U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of NANCY B. NEWLIN and U.S. POSTAL SERVICE,
POST OFFICE, Kansas City, MO

Docket No. 98-2634; Oral Argument Held January 5, 2000;
Issued September 1, 2000

Appearances: *David W. White, Esq.*, for appellant; *Sheldon G. Turley, Jr., Esq.*,
for the Director, Office of Workers' Compensation Programs.

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether appellant has more than a one percent permanent impairment of her right upper extremity for which she has received a schedule award.

On September 15, 1991 appellant, then a 32-year-old small bundle and parcel sorter clerk, filed a notice of occupational disease, alleging that she suffered severe pain in her right shoulder as a result of her federal employment. On January 30, 1992 the Office of Workers' Compensation Programs accepted appellant's claim for tendonitis of the right shoulder and awarded appropriate compensation. On January 15, 1993 the Office authorized appellant's treating physician, Dr. Mark S. Humphrey, a Board-certified orthopedic surgeon, to perform a right shoulder acromioplasty with a distal clavicle resection. On November 1, 1993 appellant requested a schedule award for her right upper extremity.

The Office subsequently referred appellant to Dr. George Varghese, a Board-certified orthopedic surgeon, to provide an opinion concerning her request for a schedule award. On February 4, 1994 Dr. Varghese reviewed appellant's history of treatment, including the fact that she underwent an acromioplasty. He noted a well-healed scar at the acromion area and stated that there was no evidence of deformity or muscle atrophy. Dr. Varghese measured appellant's right shoulder range of motion with a goniometer. He found that abduction was 180 degrees, that adduction was 50 degrees, that forward flexion was 180 degrees and that extension was 50 degrees. Dr. Varghese further found that external rotation was 90 degrees and that internal

rotation was 80 degrees. He stated that appellant's only range of motion limitation was the 10 degree loss of internal rotation, which when applied to Figure 44, page 45,[1] of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[2] resulted in 0 percent impairment. Dr. Varghese noted that his muscle strength examination of the shoulder was normal in all plains and that appellant had reached maximum improvement. He further stated that since no weakness was documented, he did not provide a rating for weakness. Dr. Varghese, however, found that appellant suffered pain from the suprascapular nerve, which, pursuant to Table 15, page 54, of the A.M.A., *Guides* had a maximum five percent upper extremity impairment. He then graded appellant's pain in the shoulder joint at 20 percent pursuant to Table 11, page 48 of the A.M.A., *Guides*, because she had some pain forgotten during activity, which limited overhead activities. Finally, Dr. Varghese multiplied the maximum impairment allowed for the suprascapular nerve, totaling 5 percent, by the severity of the grade of pain of 20 percent, to find that appellant had a 1 percent permanent impairment of the right upper extremity.

On March 15, 1994 the Office medical adviser reviewed Dr. Varghese's report and found that the rating was correct and based on the A.M.A., *Guides*. He recommended that the Office accept this impairment rating for appellant's right upper extremity.

By decision dated March 21, 1994, the Office awarded appellant a schedule award based on a one percent impairment of the right upper extremity.

On August 30, 1994 appellant's representative requested reconsideration. In support, he submitted a June 9, 1994 report from Dr. Humphrey. Dr. Humphrey stated, "it is felt she has a 16 percent impairment of the right upper extremity as result of her shoulder injury. Her right upper extremity impairment includes impairment for loss of function due to pain as well as loss of right upper extremity function due to loss of strength and endurance."

On September 13, 1994 the Office medical adviser stated that Dr. Humphrey failed to indicate how he arrived at his impairment rating or how he utilized the A.M.A., *Guides* to reach his rating. In contrast, the Office medical adviser stated that Dr. Varghese measured range of motion; graded chronic pain, sensory deficit and discomfort; and offered a grade for weakness. He further stated that Dr. Varghese provide a report conforming with the A.M.A., *Guides*.

By decision dated December 1, 1994, the Office denied modification of the March 21, 1994 decision.

On October 13, 1995 appellant's representative requested reconsideration. In support, he submitted a February 22, 1995 report from Dr. Humphrey, restating his conclusion that appellant had a 16 percent permanent impairment to her right upper extremity for loss of function due to pain, as well as loss of right upper extremity function due to loss of strength and endurance. In this regard, Dr. Humphrey identified both axillary and suprascapular nerves as causing pain in

[1] Dr. Varghese mistakenly referred to Figure 44, page 45 of the A.M.A., *Guides* as "Table 44". Nevertheless, it is clear that he was applying Figure 44.

[2] A.M.A., *Guides* (4th ed. 1993).

appellant's upper extremity. He noted that both nerves caused a maximum five percent impairment of the upper extremity pursuant to Table 15, page 54 of the A.M.A., *Guides*. Dr. Humphrey then graded the impairment of the upper extremity due to pain at 20 percent pursuant to Table 11, page 48. Pursuant to that same table, he multiplied the maximum percent of upper extremity impairment of 5 percent for both the axillary and suprascapular nerve by the 20 percent grade for pain in the upper extremity. Accordingly, Dr. Humphrey found that appellant had a one percent impairment of the upper extremity due to pain from the axillary nerve and a one percent impairment of the upper extremity due to pain from the suprascapular nerve, for a total of a two percent impairment of the upper extremity due to pain. He also identified the maximum percentage of upper extremity impairment appellant suffered due to motor deficit emanating from the axillary, suprascapular, thoracodorsal, dorsal scapular and subscapular nerves pursuant to Table 15, page 54 of the A.M.A., *Guides.* The maximum percentages were 35 percent for the axillary, 16 percent for the suprascapular, 10 percent for the thoracodorsal, 5 percent for the dorsal scapular and 5 percent for the subscapular. Dr. Humphrey then graded the loss of motor deficit due to each nerve at 20 percent pursuant to Table 12, page 49 of the A.M.A., *Guides* and properly multiplied the maximum percentage of upper extremity impairment appellant suffered due to motor deficit emanating from the axillary, suprascapular, thoracodorsal, dorsal scapular and subscapular nerves by 20 percent. He therefore found that appellant suffered motor deficit impairments of seven percent due to the axillary nerve, three percent due to suprascapular nerve, two percent impairment due to the thoracodorsal nerve, one percent due to the dorsal scapular nerve and one percent due to the subscapular nerve. Dr. Humphrey added the impairments due to motor deficit together to find a 14 percent impairment. He concluded that using the Combined Values Chart of the A.M.A., *Guides*, pages 322-24, that the 2 percent impairment due to pain and the 14 percent impairment due to motor deficit equaled a 16 percent total impairment of the right upper extremity.

On January 30, 1996 the Office medical adviser noted that Dr. Humprhey's findings of a 20 percent gradation of loss of shoulder strength in his February 22, 1995 report were inconsistent with his finding in his June 9, 1994 report that appellant had "good strength of the rotator cuff tendon against 90 degree abduction with resistance." He, therefore, found that Dr. Humphrey's February 22, 1995 report was not sufficiently rationalized to support a greater award.

By decision dated January 30, 1996, the Office denied modification of the prior decision.

On July 19, 1996 appellant's representative again requested reconsideration. In support, he submitted a June 15, 1995 deposition from Dr. Humphrey in which he restated his previous application of the A.M.A., *Guides* finding that appellant suffered a 16 percent impairment of her right upper extremity. He noted that, pursuant to Table 11, page 48, of the A.M.A., *Guides,* appellant had a 20 percent severity of pain, which resulted in a loss of function of 1 percent for the axillary nerve and 1 percent for the suprascapular nerve when applied to Table 15, page 54 of the A.M.A., *Guides*. He used similar tables for loss of strength and indicated that appellant had a loss of function due to a calculated loss of strength of seven percent for the axillary nerve, three percent for the suprascapular nerve, one percent for the subscapular nerve, two percent for the thoracodorsal nerve and one percent for the dorsal scapular nerve. Dr. Humphrey then stated

that using the Combined Values Chart of the A.MA., *Guides*, pages 322-24, he found that appellant had a 16 percent impairment of her right upper extremity.

On August 19, 1996 the Office medical adviser indicated that Dr. Humphrey relied on a work capacity assessment conducted by a physical therapist in determining his impairment rating for the right upper extremity. Consequently, the Office medical adviser stated that Dr. Humphrey's impairment rating was not in conformance with the A.M.A., *Guides* because he relied on the physical findings of ancillary personnel.

By decision dated September 2, 1996, the Office denied modification of the prior decisions.

On January 13, 1997 appellant's representative again requested reconsideration. In support, appellant submitted an affidavit from Dr. Humphrey, who stated that he examined appellant on May 3, 1993 and again on March 25, 1994. He indicated that on the latter date he found that appellant had reached maximum medical improvement and that he rated her pursuant to the A.M.A., *Guides*. Dr. Humphrey stated that he relied on testing conducted by personnel from a rehabilitation center as an important component of his impairment evaluation. He stated that on June 9, 1994 he rated appellant for permanent partial impairment of her right upper extremity and that his rating was based on his treatment from September 11, 1991 through March 25, 1994, his examination on March 25, 1994 and the functional assessment test of March 28, 1994 conducted by his physical therapist.

By decision dated April 15, 1997, the Office denied appellant's request for reconsideration because the evidence submitted in its support was cumulative.

On September 10, 1997 appellant's representative again requested reconsideration and submitted an August 18, 1997 report from Dr. Humphrey. Dr. Humphrey stated that he examined appellant on June 23, 1997 and found that she had a full range of motion of her right shoulder. He noted that shoulder strength was 4+/5 for right shoulder forward flexion and abduction, while the left shoulder was 5/5. Dr. Humphrey also found that appellant had 4+/5 right shoulder external rotation and internal rotation compared to 5/5 left shoulder external rotation and internal rotation strength. He concluded that appellant had a permanent loss of function due to both weakness and pain in the right shoulder.

Appellant also submitted an October 7, 1997 report from Dr. Jeffrey T. MacMillan, a Board-certified orthopedic surgeon, who noted appellant's right shoulder pain and the fact that she had surgery for a right subacromial decompression with distal clavicle resection. He concluded that appellant had no measurable physical impairment, but that because she underwent an iatrogenic right shoulder separation, she had between a 5 and 10 percent impairment of the right upper extremity. Dr. MacMillan stated that, on examination, appellant demonstrated normal range of motion and normal strength, so she showed no measurable impairment pursuant to the A.M.A., *Guides*. He noted, however, that in a rare case the A.M.A., *Guides*, pages 63-64, allows a physician to increase an impairment rating if the anatomic impairment did not sufficiently reflect the severity of the patient's condition and the physician explains the reason for the increase in writing. In this regard, Dr. MacMillan stated that appellant's surgery does not allow her to stabilize her scapula for the purpose of lifting and

carrying with her upper extremity. He stated that, while appellant reports of only being able to carry 10 to 15 pounds was excessively low, he would expect that her abilities to lift and carry would not be normal. Consequently, he concluded that appellant had a loss of function of between 5 and 10 percent of the right upper extremity due to the resection of the distal clavicle.

On November 10, 1997 the Office medical adviser stated that Dr. Humphrey's August 18, 1997 report failed to provide a sufficient basis for reconsidering appellant's schedule award. He indicated that Dr. MacMillan's October 7, 1997 report stating that appellant had no measurable physical impairment failed to provide a sufficient explanation for changing appellant's schedule award.

By decision dated November 12, 1997, the Office denied modification of its prior decisions.

On May 7, 1998 appellant's representative requested reconsideration. In support, he submitted photographs of appellant's back taken on April 11, 1998 and a deposition from Dr. MacMillan taken on April 7, 1998. Dr. MacMillan stated that appellant complained of right shoulder pain and expressed difficulties in her right hand above shoulder height and at shoulder level, if she had to maintain the position for more than a few minutes or if she had a weight in the hand. He stated that on examination appellant's right shoulder sagged in comparison to the left shoulder. Dr. MacMillian found that there was no obvious rotator cuff weakness in her right shoulder and that she had a normal range of motion. He did, however, note that appellant had about a 10 percent forward flexion loss in the right shoulder. Dr. MacMillian stated that he did not measure functional strength. He noted that appellant stated that she was limited to overhead lifting to between 10 and 15 pounds and that he found this was appropriate. Dr. MacMillan diagnosed continued right shoulder pain following a subacromial decompression with resection of the distal clavicle. He indicated that appellant would continue to have problems in using her right hand at or above shoulder level. Dr. MacMillian indicated that appellant's condition was stable and that pursuant to the A.M.A., *Guides* she had an impairment in the range of 5 to 10 percent with respect to the right upper extremity. He stated that by virtue of having had a resection of the distal clavicle and no longer having stable support for the scapula, appellant would not have the same functional use of her hand above shoulder level. Dr. MacMillian stated that this was the rare case contemplated by the A.M.A., *Guides*, pages 63-64, in which the anatomic impairment did not sufficiently reflect the severity of the patient's condition. He reiterated that his rating of a 5 to 10 percent impairment was based on the unstable platform that she has in her shoulder with the scapula as well as limitations she has in lifting above her head. Dr. MacMillian also opined that the droop in appellant's shoulder could constitute an impairment based on disfigurement.

On May 25, 1998 the Office medical adviser stated that because Dr. MacMillan did not provide a specific impairment rating, but rated appellant's impairment from 5 to 10 percent, he did not provide a careful assessment.

By decision dated June 3, 1998, the Office denied modification of its prior decisions. The Office noted that Dr. MacMillan rendered an equivocal decision because he did not indicate a specific numerical percentage of loss.

The Board finds that this case is not in posture for a decision.

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulations,[4] set forth that schedule awards are payable for permanent impairment of specified body members, functions or organs. However, neither the Act nor the regulations specify the manner in which the percentage of impairment is to be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment.[5]

In obtaining medical evidence for schedule award purposes, the Office must obtain an evaluation by an attending physician which includes a detailed description of the impairment including, where applicable, the loss in degrees of motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment. The description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[6] If the attending physician has provided a detailed description of the impairment, but has not properly evaluated the impairment pursuant to the A.M.A., *Guides*, the Office may request that the Office medical adviser review the case record and determine the degree of appellant's impairment utilizing the description provided by the attending physician and the A.M.A., *Guides*.[7]

In the present case, Dr. Humphrey, appellant's treating physician and a Board-certified orthopedic surgeon, opined that appellant had a 16 percent impairment of her right upper extremity. He determined that pain affected appellant's axillary and suprascapular nerves and that pursuant to Table 15, page 54 of the A.M.A., *Guides*, that these nerves each had a maximum five percent upper extremity impairment. Dr. Humphrey further found that, pursuant to Table 11, page 48, of the A.M.A., *Guides* that appellant had a 20 percent grade of pain. Pursuant to that same table, he multiplied the maximum 5 percent upper extremity impairment for each nerve by his 20 percent grade for pain to find that appellant had a 1 percent impairment due to pain from the axillary nerve and a 1 percent impairment due to pain from the suprascapular nerve. Consequently, he found that appellant had two percent impairment due to pain of the right upper extremity. Furthermore, Dr. Humphrey found that appellant suffered an impairment of the right upper extremity due to weakness. He indicated that appellant suffered motor deficits from the axillary, suprascapular, thoracodorsal, dorsal scapular and subscapular nerves and that pursuant to Table 15, page 54 of the A.M.A., *Guides* that the maximum percent of impairment of these nerves due to motor deficits was 35 percent, 16 percent, 10 percent, 5 percent and 5 percent, respectively. Dr. Humphrey then graded the severity of the motor deficit pursuant to Table 12, page 49 of the A.M.A., *Guides* at 20 percent for all the nerves. Pursuant to that same

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.304.

[5] *Leisa D. Vassar*, 40 ECAB 1287 (1989).

[6] *Joseph D. Lee*, 42 ECAB 172 (1990).

[7] *Paul R. Evans, Jr.*, 44 ECAB 646 (1993).

table, he then multiplied the maximum percent impairment of each of the identified nerves due to motor deficit by his 20 percent grade of severity of all the nerves involved, to find that appellant had motor deficit impairments of 7 percent for the axillary nerve, 3 percent for the suprascapular nerve, 2 percent for the thoracodorsal nerve, 1 percent for the dorsal scapular nerve and 1 percent for the subscapular nerve. He added these impairments together to find that appellant had a 14 percent impairment due to motor deficit. Dr. Humphrey then utilized the Combined Values Charts, pages 322-24, to find that appellant's 2 percent impairment due to pain and her 14 percent impairment due to motor deficit equaled a 16 percent impairment of the right upper extremity.

In contrast, Dr. Varghese, the second opinion physician and a Board-certified orthopedic surgeon, found that appellant had only a one percent impairment of the right upper extremity. He stated that appellant demonstrated no weakness on examination and that, therefore, he could find no impairment based on a motor deficit. Dr. Varghese indicated that only the suprascapular nerve was involved in appellant's pain and that pursuant to Table 15, page 54 of the A.M.A., *Guides*, that there was a maximum five percent upper extremity impairment. He then graded appellant's pain at 20 percent pursuant to Table 11, page 48 of the A.M.A., *Guides* and multiplied the maximum 5 percent upper extremity impairment of the suprascapular nerve by his grade of 20 percent for pain to find that appellant had a 1 percent impairment of her right upper extremity.

Accordingly, Dr. Humphrey, appellant's treating physician, and Dr. Varghese, the second opinion physician, applied the A.M.A., *Guides* to their physical findings and reached different conclusions regarding the percentage of impairment found in appellant's right upper extremity. When there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act,[8] to resolve the conflict in the medical opinion.

As an unresolved conflict exists in the medical opinion evidence, this case will be remanded to the Office for referral to an impartial medical specialist. After such further development as necessary, the Office shall issue a *de novo* decision.

[8] 5 U.S.C. § 8123(a); *see Martha A. Whitson (Joe D. Whitson)*, 36 ECAB 370 (1984).

The decisions of the Office of Workers' Compensation Programs dated June 3, 1998 and November 12, 1997 are hereby set aside and this case remanded to the Office for further development consistent with this opinion.

Dated, Washington, D.C.
September 1, 2000

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member