United States Department of Labor
Employees' Compensation Appeals Board

T.S., Appellant	)	
and	)	**Docket No. 07-1358**
	)	**Issued: October 4, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Frazer, PA, Employer	)	

Appearances:
Thomas R. 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
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On April 25, 2007 appellant filed a timely appeal from the November 8, 2006 merit decision of the Office of Workers' Compensation Programs' hearing representative, who affirmed the denial of her claim for an increased schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of her claim.

ISSUE

The issue is whether appellant is entitled to an increased schedule award.

FACTUAL HISTORY

On a prior appeal of this case,[1] the Board noted that appellant sustained a right shoulder injury on January 9, 1999 while loading mail. The Office accepted her claim for adhesive capsulitis and tendinitis. On June 4, 1999 appellant underwent an arthroscopic acromioplasty. The Office granted a schedule award for a 13 percent permanent impairment of her right upper

[1] Docket No. 02-1928 (issued December 24, 2002).

extremity which a hearing representative affirmed on July 26, 2001. The Board set aside that decision finding a conflict between appellant's physician and an Office medical adviser on the nature of the surgery and the degree of impairment. The Board remanded the case for resolution of the conflict. The facts of this case as set forth in the Board's prior decision are hereby incorporated by reference.

The Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. Evan S. Kovalsky, a Board-certified orthopedic surgeon, selected as the impartial medical specialist. On March 3, 2006 Dr. Kovalsky related appellant's history and complaints. He noted that motor strength was excellent throughout the upper extremities without any indication of weakness. Other clinical findings included the following:

> "[Appellant's] shoulders were symmetrical in appearance without swelling, discoloration or effusion. Her shoulder motions were excellent and slightly limited and was to T8 versus T6 on the left. On passive range of motion of the shoulders, the left shoulder actually had some clicking within it but the right did not. There is no pain in the left shoulder. Impingement testing with Neer and Hawkin's revealed minimal discomfort posterior in the right shoulder but not in the subacromial region itself. There is no evidence of laxity or instability in the right shoulder. Apprehension, relocation, Sulcus, Speed's, crossover and lift off were all negative. There is no tenderness at the AC [acromioclavicular] joint and no focal tenderness in the shoulder. [Appellant] had very well healed, barely visible posterior and lateral shoulder scars from her arthroscopy. There was very minimal posterior lateral tenderness behind the shoulder but no tenderness over the acromion or rotator cuff itself, laterally.
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> "Examination of the remaining portion of the upper extremities revealed full, painless range of motion of the elbows, wrists and fingers without evidence of contracture or deficits."
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> * * *
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> "It is my opinion that the surgery that she underwent which is an acromioplasty is not a true 'arthroplasty.' Based on these findings, I do not feel that a diagnosis relating to arthroplasty can be utilized to determine impairment. The procedure is a completely extra-articular procedure and would not be adequately described by an arthroplasty. Under these circumstances, the only impairment which can be attributed to [appellant's] shoulder would be that of her restricted motion which on internal rotation was, as most, 10 [to] 15 degrees of restriction. This would give her impairment, due to loss of internal rotation, of one percent. This would be the percentage of the impairment of the upper extremity. The only other impairment which can be rated would be for [appellant's] subjective pain. It is my opinion that the pain only slightly impairs [appellant's] ability to do things and to use the shoulder. Using the [algorithm] in [F]igure 18-1, I would rate her impairment, based upon this, at three percent. Using [T]able 16.3, the impairment of the right upper extremity would be one percent based on loss of motion plus

the three percent for [appellant's] pain which would give her an upper extremity impairment percentage of four percent."

In a decision dated March 15, 2006, the Office denied appellant's schedule award claim. It found that the weight of the medical opinion evidence rested with Dr. Kovalsky who determined that appellant had a four percent permanent impairment of her right upper extremity.

At a July 31, 2006 hearing before an Office hearing representative, appellant argued that the impartial medical specialist reported clinical findings that were too general to be sufficiently probative. He did not explain how he tested motor strength or how he determined that there was no atrophy. Appellant noted that he did not give range of motion measurements as a basis for using the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001).

In a decision dated November 8, 2006, the hearing representative affirmed the Office's schedule award denial. She found that Dr. Kovalsky's opinion represented the weight of the medical evidence and established that appellant had less than the 13 percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[2] authorizes the payment of schedule awards for the loss or loss of use, of specified members, organs or functions of the body. Such loss or loss of use, is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[3]

To support a schedule award, the file must contain competent medical evidence that describes the impairment in sufficient detail for the adjudicator to visualize the character and degree of disability.[4] The report of the examination must always include a detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive 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.[5] The Office should advise any physician evaluating permanent impairment to use the fifth edition of the A.M.A., *Guides* and to report findings in accordance with those guidelines.[6]

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001 the Office began using the A.M.A., *Guides* (5th ed. 2001).

[4] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.b(2) (August 2002).

[5] *Id*., Chapter 2.808.6.c(1).

[6] *Id*., Chapter 2.808.6.a (noting exceptions).

If there is 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.[7] When there exist 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.[8] When the opinion from the specialist requires clarification or elaboration, however, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report. When the impartial medical specialist's statement of clarification or elaboration is not forthcoming or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative or lacks rationale, the Office must submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question.[9] Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Act will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[10]

ANALYSIS

Dr. Kovalsky, the Board-certified orthopedic surgeon and impartial medical specialist, concluded that a diagnosis relating to "arthroplasties" could not be used to determine impairment. He reviewed the operative report and noted that appellant underwent an acromioplasty, not a true arthroplasty. Appellant's operation Dr. Kovalsky explained, was a completely extra-articular procedure that is not adequately described by an arthroplasty. He found that she was not entitled to a schedule award based on Table 16-27, page 506 of the A.M.A., *Guides*, "Impairment of the Upper Extremity After Arthroplasty of Specific Bones or Joints."

Dr. Kovalsky found a three percent pain-related impairment under Chapter 18 of the A.M.A., *Guides*. However, the A.M.A., *Guides* provide limitation on integrating pain-related impairment into an impairment rating system. It states:

> "Finally, at a practical level, a chapter of the A.M.A., *Guides* devoted to pain-related impairment should not be redundant of or inconsistent with principles impairment rating described in other chapters. The A.M.A., *Guides'* impairment ratings currently include allowances for the pain that individuals typically experience when they suffer from various injuries or diseases, as articulated in Chapter 1 of the A.M.A., *Guides*: 'Physicians recognize the local and distant pain that commonly accompanies many disorders. Impairment ratings in the A.M.A., *Guides* already have accounted for pain. For example, when a cervical spine

[7] 5 U.S.C. § 8123(a).

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

[9] *See Nathan L. Harrell*, 41 ECAB 402 (1990).

[10] *Harold Travis*, 30 ECAB 1071 (1979).

> disorder produces radiating pain down the arm, the arm pain which is commonly seen, has been accounted for in the cervical spine impairment rating' (page 10). Thus, if an examining physician determines that an individual has pain-related impairment, he or she will have the additional task of deciding whether or not that impairment has already been adequately incorporated into the rating the person has received on the basis of other chapters of the A.M.A., *Guides*."[11]

Without a sound explanation for incorporating pain-related impairment, Dr. Kovalsky has not justified a three percent increase in appellant's rating. The Board will remand the case for a supplemental report from Dr. Kovalsky explaining whether the body and organ impairment rating systems provided in Chapter 16 is a proper basis to rate appellant's condition.

Dr. Kovalsky must also clarify another matter. He found a one percent impairment of the right upper extremity due to restricted shoulder motion, but Dr. Kovalsky did not report actual measured goniometer readings.[12] Without these readings, the Board cannot properly review this determination. Describing shoulder motion as "excellent" and "complete," except for internal rotation which was "slightly limited," does not provide the specific clinical measurements necessary to use the pie charts at Chapter 16.4i. Dr. Kovalsky's comment that internal rotation was, "at most, 10 [to] 15 degrees of restriction," gives the impression that he made visual estimates rather than specific measurements.

CONCLUSION

The Board finds that this case is not in posture for decision. The opinion of the impartial medical specialist requires clarification. Following such further development of the evidence as may be necessary the Office shall issue an appropriate final decision on appellant's claim for an increased schedule award.

[11] A.M.A., *Guides* 570.

[12] *Id*. at 451 (the actual measured goniometer readings or linear measurements are recorded).

ORDER

IT IS HEREBY ORDERED THAT the November 8, 2006 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: October 4, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board