United States Department of Labor
Employees' Compensation Appeals Board

F.M., claiming as executrix of the estate of J.M., Appellant	)	
and	)	**Docket No. 10-225**
DEPARTMENT OF THE NAVY, NAVAL SUBMARINE BASE, Groton, CT, Employer	)	**Issued: July 26, 2010**

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, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 2, 2009 appellant filed a timely appeal of an August 7, 2009 schedule award decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether the employee sustained more than a 24 percent permanent impairment of the right upper extremity.

On appeal appellant asserts that the report of the impartial medical specialist is insufficient to resolve the conflict in medical opinion.

FACTUAL HISTORY

This case has previously been before the Board.[1] By decision dated August 12, 2008, the Board set aside October 20, 2006 and May 15, 2007 Office decisions and remanded the case for a supplemental report from Dr. Ian B. Fries, the impartial medical specialist selected to resolve a conflict in medical opinion.[2] By decision September 23, 2005, the Board set aside an October 26, 2004 Office decision and remanded the case for further development of the medical evidence. The facts of the previous Board decisions are incorporated herein by reference.

By letter dated December 10, 2008, the Office asked Dr. Fries to provide a supplemental report addressing the deficiencies described in the Board's August 12, 2008 decision.

In a December 19, 2008 report, Dr. Fries stated that the employee had 2.5 percent impairment of the right upper extremity based on 45 degrees of internal shoulder rotation rather than 30 degrees because it was inappropriate to award a greater impairment based upon voluntary restriction during a second trial. He noted that the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, fifth edition, (the A.M.A., *Guides*),[3] states at page 451 that in assessing range of motion "Both extremities should be compared" and "Measurements of active motion take precedence in the [A.M.A.,] *Guides*." Dr. Fries explained that 25 degrees of right shoulder adduction did not constitute one percent impairment because this range of motion was matched by the opposite normal extremity. In other words, there was no demonstrated right shoulder adduction impairment compared with his normal side. Dr. Fries noted that the A.M.A., *Guides* states at page 453 that "If a contralateral 'normal' joint has a less than average mobility, the impairment value(s) corresponding to the uninvolved joint can serve as a baseline and are subtracted from the calculated impairment for the involved joint." He explained that he applied the greater degree of elbow flexion, 135 degrees, resulting in zero percent impairment, because the trial resulting in 130 degrees of flexion was due to voluntary restriction by the employee.

Dr. Fries stated that he did not specifically address impairment due to right shoulder pain because pain commonly accompanying a disorder is already included in the A.M.A., *Guides* impairment ratings. The A.M.A., *Guides* provides at page 10 that "Physicians recognize the local and distant pain that commonly accompanies many disorders. Impairment ratings in the [A.M.A.,] *Guides* already have accounted for commonly associated pain.…" Dr. Fries did not consider the employee's pain complaints to exceed what was reasonable for his right shoulder

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[1] *See* Docket No. 08-122 (issued August 12, 2008); Docket No. 05-762 (issued September 23, 2005). On January 8, 1994 the employee sustained a strain of the right rotator cuff when he slipped on ice in the employing establishment parking lot and fell. He underwent right shoulder arthroscopic repair and debridement on June 15, 1994. The employee sustained work-related lateral epicondylitis of his right elbow on September 4, 1999 and underwent debridement on May 15, 2000.

[2] On February 12, 2001 the Office granted the employee a schedule award for 24 percent impairment to his right arm. The employee died on March 24, 2007.

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

and elbow conditions and did not assess an additional discretionary award for pain. He explained that he did not apply Table 16-10 at page 482 and Table 16-11 at page 484, respectively, in assessing the employee's pain and strength, because those tables are used for peripheral nerve disorders and the employee's conditions were not caused by such nerve disorders.

Dr. Fries explained that grip strength was an appropriate rating method in the employee's case because the A.M.A., *Guides* provides at page 507 that "If an individual … has undergone surgical release of the … extensor origins, medial, lateral epicondylitis or has had excision of the epicondyle, there may be some permanent weakness of grip as a result of … surgery. In this case, impairment can be given on the basis of grip strength according to section 16.8b." Dr. Fries explained that grip strength was an appropriate rating method because the employee had undergone right elbow lateral epicondyle surgery. He reiterated his opinion that the employee sustained 16.5 percent right upper extremity impairment.

By decision dated January 12, 2009, the Office found that the employee did not have more than the 24 percent impairment to his right upper extremity previously awarded.

On January 15, 2009 appellant requested a hearing before an Office hearing representative that was held on June 22, 2009.

By decision dated August 7, 2009, an Office hearing representative affirmed the January 12, 2009 decision.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[4] 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*.[5]

Section 8123(a) of the Act provides that 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.[6] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist,

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2008).

[6] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[7]

Board case precedent provides that, when the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, it must secure a supplemental report from the specialist to correct the deficiency in his original report. Only when the impartial specialist is unable or unwilling to clarify or elaborate on his original report or if his supplemental report is incomplete, vague, speculative or lacking in rationale, should the Office refer the claimant to a second impairment specialist.[8]

ANALYSIS

The Board finds that the employee sustained no more than 24 percent permanent impairment to the right upper extremity.

Dr. Fries, the impartial medical specialist, provided a supplemental report on December 19, 2008 that addressed the deficiencies described in the Board's August 12, 2008 decision. He explained his choice of range of motion measurements and cited to applicable portions of the A.M.A., *Guides* in his rationale. Dr. Fries explained why he did not include a separate impairment rating for pain and he cited to appropriate portions of the A.M.A., *Guides.* He explained why grip strength was an appropriate rating method, with reference to applicable sections of the A.M.A., *Guides.* The Board finds that Dr. Fries' supplemental report addressed the issues. As that of an impartial medical specialist, Dr. Fries' opinion is entitled to special weight and establishes that the employee sustained no more than 24 percent right upper extremity impairment.

CONCLUSION

The Board finds that the employee sustained no more than 24 percent permanent impairment to his right upper extremity.

[7] *See Roger Dingess,* 47 ECAB 123 (1995); *Glenn C. Chasteen,* 42 ECAB 493 (1991).

[8] *See Nancy Keenan*, 56 ECAB 687 (2005).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 7, 2009 is affirmed.

Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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