U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of RAYMOND C. DOCKREY and DEPARTMENT OF AIRFORCE, TINKER AIRFORCE BASE, OKLAHOMA CITY, OK

Docket No. 99-1700; Submitted on the Record;
Issued September 22, 2000

DECISION and ORDER

Before WILLIE T.C. THOMAS, A. PETER KANJORSKI, VALERIE D. EVANS-HARRELL

The issue is whether appellant has more than a 15 percent permanent impairment of the left upper extremity.

On August 29, 1997 appellant, then an aircraft sheet metal mechanic filed a claim alleging he developed impingement syndrome of the left shoulder which was causally related to his federal employment. The Office of Workers' Compensation Programs accepted his claim for left shoulder impingement and authorized surgical procedures.[1] Appellant retired November 19, 1998.

On December 18, 1997 appellant filed a claim for compensation on account of traumatic injury or occupational disease (Form CA-7) and requested a schedule award. He submitted employing establishment medical records from August 28 to October 1, 1997; progress notes from Dr. Kevin Hargrove, an orthopedic surgeon, dated September 10 to 24 1997; a narrative statement and a statement from his supervisor. The employing establishment medical records document appellant's left shoulder complaints with a diagnosis of impingement syndrome of the left shoulder. Dr Hargrove's progress notes indicated appellant's complaints of left shoulder pain, with signs of impingement. He noted a possible tear of the rotator cuff. Appellant's narrative statement provides a description of his employment duties and the development of his left shoulder injury. The letter from the employing establishment provides a job description.

Thereafter, appellant submitted a magnetic resonance imaging (MRI) report dated November 13, 1997; medical reports from Dr. Hargrove dated November 26, 1997 and January 16, 1998; and an operative report dated January 9, 1998. The MRI report indicated a tear of the rotator cuff. The medical report dated November 26, 1997 from Dr. Hargrove diagnosed appellant with a rotator cuff tear with a recommendation of arthroscopy,

[1] Appellant previously had a claim for right shoulder impingement syndrome which was accepted and appellant received a schedule award for a 19 percent impairment to the upper extremity.

decompression and debridement. The medical report dated January 9, 1998 notes appellant's progress one week status post repair of the rotator cuff tear, the doctor noted appellant would remain temporarily totally disabled. The operative report describes the repair of appellant's rotator cuff tear. Dr. Hargrove performed a left shoulder arthroscopy with subacromial decompression and distal clavicle resection. The postoperative diagnosis was a large rotator cuff tear, impingement and joint arthrosis.

Appellant submitted medical records from Dr. Hargrove dated April 8 and May 6, 1998. The medical records dated April 8, 1998 indicated that appellant was experiencing persistent pain. The report dated May 6, 1998 indicated that appellant's left shoulder was still problematic and he recommended a repeat arthroscopy.

The Office referred appellant for a second opinion to Dr. Houshang Seradge, an orthopedic surgeon, for an evaluation as to the necessity of the arthroscopic surgery proposed by Dr. Hargrove. Dr. Seradge, in his report dated June 12, 1998, indicated that before he could render an opinion on the necessity of the arthroscopic surgery he wanted to review the preoperative shoulder x-rays. In a report dated June 29, 1998, Dr. Seradge recommended appellant undergo an MRI study to determine if the rotator cuff was torn and if in fact it was torn, then arthroscopic surgery would be warranted. The MRI study revealed a torn rotator cuff. On August 18, 1998 appellant underwent surgery to repair the rotator cuff. He returned to full-time limited duty on August 25, 1998.

The Office referred appellant to Dr. Hargrove, for an evaluation of the extent of any permanent impairment arising from his accepted employment injury in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. By report dated November 16, 1998, Dr. Hargrove determined utilizing the A.M.A., *Guides* that appellant sustained a 30 percent impairment of the upper extremity; however, he did not explain how he calculated the impairment rating under the A.M.A., *Guides*. In a letter dated December 30, 1998, the Office requested that Dr. Hargrove clarify his impairment rating by revealing his calculations for the rating. The record does not indicate that Dr. Hargrove responded to the Office's request.

Dr. Hargrove's report and the case record were referred to the Office's medical adviser who, in a February 8, 1999 report, determined that appellant sustained a 15 percent impairment of the left upper extremity.

Based on the Office medical adviser's review of Dr. Hargrove's report, in a decision dated March 10, 1999, the Office granted appellant a schedule award for a 15 percent impairment of the left upper extremity.

The Board finds that appellant has no more than a 15 percent impairment of the left upper extremity.

Section 8107 of the Federal Employees' Compensation Act specifies the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body. The Act, however, does not specify the manner by which the percentage of loss of a member, function or organ shall be determined. The method used in making such a

determination is a matter which rests in the sound discretion of the Office.[2] For consistent results and to ensure equal justice under the law to all claimants, the Office has adopted the A.M.A., *Guides*, as the standard for determining the percentage of permanent impairment, and the Board has concurred in such adoption.[3]

The Board has carefully reviewed Dr. Hargrove's report dated November 16, 1998 which determined appellant's left upper extremity impairment and notes that Dr. Hargrove did not adequately explain how his determination was reached in accordance with the relevant standards of the A.M.A., *Guides*.[4] Specifically, he noted figures for forward flexion at 150 degrees; external rotation at 30 degrees; arm abduction of 110 degrees; and four plus strength over five plus strength, from which the doctor determined a 30 percent impairment of the left upper extremity. However, Dr. Hargrove did not cite to tables or charts to confirm his impairment rating determination.

The Office medical adviser who reviewed Dr. Hargrove's report correlated findings from Dr. Hargrove's report to specific provisions in the A.M.A., *Guides.* The Office medical adviser specifically noted his figure for flexion was 150 degrees which provides an impairment of 2 percent; extension was not reported and assumed normal; abduction was 110 degrees which provides an impairment of 3 percent; adduction was not reported and assumed normal; internal rotation was not reported and assumed normal; external rotation was 30 degrees which provides an impairment of 1 percent. The Office medical adviser added the range of motion impairments to equal six percent impairment. The Office medical adviser then found that a distal clavicle resection entitled appellant to a 10 percent impairment rating under Table 27 on page 61 of the A.M.A., *Guides.* The Office medical adviser combined the 6 percent impairment for loss of range of motion with the 10 percent for appellant's distal clavicle resection for a combined impairment of the left upper extremity of 15 percent.[5] The Office medical adviser further explained the difference between Dr. Hargrove's figure of 30 percent and his, which was primarily due to the duplication in Dr. Hargrove's evaluation, whereby Dr. Hargrove apparently duplicated his rating by separately adding in crepitus, pain and strength. The Office medical adviser noted that these figures are generally included in the combined shoulder range of motion. The Office medical adviser noted that he did not allow for pain as Dr. Hargrove's report of November 16, 1998 indicated appellant's pain had improved. As to the strength, the Office medical adviser noted that the rating is based upon anatomic impairment and the A.M.A., *Guides* do not assign a large role to such measurement and only in rare cases is an exception made.[6] In this case, Dr. Hargrove provided no explanation as to appellant's condition being an exception and therefore the Office medical adviser gave no consideration for decreased strength.

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[2] *Daniel C. Goings,* 37 ECAB 781 (1986); *Richard Beggs*, 28 ECAB 387 (1977).

[3] *Henry L. King*, 25 ECAB 39 (1973); *August M. Buffa,* 12 ECAB 324 (1961), *Francis John Kilcoyne,* 38 ECAB 168 (1987).

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

[5] *See* page 43, Figure 38, page 44, Figure 41, page 45, Figure 44 of the A.M.A., *Guides.* The A.M.A., *Guides* provide for combining decreased motion ratings with arthroplasty impairments; *see* page 62 of the A.M.A., *Guides.*

[6] *See* page 64 of the A.M.A., *Guides.*

The Board therefore finds that the Office medical adviser properly applied the A.M.A., *Guides* in finding that appellant had a 15 percent impairment of his left upper extremity due to his left shoulder condition. Appellant's distal clavicle resection[7] provides an impairment of the left upper extremity of 10 percent, and when combined with the shoulder range of motion impairment of 6 percent, appellant is entitled to a 15 percent impairment of the left upper extremity. The Office specifically requested that Dr. Hargrove correlate his findings to the A.M.A., *Guides* but no response was received. The Board therefore finds that the weight of the evidence rests with the calculations of the Office medical adviser. Appellant is therefore entitled to a schedule award for no more than 15 percent impairment of the left upper extremity.

The decision of the Office of Workers' Compensation Programs dated March 10, 1999 is hereby affirmed.

Dated, Washington, DC
September 22, 2000

Willie T.C. Thomas
Member

A. Peter Kanjorski
Alternate Member

Valerie D. Evans-Harrell
Alternate Member

[7] *See* page 61, Table 27 of the A.M.A., *Guides.*