United States Department of Labor
Employees' Compensation Appeals Board

W.E., Appellant	)	
and	)	**Docket No. 09-2016**
	)	**Issued: August 25, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Trenton, NJ, Employer	)	

Appearances:
Carolyn B. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 13, 2009 appellant filed a timely appeal from an Office of Workers' Compensation Programs' schedule award decision dated April 21, 2009. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award case.

ISSUE

The issue is whether appellant has more than an 11 percent permanent impairment to his left upper extremity.

FACTUAL HISTORY

This is the third appeal in this case before the Board. Appellant injured his left arm on October 30, 1991. The Office accepted a claim for left shoulder sprain and authorized arthroplasty surgery on April 3, 1992. By decisions dated January 4 and November 15, 1996, it denied appellant's claim for a schedule award for his left upper extremity. In a decision issued January 14, 1999,[1] the Board found that there was a conflict in the medical evidence on the issue

[1] Docket No. 97-1173 (issued January 14, 1999).

of whether he sustained any permanent impairment due to his October 30, 1991 employment injury. It therefore set aside the November 15, 1996 decision of the Office hearing representative and remanded the case for referral to an impartial medical specialist.

By decision dated October 13, 1999, the Office granted appellant a schedule award for a seven percent permanent impairment of the left arm based on a March 10, 1999 report from Dr. Alexander Fasulo, a referee medical examiner and Board-certified orthopedic surgeon. By decision dated June 28, 2000, an Office hearing representative affirmed the October 13, 1999 Office decision. Appellant's attorney requested reconsideration and submitted an October 31, 2000 report from Dr. David Weiss, an osteopath, who found that appellant had a 48 percent impairment of the left upper extremity pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). By decision dated March 9, 2001, the Office denied modification of the October 13, 1999 Office decision.

In a decision issued on March 7, 2002,[2] the Board found that there was a conflict in the medical evidence on the issue of whether appellant sustained any additional permanent impairment to his left upper extremity due to his October 30, 1991 employment injury. The Board stated that the Office's October 13, 1999 decision was proper at the time it was issued, as it was based on the weight of the medical evidence in the record at the time of the decision. It noted, however, that subsequent to the Office's decision appellant submitted the October 31, 2000 report of Dr. Weiss, who calculated a 48 percent impairment rating of the left upper extremity based on a different set of factors. This created a conflict in the medical evidence regarding the precise impairment rating applicable to his left upper extremity. The Board set aside the March 9, 2001 Office decision and remanded the case for referral to an impartial medical specialist. The complete facts of this case are set forth in the Board's January 14, 1999 and March 7, 2002 decisions and are herein incorporated by reference.

The Office referred appellant for an impartial examination with a referee physician, Dr. Stanley R. Askin, Board-certified in orthopedic surgery, who stated in an April 13, 2002 report that appellant did not have any measurable impairment of the left shoulder or left upper extremity causally related to the original work injury.

By decision dated April 25, 2002, the Office found that appellant was not entitled to an additional schedule award for his left upper extremity.

By letter dated April 30, 2002, appellant's attorney requested a hearing, which was held on October 19, 2004.

By decision dated January 19, 2005, an Office hearing representative found that Dr. Askin did not provide sufficient medical rationale to support his conclusion that appellant did not sustain a measurable permanent impairment from his October 30, 1991 work injury. The hearing representative therefore remanded the case to the district Office and instructed it to request a supplemental report from Dr. Askin, which would clarify his opinion and contain the requisite supporting medical rationale.

[2] Docket No. 01-1629 (issued March 7, 2002).

In a March 19, 2005 report, Dr. Askin stated that based on clinical examination he did not believe that appellant was impaired to any substantial degree. He based his medical rationale for finding that appellant did not sustain a permanent impairment greater than seven percent on his full range of motion, absence of muscle deficit and atrophy and concomitant ability to work full duty at the time he examined him. Dr. Askin stated that appellant sustained an injury which had responded to the passage of time and adequate treatment.

By decision dated May 2, 2005, the Office found that appellant was not entitled to an additional schedule award.

By letter dated May 6, 2005, appellant's attorney requested an oral hearing.

By decision dated December 29, 2005, an Office hearing representative again set aside the Office's schedule award decision. It found that Dr. Askin failed to appreciate the concept of impairment for compensation purposes and failed to provide medical rationale for his conclusions. The hearing representative remanded for referral to a new impartial medical specialist.

The Office referred appellant for a referee medical examination with Dr. Howard Zeidman, Board-certified in orthopedic surgery, who submitted a report dated May 10, 2006. Dr. Zeidman rated appellant a 20 percent left upper extremity impairment based on a 50 percent loss of grip strength pursuant to Table 16-34 at page 509 of the A.M.A., *Guides*.

In a July 12, 2006 report, an Office medical adviser stated that Dr. Zeidman's 20 percent impairment rating was not rendered in accordance with the A.M.A., *Guides* because Dr. Zeidman provided no quantifiable values to support his finding of a 50 percent loss of grip strength; the medical adviser noted that Dr. Zeidman stated that he used a Jamar dynameter to measure grip strength but did not include any actual values in his report.

In a December 11, 2006 report, Dr. Zeidman noted that he had reevaluated appellant on November 30, 2006, at which time he recorded a 29 percent loss of grip strength based on testing with a Jamar dynameter, which yielded a 20 percent left upper extremity impairment under Table 16-34.

In a January 11, 2007 report, an Office medical adviser found that Dr. Zeidman's finding of a 29 percent loss of grip strength equaled a 10 percent left upper extremity impairment under Table 16-34.

By decision dated January 18, 2007, the Office granted appellant an additional 3 percent impairment to the left arm, for a total 10 percent impairment.

By letter dated January 29, 2007, appellant's attorney requested a hearing, which was held on May 17, 2007. Counsel argued that Dr. Zeidman's report should be invalidated because he was not properly selected from the Physician's Directory System (PDS).

By decision dated June 1, 2007, an Office hearing representative found that Dr. Zeidman was not properly selected from the PDS. He therefore remanded the case for referral to another impartial medical specialist.

The Office referred appellant to an impartial medical specialist, Dr. Ian B. Fries, Board-certified in orthopedic surgery, who found in a February 5, 2007 report that appellant had a seven percent impairment of the left upper extremity based on the following calculations: a one percent impairment for loss of flexion based on 140 degrees range of motion pursuant to Figure 16-40 at page 476 of the A.M.A., *Guides*; a two percent impairment for loss of abduction based on 120 degrees range of motion pursuant to Figure 16-43 at page 477 of the A.M.A., *Guides* and a two percent impairment for loss of flexion based on 140 degrees range of motion pursuant to Figure 16-46 at page 479 of the A.M.A., *Guides*. Dr. Fries also accorded a two percent impairment for "consistent left shoulder pain with overhead work."[3] He did not find any impairment for grip strength. Dr. Fries opined that grip strength evaluation was incidental to local shoulder pathology and therefore was not useful in determining shoulder impairment. He advised that while appellant had mildly decreased left grip strength by dynamometer this was not reflected in measurable forearm atrophy or isolated muscle weakness in the left upper extremity.

Dr. Fries stated that page 453 of the A.M.A., *Guides* indicated that, "if a contralateral 'normal' joint has less than average mobility, the impairment value(s) corresponding to the uninvolved joint may serve as a baseline and are subtracted from the calculated impairment for the involved joint."[4] He then stated that, if appellant had right shoulder permanent motion residuals from his prior injury, then the right shoulder could not be used as a basis for determining left shoulder impairment; this would increase the calculated left shoulder impairment due to motion deficits as much as 10 percent.

In a September 28, 2007 report, an Office medical adviser, Dr. Arnold T. Berman, Board-certified in orthopedic surgery, reviewed Dr. Fries' report and found that appellant had an 11 percent impairment of the left upper extremity. He stated that Dr. Fries did not apply the tables in the A.M.A., *Guides* correctly and did not add up the numbers correctly. Relying on Dr. Fries' findings on examination, Dr. Berman made the following calculations:

> "Utilizing page 476, Figure 16-40 ... the right shoulder is 140 degrees of flexion which represents three percent impairment and the left upper extremity equals 140 degrees of extension. This also represents three percent impairment. Extension of the right and left shoulders are 50 and 55 degrees respectively and this represents zero percent impairment.
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> "Utilizing page 477, Figure 16-43 … the left shoulder is 120 degrees of abduction which is equivalent to three percent impairment and the right shoulder 150 degrees of abduction which is equivalent to one percent impairment. Adduction is 30 degrees bilaterally.
>
> "Therefore, according to page 477, Figure 16-43 ... both right and left sides are equivalent to one percent impairment.

[3] Dr. Fries noted that appellant had rated his left shoulder pain as a 6 on a scale of 1 to 10, depending on the type of work he was doing.

[4] A.M.A., *Guides* 453.

> "Utilizing page 479, Figure 16-46 ... external rotation of the left shoulder is 70 degrees which equals zero percent impairment and external rotation of the right shoulder equals 90 degrees which equals zero percent impairment. Internal rotation of the left shoulder equals 30 degrees which is four percent impairment and 40 degrees internal rotation of the right shoulder equals three percent impairment.
>
> "Therefore, the left shoulder has 3 percent impairment due to flexion, 3 percent impairment due to abduction, 1 percent due to adduction and 4 percent due to internal rotation for a total of ... 11 percent impairment utilizing the Combined Values Chart for the left shoulder."

Dr. Berman further found that appellant had an eight percent impairment in the right shoulder based on three percent impairment for loss of flexion, three percent impairment due to loss of internal rotation, one percent impairment due to loss of abduction and one percent due to loss of extension.

By decision dated October 5, 2007, the Office granted appellant an additional 1 percent impairment to the left upper extremity, for a total 11 percent impairment of the left upper extremity.

By letter dated October 16, 2007, appellant's attorney requested a hearing which was held on February 21, 2008. Counsel argued that Dr. Fries' report should be invalidated because he was not properly selected from the PDS and because Dr. Berman, the Office medical adviser, found that his report lacked sufficient medical rationale.

By decision dated May 12, 2008, an Office hearing representative set aside the October 5, 2007 Office decision. She rejected the argument of appellant's attorney that Dr. Fries was not properly selected pursuant to PDS guidelines. The hearing representative further stated that it was proper for Dr. Berman to reject Dr. Fries' impairment calculations and devise his own calculations based on the same range of motion findings made by Dr. Fries.[5] She stated, however, that Dr. Berman did not indicate that he fully addressed the other factors to be considered for a left upper extremity impairment, such as pain, loss of strength and sensory deficit, especially given that Dr. Fries noted that he accorded an additional two percent for pain. The hearing representative therefore set aside the October 5, 2007 Office decision and remanded for referral to Dr. Berman to obtain a supplemental report addressing the additional factors to be considered in determining a left upper extremity impairment. She directed the Office to ask Dr. Berman to explain with medical rationale whether Dr. Fries' additional findings, including pain, are ratable under the A.M.A., *Guides*.

[5] Where an examining physician has provided a description of physical findings but failed to properly apply the A.M.A., *Guides*, a detailed opinion by the Office medical adviser giving an impairment rating based on the reported findings and the A.M.A., *Guides* may constitute the weight of medical evidence. *Tommy R. Martin*, 56 ECAB 273 (2005). *See* Federal (FECA) Procedure Manual, Part 2 -- Developing and Evaluating Medical Evidence, *Reviews of District Medical Advisers*, Chapter 2.810.7(h) (April 1993). When an Office medical adviser explains his or her opinion, shows values and computation of impairment based on the A.M.A., *Guides* and considers each of the reported findings of impairment, his or her opinion may constitute the weight of medical evidence.

In a June 26, 2008 report, Dr. Berman reviewed the Office's instructions and reiterated that appellant had an 11 percent impairment of the left upper extremity. With regard to whether appellant had any additional impairment for loss of strength he noted that the A.M.A., *Guides* at section 16.8a, page 508,[6] indicates that decreased strength cannot be rated in the presence of decreased motion or painful conditions. As appellant had decreased motion and a painful condition, Dr. Berman found that an impairment based on decreased strength was not warranted. Regarding an impairment for pain, appellant stated that none of the three situations listed in the A.M.A., *Guides* at page 570-71 which would warrant an impairment rating based on pain applied to him. These included: where there is excess pain in the context of verifiable medical conditions that cause pain; when there are well-established pain syndromes without significant identifiable organ dysfunction to explain the pain or where there are other associated pain syndromes. Dr. Berman also noted that Dr. Fries did not indicate any objective sensory deficit that would justify an additional award. He therefore concluded that appellant had no additional ratable impairment greater than 11 percent for the left upper extremity and 8 percent for the right upper extremity.

By decision dated July 25, 2008, the Office found that appellant was not entitled to an additional schedule award for his left upper extremity greater than the 11 percent already awarded.

By letter dated September 2, 2008, appellant's attorney requested an oral hearing, which was held on January 13, 2009. She argued that the portion of the A.M.A., *Guides* at page 508 which indicates that decreased strength cannot be rated in the presence of decreased motion or painful conditions, section 16.8a, also stipulates that strength loss cannot be considered where pain is so great that it does not allow full strength to be applied, which is not indicated in Dr. Fries' report. Counsel also asserted that Dr. Berman arbitrarily disregarded Dr. Fries' recommendation that appellant should be accorded a two percent impairment for pain. Finally, she noted that Dr. Berman indicated that, in the event that appellant also manifested right shoulder impairment from the 1999 work injury, then the right shoulder should not be used as the basis for determining left shoulder impairment; this would increase his left shoulder impairment due to range of motion deficit by as much as 10 percent. Counsel noted that Dr. Berman also found that appellant had an eight percent right upper extremity impairment and contended that appellant should be granted an award based on this finding, regardless of whether the right shoulder impairment was causally related to the 1999 work injury. She therefore argued that the Office's July 25, 2008 decision should be set aside and the case should be remanded to Dr. Fries for clarification; alternatively, she contended that appellant should be referred to a new impartial examiner.

By decision dated April 21, 2009, an Office hearing representative affirmed the July 25, 2008 Office decision.

[6] A.M.A., *Guides* 508.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] set forth the number of weeks of compensation to be paid for permanent loss or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[8] However, the Act does not specify the manner in which the percentage of loss of use of a member is to be determined. For consistent results and to ensure equal justice under the law to all claimants, the Office has adopted the A.M.A., *Guides* fifth edition as the standard to be used for evaluating schedule losses.[9] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10] The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.

In situations where there are opposing medical reports 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.[11]

With regard to rating loss of strength, section 16.8 of the A.M.A., *Guides* note that such measurements are functional tests influenced by subjective factors that are difficult to control. Therefore, the A.M.A., *Guides* do not assign a large role to such measurements. Section 16.8a states:

> "In a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the A.M.A., *Guides*, the loss of strength may be rated separately…. 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. Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region to be evaluated."[12]

[7] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[8] *Id*. at § 8107(c)(19).

[9] 20 C.F.R. § 10.404.

[10] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003). As of May 1, 2009, the sixth edition will be used. FECA Bulletin No. 09-03 (issued March 15, 2008).

[11] *See Gloria J. Godfrey*, 52 ECAB 486 (2001).

[12] *Supra* note 6.

ANALYSIS

In the present case, the Office found that appellant was not entitled to an award greater than the 11 percent for left upper extremity impairment already awarded based on Dr. Berman's opinion. Dr. Berman reviewed Dr. Fries' report and rated a three percent impairment for left shoulder range of motion deficit based on 140 degrees flexion pursuant to Figure 16-40 at page 476 of the A.M.A., *Guides*; a three percent impairment for left shoulder range of motion deficit based on 120 degrees abduction based on Figure 16-43 at page 477 of the A.M.A., *Guides*; a one percent impairment for left shoulder range of motion deficit based on 30 degrees adduction based on Figure 16-43 at page 477 of the A.M.A., *Guides* and a four percent impairment based on 30 degrees of internal rotation pursuant to Figure 16-46 at page 479 of the A.M.A., *Guides*. These findings were proper and in conformance with the applicable tables of the A.M.A., *Guides*.[13] In addition, Dr. Berman properly rejected the two percent impairment Dr. Fries awarded for pain based on the criteria he cited at page 570-71 of the A.M.A., *Guides*; this was within his discretion as Office medical adviser.

The Board finds that Dr. Berman's opinion constituted a sufficient basis for an award based on an 11 percent left upper extremity impairment. The Office therefore properly found that his opinion constituted the weight of the medical evidence. On appeal, counsel contends that the Office medical adviser erred by not according an impairment for left grip strength. She also contends on appeal that the rating by the examining physician should take precedence over that of the Office medical adviser.

As noted, the A.M.A., *Guides* at section 16.8 do not assign a large role to grip or pinch strength measurements as they are too influenced by subjective factors. In light of the principles found at section 16.8, appellant's attorney provided no explanation as to why appellant's loss of strength could not be adequately considered with reference to the other methods of the A.M.A., *Guides*. Dr. Fries merely listed measurements obtained on grip and pinch strength testing. He did not find any impairment for grip strength, stating that grip strength evaluation was incidental to local shoulder pathology and therefore was not useful in determining shoulder impairment. Dr. Fries opined that while appellant had mildly decreased left grip strength by dynamometer this was not reflected in measurable forearm atrophy or isolated muscle weakness in the left upper extremity. Counsel argued that appellant was able to exercise maximal force on testing despite pain; however, the report of Dr. Fries is silent on this point.

In addition, the Board notes that, while the report of an examining physician may be found to constitute the weight of medical opinion, such physician should clearly address the principles of the A.M.A., *Guides* in explaining how an impairment rating is reached. Absent such explanation, the Office may rely on the opinion of its medical adviser.[14] Although Dr. Berman, the Office medical adviser, did not agree with Dr. Fries' impairment calculations, he properly applied the A.M.A., *Guides* to the findings on examination reported by Dr. Fries and

[13] These findings for loss of range of motion are supported by the figures and tables referenced in subchapter 16.4i, "Shoulder Motion Impairment," at pages 474-77 of the A.M.A., *Guides*. The Board notes that Dr. Berman accorded a greater degree of impairment for loss of flexion and abduction than did Dr. Fries.

[14] *See Tommy R. Martin*, *supra* note 5.

explained in his June 26, 2008 supplemental report why he did not find any impairment based on pain, loss of strength or sensory deficit. The Board finds that the Office did not abuse its discretion by relying counsel on the Office medical adviser's rating.

Counsel also contends that the Office erred by failing to ask Dr. Fries for clarifying information regarding a right upper extremity impairment. She argues that this clarification was required in light of Dr. Fries' opinion that the comparison of range of motion deficits in the right and left upper extremities might yield additional impairment for the accepted left upper extremity condition. The Board rejects this argument. The A.M.A., *Guides* at page 453 provide that, if a contralateral "normal" joint has a less than average mobility, the impairment values corresponding to the uninvolved joint can serve as a baseline and are subtracted from the calculated impairment for the involved joint. The rationale for this decision must be explained in the physician's report. Measurements and comparison of the normal joint is the exception not the rule. Dr. Fries did not provide the necessary explanation to establish this exception should be applied, *i.e.*, that the "normal" joint has less than average mobility.

As there is no other medical evidence establishing that appellant sustained any additional permanent impairment, the Board finds that he is entitled to an 11 percent impairment of the left upper extremity. The Board therefore affirms the April 21, 2009 decision of the Office hearing representative.

CONCLUSION

The Board finds that appellant has no more than an 11 percent impairment of his left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the April 21, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 25, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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