United States Department of Labor
Employees' Compensation Appeals Board

F.M., claiming as executrix of the estate of (J.M.), Appellant **and** **DEPARTMENT OF THE NAVY, NAVAL SUBMARINE BASE, Groton, CT, Employer**	)	**Docket No. 08-122** **Issued: August 12, 2008**

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 October 16, 2007 appellant filed a timely appeal from October 20, 2006 and May 15, 2007 decisions of the Office of Workers' Compensation Programs, adjudicating the employee's schedule award claim. 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 had more than a 24 percent permanent impairment of the right upper extremity.

FACTUAL HISTORY

This is the second appeal in this case.[1] By decision dated 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 Board found that an impartial medical specialist had a prior professional relationship with an attending physician and, therefore, the Office improperly selected him to resolve a conflict in the medical opinion evidence. The law and the facts of the previous Board decision are incorporated herein by reference.

The Office referred the employee to Dr. Joseph A. Kozielski for an independent medical examination. However, he was evaluated by Dr. Howard Zeidman, an associate of Dr. Kozielski. On February 17, 2006 the Office denied the employee's claim for an additional schedule award. The employee requested a hearing that was held on June 8, 2008. At the hearing, the hearing representative vacated the February 17, 2006 decision because Dr. Zeidman was not selected according to the Office's procedures.

On August 14, 2006 the Office referred the employee, together with a statement of accepted facts, a list of questions and the case file, to Dr. Ian B. Fries, a Board-certified orthopedic surgeon and impartial medical specialist, for an evaluation of his right upper extremity impairment.

In a September 23, 2006 report, Dr. Fries reviewed the medical history and provided findings on physical examination. He found that the employee had 16.50 percent impairment of his right upper extremity, including 10 percent for decreased grip strength and 6.50 percent for loss of range of motion. Dr. Fries stated:

> "[The employee's] right elbow is stiff in the morning from lack of movement. The stiffness resolves in several hours. Once about every two months he feels an ache -- pointing to the posterolateral right elbow. This lasts for a few minutes and then resolves spontaneously.
>
> "[The employee] denies numbness, tingling or loss of sensation. [The employee] believes he has some loss of lifting and grip strength in his right upper extremity."
>
> * * *
>
> "Forward flexion of the right shoulder is 160 degrees…. Extension of the right shoulder is 45 degrees with pain in the superior ridge of the left trapezius…. Abduction right shoulder is 130 degrees…. Adduction is 25 degrees….
>
> "An attempt to measure right shoulder external rotation in 90 degrees of abduction is 70 degrees and causes shoulder pain. Internal rotation on the right is

[1] 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.

45 degrees. Right shoulder motion is not accurately measured due to pain elicited….

"Right shoulder motion while supine at 90 degrees of abduction is external rotation 100 degrees and internal rotation 30 degrees with some discomfort. No apprehension or instability is elicited."

* * *

"Right elbow motion is 0 [degrees] [extension] to 130 degrees [flexion]…. Repeat on the right side is 10 [degrees] [extension] to 135 degrees [flexion]…. Touching his hands to his shoulders he achieves 145 degrees of elbow flexion…. Supination is 90 degrees right…. Pronation is 80 degrees…. However, repeat measurements are 90 degrees of pronation … and 90 degrees of supination…."

* * *

"[The employee] has reached maximum benefit from musculoskeletal care for injuries sustained to his right shoulder on January 8, 1994 and right elbow on September 4, 1999. He has recovered well from operations at each joint and now has mild residual subjective symptoms and minor objective residuals."

* * *

"[The employee's] right shoulder and right elbow operations do not qualify as arthroplasties in accordance with the A.M.A., *Guides* [the American Medical Association, *Guides to the Evaluation of Permanent Impairment*]….

"[The employee] does not qualify for impairment based upon Table 16-27, page 506 [arthroplasty] for several reasons:

> 1. He did not have an implant arthroplasty.
>
> 2. He did not have a resection arthroplasty, which requires excision of a large amount of bone. Essentially, no bone was resected during his operative procedures….
>
> 3. Options offered by the [A.M.A., *Guides*] for shoulder evaluation include a total shoulder arthroplasty, which clearly was not performed. An isolated distal clavicular resection was not performed [or] a proximal clavicular resection….
>
> 4. [The employee] had neither a total elbow arthroplasty, nor an isolated radial head arthroplasty."

* * *

"**Right shoulder impairment based upon range of motion**….

"Range of motion right shoulder motion was inconsistent and best efforts were accepted.

"Measured [f]lexion [r]ight [s]houlder 160 degrees … [equals] one percent [impairment].

"Measured [e]xtension [r]ight [s]houlder 45 degrees … [equals] one percent."

* * *

"Measured [a]bduction [r]ight [s]houlder 130 degrees … [equals] two percent [impairment].

"Measured [a]dduction [r]ight … [s]houlder … 25 degrees … [equals] zero percent."

* * *

"Measured [e]xternal [r]otation [r]ight [s]houlder 100 degrees (best) … [equals] zero percent.

"Measured [i]nternal [r]otation [r]ight [s]houlder 45 degrees (best) … [equals] 2.50 percent.

"Total [r]ight [u]pper [e]xtremity [i]mpairment due to [s]houlder [equals] 6.50 percent.

"**Right elbow impairment based upon grip strength."**

* * *

"There was some inconsistency in right elbow motion, but best efforts were accepted and were normal."

* * *

"Average [r]ight 26.6 kilograms….

"(37.3-26.6) / 37.3 [equals] 29 [s]trength [l]oss [i]ndex.

"Equates to 10 percent upper extremity impairment (Table 16-34, [p]age 509).

"However, right forearm circumference is larger than the left, inconsistent with grip strength loss he demonstrates on dynamometer testing. Therefore, 10 percent is an overestimation, though forearm measurements are not mandated by the [A.M.A.,] *Guides*."

On October 17, 2006 an Office medical adviser stated that the employee had a 16.50 percent impairment of the right upper extremity based on the September 23, 2006 report of Dr. Fries.

By decision dated October 20, 2006, the Office denied the employee's claim for an additional schedule award.

The employee requested an oral hearing that was held on February 22, 2007.[2] By decision dated May 15, 2007, the Office denied the employee's claim for an additional schedule award.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[3] 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*.[4]

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.[5] Where 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 a proper factual and medical background, must be given special weight.[6]

ANALYSIS

The Board finds that this case is not in posture for a decision. The opinion of Dr. Fries is not entitled to special weight and is insufficient to resolve the conflict in the medical opinion evidence.

Dr. Fries correctly found that 160 degrees of flexion and 45 degrees of extension for the employee's right shoulder constituted one percent impairment for each motion according to Table 16-40 at page 476 of the A.M.A., *Guides.* He correctly found zero percent impairment for

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[2] On March 24, 2007 the employee died from nonwork-related causes.

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

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

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

100 degrees of external rotation.[7] Dr. Fries determined that the employee had 2.50 percent impairment for 45 degrees of internal rotation according to Table 16-46 at page 479.[8] However, he measured internal rotation twice and should have used the measurement showing the greater impairment, 30 degrees, which constitutes four percent impairment according to Figure 16-46. Dr. Fries correctly found that 130 degrees of abduction constitutes two percent impairment of the shoulder according to Table 16-43 at page 477. However, his finding of 25 degrees of adduction constitutes one percent impairment according to Table 16-43, not zero percent as he indicated. Regarding the employee's right elbow, Dr. Fries found that all range of motion measurements were normal. However, 135 degrees of elbow flexion (the higher impairment of the two measurements provided, 130 degrees and 135 degrees falls between 37 percent impairment for 130 degrees of flexion and 42 percent for 140 degrees of flexion, according to Figure 16-34 at page 472.[9] Additionally, Dr. Fries should have applied the measurement showing greater impairment due to elbow extension, 10 degrees, not 0 degrees. Ten degrees of elbow extension constitutes one percent impairment according to Figure 16-34 at page 472.

Dr. Fries did not address the issue of whether the employee had any impairment due to right shoulder pain.[10] As noted, the nature and severity of the employee's accepted employment injury required surgery on both his right shoulder and right elbow. Although he denied numbness, tingling or loss of sensation, the employee did report aching in his lateral right shoulder everyday for several hours each day. The employee also experienced right shoulder pain when he moved his arm upward and avoided using his hand overhead because of the pain. The A.M.A., *Guides* provides for impairment due to loss of sensation or pain in Table 16-10 at page 482. Dr. Fries did not address the issue of whether the employee had impairment due to right shoulder pain.

Dr. Fries found that the employee had 10 percent impairment due to decreased right elbow grip strength. The A.M.A., *Guides* states in section 16.8 at page 508:

> "In a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the [A.M.A.,] *Guides*, the loss of strength may be rated separately…. If the examiner judges that loss of strength should be rated separately in an extremity that presents other impairments, the impairment due to loss of strength *could be combined* with the other impairments, *only* if based on unrelated etiologic or

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[7] Dr. Fries took two measurements for the employee's right shoulder external rotation, yielding 100 degrees and 70 degrees. Both 100 degrees and 70 degrees of external rotation constitute zero percent impairment according to Table 16-46. Dr. Fries also took two measurements for internal rotation, yielding 45 degrees and 30 degrees.

[8] The A.M.A., *Guides* provides at page 474, section 16.4i, "Shoulder Motion Impairment," that "Impairment values for motion measurements falling between those shown in the pie chart may be adjusted or interpolated proportionally in the corresponding interval."

[9] The A.M.A., *Guides* provides at page 470, section 16.4h, "Elbow Motion Impairment," that "Impairment values for motion measurements falling between those shown in the pie chart may be adjusted or interpolated proportionally in the corresponding interval."

[10] Dr. Fries noted minimal right elbow aching, occurring for a few minutes approximately once every two months.

pathomechanical causes. *Otherwise, the impairment ratings based on objective anatomic findings take precedence*…. (Emphasis in the original.)

Dr. Fries did not adequately explain why grip strength deficit was an appropriate rating method to apply in determining the employee's right upper extremity impairment. He did not explain why his loss of strength represented an impairing factor that had not been considered adequately by other methods in the A.M.A., *Guides*. Specifically, Dr. Fries did not explain why he did not apply Table 16-11 at page 484, which provides for determining upper extremity impairment due to motor and loss of power deficits, rather than applying the section on grip strength. His report notes that the employee had some loss of lifting strength.

The Board finds that the report of Dr. Fries requires clarification. The Office should ask him to provide a supplemental report addressing the deficiencies described above.

On appeal, appellant contends that Dr. Zeidman's report should have been removed from the case record because the Office determined that he was not properly selected from the Physicians Directory System (PDS) and that Dr. Fries relied on that report in his impairment determination. However, the Board has required the exclusion of medical reports only if: (1) the physician selected for a referee examination is regularly involved in performing fitness-for-duty examination for the claimant's employing agency; (2) a second referee specialist's report is requested before the Office has attempted to clarify the original referee specialist's report; (3) a medical report is obtained through telephone contact or submitted as a result of such contact; and (4) a medical report is obtained as a result of leading questions to the physician in either the referee or second opinion context.[11] These circumstances do not apply to this case. Therefore, the Office was not required to exclude the report of Dr. Zeidman. Appellant contends that Dr. Fries relied on Dr. Zeidman's report in his determination of the employee's impairment. However, an examination of Dr. Fries' report shows that he merely included Dr. Zeidman's report in his review of the reports of the employee's previous physicians, *i.e.*, his review of the medical history. He did not rely on Dr. Zeidman's report for his own determination of the employee's right upper extremity impairment. Appellant also contends that Dr. Fries was not properly selected from the PDS because he was scheduled to conduct an impartial medical examination for another claimant on the same date that he examined appellant and "it is difficult to imagine how two examinations can be scheduled on the same date for the same referee physician." She argued that the Office did not provide copies of the selections from the PDS to confirm that Dr. Fries was properly selected. However, the record indicates that Dr. Fries was selected from the PDS and contains bypass records for two physicians. The Board finds that appellant has not established that Dr. Fries was not properly selected as an impartial medical specialist.

CONCLUSION

The Board finds that this case is not in posture for a decision. The case will be remanded for the Office to obtain a supplemental report from Dr. Fries addressing the deficiencies in his September 23, 2006 report.

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[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.13 (April 1993).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated May 15, 2007 and October 20, 2006 are set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: August 12, 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