United States Department of Labor
Employees' Compensation Appeals Board

B.S., Appellant	)	
and	)	**Docket No. 09-1834**
	)	**Issued: April 2, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Troy, NY, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 13, 2009 appellant filed a timely appeal from the March 20, 2009 merit decision of the Office of Workers' Compensation Programs, which denied 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 the case.

ISSUE

The issue is whether appellant has more than a 12 percent impairment of his right upper extremity.

FACTUAL HISTORY

On January 5, 1999 appellant, then a 41-year-old mail handler, filed a claim alleging that he sustained a right shoulder injury lifting a sack of mail off a flatbed truck and lifting heavy boxes in the performance of duty. In 1979, while in the military, he had a dislocated shoulder that required pinning. The Office accepted appellant's claim for right shoulder tendinitis and on

June 3, 2003 paid a schedule award for a 12 percent impairment of the right upper extremity due to loss of shoulder motion.[1]

On June 6, 2007 appellant underwent a right shoulder arthroscopy with labrum debridement and biceps tenodesis. On October 9, 2008 he filed a claim for an increased schedule award. On October 28, 2008 the Office wrote to appellant's orthopedic surgeon, Dr. Joseph Mileti and requested an impairment rating of the right upper extremity following specific guidelines. It asked for a response within 30 days.

In a decision dated December 8, 2008, the Office denied appellant's claim for an increased schedule award. It received no response from Dr. Mileti.

On December 11, 2008 Dr. Mileti enclosed a functional capacity evaluation obtained on May 15, 2008 "with which we are in agreement and have accordingly signed." He made clear that appellant had reached maximum medical improvement.

The May 15, 2008 functional capacity evaluation concluded that appellant demonstrated self-limiting behavior throughout the evaluation. Ranges of right shoulder motion were 80 degrees flexion, 25 degrees extension, 50 degrees abduction, "WNL [within normal limits]" adduction, 30 degrees internal rotation and 45 degrees external rotation. Strength was described as 3/5 in all ranges of shoulder motion.

On January 14, 2009 Dr. Charles J. Kistler, Jr., an osteopath, examined appellant and offered a 32 percent rating for loss of motion plus a 3 percent additional impairment for pain. He found 40 degrees right shoulder flexion and 20 degrees extension. Dr. Kistler found 130 degrees abduction, 30 degrees adduction and 40 degrees ankylosis. He also found 70 degrees internal rotation, 30 degrees external rotation and 50 degrees ankylosis. Dr. Kistler noted persistent moderate pain and weakness.

In a decision dated March 20, 2009, an Office hearing representative reviewed the written record and affirmed the denial of appellant's claim for an increased schedule award. The hearing representative found that the reports of Dr. Mileti and Dr. Kistler were insufficient to establish that appellant had more than a 12 percent impairment of his right upper extremity.

On appeal, appellant argues that Dr. Kistler reported impairment according to the applicable guidelines.

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

[1] Appellant sustained an injury in the performance of duty on September 13, 1999 while lifting 20-pound bundles. The Office accepted his claim for bicepital tendinitis of the right shoulder. OWCP File No. xxxxxx199.

[2] 5 U.S.C. § 8107.

American Medical Associations, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

ANALYSIS

The Office asked Dr. Mileti, the attending orthopedic surgeon, to provide an impairment rating of appellant's right upper extremity according to the A.M.A., *Guides*, but he did not comply. Dr. Mileti simply indicated his agreement with a functional capacity evaluation. However, the functional capacity evaluation concluded that appellant demonstrated self-limiting behavior throughout the evaluation, which calls into question the reliability of the reported ranges of shoulder motion. Those measurements are of little probative value.

Dr. Kistler, the osteopath, also reported ranges of shoulder motion, but the measurements were inconsistent, in some cases grossly so, with the measurements found in the functional capacity evaluation. He reported only 40 degrees flexion or half the flexion appellant demonstrated eight months earlier. Extension was 20 percent worse. Abduction was 260 percent better. Adduction was perhaps 25 percent worse. Internal rotation was 233 percent better. External rotation was two-thirds what it was during the functional capacity evaluation.

Two physicians following the methods of the A.M.A., *Guides* to evaluate the same patient should report similar results and reach similar conclusions.[4] It is understood that an individual's condition is dynamic.[5] As with any biological measurements, some variability and normal fluctuations are inherent in permanent impairment ratings. However, measurements should be consistent between two trained observers, assuming the individual's condition is stable.[6]

The evidence submitted to support appellant's claim for an increased schedule award is simply too dissimilar to establish any reliable increase in the permanent impairment due to his accepted employment injury. Further, Dr. Kistler reported both active ranges of motion and ankylosis in two of the three planes. Ankylosis is defined as "the complete absence of joint motion" and is expressed as a fixed position.[7] It is the fixation of a joint in a specific position by disease, injury or surgery.[8] So it is unclear how Dr. Kistler could report 130 degrees abduction and 30 degrees adduction, yet find ankylosis at 40 degrees or 70 degrees internal rotation and 30 degrees external rotation, yet find ankylosis at 50 degrees. Appellant cannot have both active range of motion through functional positions and the complete absence of joint motion at the same time. This further diminishes the probative value of the measurements reported.

[3] 20 C.F.R. § 10.404.

[4] A.M.A., *Guides* 17 (5th ed. 2001).

[5] *Id*. at 19.

[6] *Id.* at 20. Two measurements by the same examiner would be consistent if they fall within 10 percent of each other.

[7] *Id*. at 402.

[8] *Id*. at 599.

Dr. Kistler noted persistent moderate pain and weakness but did not evaluate impairment due to a peripheral nerve disorder. Instead, he added a three percent additional impairment due to pain. Discussing the difficulties associated with integrating pain-related impairment into an impairment rating system, the A.M.A., *Guides* state:

> "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 of 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 disorder produces radiating pain down the arm, the arm pain, which is commonly seen, has been accounted for in the cervical spine impairment rating.' 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*."[9]

Therefore, without a sound explanation for incorporating an additional pain-related impairment,[10] Dr. Kistler's opinion does not justify a three percent increase in appellant's rating.

Appellant argues that Dr. Kistler reported impairment in accordance with the A.M.A., *Guides*. However, as the Board has explained, this is not the case. Because appellant has not submitted an impairment evaluation sufficient to justify an increased schedule award, the Board will affirm the Office's March 20, 2009 decision affirming the denial of his claim.

CONCLUSION

The Board finds that the medical evidence is insufficient to establish that appellant has more than a 12 percent impairment of his right upper extremity.

[9] *Id*. at 570.

[10] *See id.* ("When This Chapter Should Be Used to Evaluate Pain-Related Impairment").

ORDER

IT IS HEREBY ORDERED THAT the March 20, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 2, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board