United States Department of Labor
Employees' Compensation Appeals Board

G.T., Appellant	)	
and	)	**Docket No. 13-125**
	)	**Issued: June 26, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Farmingdale, NY, Employer	)	

Appearances:
Thomas R. Hawkins, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 22, 2012 appellant, through his attorney, filed a timely appeal of an August 6, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) denying an additional schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

ISSUE

The issue is whether appellant has more than 14 percent impairment of his right upper extremity for which he received a schedule award.

On appeal, counsel argued that the medical evidence represented by an attending Board-certified orthopedic surgeon, established that appellant had 24 percent impairment of his right arm.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] On August 20, 2002 appellant, then a 56-year-old equipment operator, injured his right shoulder while pulling a brake. X-rays demonstrated degenerative changes of the glenohumeral joint. On September 11, 2002 OWCP accepted appellant's claim for right shoulder sprain.

An October 24, 2002 magnetic resonance imaging (MRI) scan of the right shoulder demonstrated a full thickness tear of the rotator cuff near the insertion of the supraspinatus tendon as well as acromioclavicular (AC) joint changes and a subchondral injury to the humeral head. In a report dated December 3, 2002, Dr. Jonathan B. Ticker, a Board-certified orthopedic surgeon, diagnosed right shoulder impingement syndrome with glenohumeral degenerative arthritis and a lipoma. Appellant underwent a bone scan on March 29, 2003 which demonstrated osteoarthritic changes in the right shoulder girdle involving the humeral head and AC joint. On January 13, 2005 Dr. Ticker diagnosed borderline carpal tunnel syndrome. Appellant underwent a computerized tomography (CT) scan on March 21, 2006. It demonstrated extensive osteoarthritic degeneration of the glenohumeral and AC joints. OWCP authorized surgery on March 6, 2006. On July 27, 2006 Dr. Ticker performed a right proximal humerus hemiarthroplasty, biceps tenodesis and distal clavicle excision. He found right glenohumeral osteoarthritis, AC joint osteoarthritis and biceps tendinitis with degeneration. On September 5, 2006 OWCP accepted appellant's claim for a recurrence of disability commencing July 26, 2006.

Dr. Ticker found that appellant had reached maximum medical improvement on September 28, 2007. On October 31, 2008 he listed appellant's right shoulder range of motion as 140 degrees of forward flexion, abduction of 70 degrees, 45 degrees of external rotation and 30 degrees of internal rotation and 30 degrees of adduction and extension. Dr. Ticker stated that appellant had diminished strength on the right of 4+/5. He stated that x-rays revealed that the implant was in good position. Dr. Ticker found that appellant had 24 percent impairment due to the total shoulder implant, including the distal clavicle excision and biceps surgery under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. In a note dated July 16, 2010, he stated that he had reviewed the sixth edition of the A.M.A., *Guides* and there was no change in the impairment rating of 24 percent.

OWCP referred appellant for a second opinion evaluation to Dr. P. Leo Varriagle, a Board-certified orthopedic surgeon. In a report dated October 20, 2010, Dr. Varriagle, reviewed the statement of accepted facts and provided range-of-motion findings including 30 degrees of both external and internal rotation, and 150 degrees of abduction. He found mild weakness of internal and external rotation and good strength of the biceps and triceps. Dr. Varriagle opined that appellant had reached maximum medical improvement in July 2007. He rated appellant's impairment as a shoulder arthroplasty[3] and also utilized the range-of-motion provisions to make an impairment rating. Dr. Varriagle stated that utilizing Table 15-7 with a grade modifier of 2

[2] Docket No. 11-1336 (issued February 7, 2012).

[3] A.M.A., *Guides* 405, Table 15-5.

and a *Quick*DASH score of between 41 and 60 resulted in a final impairment of 50 percent.[4] He completed an addendum on November 3, 2010 and provided additional range-of-motion measurements, including flexion of 150 degrees, extension of 40 degrees, external and internal rotation of 30 degrees. Dr. Varriagle noted mild weakness of internal and external rotation with no tenderness. Based on range of motion loss, appellant had three percent impairment due to loss of flexion and abduction, four percent impairment as a result of loss of internal rotation, one percent impairment each due to loss of the extension and adduction and two percent impairment due to loss of external rotation. This represented 14 percent impairment under the sixth edition of the A.M.A., *Guides* due to loss of range of shoulder motion.[5] Dr. Varriagle stated that appellant's functional history adjustment was grade 2 and his range of motion was grade 2 resulting in a percentage of loss of 14 percent of the right arm.

An OWCP medical adviser subsequently concluded that Dr. Varriagle supported 14 percent impairment of the right arm based on loss of range of motion.

In its February 7, 2012 decision, the Board remanded the case for OWCP to request a supplemental report from Dr. Varriagle explaining how he reached the diagnosis-based impairment estimate of 50 percent. OWCP was directed to determine whether the range-of-motion assessment was most appropriate in this case.

OWCP requested a supplemental report from Dr. Varriagle regarding appellant's impairment. On June 11, 2012 Dr. Varriagle stated that he had made an error in rating 50 percent impairment as it was based solely on the functional history adjustment and *Quick*DASH score alone. He opined that evaluating appellant's permanent impairment under the range-of-motion assessment of the sixth edition of the A.M.A., *Guides* was more appropriate than the diagnosis-based estimate. Dr. Varriagle reiterated the impairment rating of 14 percent to appellant's right arm.

By decision dated August 6, 2012, OWCP found that appellant had no more than 14 percent impairment of his right upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing regulations[7] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the

[4] *Id.* at 406, Table 15-7.

[5] *Id.* at 475, Table 15-34.

[6] 5 U.S.C. §§ 8101-8193, 8107.

[7] 20 C.F.R. § 10.404.

degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[8] The Board notes that the A.M.A., *Guides* provide that the diagnosis-based impairments is the method of choice for calculating impairment.[9]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10]

The Shoulder Regional Grid: Upper Extremity Impairments, Table 15-5, of the A.M.A., *Guides*, provides that, if motion loss is present, impairment may alternatively be assessed using Section 15.7, Range of Motion Impairment. A range of motion impairment stands alone and is not combined with diagnosis impairment.[11]

ANALYSIS

Appellant filed a claim for a schedule award based on his accepted right shoulder condition for which he underwent surgery. The consensus of the medical opinion is that the range of motion evaluation is the most appropriate method to rate his impairment. Dr. Ticker initially rated appellant's impairment under the fifth edition of the A.M.A., *Guides* as 24 percent. On July 16, 2010 he reviewed the sixth edition of the A.M.A., *Guides* and stated that there was no change in the impairment rating of 24 percent. Dr. Ticker provided range-of-motion measurements including 140 degrees of forward flexion and abduction of 70 degrees, 45 degrees of external rotation, 30 degrees of internal rotation, and 30 degrees of adduction and extension. He did not specifically correlate his findings to the appropriate edition of the A.M.A., *Guides*.[12]

Dr. Varriagle, the second opinion physician, reviewed the statement of accepted facts on July 16, 2010 and provided range-of-motion measurements. He found 30 degrees of both external and internal rotation, resulting in two percent impairment due to external rotation and four percent impairment due to internal rotation.[13] Dr. Varriagle reported 150 degrees of abduction, or three percent impairment; 30 degrees of adduction, or one percent impairment; flexion of 150 degrees, or three percent impairment, and extension of 40 degrees, or one percent

[8] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[9] A.M.A., *Guides* 461.

[10] *Id.* at 411.

[11] *Id.* at 405.

[12] Under the sixth edition of the A.M.A., *Guides*, Table 15-34[12] these figures result in impairments of three percent impairment for loss of flexion, six percent for abduction, two percent for external rotation, four percent impairment for internal rotation, one percent of adduction and one percent for extension. These impairments total 17 percent impairment not the 24 percent reached by Dr. Ticker, appellant's physician.

[13] A.M.A., *Guides* 475, Table 15-34.

impairment.[14] He totaled the losses as 14 percent impairment of the right shoulder under the sixth edition of the A.M.A., *Guides.* The Board requested an additional opinion on whether the diagnosis-based method or range-of-motion method best represented the extent of impairment. On June 11, 2012 Dr. Varriagle stated that the range-of-motion assessment of the sixth edition of the A.M.A., *Guides* was more appropriate than the diagnosis-based estimate. He noted an error in his diagnosis-based estimate and reiterated the impairment rating of 14 percent. Dr. Varriagle provided his findings on physical examination and correlated the range-of-motion measurements with the appropriate edition and table of the A.M.A., *Guides*.

It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative value. OWCP properly relied upon Dr. Varriagle to find that appellant had no more than 14 percent impairment of his right upper extremity. Dr. Varriagle clarified his opinion as to the proper method by which appellant's impairment should be rated.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has 14 percent impairment of his right arm for which he received a schedule award.

[14] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the August 6, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 26, 2013
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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