United States Department of Labor
Employees' Compensation Appeals Board

G.C., Appellant	)	
and	)	**Docket No. 09-1024**
	)	**Issued: March 23, 2010**
DEPARTMENT OF TRANSPORTATION, FEDERAL AVIATION ADMINISTRATION, Atlantic City, 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:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 9, 2009 appellant, through his attorney, filed a timely appeal of the December 17, 2008 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 appellant has more than 16 percent impairment of his right upper extremity.

FACTUAL HISTORY

On November 9, 2004 appellant, then a 54-year-old dock worker, filed an occupational disease claim alleging that on May 1, 2001 he became aware of torn rotator cuffs in both shoulders which he attributed to lifting in the performance of duty. On November 4, 2004 appellant underwent a left upper extremity magnetic resonance imaging (MRI) scan which

demonstrated an extensive tear of the supraspinatus tendon with retraction and degenerative joint disease of the acromioclavicular joint. His right upper extremity MRI scan on November 5, 2004 demonstrated degenerative joint disease of the acromioclavicular joint, articular tears of the supraspinatus tendon and thinning of the biceps tendon. Appellant underwent a left open rotator cuff repair on January 4, 2005. The Office accepted his claim for sprain/strain rotator cuff on June 22, 2005.

The Office authorized right shoulder arthroscopy surgery on August 17, 2005. Dr. Matthew Pepe, a Board-certified orthopedic surgeon, performed a surgical arthrocopic subacromial decompression, arthroscopic distal clavical excision, arthroscopic superior labral tear and arthroscopic rotator cuff repair on September 8, 2005. Appellant returned to light-duty work on December 7, 2005.

In a note dated March 6, 2006, Dr. Pepe found that appellant had reached maximum medical improvement regarding his right shoulder. He found that appellant had a full range of motion, normal strength bilaterally, negative impingement signs and biceps maneuvers.

Dr. Nicholas Diamond, an osteopath, examined appellant on April 27, 2006 for schedule award purposes. He noted appellant's history of injury and medical treatment. On physical examination, Dr. Diamond found loss of range of motion of the cervical spine. In regard to appellant's right shoulder, forward elevation was 160 degrees abduction of 160 degrees, adduction of 60 degrees and internal rotation of 70 degrees. In appellant's left shoulder, Dr. Diamond found elevation of 150 degrees, abduction of 155 degrees and adduction of 65 degrees. On manual muscle testing, appellant demonstrated loss of strength in the supraspinatus, deltoids and biceps. Dr. Diamond diagnosed post-traumatic C3-4 disc herniation and C6-7 spondylosis and herniated disc. He found bilateral C5-6 radiculopathy and right and left shoulder cuff tears with surgical repairs. Dr. Diamond found 2 percent impairment of the left shoulder due to loss of flexion, 1 percent impairment due to loss of abduction and total left upper extremity impairment of 30 percent. Appellant's right shoulder demonstrated one percent impairment due to loss of flexion, one percent impairment due to loss of abduction and one percent impairment due to loss of internal rotation. Dr. Diamond found 10 percent impairment due to loss of grip strength, and 3 percent impairment due to pain for total right upper extremity impairment of 16 percent.

In a report dated December 4, 2006, Dr. David Weiss, an osteopath, rated the permanent impairment to appellant's right shoulder. He found that appellant had one percent impairment each due to loss of flexion, abduction and internal rotation. Dr. Weiss stated that appellant had 10 percent impairment due to the right shoulder resection arthroplasty and 20 percent impairment due to grip strength deficit for a combined impairment of the right upper extremity of 21 percent. He also found that appellant had 3 percent impairment due to pain in accordance with Chapter 18 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) resulting in a 24 percent impairment of the right upper extremity.

The district medical adviser reviewed the medical records on March 20, 2007. He found that appellant had three percent impairment of the left shoulder due to loss of range of motion and 16 percent of the right upper extremity based on loss of range of motion and resection of the clavicle as well as pain in accordance with Chapter 18 of the A.M.A., *Guides*. The district

medical adviser stated that Drs. Diamond and Weiss did not support the additional 30 percent impairment of the left upper extremity and that grip strength should not be evaluated due to the right shoulder condition.

The Office found a conflict of medical opinion evidence between Drs. Diamond and Weiss and the district medical adviser regarding the extent of appellant's permanent impairment. The record contains screen printouts indicating that the Office bypassed Dr. Stanley Marczyk, stating, "left a message" at 10:04 a.m. Dr. Joseph Salvatore, a Board-certified orthopedic surgeon, was bypassed at 10:08 a.m. for the same reason as were Drs. John Baker at 10:09 a.m.; Frederick Dalzell at 10:10 a.m.; and Daniel DeMeo at 10:12 a.m. By letter dated May 9, 2007, the Office referred appellant to Dr. Jonathan Fox, a Board-certified orthopedic surgeon.

In a report dated May 22, 2007, Dr. Fox reviewed appellant's history of injury and medical treatment. On physical examination, he found no obvious muscle atrophy of the left shoulder, with full range of motion, no muscle weakness in the deltoid, biceps, triceps or external rotators. Dr. Fox found weakness to forward elevation and lateral abduction rated four and a half on a scale of five. He noted flexion of 180 degrees, abduction of 180 degrees, adduction 75 degrees, external rotation, 90 degrees and internal rotation 90 degrees. In the right shoulder, Dr. Fox found flexion of 160 degrees, abduction of 160 degrees, adduction 60 degrees, external rotation of 90 degrees and internal rotation of 75 degrees. He stated that appellant sustained tears of his rotator cuffs at the supraspinatus muscle in both shoulders as the result of repetitive wear and tear related to his work. Dr. Fox concluded that appellant reached maximum medical improvement in March 2006. He found that appellant had 16 percent impairment of the right upper extremity and 3 percent of the left upper extremity stating that he agreed with the district medical adviser.

The district medical adviser reviewed the report of Dr. Fox on June 6, 2007 and notes that the physician advised that appellant's left upper extremity had full range of motion, no weakness and no pain which did not result in a ratable impairment. In regard to appellant's right upper extremity, he found 2 percent impairment due to loss of range of motion and 16 percent impairment due to weakness. As the two assessments could not be combined, he found appellant entitled to 16 percent impairment of his right upper extremity.

By decision dated June 21, 2007, the Office granted appellant a schedule award for 16 percent impairment of the right upper extremity and found no ratable impairment of the left upper extremity.

Appellant, through his attorney, requested an oral hearing on June 27, 2007. By decision dated September 6, 2007, the Branch of Hearings and Review set aside the June 21, 2007 decision and remanded the case to obtain a supplemental report from Dr. Fox addressing the permanent impairment to each of appellant's upper extremities with citation to the A.M.A., *Guides* and to consider whether Chapter 18 of the A.M.A., *Guides* was applicable. The hearing representative also noted that the Office had accepted appellant's claim for bilateral shoulder cuff sprain and tears and directed the Office to obtain a copy of the January 4, 2005 surgical report.

Appellant submitted a copy of the January 4, 2005 operative report on January 9, 2008. Dr. Pepe performed a surgical arthroscopy of the left shoulder with open chronic supraspinatus repair and subacromial decompression, biceps tenodesis and acromioclavical joint resection.

The Office requested a supplemental report from Dr. Fox on March 31, 2008 asking that he provide the percentage of permanent impairment for each upper extremity based on the A.M.A., *Guides*, citing to the appropriate pages and sections.

In a report dated May 6, 2008, Dr. Fox reviewed appellant's record and the statement of accepted facts. Based on his prior examination on the right, appellant had 160 degrees forward flexion or 1 percent impairment; 160 degrees abduction or 1 percent impairment; 60 degrees adduction which was not a ratable impairment; and 75 degrees internal rotation or 1 percent impairment, for a total of 3 percent right upper extremity impairment for reduced range of motion. Dr. Fox noted, "In addition, per [T]able 16-27, page 506, resection of the right clavicle equals 10 percent PPI [permanent partial impairment], for a total of 13 percent on the right." He found that appellant had no ratable range of motion deficits in the left shoulder. Dr. Fox concluded, "Moreover, I assigned an additional 3 percent for pain, weakness and decreased endurance bilaterally, per [T]able 18-1, for a total of 16 percent PPI on the right, and 3 percent PPI on the left. In my opinion, [C]hapter 18 should be used since PPI cannot be adequately rated on the basis of body impairment systems given in other chapters of the [A.M.A., *Guides*]."

By decision dated June 6, 2008, the Office denied appellant's claim for an additional schedule award of the right upper extremity.[1]

The district medical adviser reviewed this report on June 8, 2008 and found that appellant had 13 percent impairment of the right shoulder and 10 percent impairment of the left shoulder. He disagreed with Dr. Fox's assignment of an additional three percent impairment due to pain asserting that this rating was already included in the loss of range of motion and diagnoses-based impairment ratings and that assigning an additional pain rating would be duplicative. The district medical adviser also found that as appellant underwent an acromial-clavical joint resection along with subacromial decompression on the left this would "place the same impairment upon his extremity as if he had undergone a distal clavicle [resection]." He found that appellant was entitled to 10 percent impairment for the left upper extremity. The district medical adviser discounted Dr. Fox's three percent impairment rating for pain noting that, although appellant complained of right shoulder pain, he did not have similar complaints on the left.

Appellant, through his attorney, requested an oral hearing that was held on October 27, 2008. Appellant noted that he had two additional accepted claims, a neck injury in October 2002 and bilateral carpal tunnel on June 14, 2004. Following the oral hearing, appellant contended that Dr. Fox did not adequately examine him, that he was always in discomfort and that he had obvious atrophy of the left side of his chest.

[1] The Office has not issued a final schedule award decision for 10 percent impairment of the left upper extremity as found by the district medical adviser. Furthermore, the hearing representative did not review this aspect of appellant's claim. The Board may not address this aspect of appellant's claim on appeal as it is in an interlocutory position. *See* 20 C.F.R. § 501.2(c)(2).

On appeal, appellant's attorney alleged that Dr. Fox was not properly selected under the Physicians Directory System (PDS) as other physicians were bypassed without waiting for their responses to messages. Further, the report of Dr. Fox was not sufficiently detailed or well rationalized to constitute the weight of the medical opinion.

By decision dated December 17, 2008, the hearing representative found that appellant had no more than 16 percent impairment of his right upper extremity for which he has received a schedule award. The hearing representative found that Dr. Fox's reports were entitled to the special weight of the medical evidence.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] 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.[4] Effective February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[5]

The fifth edition of the A.M.A., *Guides* allows for impairment percentage to be increased by up to three percent for pain by using Chapter 18, which provides a qualitative method for evaluating impairment due to chronic pain. If an individual appears to have a pain-related impairment that has increased the burden on his or her condition slightly, the examiner may increase the percentage up to three percent. However, examiners 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*.[6]

The Act provides that if there is a 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] The implementing regulations regarding impartial medical examinations states that if a conflict exists between the medical opinion of the

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] *Id.*

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

[6] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); A.M.A., *Guides*, 571, 18.3(b); *P.C.*, 58 ECAB 539 (2007); *Frantz Ghassan*, 57 ECAB 349 (2006).

[7] 5 U.S.C. §§ 8101-8193, 8123.

employee's physician and the medical opinion of either a second opinion physician of an Office medical adviser or consultant, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.[8]

A physician selected by the Office to serve as an impartial medical specialist should be wholly free to make a completely independent evaluation and judgment. To achieve this, the Office has developed specific procedures for the selection of impartial medical specialists designed to provide safeguards against any possible appearance that the selected physician's opinion is biased or prejudiced. The procedures contemplate that impartial medical specialists will be selected from Board-certified specialists in the appropriate geographical area on a strict rotating basis in order to negate any appearance that preferential treatment exists between a particular physician and the Office.[9] The Federal (FECA) Procedure Manual (the procedure manual) provides that the selection of referee physicians (impartial medical specialists) is made through a strict rotational system using appropriate medical directories. The procedure manual provides that the PDS should be used for this purpose wherever possible.[10] The PDS is a set of stand-alone software programs designed to support the scheduling of second opinion and referee examinations.[11] The PDS database of physicians is obtained from the American Board of Medical Specialties (ABMS) which contains the names of physicians who are Board-certified in certain specialties. The Board has held that an appropriate notation should be made in the directory when a specialist indicates his or her unwillingness to accept a case or when, for other valid reasons it is not advisable or practicable to use his or her services.[12]

It is well established that, when a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on proper factual and medical background must be given special weight.[13]

ANALYSIS

Appellant received a schedule award for 16 percent impairment of his right upper extremity. The Office found that there was a conflict of medical opinion evidence between appellant's physicians, Drs. Weiss and Diamond, osteopaths, who found that he had 24 percent impairment of the right upper extremity. The district medical adviser found that appellant had 16 percent impairment of the right upper extremity. The Board finds that the Office properly concluded that there was a conflict of medical opinion evidence requiring an impartial medical evaluation.

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[8] 20 C.F.R. § 10.321.

[9] *B.P.*, 60 ECAB ___ (Docket No. 08-1457, issued February 2, 2009).

[10] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4b (May 2003).

[11] *Id*. at Chapter 3.500.7 (September 1995, May 2003).

[12] *David Peisner*, 39 ECAB 1167 (1988).

[13] *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

The Office selected Dr. Fox, a Board-certified orthopedic surgeon, through the PDS to serve as the impartial medical examiner. On appeal, appellant's attorney objected to Dr. Fox's selection on the grounds that several other physicians were bypassed before the claims examiner scheduled examination by Dr. Fox. He noted that the claims examiner had left messages with other physicians. Counsel noted that the claims examiner did not allow the physicians' offices any time to respond to the messages prior to moving to the next physician appearing in the PDS. The Board finds that Dr. Fox was properly selected to serve as the impartial medical examiner. The Office has an interest in the timely scheduling of appointments. The record reveals the claims examiner was not able to contact the other physicians to schedule an appointment. There is no evidence that the Office acted improperly in bypassing these physicians in order to make an appointment with a physician who was available to schedule the examination.

Dr. Fox submitted two reports dated May 22, 2007 and May 6, 2008. In his initial report, he provided his findings on physical examination, but apparently believed that he was to select the physician whose rating he believe was most appropriate rather than provide an independent opinion on the matter. Due to this error, the Office properly requested a supplemental report from Dr. Fox. The Board finds that Dr. Fox's reports are entitled to the weight of the medical evidence and establish that appellant has 16 percent impairment of his right upper extremity for which he has received a schedule award. In his initial report, Dr. Fox noted appellant's history of injury and medical history as well as providing findings on physical examination. In the right shoulder, he found flexion of 160 degrees, abduction of 160 degrees, adduction 60 degrees, external rotation of 90 degrees and internal rotation of 75 degrees. Dr. Fox stated that appellant sustained tears of his rotator cuffs at the supraspinatus muscle in both shoulders as the result of repetitive wear and tear related to his work. He concluded that appellant reached maximum medical improvement in March 2006.

In a supplemental report, Dr. Fox applied the A.M.A., *Guides* to his previous findings. In regard to appellant's right upper extremity, he noted that 160 degrees forward flexion is 1 percent impairment,[14] 160 degrees abduction is 1 percent impairment, 60 degrees adduction is not a ratable impairment[15] and 75 degrees internal rotation is 1 percent impairment.[16] This totals three percent impairment of the right upper extremity for reduced range of motion. He also found that appellant had 10 percent impairment of the right upper extremity due to resection of the right clavicle.[17] Dr. Fox also assigned an additional 3 percent for pain in accordance with Chapter 18 of the A.M.A., *Guides*, for a total of 16 percent impairment the right. Dr. Fox stated, "In my opinion, [C]hapter 18 should be used since PPI cannot be adequately rated on the basis of body impairment systems given in other chapters of the [A.M.A., *Guides*]."

Dr. Fox provided his findings on physical examination and correlated these findings with the A.M.A., *Guides*. He specifically noted the use of Chapter 18 for pain was appropriate as the other chapters could not be used to adequately rate this impairment. The Board finds that this

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

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

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

[17] *Id*. at 506, Figure 16-27.

well-reasoned report of the impartial medical examiner constitutes the weight of the medical evidence and establishes that appellant has 16 percent impairment of his right upper extremity for which he has received a schedule award.

CONCLUSION

The Board finds that appellant has no more than 16 percent impairment of his right upper extremity for which he has received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the December 17, 2008 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: March 23, 2010
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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