United States Department of Labor
Employees' Compensation Appeals Board

M.D., Appellant	)	
	)	**Docket No. 07-1896**
and	)	**Issued: March 12, 2008**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Hot Springs, SD, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 10, 2007 appellant filed a timely appeal from the Office of Workers' Compensation Programs' April 25, 2007 decision of a hearing representative 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 21 percent permanent impairment of the right upper extremity and 5 percent permanent impairment of the left upper extremity for which he received a schedule award.

FACTUAL HISTORY

On February 27, 2004 appellant, then a 37-year-old painter filed an occupational disease claim alleging that he developed diffuse arthritis of the shoulders as a result of performing his

work duties.[1] The Office accepted his claim for temporary aggravation of osteoarthritis of both shoulders. Appellant retired on June 3, 2000.

On August 5, 2004 appellant filed a claim for a schedule award. He came under the treatment of Dr. James A. Engelbrecht, a Board-certified orthopedic surgeon, who noted limited mobility of the right shoulder with crepitus in the left shoulder. Dr. Engelbrecht diagnosed diffuse osteoarthritis.

In a decision dated December 6, 2004, the Office denied appellant's claim for a schedule award.

Appellant requested reconsideration. In a December 15, 2004 report, Dr. James B. Kullbom, a Board-certified orthopedic surgeon, noted treatment of appellant since 1987 for a right shoulder rotator cuff tear and left shoulder arthritis. He advised that appellant was treated in 1994 for right shoulder arthritis and underwent a Mumford procedure and subsequently developed right rotator cuff symptoms. Dr. Kullbom advised that conservative treatment failed and on February 23, 2000 appellant underwent a right rotator cuff repair and decompression. On January 3, 2005 he noted that the right shoulder had 130 degrees of flexion, extension of 30 degrees, abduction of 125 degrees, adduction of 15 degrees, internal rotation of 30 degrees, and external rotation of 72, for total impairment of 13 percent. Dr. Kullbom further found 10 percent impairment for distal claviculectomy. He opined that, under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[2] appellant had 13 percent permanent impairment of the right arm for lost motion and 10 percent impairment of the distal clavicle resection arthroplasty, for a 22 percent impairment of the right shoulder using the Combined Values Chart. For the left shoulder, Dr. Kullbom noted 130 degrees of flexion, 35 degrees of extension, 15 degrees of adduction, 130 degrees of abduction, 50 degrees of internal rotation and 80 degrees of external rotation. He opined that appellant had 12 percent impairment for loss of motion in the left arm. Dr. Kullbom advised that appellant reached maximum medical improvement with regard to both arms.

In a report dated March 7, 2005, an Office medical adviser found that appellant had 21 percent impairment of the right arm. The medical adviser calculated that flexion was 130 degrees for three percent impairment,[3] extension was 30 degrees for one percent impairment,[4]

[1] Appellant filed a separate claim for compensation on July 22, 1987, File No. 12-2024376 that was accepted for temporary aggravation of bilateral shoulder osteoarthritis. The Office accepted a July 19, 1994 claim, File No. A12-0147352, for right adhesive capsulitis and authorized a right lateral clavicle resection, performed on July 29, 1994 and a right rotator cuff repair and decompression, performed on February 23, 2000. On February 27, 1995 appellant was granted a schedule award for 10 percent permanent impairment of the right arm. A December 15, 2003, claim for a shoulder injury, File No. 12-2022427, was closed because it was a duplicate of File No. 12-0147352. These claims are consolidated into the claim before the Board.

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

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

[4] *Id.*

abduction was 125 degrees for three percent impairment,[5] adduction was 15 degrees for one percent impairment,[6] internal rotation was 30 degrees for four percent impairment,[7] and external rotation was 72 degrees for zero percent impairment.[8] He further found 10 percent impairment for distal claviculectomy.[9] The medical adviser found a total of 21 percent permanent impairment of the right upper extremity using the Combined Values Chart, combining the 12 percent loss of motion impairment with the 10 percent diagnosis-based impairment.[10]

On March 10, 2005 the Office determined that appellant had 21 percent impairment of the right arm. It noted that he was previously granted a schedule award for 10 percent impairment of the right arm and would receive an additional award for 11 percent impairment.[11] The Office found that the medical evidence did not establish any permanent impairment of the left arm. In an April 1, 2005 decision, the Office granted appellant a schedule award for 21 percent permanent impairment of the right arm.

On June 21, 2005 appellant appealed his case to the Board. In an order dated November 1, 2005, the Board remanded the case to the Office for combination of appellant's claims pertaining to his accepted right shoulder injuries in claim numbers A12-2024376 and A12-0147352 and to issue an appropriate merit decision on appellant's claim for a schedule award.[12]

On February 9, 2006 the Office advised that it combined claim numbers A12-2024376, A12-0147352 and A12-2022427. It indicated that the most recent medical documentation was dated January 11, 2005. The Office found that appellant was not entitled to a schedule award for the left arm. The Office reissued the April 1, 2005 decision.

On March 1, 2006 appellant requested a hearing and submitted another copy of Dr. Kullbom's January 3, 2005 report.

In a July 5, 2006 decision, the hearing representative set aside the February 9, 2006 decision and remanded the matter for further medical development. The hearing representative instructed the Office to refer appellant to a specialist to determine if he sustained a temporary or permanent aggravation of bilateral shoulder arthritis and to provide findings for a schedule award determination.

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

[6] *Id.*

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

[8] *Id.*

[9] *Id.* at 506, Table 16-27.

[10] *Id.* at 604.

[11] *See supra* note 1.

[12] Docket No. 05-1435 (issued November 1, 2005).

On September 1, 2006 the Office referred appellant for a second opinion to Dr. Michael Kaplan, a Board-certified physiatrist. In a September 21, 2006 report, Dr. Kaplan indicated that he reviewed the records provided to him and examined appellant. He noted the history of appellant's shoulder conditions and diagnosed bilateral shoulder osteoarthritis and chronic impingement syndrome. Dr. Kaplan noted that appellant underwent a distal clavicle resection and remained symptomatic with a permanent condition. He noted that right shoulder abduction was 165 degrees for 1 percent impairment,[13] adduction was 30 degrees for 1 percent impairment,[14] internal rotation was 65 degrees for 2 percent impairment,[15] external rotation was 85 degrees for 0 percent impairment,[16] flexion was 150 degrees for 2 percent impairment,[17] extension was 55 degrees for 0 percent impairment,[18] and a distal clavicle resection merited 10 percent impairment.[19] Dr. Kaplan opined that appellant had 15 percent impairment to the right arm under the A.M.A., *Guides*. With regard to the left shoulder, abduction was 155 degrees for one percent impairment,[20] adduction was 30 degrees for one percent impairment,[21] internal rotation was 85 degrees for zero percent impairment,[22] external rotation was 80 degrees for zero percent impairment,[23] flexion was 140 degrees for three percent impairment[24] and extension was 55 degrees for zero percent impairment.[25] Dr. Kaplan opined that under the A.M.A.., *Guides* appellant had five percent impairment of the left arm. He noted that appellant reached maximum medical improvement in the summer of 2000.

In an October 6, 2006 report, an Office medical adviser opined that appellant had 14 percent right arm impairment and 5 percent left arm impairment. With regard to the right shoulder, he noted that flexion was 150 degrees for 2 percent impairment,[26] extension was 55

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

[14] *Id.*

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

[16] *Id.*

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

[18] *Id.*

[19] *Id.* at 506, Table 16-27.

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

[21] *Id.*

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

[23] *Id.*

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

[25] *Id.*

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

degrees for 0 percent impairment,[27] abduction was 165 degrees for 0 percent impairment,[28] adduction was 30 degrees for 1 percent impairment,[29] internal rotation was 65 degrees for 1 percent impairment,[30] external rotation was 85 for 0 percent impairment.[31] He rated 10 percent impairment for the distal clavicle resection.[32] With regard to the left arm, the medical adviser calculated that flexion was 140 degrees for three percent impairment,[33] extension was 55 degrees for zero percent impairment,[34] abduction was 155 degrees for one percent impairment,[35] adduction was 30 degrees for one percent impairment,[36] internal rotation was 85 degrees for zero percent impairment,[37] and external rotation was 80 for zero percent impairment.[38] The medical adviser determined that appellant reached maximum medical improvement on July 21, 2000. He noted that appellant was previously granted a 21 percent permanent impairment of the right arm and had no additional impairment.

In a November 2, 2006 decision, the Office granted appellant a schedule award for five percent permanent impairment of the left arm. The period of the schedule award was from July 21 to November 7, 2000. The Office found that appellant was previously granted a 21 percent permanent impairment of the right arm and was not entitled to an award for impairment of the right upper extremity.

Appellant requested an oral hearing but later requested a review of the written record. He submitted a duplicate copy of Dr. Kullbom's January 3, 2005 report.

By decision dated April 25, 2007, the hearing representative affirmed the November 2, 2006 decision.

[27] *Id.*

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

[29] *Id.*

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

[31] *Id.*

[32] *Id.* at 506, Table 16-27.

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

[34] *Id.*

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

[36] *Id.*

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

[38] *Id.*

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[39] and its implementing regulations[40] 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 regulation as the appropriate standard for evaluating schedule losses.

ANALYSIS

On appeal, appellant contends that he has more than 21 percent permanent impairment of the right arm and 5 percent permanent impairment of the left arm. The Office accepted appellant's claim for permanent aggravation of bilateral shoulder osteoarthritis, claim number 12-2024376 and right adhesive capsulitis in claim number A12-0147352 and authorized a right lateral clavicle resection which was performed on July 29, 1994 and a right rotator cuff repair and decompression was performed on February 23, 2000.

Regarding the right arm, Dr. Kullbom opined on January 3, 2005 that appellant had 22 percent permanent impairment of the right arm. He noted that the right shoulder had 130 degrees of flexion for a 3 percent impairment,[41] extension was 30 degrees for 1 percent impairment,[42] abduction was 125 degrees for 3 percent impairment,[43] adduction was 15 degrees for 1 percent impairment,[44] internal rotation was 30 degrees for 4 percent impairment,[45] and external rotation was 72 for 0 percent impairment.[46] However, Dr. Kullbom incorrectly noted that these measurements totaled 13 percent. Rather, the loss of range motion values, when added, equal 12 percent. Dr. Kullbom further found 10 percent impairment for distal claviculectomy.[47] The Board notes that using the Combined Values Chart results in 21 percent impairment of the right arm, the total amount received by appellant.[48]

[39] 5 U.S.C. § 8107.

[40] 20 C.F.R. § 10.404.

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

[42] *Id.*

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

[44] *Id.*

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

[46] *Id.*

[47] *Id.* at 506, Table 16-27.

[48] *Id.* at 604.

The Office subsequently referred appellant for a second opinion evaluation to Dr. Kaplan. In a report dated September 21, 2006, Dr. Kaplan noted findings upon physical examination of the right shoulder for abduction was 165 degrees for 1 percent impairment,[49] adduction was 30 degrees for 1 percent impairment,[50] internal rotation was 65 degrees for 2 percent impairment,[51] external rotation was 85 degrees for 0 percent impairment,[52] flexion was 150 degrees for 2 percent impairment,[53] extension was 55 degrees for 0 percent impairment,[54] and 10 percent impairment for distal clavicle resection.[55] Using the Combined Values Chart, he determined that appellant sustained 15 percent impairment to the right upper extremity. The Office medical adviser, as noted, applied the A.M.A., *Guides* to Dr. Kaplan's September 21, 2006 report and found 14 percent impairment.[56] Consequently, Dr. Kaplan's examination did not reveal impairment of the right arm that was greater than the 21 percent previously awarded. Therefore, the medical evidence, conforming with the A.M.A., *Guides*, does not show that appellant has greater than 21 percent permanent impairment of the right arm.

However, the Board finds that there is a conflict in medical opinion between the Office referral physician and Office medical adviser and Dr. Kullbom, appellant's treating physician with regard to the permanent impairment of the left upper extremity.

Dr. Kaplan and the medical adviser found that appellant had five percent impairment of the left arm due to range of motion deficits. They noted left shoulder abduction was 155 degrees for one percent impairment,[57] adduction was 30 degrees for one percent impairment,[58] internal rotation was 85 degrees for zero percent impairment,[59] external rotation was 80 degrees for zero

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

[50] *Id.*

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

[52] *Id.*

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

[54] *Id.*

[55] *Id.* at 506, Table 16-27.

[56] Unlike Dr. Kaplan, the medical adviser noted that abduction was 165 degrees for zero percent impairment and internal rotation was 65 degrees for 1 percent impairment. The A.M.A., *Guides* provides that "impairment values for motion measurements falling between those shown in the pie chart may be adjusted or interpolated proportionally in the corresponding interval." Dr. Kaplan, the examining physician, adjusted the impairment value for 165 degrees of abduction to the corresponding higher impairment value of one percent and the impairment value for 65 degrees of internal rotation to the corresponding higher value of two percent. The medical adviser did not provide any reasoning for adjusting the impairment to the lower values.

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

[58] *Id.*

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

percent impairment,[60] flexion was 140 degrees for three percent impairment[61] and extension was 55 degrees for zero percent impairment,[62] for a total five percent impairment to the left arm. In contrast, Dr. Kullbom applied the A.M.A., *Guides* and found that appellant sustained nine percent[63] permanent impairment of the left arm for loss of motion. He calculated 130 degrees of flexion for three percent impairment,[64] 35 degrees of extension for one percent impairment,[65] 15 degrees of adduction for one percent impairment,[66] 130 degrees of abduction for two percent impairment,[67] 50 degrees of internal rotation for two percent impairment[68] and 80 degrees of external rotation for zero impairment,[69] for total impairment of nine percent.

The evidence shows that each physician used the same part of the A.M.A., *Guides* to come to differing calculations, after examining appellant, regarding his impairment of the left upper extremity due to loss of range of motion.

Section 8123(a) of the Act provides in pertinent part: "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."[70] When there are opposing 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, to resolve the conflict in the medical evidence.[71] The case will remanded to refer appellant to an impartial medical specialist to resolve the medical conflict regarding the extent of left arm permanent impairment arising from appellant's accepted claims. After such further development as the Office deems necessary, an appropriate decision should be issued regarding the extent of appellant's left arm impairment.

[60] *Id.*

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

[62] *Id.*

[63] The Board notes that Dr. Kullbom incorrectly calculated a 12 percent permanent impairment for range of motion deficit for the left arm as the individual impairments, when added, total 9 percent.

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

[65] *Id.*

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

[67] *Id.*

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

[69] *Id.*

[70] 5 U.S.C. § 8123(a).

[71] *William C. Bush*, 40 ECAB 1064 (1989).

CONCLUSION

The Board finds that appellant has no more than 21 percent impairment to his right arm. The case is not in posture for decision as to the left arm impairment due to a conflict in medical opinion.

ORDER

IT IS HEREBY ORDERED THAT the April 25, 2007 and November 2, 2006 decisions of the Office of Workers' Compensation Programs be affirmed with regard to the right upper extremity and set aside with respect to the left upper extremity impairment determination. The case is remanded for further action consistent with this decision.

Issued: March 12, 2008
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

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

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