# United States Department of Labor
# Employees' Compensation Appeals Board

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| **T.H., Appellant** | ) | |
| | ) | **Docket No. 08-1314** |
| **and** | ) | **Issued: November 21, 2008** |
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| **U.S. POSTAL SERVICE, POST OFFICE, Bellmawr, NJ, 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
COLLEEN DUFFY KIKO, Judge

### *JURISDICTION*

On March 25, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs October 30, 2007 decision, regarding her schedule award claim. She also appealed a decision dated January 2, 2008, which denied a request for an oral hearing pursuant to 5 U.S.C. § 8124(b)(1). Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

### *ISSUES*

The issues are: (1) whether appellant has more than a 14 percent permanent impairment of the left upper extremity, for which she received a schedule award; and (2) whether the Office properly denied appellant's request for an oral hearing pursuant to 5 U.S.C. § 8124(b)(1).

### *FACTUAL HISTORY*

On January 16, 2004 appellant, then a 32-year-old clerk, filed an occupational disease claim alleging that she developed shoulder tendinitis as a result of performing her work duties. The Office accepted appellant's claim for left rotator cuff syndrome and left wrist tendinitis and

authorized arthroscopic surgery on the left shoulder, which was performed on March 21, 2005. Appellant did not stop work but returned to a limited-duty job.

Appellant came under the treatment of Dr. Thomas P. Obade, a Board-certified orthopedist, who treated her from June 30, 2004 to May 10, 2005 for an onset of left shoulder pain beginning December 18, 2003. Dr. Obade diagnosed rotator cuff tendinitis, rule out tear and recommended additional diagnostic testing. He noted that a magnetic resonance imaging (MRI) scan of the left shoulder dated August 5, 2004, revealed a tendinopathy without evidence of a full thickness rotator cuff tear. Dr. Obade recommended a course of physical therapy and continued appellant on limited duty. On March 21, 2005 he performed arthroscopic debridement of the supraspinatus tendon, bursal surface and subacromial decompression of the left shoulder and diagnosed rotator cuff tendinitis of the left shoulder.

On December 5, 2005 appellant filed a claim for a schedule award.

In a letter dated March 13, 2006, the Office requested Dr. Obade provide the extent of permanent impairment of the left upper extremity due to the employment injury in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[1]

In reports dated November 4, 2005 to March 15, 2006, Dr. Obade noted that appellant was progressing well postoperatively and could return to work with a five-pound weight restriction. In a report dated March 23, 2006, he responded to the Office's questionnaire for impairment and noted that appellant experienced mild, frequent pain or discomfort in her shoulder. Dr. Obade noted no deficit in range of motion and weakness in the rotator cuff. He opined that appellant reached maximum medical improvement on May 10, 2005.

The Office referred Dr. Obade's report and the case record to the Office's medical adviser who, in a report dated April 20, 2006, found that Dr. Obade provided no objective data to calculate a schedule award.

On March 18, 2006 the Office referred appellant for a second opinion to Dr. Zohar Stark, a Board-certified orthopedic surgeon, for an evaluation of the extent of permanent impairment in accordance with the A.M.A., *Guides.* In a report dated June 13, 2006, Dr. Stark noted no sensory or motor deficit in the upper extremities, the left shoulder revealed forward flexion of 170 degrees, extension of 40 degrees, abduction of 170 degrees, adduction of 30 degrees, external rotation of 80 degrees and internal rotation of 70 degrees. Examination of the left wrist revealed no swelling, no tenderness, normal range of motion and Tinel's, Phalens and Finkelstein tests were negative. Dr. Stark opined that appellant sustained four percent impairment to her left upper extremity pursuant to the A.M.A., *Guides* and no impairment for her left wrist. He noted that appellant reached maximum medical improvement as of March 26, 2006.

[1] A.M.A., *Guides* (5th ed. 2001).

In a report dated November 25, 2006, an Office medical adviser found that appellant had four percent impairment of the left upper extremity. He calculated that forward flexion was 170 degrees for one percent impairment,[2] extension was 40 degrees for one percent impairment,[3] abduction was 170 degrees for zero percent impairment,[4] adduction was 30 degrees for one percent impairment,[5] internal rotation was 70 degrees for one percent impairment[6] and external rotation was 80 degrees for zero percent impairment.[7]

Appellant continued to submit reports from Dr. Obade dated March 15, 2006 to January 3, 2007, who treated her for intermittent pain in the left shoulder.

In a decision dated February 15, 2007, the Office granted appellant a four percent impairment of the left upper extremity. The period of the award was from June 13 to September 8, 2006.

Appellant requested reconsideration. She submitted reports from Dr. Obade dated January 3 to August 15, 2007, who noted appellant's complaints of intermittent pain in the shoulder, full range of motion and minimal anterior capsular tenderness. Appellant also submitted a May 1, 2007 report from Dr. Steve M. Allon, a Board-certified orthopedist, who evaluated appellant for an impairment rating for her accepted conditions. Dr. Allon noted that physical examination of the left shoulder revealed a well-healed anterior medial and lateral surgical scar, range of motion of the left shoulder revealed flexion of 110 degrees, abduction of 85 degrees, external rotation of 45 degrees and internal rotation of 45 degrees, all with pain. He diagnosed acromioclavicular arthropathy with impingement to the left shoulder, left shoulder rotator cuff tendinitis, status post arthroscopic debridement of the left supraspinatus tendon, bursal surface on March 21, 2005 and status post arthroscopic subacromial decompression of the left shoulder. Dr. Allon noted that based on the A.M.A., *Guides* appellant would receive a 26 percent permanent impairment of the left upper extremity. He calculated that forward flexion was 110 degrees for 5 percent impairment,[8] abduction was 85 degrees for 5 percent impairment,[9] internal rotation was 45 degrees for 3 percent impairment[10] and external rotation was 45 degrees

[2] *Id.* at 476, Figure 16-40.

[3] *Id.*

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

[5] *Id.*

[6] *Id.* at 479, Figure 16-46.

[7] *Id.*

[8] *Id.* at 476, Figure 16-40.

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

[10] *Id.* at 479, Figure 16-46.

for 1 percent impairment,[11] left shoulder resection arthroplasty for 10 percent impairment[12] and 3 percent for pain-related impairment.[13]

The Office found that a conflict of medical opinion existed between Dr. Allon, appellant's treating physician, and Dr. Stark, the Office referral physician, regarding the degree of permanent impairment of the upper extremities due to her work-related injury.

To resolve the conflict, on September 13, 2007, the Office referred appellant to a referee physician, Dr. Gregory S. Maslow, a Board-certified orthopedic surgeon, who indicated, in a report dated September 27, 2007, that he reviewed the records provided to him and performed a physical examination of appellant. Dr. Maslow noted a history of appellant's work-related injury. He noted findings upon physical examination of well-healed arthroscopic scars on the left side, no evidence of brachial plexitis, no atrophy, range of motion was full on all planes with the exception of internal rotation which had a deficit of 20 degrees. Dr. Maslow noted no evidence of cuff or biceps tendinopathy on the left side other than mild subacromial crepitus, strength testing of the left shoulder was normal with full range of motion of the elbows, wrists and forearms. He opined that appellant had nine percent impairment of the left arm due to her work injury. Dr. Maslow calculated one percent deficit for internal rotation deficit of 20 degrees.[14] He noted that the A.M.A., *Guides* provide for a 10 percent impairment of the upper extremity for resection arthroplasty of the distal clavicle;[15] however, he opined that in this case Dr. Obade did not perform a complete resection arthroplasty of the distal clavicle and therefore would be entitled on only a five percent impairment for the resection of the distal clavicle. He concurred with Dr. Allon's determination of three percent impairment for pain-related impairment.[16]

Dr. Maslow's report of September 27, 2007 and the case record were referred to the Office's medical adviser. In a report dated October 16, 2007, the Office medical adviser determined that appellant was entitled to schedule award for 14 percent permanent impairment of the left upper extremity. He noted that internal rotation deficit of 20 degrees was 1 percent impairment;[17] however, he advised that the A.M.A., *Guides* provide for 10 percent impairment for acromioplasty clavicle resection[18] and did not allow for splitting of the impairment as indicated by Dr. Maslow. The Office medical adviser further concurred with Dr. Maslow's

[11] *Id.*

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

[13] *Id.* at 574, Figure 18-1.

[14] *Id.* at 479, Figure 16-46.

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

[16] *Id.* at 574, Figure 18-1.

[17] *Id.* at 479, Figure 16-46.

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

determination that appellant was entitled to a three percent impairment for pain-related impairment.[19]

In a decision dated October 30, 2007, the Office granted appellant a schedule award for 14 percent permanent impairment of the left upper extremity. It noted that appellant was previously granted four percent impairment and would be entitled to an additional award of nine percent.

On November 7, 2007 appellant requested an oral hearing.

In a decision dated January 2, 2008, the Office's Branch of Hearings and Review denied appellant's request for an oral hearing. The Branch of Hearings and Review found that, since appellant had previously requested reconsideration on the same issue, she was not entitled to an oral hearing as a matter of right. Appellant was informed that her case had been considered in relation to the issues involved and that the request was further denied for the reason that the issues in this case could be addressed by requesting reconsideration from the Office and submitting evidence not previously considered.

## ***LEGAL PRECEDENT -- ISSUE 1***

The schedule award provision of the Federal Employees' Compensation Act[20] and its implementing regulation[21] 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 regulation as the appropriate standard for evaluating schedule losses.[22]

## ***ANALYSIS -- ISSUE 1***

On appeal, appellant contends that she has more than 14 percent permanent impairment of the left upper extremity. The Office accepted appellant's claim for left rotator cuff syndrome and left wrist tendinitis and authorized arthroscopic surgery on the left shoulder, which was performed on March 21, 2005. It properly found that, a conflict in the medical evidence existed between appellant's attending physician, Dr. Allon, who disagreed with the Office referral physician, Dr. Stark, concerning the extent of appellant's impairment of the left upper extremity. Consequently, the Office referred appellant to Dr. Maslow to resolve the conflict.

[19] *Id.* at 574, Figure 18-1.

[20] 5 U.S.C. § 8107.

[21] 20 C.F.R. § 10.404.

[22] *Donald E. Stockstad*, 53 ECAB 301 (2002), *petition for recon., granted* (*modifying prior decision*), Docket No. 01-1570 (issued August 13, 2002).

Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[23]

The Board finds that, under the circumstances of this case, the opinion of Dr. Maslow is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight and establishes that appellant sustained no more than a 14 percent impairment of the left upper extremity.

Dr. Maslow reviewed appellant's history and reported findings. He noted findings upon physical examination of no atrophy, full range of motion on all planes with the exception of internal rotation, which had a deficit of 20 degrees. Dr. Maslow noted mild subacromial crepitus, strength testing of the left shoulder was normal with full range of motion of the elbows, wrists and forearms. He opined that appellant sustained a nine percent impairment of the left upper extremity causally related to her work injury. Dr. Maslow calculated a one percent deficit for internal rotation deficit of 20 degrees,[24] five percent impairment for the resection of the distal clavicle; and three percent impairment for pain-related impairment.[25] He noted that the A.M.A., *Guides* provide for a 10 percent impairment of the upper extremity for resection arthroplasty of the distal clavicle;[26] however, he allocated a 5 percent rating because Dr. Obade did not perform a complete resection arthroplasty of the distal clavicle. The Board notes that the A.M.A., *Guides* provide for 10 percent impairment for a acromioplasty clavicle resection and there is no provision in the A.M.A., *Guides* to divide the impairment value.

In an October 16, 2007 report, the Office medical adviser applied the A.M.A., *Guides* to Dr. Maslow's findings and determined that appellant was entitled to schedule award for 14 percent permanent impairment of the left upper extremity. He concurred with Dr. Maslow's determination that internal rotation deficit of 20 degrees was 1 percent impairment.[27] The medical adviser noted that the A.M.A., *Guides* provide for 10 percent impairment for acromioplasty clavicle resection[28] and do not allow for splitting of the impairment as indicated by Dr. Maslow. The medical adviser further concurred with Dr. Maslow's determination that appellant was entitled to a three percent impairment for pain-related impairment.[29]

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[23] *Aubrey Belnavis*, 37 ECAB 206 (1985). *See* 5 U.S.C. § 8123(a).

[24] A.M.A., *Guides* 479, Figure 16-46.

[25] *Id.* at 574, Figure 18-1.

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

[27] *Id.* at 479, Figure 16-46.

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

[29] *Id.* at 574, Figure 18-1. The Board notes that each physician erroneously attributed pain-related impairment under Chapter 18 of the A.M.A., *Guides*. *See id*. The Board has held that physicians should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*. *See Linda Beale*, 57 ECAB 429 (2006); *Frantz Ghassan*, 57 ECAB 349 (2006).

The Board finds that the report of Dr. Maslow is entitled to special weight and establishes that there is no basis under the A.M.A., *Guides* for an award greater than the 14 percent impairment previously granted. This evaluation conforms to the A.M.A., *Guides* and establishes that appellant has no more than a 14 percent of the left upper extremity.

The Office properly noted that appellant was previously granted a schedule award for 4 percent permanent impairment of the left upper extremity therefore she was entitled to an additional schedule 10 percent award for the left upper extremity.

On appeal, appellant asserts that the medical adviser improperly resolved the conflict of opinion after referral to a referee physician. The Board finds this argument to be without merit. To properly resolve a medical conflict, it is the impartial medical specialist who should provide a reasoned opinion as to the extent of permanent impairment in accordance with the A.M.A., *Guides.* An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.[30] In this case, the referee physician resolved the conflict of opinion. The medical adviser concurred with the referee physician's impairment determination and applied the A.M.A., *Guides* to the referee physician's report. He corrected an error by Dr. Maslow in applying the A.M.A., *Guides*, noting that, although, Dr. Maslow calculated 5 percent impairment for acromioplasty clavicle resection,[31] the A.M.A., *Guides* provide for a 10 percent which would allow for an impairment rating of 14 percent. Thus, the findings of Dr. Maslow establish that appellant has no greater permanent impairment than that awarded by the Office.

## ***LEGAL PRECEDENT -- ISSUE 2***

Section 8124(b)(1) of the Act provides that "before review under section 8128(a) of this title, a claimant for compensation not satisfied with a decision of the Secretary ... is entitled, on request made within 30 days after the date of the issuance of the decision, to a hearing on his claim before a representative of the Secretary."[32] Section 10.615 of the federal regulations implementing this section of the Act provides that a claimant shall be afforded a choice of an oral hearing or a review of the written record.[33] The Office's regulations provide that the request must be sent within 30 days of the date of the decision, for which a hearing is sought and also that "the claimant must not have previously submitted a reconsideration request (whether or not it was granted) on the same decision."[34]

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[30] *See Richard R. LeMay*, 56 ECAB 341(2005) (where the Board found that the Office medical adviser may review the opinion of the referee physician; however, the resolution of the conflict is the responsibility of the impartial specialist). *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.5(c)(1) (provides that an Office medical adviser may review the report of a referee specialist where determination of a schedule award is involved and that the medical adviser may note any medical errors found, such as improper application of the A.M.A., *Guides*).

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

[32] 5 U.S.C. § 8124(b)(1).

[33] 20 C.F.R. § 10.615.

[34] *Id*. at § 10.616(a).

Additionally, the Board has held that the Office, in its broad discretionary authority in the administration of the Act,[35] has the power to hold hearings in certain circumstances where no legal provision was made for such hearings and that the Office must exercise this discretionary authority in deciding whether to grant a hearing.[36] The Office's procedures, which require the Office to exercise its discretion to grant or deny a hearing when the request is untimely or made after reconsideration, are a proper interpretation of the Act and Board precedent.[37]

## ***ANALYSIS -- ISSUE 2***

Appellant's request for an oral hearing dated November 7, 2007 was denied on the grounds that she had previously requested reconsideration pursuant to 5 U.S.C. § 8128(a) of the Act.[38] The Board finds that appellant's request for an oral hearing was made after the Office issued its October 30, 2007 decision on her request for reconsideration made pursuant to 5 U.S.C. § 8128. Hence, the Office correctly found that appellant was not entitled to an oral hearing before an Office hearing representative as a matter of right as she had previously requested reconsideration.

In its January 2, 2008 decision, the Office acknowledged that although there was no entitlement to an oral hearing, it could allow such an oral hearing within its discretion. It properly exercised its discretion by indicating that it had also denied appellant's hearing request on the basis that the case could be equally well addressed by requesting reconsideration and submitting additional medical evidence. There is no evidence of an abuse of discretion in this case.[39]

## ***CONCLUSION***

The Board finds that the Office properly determined that appellant had no more than a 14 percent permanent impairment of the left upper extremity, for which she received a schedule award. The Board further finds that the Office properly denied appellant's request for an oral hearing pursuant to 5 U.S.C. § 8124(b)(1).

[35] 5 U.S.C. §§ 8101-8193.

[36] *Marilyn F. Wilson*, 52 ECAB 347 (2001).

[37] *Teresa M. Valle*, 57 ECAB 542 (2006). *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Hearings and Reviews of the Written Record*, Chapter 2.1601.4(b)(3) (June 1997).

[38] *See Peggy R. Lee*, 46 ECAB 527 (1995) (where the Board found that appellant's request for an oral hearing was made after the Office issued its decision on his request for reconsideration made pursuant to 5 U.S.C. § 8128 and therefore appellant was not entitled to an oral hearing before an Office hearing representative as a matter of right).

[39] *See Daniel J. Perea*, 42 ECAB 214 (1990).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the January 2, 2008 and October 30, 2007 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: November 21, 2008
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board