United States Department of Labor
Employees' Compensation Appeals Board

JAMES R. TAYLOR, Appellant **and** **DEPARTMENT OF THE ARMY, FORT MONMOUTH, NJ, Employer**	))))))))	**Docket No. 05-135** **Issued: May 13, 2005**

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
MICHAEL E. GROOM, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On October 13, 2004 appellant filed a timely appeal from a merit decision of the Office of Workers' Compensation Programs dated July 13, 2004, in which an Office hearing representative affirmed a September 19, 2003 decision which granted a schedule award for 10 percent impairment of the right upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award issue.

ISSUE

The issue is whether appellant has more than a 10 percent impairment of the right upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On July 8, 1995 appellant, then a 48-year-old police officer, filed a traumatic injury claim asserting that on July 3, 1995 he injured his right shoulder when he reached behind his right side during a training exercise. The Office accepted his claim for a right shoulder strain. On November 6, 1996 the Office authorized surgery for an arthroscopic subacromial decompression,

arthroscopic distal clavicle resection and biceps tenodesis with mitek anchors which appellant underwent on February 4, 1997. The Office also approved surgery for an open capsular shift with Mitek anchors which he underwent on June 1, 2000. Appropriate compensation was paid for all periods of wage loss. Appellant returned to light-duty work on September 10, 2000 and full active duty on October 8, 2000.

On November 17, 2000 Dr. Steven Berkowitz, a Board-certified orthopedic surgeon and treating physician, discharged appellant from active care. He found that appellant had excellent reconstitution of the muscles of his right shoulder, with full range of motion and good strength and opined that his complaints concerning tightness and pain very likely represented permanency.

On April 20, 2001 appellant filed a claim for a schedule award for impairment to his right upper extremity. He submitted a report dated February 7, 2001, from Dr. David Weiss, a Board-certified family practitioner, who noted that appellant had reached maximum medical improvement on January 31, 2001 and that testing of the right shoulder revealed forward elevation of 150 degrees, an abduction of 145 degrees, cross-over adduction of 65 degrees and external rotation of 90 degrees and internal rotation to T10 on the right and T6 on the left. Dr. Weiss found that circumduction revealed crepitance within the acromioclavicular (AC) joint and the interior apprehension sign produces pain within the AC joint. Hawkin's impingement sign was negative as well as the drop test. Isolated testing of the right upper extremity revealed the supraspinatus musculature at 4/5; biceps testing was 4/5 and deltoid testing was 5/5. Grip strength testing performed with the Jamar Hand Dynamometer at Level 3 revealed 48 kilograms of force strength involving the right hand, versus 52 kilograms of force strength involving the left hand. This was noted to be abnormal as appellant was right-hand dominant. Dr. Weiss noted that the July 3, 1995 work injury was the cause of all of his right extremity findings and concluded that, pursuant to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, appellant had a 30 percent impairment due to the right shoulder arthroplasty,[1] a 2 percent impairment due to the range of motion deficit of right shoulder flexion[2] and a 2 percent impairment due to range-of-motion deficit right shoulder abduction[3] and a 10 percent right grip strength deficit,[4] for a combined total right upper extremity impairment of 40 percent.

The Office referred appellant for a second opinion evaluation with Dr. David Rubinfeld, a Board-certified orthopedic surgeon. He was provided with a statement of accepted facts, a list of questions to be addressed and copies of the relevant medical evidence of record. In a report dated March 21, 2002, Dr. Rubinfeld provided findings on range-of-motion testing of appellant's

[1] A.M.A., *Guides*, Table 16-27 at 506.

[2] A.M.A., *Guides*, Figure 16-40 at 476.

[3] A.M.A., *Guides*, Figure 16-43 at 477.

[4] A.M.A., *Guides*, Table 16-34 at 509.

right and left shoulder, right and left elbow, right and left wrist and cervical spine, noting that all results were within normal limits.[5] He found that there was no restriction of active motion. Strength was normal. No atrophy or ankylosis were present. Pain after use, intermittent numbness of the right forearm and fingers were the primary and difficulty moving the right arm were the subjective complaints. Dr. Rubinfeld opined that appellant reached maximum medical improvement on January 1, 2001, six months after the open capsular shift procedure and concluded that, pursuant to the fifth edition of the A.M.A., *Guides*, he had a 10 percent right upper extremity impairment.[6] He explained that his impairment rating differed from Dr. Weiss, who allowed 30 percent impairment for a total shoulder resection arthroplasty, which was not done in this case, as only the distal clavicle was resectioned. Dr. Rubinfeld explained that Dr. Weiss described restricted shoulder motion and right grip strength weakness, which was not present on his examination.

On April 4, 2002 an Office medical adviser reviewed medical evidence and concurred with Dr. Rubinfeld's findings. The Office medical adviser agreed that appellant had a 10 percent impairment under Table 16-27, page 506 of the A.M.A., *Guides* for a resection of the distal clavicle.

By decision dated April 5, 2002, the Office granted appellant a schedule award for a 10 percent impairment of his right upper extremity.

Appellant requested an oral hearing, which was held on March 11, 2003. By decision dated June 30, 2003, an Office hearing representative set aside the April 5, 2002 decision and remanded the case for further development of the medical evidence. The Office hearing representative directed that the Office seek clarification from Dr. Rubinfeld to support his 10 percent impairment rating.

In a letter dated July 23, 2003, the Office requested that Dr. Rubinfeld clarify his opinion. In an August 6, 2003 report, he advised that grip strength was not measured with a dynamometer, but rather was tested by having appellant make a fist and/or by his trying to open a clenched fist. He advised that his impairment rating was based on appellant's partial arthroplasty which, under Table 16-27, page 506 of the A.M.A., *Guides*, was a 10 percent impairment of the upper extremity for that procedure. Dr. Rubinfeld further stated that a full range of motion of the entire right upper extremity was present on his March 21, 2002 examination.

On August 7, 2003 an Office medical adviser reviewed the medical evidence and stated that the total shoulder arthroplasty, which is given a 30 percent impairment rating under the A.M.A., *Guides,* was a much more extensive procedure than that which appellant underwent and

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[5] Active range of motion for the right shoulder was noted as follows: forward elevation of 150 degrees, backward elevation of 40 degrees, abduction of 150 degrees, adduction of 30 degrees, external rotation of 90 degrees and internal rotation of 40 degrees. Range of motion for the right elbow was reported as follows: flexion of 150 degrees, pronation of 80 degrees and supination of 80 degrees. Range of motion for the right wrists was noted as follows: dorsiflexion of 60 degrees; palmarflexion 70 degrees; radial deviation 20 degrees; and ulnar deviation 30 degrees.

[6] A.M.A., *Guides*, Table 16-27 at 506.

involved resection of all or part of the humeral head. The Office medical adviser stated that at times an implant cannot be used so a soft tissue resection is done to create a false joint or pseudoarthrosis. The Office medical adviser noted that the term "resection" meant that bone was cut away. The Office medical adviser stated that there was a distinction between the capsular repair which occurred in this case and a total shoulder arthroplasty. The Office medical adviser indicated that there was no table for this procedure in the A.M.A., *Guides* and impairment was usually based on residual loss of motion and weakness of the shoulder muscle groups.

By decision dated September 19, 2003, the Office found that appellant was not entitled to a greater schedule award. The Office noted that the 30 percent impairment rating under the A.M.A., *Guides* for a total arthroplasty did not accurately describe his open capsular shift surgery, which was not as extensive of a procedure as described for a true total arthroplasty.

In a September 25, 2003 letter, appellant, through his attorney, requested an oral hearing which was held on April 21, 2004. He argued that the opinion of Dr. Rubinfeld did not constitute the weight of the medical evidence. Alternatively, he argued that a conflict in medical opinion evidence was created between Dr. Rubinfeld and Dr. Weiss, which required resolution by an impartial medical specialist.

By decision dated July 13, 2004, the Office hearing representative affirmed the September 19, 2003 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[7] and its implementing regulation[8] 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 regulations as the appropriate standard for evaluating schedule losses.[9]

The weight of medical opinion evidence is determined by the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested and the medical rationale expressed in support of the opinion.[10] The opinion of a physician supporting causal relation must be one of reasonable medical certainty, supported with affirmative evidence, explained by medical rationale and based on a complete and accurate factual and medical background.[11]

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[7] 5 U.S.C § 8107.

[8] 20 C.F.R § 10.404 (1999).

[9] *See id.*; *Jacqueline S. Harris*, 54 ECAB ___ (Docket No. 02-203, issued October 4, 2002).

[10] *Anna C. Leanza*, 48 ECAB 115 (1996).

[11] *See Manuel Gill*, 52 ECAB 282 (2001).

ANALYSIS

The Office found that appellant had a 10 percent impairment of his right upper extremity based on the findings reported by Dr. Rubinfeld, a referral physician. He determined that appellant had a 10 percent impairment rating for resection of the distal clavicle in his reports dated March 21, 2002 and August 6, 2003. The Office further noted that Dr. Rubinfeld's findings and the entire medical record had been reviewed by an Office medical adviser, who concurred with Dr. Rubinfeld's conclusions.

The Board notes that both Dr. Weiss and Dr. Rubinfeld discussed impairment ratings based on arthroplasty, range of motion deficit and grip strength deficit. However, the A.M.A., *Guides* at page 526 states that methods of evaluation based on diagnosed-based estimates, range of motion ankylosis and muscle strength may not be combined with each other.[12] Thus, Dr. Weiss' combined rating of a 40 percent impairment to the right upper extremity is not in accord with the A.M.A., *Guides*.[13] However, as an impairment rating can be evaluated for each category the physicians discussed pertaining to arthroplasty, range of motion deficit and grip strength deficit, the Board will examine each of the physician's different methods of evaluation to determine whether the evidence reveals greater than the 10 percent impairment to appellant's right upper extremity.

Dr. Rubinfeld reported that his findings on range-of-motion testing were normal. However, a review of such findings, under the A.M.A., *Guides*, result in an impairment rating of eight percent for appellant's right shoulder. For range-of-motion findings for his right shoulder, under Figure 16-40 page 476, forward elevation (flexion) of 150 degrees is a 2 percent impairment and a backward elevation of 40 degrees is a 1 percent impairment. Under Figure 16-40 page 476, an abduction of 150 degrees is a 1 percent impairment and adduction of 30 degrees is a 1 percent impairment. Under Figure 16-46 page 479, external rotation of 90 degrees is a 0 percent impairment and internal rotation of 40 degrees is 3 percent impairment. This amounts to a total range-of-motion impairment of eight percent to appellant's right shoulder. Furthermore, the Board notes that Dr. Weiss found a 4 percent impairment by assigning a 2 percent impairment rating under Figure 16-40, page 476 for a 150 degree right shoulder flexion/elevation and, under Figure 16-43, page 477, a 2 percent impairment rating for right shoulder abduction of 145 degrees. However, neither Dr. Rubinfeld's 8 percent range of motion deficit, nor Dr. Weiss's 4 percent range of motion deficit is enough to establish more than the 10 percent upper extremity impairment awarded.

Based on an alternate method of testing appellant's grip strength, Dr. Rubinfeld opined that his grip strength was normal. Dr. Weiss, however, reported an abnormal grip strength in the right hand through dynamometer readings and assigned a 10 percent impairment under Table 16-34, page 509 of the A.M.A., *Guides*. The fifth edition of the A.M.A., *Guides* provides, however, that loss of strength should be rated separately only if it is based on an unrelated cause or mechanism, "otherwise the impairment ratings based on objective anatomic findings take

[12] A.M.A., *Guides*, Table 17-2 at 526.

[13] *Id.*

precedence."[14] Dr. Weiss provided no explanation as to why a 10 percent impairment was assigned. The Board notes that the percentage strength loss index in this case is less than the categories provided in Table 16-34 necessary to obtain a 10 percent upper extremity impairment.[15] Thus, without any explanation or rationale, Dr. Weiss' impairment rating based on abnormal grip strength is of diminished probative value and is insufficient to establish greater than the 10 percent impairment of the right upper extremity awarded.[16]

Although Dr. Weiss assigned 30 percent impairment due to the right shoulder arthroplasty under Table 16-27, page 506 of the A.M.A., *Guides*, he provided no explanation as to why he thought the total arthroplasty rating was appropriate. The surgical reports specifically describe the proposed surgery as that of an open capular shift as opposed to an arthroscopy or arthroplasty. The Office medical adviser concurred with Dr. Rubinfeld's explanation that appellant had 10 percent impairment for a resection arthroplasty of the distal clavicle. The Office medical adviser noted that a total shoulder arthroplasty was not performed in this case, as appellant did not undergo a resection of all or part of the humeral head and advised that a capsular repair was standard medical terminology among orthopedics and was not a matter of interpretation. It is well established that medical reports must be based on a complete and accurate factual and medical background and medical opinions based on an incomplete or inaccurate history are of diminished probative value.[17] This impairment rating of Dr. Weiss is based on an inaccurate description of the surgery and is of diminished probative value. It does not establish greater than the 10 percent impairment of the right upper extremity awarded.[18] The Board finds that the weight of the medical evidence is represented by the thorough and well-rationalized opinion of Dr. Rubinfeld, who reviewed the record, which included appellant's discussion of surgical procedure and provided a reasoned explanation regarding why his open capsular repair was not considered a total but, rather, a partial arthroplasty under Table 16-27, page 506 of the A.M.A., *Guides*. This report was reviewed by an Office medical adviser, who concurred with his statements regarding the open capsular repair procedure not representing a total arthroplasty. For these reasons, under the alterative methods described in the A.M.A., *Guides* for rating appellant's right shoulder impairment, the medical evidence does not establish more than the 10 percent impairment awarded.

CONCLUSION

The Board finds that appellant has not established that he has more than a 10 percent impairment of the right upper extremity.

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[14] A.M.A., *Guides*, section 16.8a at 508.

[15] An index of loss of strength uses the following formula: normal strength minus limited strength divided by normal strength equals the percentage of strength loss index. A.M.A., *Guides*, Table 16-34 at 509. In this case 52 kilograms (normal strength) -- 48 kilograms (limited strength) divided by 52 kilograms (normal strength) equals a 7 percent strength loss index which is less than the 10 to 30 category range permitted by the A.M.A., Guides for a 10 percent upper extremity impairment.

[16] *See Lucrecia M. Nielson*, 42 ECAB 583, 594 (1991).

[17] *Douglas M. McQuaid*, 52 ECAB 382 (2001).

[18] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 13, 2004 is hereby affirmed.

Issued: May 13, 2005
Washington, DC

Colleen Duffy Kiko
Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member