulder instability. Using the Combined Values Chart, he determined that the 19 percent impairment of the upper extremity due to motor weakness and shoulder instability and the 9 percent impairment for restricted range of motion resulted in an impairment of 26 percent to the right upper extremity.

By decision dated July 17, 2003, the Office hearing representative found that it was necessary to remand the case for an Office medical adviser to review Dr. Gordon's May 23, 2003 report.

In a report dated August 7, 2003, the district medical adviser reviewed the Office's statement of accepted facts dated August 1, 2003 and Dr. Gordon's May 23, 2003 report. The district medical adviser agreed with Dr. Gordon's impairment of 9 percent for appellant's range of motion, and submitted a worksheet showing that using the appropriate figures in the A.M.A., *Guides* (5th ed. 2001) he obtained the same percentages of impairment as Dr. Gordon for appellant's flexion, extension, adduction, abduction, and internal and external rotation. The district medical adviser stated that the issue of causalgia or reflex sympathetic dystrophy (RSD) did not meet the criteria as noted by Dr. Gordon. Citing section 16.8a on page 508, he noted that "[i]f the examiner judges that the 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 other impairments, only if based on unrelated etiologic or pathomechanical causes," and that "[*o*]*therwise the impairment ratings based on objective anatomic findings take precedence*." (Emphasis in the original.) The district medical adviser stated that the elbow was not part of the rotator cuff repair, and if the elbow was deemed to be related, then the issue of a different pathomechanical origin still loomed. He stated that the issue would appear to be secondary to the rotator cuff which would make the assessment of the strength in the elbow moot since there was not a different pathomechanical etiology. The district medical adviser concluded that appellant had an impairment of 9 percent to the shoulder for range of motion and 6 percent for occult instability, and therefore had a total impairment to the right upper extremity of 14 percent.

To resolve the conflict between Dr. Gordon and the district medical adviser, the Office referred appellant to an impartial medical specialist, Dr. Robert G. Hansen, a Board-certified orthopedic surgeon. In his report dated September 15, 2003, using the A.M.A., *Guides* (5th ed. 2001), Dr. Hansen noted that appellant had adduction of 40 degrees, abduction of 130 degrees, flexion of 135 degrees, extension of 40 degrees, external rotation of 50 degrees, and internal rotation of 60 degrees and concluded that he had a 9 percent impairment due to limitation of range of motion. He obtained the same figures as Dr. Gordon for strength testing, 4/5 for flexion, 5/5 for extension, 4/5 for abduction, 5/5 for adduction, and 4/5 for internal and external rotation. Without mentioning specific figures or pages, Dr. Hansen concluded that appellant had a 13 percent impairment due to loss of strength. Using the Combined Values Chart on page 604, he determined that appellant had a total permanent impairment of 21 percent to the right upper extremity. He stated that appellant's prior anterior dislocation and possible mild instability symptoms would not be related to the work injury on February 4, 1999, at which time she suffered a rotator cuff tear. Dr. Hansen stated that any permanent rating due to instability would not medically or reasonably be caused by the rotator cuff tear.

In a report dated November 5, 2003, an Office medical adviser, Hugh H. Macaulay, III, considered Dr. Hansen's September 15, 2003 report and noted that Dr. Hansen felt that the instability of the shoulder was secondary to a preexisting condition and was not rated. Dr. Macaulay stated that "strength may not be rated based on the loss of range of motion and the pathoanatomic proximate cause of the rotator cuff injury." He indicated that there was no other issue present which accounted for the loss of strength. Dr. Macaulay concluded that appellant's total permanent partial impairment to her right upper extremity was nine percent due to loss of range of motion.

By decision dated November 21, 2003, the Office found that Dr. Macaulay's determination that appellant only had a 9 percent permanent impairment to her right upper extremity established that appellant did not have more than the 15 percent permanent impairment previously awarded. The Office therefore found that the medical evidence did not support an increase in the 15 percent impairment already compensated.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulation[2] 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.[3]

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.[4]

ANALYSIS

In this case, it was undisputed that the range of motion of appellant's left shoulder equaled a nine percent impairment. In his May 23, 2003 report, appellant's treating physician, Dr. Gordon, additionally found that due to occult stability, appellant had a six percent impairment pursuant to the A.M.A., *Guides*, Table 16-26 on page 505. Using Table 16-35 on page 510, he found that appellant's flexion of 4/5, extension of 5/5, abduction of 4/5, adduction of 5/5, and internal and external rotation of 4/5, resulted in a 13 percent impairment. Dr. Gordon found that appellant therefore had a 19 percent impairment due to motor weakness and shoulder instability. Using the Combine Values Chart on page 604, he determined that the 9 percent impairment due to range of motion and the 19 percent strength impairment resulted in an impairment of 26 percent to the right upper extremity.

In his report dated August 7, 2003, the district medical adviser agreed with Dr. Gordon to the extent that appellant had a nine percent impairment due to range of motion and a six percent impairment due to occult instability of the shoulder. Using the Combined Values Chart, he concluded that appellant had a total permanent impairment to the right upper extremity of 14

[1] 5 U.S.C. § 8107 *et seq.*

[2] 20 C.F.R. § 10.404.

[3] *See id*.; *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989); *Charles Dionne*, 38 306, 308 (1986).

[4] *Kathryn Haggerty*, 45 ECAB 383, 389 (1994); *Jane B. Roanhaus*, 42 ECAB 288 (1990).

percent. He found that an impairment rating for strength of the elbow was not appropriate because there was not a different pathomechanical etiology.

To resolve the conflict between Dr. Gordon and the district medical adviser's opinion regarding the degree of appellant's impairment, the Office referred appellant to an impartial medical specialist, Dr. Hansen. In his September 15, 2003 report, he found that appellant had a nine percent impairment for range of motion. He implicitly used Figure 16-35 on page 473, using the same figures for strength testing as Dr. Gordon, to determine that appellant had a 13 percent impairment due to loss of strength. Dr. Hansen found that instability in appellant's right shoulder would be related to the rotator cuff tear and did not warrant a rating. He therefore concluded that appellant had a total impairment rating to her right upper extremity of 21 percent.

In his November 5, 2003 report, the district medical adviser changed the prior impairment rating of 15 percent to 9 percent based on Dr. Hansen's finding that appellant's instability was not related to her rotator cuff, and therefore the impairment rating of 6 percent for the instability was not appropriate. The district medical adviser also found that Dr. Hansen's impairment rating of 13 percent for loss of strength was not appropriate because appellant's impairment "may not be based on the loss of range of motion and the pathoanatomic proximate cause of the rotator cuff injury." He therefore concluded that appellant had only a total permanent impairment of nine percent.

Dr. Hansen's September 17, 2003 report is proper regarding the degree of permanent impairment had due to limited range of motion. While he did not specifically refer to the figures and pages in the A.M.A., *Guides* (5th ed. 2001), he indicated that appellant had adduction of 40 degrees, abduction of 130 degrees, flexion of 135 degrees, extension of 40 degrees, external rotation of 50 degrees, and internal rotation of 60 degrees and noted that he used the A.M.A., *Guides* to determine that appellant had a 9 percent impairment due to loss of range of motion. Application of the appropriate tables of the A.M.A., *Guides* shows that appellant had the following impairment ratings for loss of motion which total 9 percent: 2 percent for abduction; 3 percent for flexion; 1 percent for extension; 1 percent for external rotation; and 2 percent for internal rotation.[5] Given the district medical adviser's opinion that an impairment for strength testing of the elbow should not be included, Dr. Hansen's inclusion of the 13 percent impairment for strength testing was erroneous and appellant's impairment to the right upper extremity was therefore only 9 percent. The question then becomes whether the Office medical adviser's opinion is correct and consistent with the A.M.A., *Guides*.

Section 16.8 on page 507 of the A.M.A., *Guides* (5th ed. 2001), entitled "Strength Evaluation," states that "[b]ecause strength measurements are functional tests influenced by subjective factors that are difficult to control and the A.M.A., *Guides* for the most part is based on anatomic impairment, the A.M.A., *Guides* does not assign a large role to such measurements." As noted by the Office medical adviser, according to section 16.8a on page 508, an impairment due to loss of strength may only be combined with other impairments if it is based on an unrelated etiology or pathomechanical causes. The A.M.A., *Guides* states in italics, "*Otherwise, the impairment ratings based on objective anatomic findings take precedence*."

[5] *See* A.M.A., *Guides* 476-77, 479, Figures 16-40, 16-43, 16-46.

(Emphasis in the original.) The A.M.A., *Guides* states that decreased strength "*cannot*" be rated in the presence of decreased motion or painful conditions which prevent effective application of maximal force in the region being evaluated. Therefore, based on the A.M.A., *Guides*, the Office medical adviser correctly determined that the impairment due to loss of strength related to the elbow should not be included in assessing appellant's impairment because that loss of strength is not based on an etiologic or pathomechanical cause unrelated to the shoulder injury. The Office therefore properly determined that appellant only had a 9 percent impairment to her right upper extremity, and that therefore she did not have more than the 15 percent impairment previously awarded.

CONCLUSION

The Board finds that the Office properly determined that appellant did not have more than a 15 percent permanent impairment to her right upper extremity based on the medical evidence of record.

ORDER

IT IS HEREBY ORDERED THAT the November 21, 2003 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: August 6, 2004
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member