United States Department of Labor
Employees' Compensation Appeals Board

D.C., Appellant	)	
	)	
and	)	**Docket No. 10-301**
	)	**Issued: September 14, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Pomona, 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
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 13, 2009 appellant filed a timely appeal from an August 14, 2009 decision of the Office of Workers' Compensation Programs regarding his schedule award claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than seven percent permanent impairment of the right upper extremity for which he received a schedule award.

FACTUAL HISTORY

On July 20, 2007 appellant, then a 30-year-old part-time flexible clerk, filed a traumatic injury claim alleging that on July 6, 2007 he injured his right shoulder when he was moving a coin bin at work. The Office accepted his claim for sprain of the right shoulder and right rotator cuff syndrome and authorized arthroscopic surgery which was performed on December 19, 2007. Appellant did not stop work.

Appellant was initially treated from July 20, 2007 to May 28, 2008, by Dr. Bruce M. Hairston, a physiatrist, who diagnosed right shoulder rotator cuff injury and impairment syndrome and recommended modified duty. He came under the treatment of Dr. Raymond Weiand, a Board-certified orthopedist, from August 6 to December 19, 2007. Dr. Weiand diagnosed a work-related trapezial rhomboid strain and sprain of the right shoulder and recommended conservative treatment. He noted that a magnetic resonance imaging (MRI) scan of the right shoulder revealed subacromial impingement secondary to degenerative change at the acromioclavicular joint, supra and infraspinatus tendinosis, rule out tear and degeneration of the anterosuperior labrum. On December 19, 2007 Dr. Weiand performed an arthroscopic debridement of intra-articular rotator cuff tear, arthroscopically-assisted repair of a superior labral tear from anterior to posterior ("SLAP") of the right shoulder and arthroscopic acromioplasty of the right shoulder. He diagnosed intra-articular partial rotator cuff tear of the supraspinatus, glenoid labral SLAP tear of the right shoulder and impingement syndrome with subacromial bursitis.

On February 12, 2008 Dr. Weiand noted that appellant was progressing well postoperatively with marked improvement with range of motion and strength. In a work capacity evaluation dated March 7, 2008, he returned appellant to work full time with restrictions. On March 21, 2008 Dr. Weiand advised that appellant had reached maximum medical improvement and could return to his preinjury position.

On September 30, 2008 appellant filed a claim for a schedule award. He submitted a June 19, 2008 report from Dr. Nicholas Diamond, an osteopath, who noted that appellant reached maximum medical improvement on June 19, 2008. Dr. Diamond stated that right shoulder examination revealed well-healed portal arthroscopy scars, focal acromioclavicular point tenderness, tenderness over the right trapezial region, anterior cuff, posterior cuff and rhomboid. He noted forward elevation of 165 degrees, abduction of 145 degrees, adduction of 70 degrees, internal rotation of 70 degrees, and external rotation of 90 degrees. Grip strength testing *via* Jamar hand dynamometer revealed 52 kilograms (kg) of force strength for the right and 63.25 kg on the left. Dr. Diamond diagnosed status post right shoulder partial rotator cuff tear and glenoid labral tear, post-traumatic subacromial impingement of the right shoulder, status post arthroscopic surgery with debridement of rotator cuff tear, status post arthroscopically-assisted repair of the labral tear of the right shoulder and status post arthroscopic acromioplasty of the right shoulder. He noted that, based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[1] appellant had 17 percent impairment of the right arm. Dr. Diamond noted abduction of 145 degrees for 2 percent impairment;[2] adduction of 70 degrees for a 0 percent impairment;[3] flexion of 165 degrees for a 1 percent impairment;[4] internal rotation of 70 degrees for a 1 percent impairment;[5] external rotation of 90 degrees for a 0

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

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

[3] *Id.*

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

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

percent impairment;[6] 10 percent impairment for right shoulder resection arthroplasty[7] and 3 percent for pain.[8]

The Office referred Dr. Diamond's report and the case record to the Office medical adviser who, in a November 1, 2008 report, found that appellant had seven percent impairment of the right upper extremity. The Office medical adviser noted that Dr. Diamond properly determined that appellant had seven percent impairment for range of motion deficits for abduction, flexion and internal rotation. He disagreed with Dr. Diamond's finding that appellant had 10 percent impairment for right shoulder resection arthroplasty and referenced Dr. Weiand's December 19, 2007 operative report which indicated that he performed an acromioplasty and not a resection arthroplasty of the acromioclavicular joint. The medical adviser noted that an acromioplasty is technically a resection of a portion of the acromion and not a resection arthroplasty of the acromioclavicular joint. He explained that appellant's procedure clearly did not qualify as a resection arthroplasty because the joint was not resected but, instead, the undersurface of the acromion was removed to provide for more room for the rotator cuff musculature. The medical adviser noted that in accordance with the fifth edition of the A.M.A., *Guides*,[9] appellant had seven percent impairment for range of motion deficit for the right shoulder.

By decision dated January 13, 2009, the Office granted appellant a schedule award for seven percent permanent impairment of the right upper extremity. The period of the award is from June 19 to November 18, 2008.

On January 20, 2009 appellant requested an oral hearing which was held on May 27, 2009.

In a decision dated August 14, 2009, the hearing representative affirmed the Office decision dated January 13, 2009.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[10] and its implementing regulations[11] 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

[6] *Id.*

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

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

[9] *Id.*

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

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.

ANALYSIS

On appeal, appellant believes that he is entitled to a greater impairment rating. The Office accepted his claim for sprain of the right shoulder and right rotator cuff syndrome and authorized arthroscopic surgery which was performed on December 19, 2007. It awarded appellant seven percent permanent impairment of the right upper extremity on January 13, 2009.

The Board has carefully reviewed Dr. Diamond's report dated June 19, 2008 which determined appellant's right upper extremity impairment and notes that, while the doctor determined that appellant sustained a 17 percent permanent impairment of the right upper extremities, it is not clear how he came to this conclusion in accordance with the relevant standards of the A.M.A., *Guides*.[12]

With regard to the right upper extremity, Dr. Diamond correctly calculated range of motion deficits for abduction of 145 degrees for two percent impairment;[13] adduction of 70 degrees for a zero percent impairment;[14] flexion of 165 degrees for a one percent impairment;[15] internal rotation of 70 degrees for a one percent impairment;[16] and external rotation of 90 degrees for a zero percent impairment.[17] The Office medical adviser, in his November 1, 2008 report, concurred with Dr. Diamond regarding impairment due to lost range of shoulder motion. Dr. Diamond further calculated 10 percent impairment for right shoulder resection arthroplasty.[18] However, as noted by the Office medical adviser, a review of the December 19, 2007 operative report indicates that Dr. Weiand performed arthroscopic acromioplasty of the right shoulder and did not perform a resection arthroplasty. Dr. Diamond did not explain why Dr. Weiand's surgical procedure qualified as a right shoulder resection arthroplasty. The medical adviser explained that appellant's procedure clearly did not qualify as a resection arthroplasty because the joint was not resected but, instead, the undersurface of the acromion was removed to provide for more room for the rotator cuff musculature. Therefore, appellant would not be entitled to 10 percent impairment for a resection arthroplasty as provided by Dr. Diamond.[19] The Board further notes that Dr. Diamond and the Office medical adviser provided three percent for pain

[12] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

[13] A.M.A., *Guides*, 477, Figure 16-43.

[14] *Id.*

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

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

[17] *Id.*

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

[19] *See Paul R. Evans, Jr.*, 44 ECAB 646 (1993); *John Constantin*, 39 ECAB 1090 (1988) (medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

under Chapter 18 of the A.M.A., *Guides*[20] but 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*.[21] The A.M.A., *Guides* explain that the impairment ratings in the body organ system chapters make allowance for expected accompanying pain.[22] Neither Dr. Diamond nor the Office medical adviser explained why the pain rating under Chapter 18 would be appropriate in light of the cautionary language of the A.M.A., *Guides*.

Consequently, the medical evidence in conformance with the A.M.A., *Guides* supports that appellant has four percent impairment of the right arm due to loss of range of motion. As the Office has awarded a schedule award for seven percent impairment of the right arm, the Board finds that appellant has no greater impairment than that for which he has already received a schedule award. There is no medical evidence before the Board, conforming with the A.M.A., *Guides*, that supports any greater impairment of the right upper extremity.

On appeal appellant, through his attorney, asserts that there is a medical conflict between Dr. Weiss, who found that appellant had 17 percent impairment to the right upper extremity and the Office medical adviser who determined that appellant had seven percent impairment of the right upper extremity.[23] A simple disagreement between two physicians does not, of itself, establish a conflict. To constitute a conflict of medical opinion, the opposing physicians' reports must be of virtually equal weight and rationale.[24] However, Dr. Diamond, in a report dated June 19, 2008, failed to adequately explain pursuant to the A.M.A., *Guides* how he determined this degree of impairment. As noted above, he attributed 10 percent impairment to a resection arthroplasty of the right shoulder; however, the medical evidence does not indicate that this procedure was performed. Additionally, Dr. Diamond provided three percent for pain under Chapter 18 of the A.M.A., *Guides*; however, as noted above Chapter 18 is not to be used to rate pain-related impairments for any condition that can be adequately rated in other chapters of the A.M.A., *Guides*.

CONCLUSION

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

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

[21] *Id*. at 571. *See Frantz Ghassan*, 57 ECAB 349 (2006); *Linda Beale*, 57 ECAB 429 (2006).

[22] A.M.A., *Guides* 20. *See B.P.*, 60 ECAB ___ (Docket No. 08-1457, issued February 2, 2009).

[23] *See* 5 U.S.C. § 8123(a).

[24] *John D. Jackson*, 55 ECAB 465 (2004); *Cleopatra McDougall-Saddler*, 47 ECAB 480 (1996); *Adrienne L. Wintrip*, 38 ECAB 373, 378-79 (1987).

ORDER

IT IS HEREBY ORDERED THAT that the August 14, 2009 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: September 14, 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