U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of RAYMOND S. SHEFFIELD and U.S. POSTAL SERVICE,
POST OFFICE, Newark, NJ

Docket No. 02-2060; Submitted on the Record;
Issued February 12, 2003

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant has established that he has greater than a 13 percent permanent impairment of his left upper extremity, for which he received schedule awards.

Appellant, a mailhandler born April 11, 1969, filed a traumatic injury claim alleging that on November 12, 1995 he injured his left shoulder while trying to free a jammed flat sorter belt on a machine at work. The Office of Workers' Compensation Programs accepted the claim for left shoulder impingement. On June 11, 1996 appellant underwent arthroscopic arthrotomy of the left shoulder with burscoscopy, subacromial decompression, acromioplasty and release of coracromial ligaments. He returned to light duty on July 3, 1996.

On August 10, 1997 appellant filed a claim for a schedule award. In support of his claim, appellant submitted a medical report dated July 18, 1997 from Dr. David Weiss, an osteopath.

In his report, Dr. Weiss discussed appellant's work injury, subsequent surgery and diagnostic findings and concluded that appellant reached maximum medical improvement on June 18, 1997. On examination, he stated that appellant's left shoulder revealed well healed portal arthroscopy shoulder scars, anterior cuff tenderness and acromioclavicular tenderness on palpation. Dr. Weiss further indicated that range of motion revealed forward elevation of 160/180 degrees, abduction of 130/180 degrees, cross over abduction of 75/75 degrees, which produced pain and external rotation of 90/90 degrees. He stated that posterior reach or internal rotation was abnormal to the sacrum, circumduction presented with crepitus in the joint and Hawkin's impingement sign was negative at that time. Dr. Weiss further stated that motor strength testing revealed a grade of 4/5 involving the left upper extremity, deltoid testing revealed a Grade of 4 plus/5 and that there was no winging or pseudo winging of the scapula noted. He indicated that a circumference taken of appellant's upper arms at three inches above the elbow revealed 37 centimeters (cm) on the right versus 36 cm on the left. Dr. Weiss concluded that the work-related injury of November 12, 1995 was the competent producing factor for appellant's subjective and objective findings. He provided an impairment rating based on the Fourth Edition of the American Medical Association, *Guides to the Evaluation of*

Permanent Impairment and stated: "[f]or the range of motion deficit flexion, 1 percent ([F]igure 38, page 43); for the range of motion deficit abduction, 2 percent ([F]igure 41, page 40); IV/V motor strength deficit deltoid, 9 percent ([F]igure 15, page 54, [F]igure 12, page 49) and arthroplasty shoulder, 24 percent ([F]igure 27, page 61) for a combined total left upper extremity [impairment], 33 percent."

The Office referred appellant for a second opinion examination with Dr. Irving Strouse, a Board-certified orthopedic surgeon. In an August 12, 1998 report, he initially concluded that appellant had 3 percent impairment from lack of full flexion, a 3 percent impairment from lack of full abduction, 1 percent impairment from lack of full adduction and 8 percent impairment for residual pain, totaling 15 percent impairment of the left upper extremity. Dr. Strouse; however, determined that a magnetic resonance imaging (MRI) scan of appellant's left shoulder was necessary prior to full examination. Appellant underwent an MRI scan on November 2, 1998 and a second on October 14, 1999. Dr. Strouse examined appellant again on November 16, 1999.

In a report dated November 16, 1999, Dr. Strouse related the facts of appellant's work injury and illness, his past occupational and medical history and subjective complaints. He noted that the October 14, 1999 MRI scan showed hypertrophic changes at the acromioclavicular joint with associated impingement and abnormal supraspinatus tendon, which suggested a full thickness rotator cuff tear. On examination, Dr. Strouse reported that appellant had no atrophy of the shoulder girdle, minimal tenderness over the rotator cuff area and very mild crepitus felt on abduction and flexion. He stated that range of motion included 140 degrees adduction, 90 degrees of internal rotation and 90 degrees of external rotation. Dr. Strouse indicated that appellant had plus five in muscle strength of the left upper extremity, some pain on forced adduction, no sensory loss and no reflex or vascular abnormalities.

In an impairment evaluation worksheet (Form CA-1303-05), dated November 16, 1999, Dr. Strouse reiterated that appellant had retained internal and external rotation from 0 degrees to 90 degrees. He outlined further that there was a retained forward elevation from 0 to 140 degrees, which yielded an impairment rating of 3 percent. Dr. Strouse further outlined that there was a retained backward elevation from 0 to 50 degrees and a retained abduction from 0 to 125 degrees, which yielded an impairment rating of 2.5 percent. He further indicated that appellant had a retained adduction from 0 to 40 degrees. Dr. Strouse recommended that appellant had an impairment rating of 5.5 percent of the left upper extremity and opined that there was no additional impairment due to weakness, atrophy, pain or loss of sensation. The reports of Dr. Strouse were referred to by the Office medical adviser who, on December 27, 1999, calculated an impairment rating based on his findings in accordance with the fourth edition of the A.M.A., *Guides*. Specifically, the Office medical adviser determined that 140 degrees flexion constituted a 3 percent impairment[1] and that 125 degrees abduction constituted another 3 percent

[1] A.M.A., *Guides* at 43, Figure 38.

impairment.[2] He further found that 50 degrees extension,[3] 40 degrees adduction[4] and 90 degrees internal and external rotation[5] all constituted 0 percent impairment. The Office medical adviser determined that appellant had a six percent impairment of the left upper extremity.

By decision dated December 29, 1999, the Office issued appellant a schedule award for a six percent permanent loss of use of the left arm from November 16, 1999 to March 27, 2000. In a letter dated January 6, 2000, appellant requested an oral hearing through counsel, attorney Thomas Uliase.

By decision dated March 17, 2000, an Office hearing representative determined that the case was not in posture for a hearing, vacated the prior decision and remanded the case to the Office. The Office hearing representative determined that there was a discrepancy in the reports of Dr. Strouse as to whether appellant had any impairment of his left upper extremity due to pain. The Office hearing representative indicated that on the November 16, 1999 CA-1303-05 form, Dr. Strouse gave a negative response to the question of whether there was additional impairment of the extremity due to pain or weakness, however, in his narrative report with the same date, Dr. Strouse described appellant as having some pain. Further, the Office hearing representative indicated that, in his August 11, 1998 report, Dr. Strouse opined that in addition to impairment due to range of motion, appellant had an 8 percent impairment of the extremity due to the effects of residual pain. However, he did not indicate whether and how that percentage was derived from the standards of the A.M.A., *Guides*. The Office hearing representative directed that, on remand the Office request clarification of Dr. Strouse's opinion regarding pain, the reasons for the discrepancy found in his reports, a grading scheme for an impairment of pain found in accordance with the A.M.A., *Guides* and an explanation for his calculations.

On remand, the Office requested clarification from Dr. Strouse regarding appellant's upper extremity impairment. In a letter dated July 17, 2000, Dr. Strouse responded that his schedule award evaluation should be as stated in the November 16, 1999 report as 5.5 percent of the left upper extremity. He indicated that, in his previous evaluation of August 12, 1998, he had included an 8 percent disability for residual pain, however, in his November 16, 1999 evaluation, he made a modification and removed the 8 percent evaluation for pain, leaving appellant with the 5.5 percent disability to his left upper extremity.

By decision dated August 17, 2000, the Office denied the claim for an additional schedule award. In a letter dated August 21, 2000, appellant through counsel, requested an oral hearing.

By decision dated January 2, 2001, an Office hearing representative remanded the case to the Office to obtain additional clarification from Dr. Strouse regarding the reason he removed the eight percent rating for pain in appellant's case.

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[2] *Id.* at 44, Figure 41.

[3] *Id*. at 43, Figure 38.

[4] *Id*. at 44, Figure 41.

[5] *Id*. at 45, Figure 44.

On remand, in a letter dated February 6, 2001, Dr. Strouse stated:

> "Please be advised that on my evaluation of November 16, 1999, I determined that the impairment, as per the [A.M.A.,] [*Guides*] from the A.M.A., considers that the allowance for pain is already included in the percent impairment. Please refer to page 9 of the [A.M.A.,] *Guide[s]*, under the paragraph concerning [p]ain, where it states that 'in general the impairment percent shown in the chapters that consider the various organ systems make allowance for the pain that may accompany the impairing condition.' Therefore, I feel that my scheduled award from the November 16, 1999 report is the more accurate award."

By decision dated May 11, 2001, the Office again denied the claim for an additional schedule award. In a letter dated May 17, 2001, appellant through counsel requested another oral hearing, which was held on October 25, 2001.

During the hearing, appellant's counsel argued that the Office based its finding of a six percent schedule award on Dr. Strouse's opinion that appellant had an impairment percentage based simply on a loss of motion and pain, which varied in his reports, with no consideration or discussion for loss of strength or surgery. He discussed that on the contrary Dr. Weiss found a nine percent impairment for motor strength deficit and a rating for surgery. Attorney Uliase argued therefore, that a conflict existed in the medical evidence, which required further development. At the hearing, the Office hearing representative indicated that the record would be held open for 30 days so that appellant could obtain another opinion regarding impairment. No new evidence was submitted.

By decision dated January 24, 2002, an Office hearing representative found that the report of the Office medical adviser conformed with the A.M.A., *Guides* and constituted the weight of the medical evidence. She found that since no further evidence provided demonstrated that appellant had an additional impairment of more than the six percent previously awarded for his upper extremity impairment, that the prior decision should be affirmed.

In a letter dated March 6, 2002, appellant through counsel requested reconsideration and submitted a report from Dr. Weiss dated December 3, 2001. In the report, he stated:

> "There is focal acromioclavicular point tenderness. Range of motion reveals forward elevation of 150/180 degrees, abduction of 160/180 degrees, cross over adduction of 75/75 degrees and external rotation of 90/90 degrees. Posterior reach (internal rotation) is abnormal to the sacrum. Circumduction is to 90 degrees with pain. There is crepitance noted involving the anterior joint on circumduction. Hawkin's impingement sign is positive…. Manual muscle testing of the supraspinatus musculature is graded at 4/5 on the left. Biceps testing is graded at 4/5 on the left. Triceps strength is graded at 5/5 on the left. Deltoid muscle testing is graded at 5/5 on the left."

Based on the Fifth Edition of the A.M.A., *Guides*, Dr. Weiss assessed:

> "For the range of motion deficit left shoulder flexion equaled 2 percent ([F]igure 16-40, pg.476); [f]or the left shoulder arthroplasty equaled 24 percent ([F]igure

16-27, pg. 506); [c]ombined left upper extremity equaled 27 percent; [f]or the pain related impairment equaled 3 percent ([F]igure 18-1, pg. 574); [t]otal left upper extremity equaled 30 percent."

On May 9, 2002 an Office medical adviser reviewed the December 3, 2001 report and found that instead of a 30 percent impairment, appellant had a 13 percent impairment of the left upper extremity. Specifically, the Office medical adviser determined that 150 degrees of forward elevation constituted a 2 percent impairment,[6] 160 degrees abduction constituted a 1 percent impairment[7] and the left shoulder arthroplasty constituted a 10 percent impairment.[8] The Office medical adviser indicated that Dr. Weiss incorrectly allowed 24 percent for the arthroplasty when the table only allowed 24 percent for a shoulder implant arthroplasty. He further indicated that he used the distal clavicle resection assessment to replace the partial acromioplasty since the acromioplasty was not listed under arthroplasty. He further indicated that there was no need to raise the assessment by 3 percent for pain since the 13 percent impairment adequately assessed the disability.

By decision dated May 16, 2002, the Office Director vacated the order filed by the Office on January 24, 2002 on the grounds that new evidence had been submitted sufficient to warrant modification of the prior decision. The Office, by decision dated May 17, 2002, then issued appellant an additional schedule award of 7 percent for loss of use of the left upper extremity, which with the previously issued award of 6 percent equaled a total schedule award of the left upper extremity of 13 percent.

On appeal, appellant's counsel, Attorney Uliase first argues that the medical evidence established in this case that appellant had sustained a 33 percent impairment to the left upper extremity. Attorney Uliase argues in the alternative that there was at least a conflict in the medical evidence between Dr. Strouse, the second opinion physician and Dr. Weiss, which required referral to an impartial examiner for further medical development.

The Board finds that the case is not in posture for decision.

The schedule award provisions of the Federal Employees' Compensation Act[9] 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.[10] 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 insure equal justice under the law to all claimants, the

[6] A.M.A., *Guides* (5th ed.) at 476, Figure 16-40.

[7] *Id*. at 477, Figure 16-43.

[8] *Id.* at 506, Table 16-27.

[9] 5 U.S.C. §§ 8101-8193; see 5 U.S.C. § 8107(c).

[10] 5 U.S.C. § 8107(c)(19).

Office has adopted the A.M.A., *Guides* (5th ed.) as the standard to be used for evaluating schedule losses.[11]

In obtaining medical evidence for schedule award purposes, the Office must obtain an evaluation by an attending physician which includes a detailed description of the impairment including, where applicable, the loss in degrees of motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other pertinent description of the impairment. The description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[12] If the attending physician has provided a detailed description of the impairment, but has not properly evaluated the impairment pursuant to the A.M.A., *Guides*, the Office may request that the Office medical adviser review the case record and determine the degree of appellant's impairment utilizing the description provided by the attending physician and the A.M.A., *Guides*.[13]

In this case, the Office determined that appellant had an additional 7 percent impairment of the left upper extremity, totaling 13 percent, based on Dr. Weiss' examination and impairment evaluation. The Office medical adviser applied this finding to the applicable table of the A.M.A., *Guides* to arrive at the total percentage of impairment in appellant's left upper extremity. The Office medical adviser thoroughly discussed his findings based on Dr. Weiss' evaluation for range of motion. He further noted that Dr. Weiss incorrectly allowed 24 percent for the arthroplasty, which only applied to a shoulder implant arthroplasty and explained why he instead attributed 10 percent impairment to the left shoulder arthroplasty. However, the Office medical adviser failed to sufficiently explain how he reached his assessment of pain. Dr. Weiss, in his December 3, 2001 report, indicated that circumduction was to 90 degrees with pain and later assessed that the pain-related impairment equaled 3 percent, based on Figure 18-1 on page 574 of the A.M.A., *Guides*. The Office medical adviser, in his report, concluded that there was no need to raise the assessment by 3 percent for pain, since the 13 percent impairment adequately assessed the disability. According to Figure 18-1 at page 574 of the A.M.A., *Guides*, the reader evaluating impairment must first conduct an informal assessment of the pain-related impairment and then use the conventional rating system to determine the impairment percentage. Step two of Figure 18-1 indicates that if the conventional impairment adequately encompasses the burden of the individual's condition, his or her impairment rating is the percentage found in step one. Step three indicates that if the pain-related impairment appears to increase the burden of the individual's condition slightly, the examiner can increase the percentage found in step one by up to 3 percent. It appears that Dr. Weiss' conclusion that appellant had a 3 percent impairment for pain is explained in step three in Figure 18-1 since he found some pain on circumduction. However, the Office medical adviser disagreed and indicated that the conventional impairment adequately encompasses the burden of appellant's condition and, therefore, pain was adequately assessed in the 13 percent impairment rating. The Office medical adviser did not explain how the conventional rating system, which determines impairment, also considers pain or explain

[11] 20 C.F.R. § 10.404.

[12] *Leisa D. Vassar*, 40 ECAB 1287 (1989).

[13] *Joseph D. Lee*, 42 ECAB 172 (1990).

how he reached his conclusion that pain had been included in the 13 percent impairment rating. This is noteworthy particularly since the Office found earlier discrepancies in the medical evidence as to whether there was impairment of the extremity due to pain. The Board will therefore, set aside and remand the Office's May 17, 2002 decision for the Office medical adviser to explain how he reached his pain assessment pursuant to the A.M.A., *Guides* based on Dr. Weiss' December 3, 2001 report and impairment evaluation.

The decision of the Office of Workers' Compensation Programs dated May 17, 2002 is set aside and remanded in accordance with this opinion.

Dated, Washington, DC
February 12, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member