U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CYNTHIA J. EMERTON and U.S. POSTAL SERVICE,
POST OFFICE, Portland, Maine

Docket No. 97-1120; Submitted on the Record;
Issued January 14, 1999

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant has more than a four percent permanent impairment of her right upper extremity for which she received a schedule award.

On December 12, 1983 appellant, then a 32-year-old clerk, slipped on wet pavement as she got out of her car and injured her right shoulder. The Office of Workers' Compensation Programs accepted that appellant sustained a corticle fracture of the right scapula tip and paravertebral muscle sprain due to the work-related injury. Appellant returned to work on February 9, 1984.

Appellant experienced a recurrence of symptoms in July 1984 and a second recurrence of disability in April 1989 which the Office accepted. On July 23, 1990 a subacromial bursectomy, partial acrominonectomy and resection of coracoacromial ligment right shoulder was completed. The Office expanded the accepted work-related condition to include right shoulder impingement with surgery. After surgery, appellant did not return to her job as a letter sorting machine operator.

Appellant experienced a recurrence of her right shoulder symptoms on August 4, 1993. She sought medical care from Dr. John P. Herzog, an osteopath. Appellant was hospitalized on August 16, 1993 and underwent a subacromial resection including bursa, scar tissue, bone on the acromion, and resection of the distal clavicle joint. Appellant was discharged on August 17, 1993 and began a course of physical therapy on August 20, 1993. Appellant continues to work in a full-time limited-duty position.[1]

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[1] The record further reflects that the Office accepted that appellant sustained contusions of the back, left arm, and left hip due to a fall on November 30, 1993. The Office further accepted appellant's July 20, 1994 surgery, in which she underwent an acromioplasty and acromioclavicular ligament release in the left shoulder, as being work related. In a September 3, 1996 decision, the Office awarded appellant an eight percent permanent impairment of her left arm for the period March 4 through August 25, 1996.

In a March 3, 1994 letter, Dr. Herzog noted that he evaluated appellant on March 1, 1994 and these values were noted in reference to appellant's right shoulder. He stated that appellant's right shoulder has sustained a prior fracture while working for the employing establishment and has resulted in a chronic impingement with impaired range of motion and a partially frozen shoulder. Dr. Herzog noted that appellant is several years postoperative and is expected to be at an end medical result. He advised that, using the guidelines of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*), appellant retained forward elevation of her shoulder at 100 degrees, which resulted in a 5 percent impairment to her shoulder. The backward elevation at 20 degrees, resulted in a 6 percent impairment. Internal rotation at 30 degrees, resulted in a 2 percent impairment, and external rotation at 40 degrees resulted in a 8 percent impairment to the shoulder. Combining the numbers together, Dr. Herzog noted a 23 percent impairment to appellant's right shoulder.

In a March 4, 1996 report, Dr. Donald P. Endrizzi, a Board-certified orthopedic surgeon, set forth his findings on physical examination. He noted that appellant's cervical spine range of motion was limited in all planes. Shoulders appeared symmetric, although there was some mild anterior deltoid atrophy visible on the left. Shoulder range of motion actively included forward flexion at about 130 degrees bilaterally. This improved to perhaps 150 degrees. External rotation was in the 60 degrees, and internal rotation was to about T12. That was bilateral. On the right side, appellant was tender in all of the scapular rotators. Appellant was nontender in the area of the distal clavicle. Her deltoid appeared to be well attached, and she had slightly decreased deltoid strength in all planes measured. Internal and external rotation strengths were good bilaterally. On the left side forward flexion was maximally at about 150 degrees. Appellant did have what appeared to be detachment of the anterior deltoid, and tenderness in the area of that detachment. That is in the area of the previous incision site. Her deltoid strength overall appeared to be good. Appellant had equivocal impingement sign, negative arc of pain. She had no evidence for instability. Strength of internal and external rotation seemed to be reasonably good. Distal neurovascular examination was intact.

In a letter dated May 30, 1996, appellant inquired as to the status of her claim for a schedule award which she claimed she filed for more than two years ago.

On August 19, 1996 the Office forwarded a statement of accepted facts and the case record to an Office medical adviser to make a determination based on the A.M.A., *Guides* as to the percentage of loss of use of both arms due to the work-related injuries and the date of maximum medical improvement.

In an August 28, 1996 report, the Office medical adviser noted that the most recent and relevant evaluation of appellant for purposes of schedule award determination was that of Dr. Endrizzi in his report dated March 4, 1996. The Office medical adviser noted that Dr. Endrizzi reported flexion of both shoulders bilaterally to 150 degrees. Using the A.M.A., *Guides* (4th ed.), page 3/43 figure 38, flexion of the shoulders to 150 degrees corresponds to a 2 percent impairment of each shoulder.

Next, the Office medical adviser noted that Dr. Endrizzi reported external rotation "in the 60's" and internal rotation to T12. The Office medical adviser noted that it was likely that these two motions, namely external and internal rotation, were confused one for the other, as it is common to measure external rotation to a level on the thoracic spine, while it would make

little if any sense anatomically to correlate a measurement of internal rotation to a thoracic spine level. Assuming this to be the case, by page 3/45 figure 44 of the A.M.A., *Guides*, internal rotation to 60 percent correlates to a 2 percent impairment on each side. External rotation to T12 rates no impairment.

Diminished motor strength to the right deltoid was described as "slightly decreased." The deltoid muscle is innervated by the axillary nerve. By page 3/54 Table 15 the maximum percent impairment for diminished motor strength is 15 percent. Using Table 12 on page 3/49 of the A.M.A., *Guides*, the Office medical adviser stated that he would rate the grade of weakness described as Grade 4, which corresponds to a 25 percent motor deficit of the involved nerve. Fifteen percent times 0.25 equals 3.75 percent, which the Office medical adviser rounded up to a 4 percent motor deficit of the left upper extremity. This degree of motor weakness accounts for the deltoid atrophy described.

Total impairment sums to 4 percent right arm and 8 percent left arm which equals 12 percent both arms combined. The Office medical adviser further advised that although there is detachment of the anterior deltoid and tenderness in the area of that detachment, he believed that this is accounted for by the range of motion and motor deficit determinations above. The Office medical adviser further noted that the date of maximum medical improvement was no later than March 4, 1996, the date of Dr. Endrizzi's report.

By decision dated September 9, 1996, the Office granted appellant a schedule award for a 4 percent permanent impairment of the right upper extremity for the period March 4 to May 30, 1996, for a total of 12.48 weeks of compensation.

The Board finds that appellant has no greater than a four percent permanent impairment of the right upper extremity, for which she received a schedule award.

Under section 8107 of the Act[2] and section 10.304 of the implementing federal regulations,[3] schedule awards are payable for permanent impairment of specified body members, functions or organs. 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,[4] and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5]

In the present case, the Office granted a schedule award for a four percent permanent impairment of the right upper extremity. The Office based this award on the calculations made by the Office medical adviser, who applied the A.M.A., *Guides* to the measurements of impairment provided by Dr. Endrizzi, a Board-certified orthopedic surgeon. The Office

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[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.304.

[4] A.M.A., *Guides* (4th ed. 1993).

[5] *James A. Sellers*, 43 ECAB 924 (1992).

medical adviser, after reviewing the case record, gave a sufficient reason as to why he chose the report of Dr. Endrizzi upon which to base the schedule award. He further indicated that based upon this report, appellant had a four percent impairment to her right arm which was based on a two percent flexion impairment and a two percent internal rotation impairment. He further found that the detachment of the anterior deltoid and tenderness in the area of detachment was accounted for by the range of motion and motor deficit determinations. Review of the procedures followed by the medical adviser establish that he properly considered flexion, external and internal rotation, and motor strength and properly applied the standard tables provided in the A.M.A., *Guides* when calculating appellant's degree of permanent impairment for her right shoulder.

Although Dr. Herzog reported a 23 percent impairment to appellant's right shoulder, his March 3, 1994 report is approximately 2 years older than Dr. Endrizzi's March 4, 1996 report, which the Office medical adviser relied. Moreover, it is not clear from Dr. Herzog's report which edition of the A.M.A., *Guides* Dr. Herzog utilized in arriving at his conclusion nor is there any references to the page numbers and charts he utilized in attaining his impairment percentage values. It is well settled that when an attending physician's report gives an estimate of permanent impairment but does not indicate that the estimate is based on the application of the A.M.A., *Guides*, the Office may follow the advice of its medical adviser or consultant where he or she has properly utilized the A.M.A., *Guides*.[6] Board cases are clear that if an attending physician does not utilize the A.M.A., *Guides*, his opinion is of diminished probative value in establishing the degree of any permanent impairment.[7] Consequently, Dr. Herzog's March 3, 1994 opinion that appellant has a 23 percent impairment to her right upper extremity has diminished probative value.

[6] *Paul R. Evans*, 44 ECAB 646, 651 (1993); *see Ronald J. Pavlik*, 33 ECAB 1596 (1982).

[7] *Paul R. Evans*, *supra* note 4 at 659; *Thomas P. Gauthier*, 34 ECAB 1060, 1063-64 (1983).

The September 9, 1996 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, D.C.
January 14, 1999

George E. Rivers
Member

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member