U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of HENRY JACKSON, III and U.S. POSTAL SERVICE,
AIRPORT MAIL FACILITY, Columbus, OH

Docket No. 98-1415; Submitted on the Record;
Issued December 7, 1999

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
BRADLEY T. KNOTT

The issues are: (1) whether appellant is entitled to more than a two percent permanent impairment of the left shoulder, for which he has already received a schedule award; and (2) whether the Office of Workers' Compensation Programs properly denied appellant's request for a hearing under 5 U.S.C. § 8124(b).

On February 10, 1997 appellant, then a 35-year-old mailhandler, filed a traumatic injury claim (Form CA-1) assigned number A9-425853 alleging that on that date he sustained a possible tear of his left shoulder rotary cuff. Appellant stated that when he tried to open the top gate of an "APC," his left shoulder popped.[1]

On April 23, 1997 appellant filed a claim for a schedule award (Form CA-7).

[1] Prior to filing the instant claim, appellant filed a traumatic injury claim (Form CA-1) assigned number A9-311923 on June 12, 1987 alleging that on that date he sustained a contusion of the left shoulder. By letter dated June 24, 1987, the Office accepted appellant's claim for a contusion of the left shoulder. In an August 26, 1987 letter, the Office also accepted appellant's claim for left shoulder acromioclavicular separation. On July 31, 1988 appellant filed a claim (Form CA-2a) alleging that he sustained a recurrence of disability on that date. In a memorandum to the file, a claims examiner recommended the creation of a new traumatic injury case for appellant's July 31, 1988 injury. The Office advised appellant on September 19, 1988 to submit a Form CA-1 for his July 31, 1988 injury. By letter dated December 1, 1988, the Office closed appellant's claim because he failed to file a Form CA-1. Subsequently, in a February 22, 1990 internal memorandum, the Office consolidated appellant's claims assigned number A9-311923 and A9-338109 into a master file assigned number A9-338109. The Office accepted appellant's claim for left shoulder strain, tendinitis of the left shoulder and decompression of the left shoulder acriomion on December 7, 1993. On July 29, 1989 and January 16, 1990 appellant filed a Form CA-2a alleging a recurrence of his June 12, 1987 employment injury. Appellant filed a Form CA-2a on September 6, 1994 alleging a recurrence of his June 12, 1987 employment injury. By decision dated February 23, 1995, the Office denied appellant's recurrence claim.

By letter dated May 1, 1997, the Office accepted appellant's claim for a left shoulder strain. In addition, the Office advised appellant that this claim would be consolidated into a master file assigned number A9-338108 for his left shoulder condition.

By letter dated May 7, 1997, the Office advised appellant that it had received his Form CA-7. The Office then advised appellant to submit a medical report from his physician regarding the extent of his impairment based on the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.

In response, the Office received a May 17, 1997 medical report from James H. Rutherford, a Board-certified orthopedic surgeon and appellant's treating physician. In this medical report, he provided a history of appellant's injuries and medical treatment and a review of medical records. On physical examination Dr. Rutherford indicated that appellant had a full range of motion of his neck and a normal examination of his right upper extremity. He further indicated that on examination of appellant's left upper extremity, appellant had a three-inch scar over the anterior shoulder from two previous surgical procedures and he had a point of tenderness over the anterior border of the acriomion. On range of motion of the left shoulder Dr. Rutherford stated that appellant had 150 degrees of functional flexion, although he could, with discomfort, elevate the left shoulder to 180 degrees and he had 120 degrees of active functional abduction, although he could also with effort bring that up to 180 degrees. He further indicated that appellant's biceps circumference was 12¾ inches on the right and only 12 inches on the left. Finally, he noted that appellant's grip strength was 80 pounds on the right and 40 pounds on the left and that sensation in the upper extremities was normal. Dr. Rutherford opined that appellant had reached maximum medical improvement concerning his left shoulder on May 17, 1997. He further opined that appellant had limitation of motion of his left shoulder. Dr. Rutherford also opined that appellant had the equivalent of a Mumford procedure due to decreased strength on the left side, as well as, point tenderness. He then opined that appellant had a 10 percent impairment of the left upper extremity as a result of two arthroplastics or acromioplastics surgeries of the left shoulder based on Table 27, page 61 of the A.M.A., *Guides*. Additionally, Dr. Rutherford opined that appellant's 150 degrees of flexion was equivalent to a 2 percent impairment of the upper extremity based on Figure 38, page 43 and that appellant's 120 degrees of abduction was based on Figure 41, page 44. He concluded that appellant had a five percent impairment of the upper extremity related to limitation of motion.[2] Dr. Rutherford added appellant's 5 percent and 10 percent impairment ratings totaling a 15 percent impairment of the left upper extremity as a result of his left shoulder problems. He then determined that appellant's 17 percent impairment equated to a 10 percent permanent impairment of the whole person based on Table 3, page 20.[3]

An Office medical adviser reviewed the medical evidence of record on June 10, 1997 and disagreed with Dr. Rutherford's finding that appellant had the equivalent of a Mumford

[2] Dr. Rutherford's finding that appellant had 120 degrees of abduction is equivalent to a 3 percent impairment based on Figure 41, page 44 of the fourth edition of the A.M.A., *Guides*.

[3] It appears that Dr. Rutherford mistakenly stated that appellant's impairment of the left upper extremity was 17 percent rather than 15 percent. Based on Table 3, page 20, of the fourth edition of the A.M.A., *Guides*, a 15 percent impairment of the upper extremity is equivalent to a 9 percent impairment of the whole person.

procedure. He determined that based on Table 18, page 58 and Table 20, page 59, it appeared that appellant had approximately a mild visibly apparent synovial hypertrophy causing a 10 percent joint impairment. Dr. Rutherford further determined that this represented a two and one-half percent impairment of the upper extremity and a one and one-half percent impairment of the person as a whole. As indicated by Dr. Rutherford, the Office medical adviser opined that limitation of motion amounted to a five percent impairment of the upper extremity. He then added the five percent and one and one-half percent impairment ratings totaling a six and one-half percent impairment of the left upper extremity. Dr. Kaufman concluded that he could not determine whether appellant had reached maximum medical improvement based on the records and that appellant should become involved in aggressive physical therapy/rehabilitation.

The Office found a conflict in the medical opinion evidence between Dr. Rutherford and the Office medical adviser regarding the extent of appellant's permanent impairment of the left shoulder. By letter dated August 20, 1997, the Office referred appellant, along with medical records, a list of specific questions and a statement of accepted facts, to Dr. Walter Hauser, a Board-certified orthopedic surgeon, for an impartial medical examination. By letter of the same date, the Office advised Dr. Hauser of the referral.

In a September 10, 1997 medical report, Dr. Hauser provided a history of appellant's injuries and medical treatment and a review of medical records. On physical examination of appellant's left shoulder, Dr. Hauser indicated a well-healed scar over the superior anterior aspect of the shoulder and diminished size of the musculature of the deltoid, biceps and forearm compared to the right side. He further indicated that on active motion, appellant was able to elevate and in an abducted position to about 110 degrees and about 120 to 130 degrees in forward flexion. Dr. Hauser stated that internal and external rotation were normal, but that appellant complained of pain in going through a range of motion. He also stated that appellant had some mild subpatellar irregularity, the alignment of the acriomion and the clavicle appeared normal and that he had some mild giving way on muscle testing in the left upper extremity, but otherwise his strength was good. Dr. Hauser also stated that appellant had a normal range of elbow, wrist and hand motion. He concluded that appellant should maintain his work activities with some mild limitations as mentioned by the Office medical adviser in his report. Dr. Hauser further concluded that appellant should be involved in an exercise program and try to increase the functional use of his shoulder.

An Office medical adviser reviewed the medical evidence of record on October 29, 1997 and determined that appellant reached maximum medical improvement on September 10, 1997. Utilizing Dr. Hauser's findings, the Office medical adviser determined that appellant had a two percent permanent impairment of the limb based on the fourth edition of the A.M.A., *Guides*. Specifically, the Office medical adviser stated that 130 degrees of flexion was equivalent to a 3 percent loss based on Figure 38, page 3/43 and a 9/10 percent loss (3 percent x 30 percent) of the upper extremity. The Office medical adviser further stated that abduction of 110 degrees was the equivalent of a 3 percent loss based on Figure 41, page 3/43[4] and a 54/100 percent loss (3

[4] The Board notes that the Office mistakenly noted that Figure 41 was on page 3/43 of the fourth edition of the A.M.A., *Guides* rather than page 3/44 of the A.M.A., *Guides*.

percent x 18 percent) of the upper extremity.[5] The Office medical adviser stated that although appellant had giving way during the examination, his strength was described as good, so loss according to strength testing equaled zero percent. He also stated that no neurologic or sensory deficits were described which equaled zero percent.

On November 4, 1997 the Office granted appellant a schedule award for a two percent permanent impairment of the left shoulder for the period September 10 through October 23, 1997.

In a December 2, 1997 letter, appellant, through his representative, requested an oral hearing before an Office representative. Appellant's request was received by the Office on December 5, 1997.

By decision dated January 6, 1998, the Office denied appellant's request for an oral hearing as untimely filed.

The Board finds that this case is not in posture for a decision regarding the issue whether appellant is entitled to more than a two percent permanent impairment of the left shoulder, for which he has already received a schedule award.

The schedule award provision of the Federal Employees' Compensation Act[6] and its implementing regulation,[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 of loss of use.[8] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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* have been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[9]

Section 8123(a) of the Act provides that if there is a 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.[10]

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[5] It appears that the Office medical adviser added .9 percent and .54 percent, which equaled 1.44 and then rounded this figure to reflect a 2 percent impairment of the left upper extremity.

[6] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[7] 20 C.F.R. § 10.304.

[8] 5 U.S.C. § 8107(c)(19).

[9] *See James J. Hjort*, 45 ECAB 595 (1994); *Luis Chapa, Jr.*, 41 ECAB 159 (1989); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[10] 5 U.S.C. § 8123(a); *see also Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

In the present case, Dr. Rutherford, determined that appellant had a 17 percent permanent impairment of the left upper extremity while an Office medical adviser determined that appellant had a 6 1/2 percent permanent impairment of the left upper extremity. As a conflict did exist in the medical opinion evidence between Dr. Rutherford and the Office medical adviser as to the extent of impairment of appellant's left shoulder, the Office properly referred appellant to Dr. Hauser, a Board-certified orthopedic surgeon, for an impartial medical evaluation.

When 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 background, must be given special weight.[11] Although Dr. Hauser made findings regarding appellant's range of motion, he did not determine an impairment rating for appellant's left shoulder based on the fourth edition of the A.M.A., *Guides*. Therefore, his report is not entitled to special weight.

Utilizing Dr. Hauser's findings, an Office medical adviser determined that appellant had a two percent permanent impairment of the left shoulder. In so doing, the Office medical adviser determined that 130 degrees of flexion was equivalent to a 3 percent loss based on Figure 38, page 3/43 of the fourth edition of the A.M.A., *Guides.* The Office medical adviser then multiplied 3 percent by 30 percent and calculated a 9/10 percent impairment. The Office medical adviser also determined that 110 degrees of abduction was equivalent to a 3 percent loss based on Figure 41, page 3/43 and multiplied this number by 18 percent to calculate a 54/100 percent impairment. The Office medical adviser then added nine-tenths and fifty-four to calculate a 2 percent permanent impairment of the upper left extremity. The Board finds that the Office medical adviser improperly utilized the A.M.A., Guides in calculating his impairment. According to the A.M.A., *Guides,* a three percent loss for flexion should be added to a three percent loss for abduction resulting in a six percent impairment of the left upper extremity. Therefore, appellant may be entitled to an additional four percent impairment of the left upper extremity.

On remand the Office should request that an appropriate physician properly determine the extent of impairment of appellant's left upper extremity based on the tables in the fourth edition of the A.M.A., *Guides*. After such further development of the case as the Office deems necessary, it should issue an appropriate decision.[12]

[11] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

[12] As this case will be remanded for further medical development, the issue relating to appellant's request for a hearing is moot.

The January 6, 1998 and November 4, 1997 decisions of the Office of Workers' Compensation Programs are hereby vacated and the case is remanded for further consideration consistent with this opinion.

Dated, Washington, D.C.
December 7, 1999

George E. Rivers
Member

David S. Gerson
Member

Bradley T. Knott
Alternate Member