# United States Department of Labor
# Employees' Compensation Appeals Board

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| **R.S., Appellant** | ) | |
| **and** | ) | **Docket No. 08-1669** |
| | ) | **Issued: February 18, 2009** |
| **U.S. POSTAL SERVICE, POST OFFICE, Olathe, KS, 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
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

### ***JURISDICTION***

On May 27, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs' October 22, 2007 and February 28, 2008 merit decisions concerning his entitlement to schedule award compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2), the Board has jurisdiction over the merits of this case.

### ***ISSUE***

The issue is whether appellant met his burden of proof to establish that he has more than a nine percent permanent impairment of his left arm, for which he received a schedule award.

### ***FACTUAL HISTORY***

The Office accepted that by late 2004 appellant, then a 52-year-old letter carrier, had sustained bilateral shoulder tendinitis and bilateral shoulder impingement due to the performance of his job duties over time. On September 9, 2005 Dr. Perm Parmar, an attending Board-certified orthopedic surgeon, performed several left shoulder procedures, including a subacromial decompression, distal clavicle excision and debridement of the superior labrum and

a partial thickness tear of the articular surface of the rotator cuff. The surgery was authorized by the Office.

On July 14, 2006 Dr. George Varghese, Board-certified in physical medicine and a rehabilitation physician, who served as an Office referral physician, determined that appellant had a nine percent permanent impairment of his left arm. He found that this impairment was based on limited active motion of his left shoulder, including four percent impairment for 120 degrees of flexion, two percent impairment for 130 degrees of abduction, one percent impairment for 40 degrees of external rotation and two percent impairment for 55 degrees of internal rotation.[1] Dr. Varghese indicated that he applied the standards of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) and determined that appellant had reached maximum medical improvement by July 14, 2006.

In a December 21, 2006 decision, the Office granted appellant a schedule award for a nine percent permanent impairment of his left arm. The award ran for 28.08 weeks from November 17 to July 14, 2006.[2]

On January 1, 2007 Dr. Scott R. Luallin, a Board-certified orthopedic surgeon, who served as an Office referral physician, concluded that appellant had a 26 percent impairment of his left arm.[3] He determined that appellant had a 15 percent impairment based on limited active motion of his left shoulder, including a 4 percent impairment for 124 degrees of flexion, a 1 percent impairment for 38 degrees of extension, a 4 percent impairment for 90 degrees of abduction, a 1 percent impairment for 22 degrees of adduction, a 1 percent impairment for 32 degrees of external rotation and a 4 percent impairment for 30 degrees of internal rotation. Dr. Luallin also asserted that appellant had 13 percent impairment for strength loss in his left arm under Chapter 16.8 of the A.M.A., *Guides*. He used the Combined Values Chart of the A.M.A., *Guides* to combine the limited motion and strength loss values and concluded that appellant had a 26 percent permanent impairment of his left arm.

In a May 14, 2007 decision, an Office hearing representative affirmed the Office's December 21, 2006 decision.[4]

[1] Dr. Varghese indicated that appellant's strength was normal and noted that his pain was considered secondary to range of motion limitation and did not warrant a separate rating.

[2] The Office also granted appellant a schedule award for a 10 percent permanent impairment of his right arm. The matter of appellant's entitlement to schedule award compensation for his right arm is not currently before the Board.

[3] The Office indicated that Dr. Luallin served as an impartial medical specialist but he actually served as an Office referral physician because there was no conflict in the medical evidence at the time of the referral. Section 8123(a) of the Federal Employees' Compensation 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." 5 U.S.C. § 8123(a).

[4] The Office hearing representative did not consider Dr. Luallin's January 1, 2007 report despite the fact that it had been submitted to the Office prior to the issuance of the May 14, 2007 decision.

On July 20, 2007 Dr. Parmar indicated that appellant had a 10 percent impairment of his left arm, under Figure 16-27 of the A.M.A., *Guides*, due to his isolated distal clavicle excision and noted that he also had 10 percent impairment due to the resection arthroplasty of his acromion which was "different than the resection of his distal clavicle." He stated that appellant had five percent impairment due to limited left shoulder motion comprised of two percent impairment due to 145 degrees of flexion,[5] two percent impairment due to 140 degrees of abduction and one percent impairment due to decreased limited internal motion.[6] Dr. Parmar noted that appellant had four percent impairment for decreased strength in his left shoulder under Chapter 16.8c of the A.M.A., *Guides*. He indicated that he used the Combined Values Chart to combine these impairment values and concluded that appellant had a 27 percent impairment of his left arm.

On October 5, 2007 Dr. Daniel D. Zimmerman, a Board-certified orthopedic surgeon who served as an Office medical adviser, posited that the January 1, 2007 report of Dr. Luallin and the July 20, 2007 report of Dr. Parmar did not show that appellant has more than a nine percent permanent impairment of his left arm. He indicated that there was no basis under Table 16-27 of the A.M.A., *Guides* to award appellant a 10 percent impairment rating for the resection arthroplasty of his acromion and asserted that Dr. Parmar did not adequately explain why appellant had a 4 percent impairment for decreased strength in his left shoulder under the standards of the A.M.A., *Guides*.[7] Dr. Zimmerman also indicated that Dr. Luallin did not adequately explain why appellant had 13 percent impairment for decreased strength in his left shoulder. With respect to Dr. Luallin's range of motion findings, he stated, "The figures relevant for ROM [range of motion] assessment using the ROM by Dr. Luallin on January 1, 2007 compared to the vastly more normal ROM by Dr. Parmar on July 20, 2007 must lead to the conclusion that the ROM reported to have been measured by Dr. Luallin on January 1, 2007 cannot represent this claimant's status at such time as [maximum medical improvement] had occurred."

In an October 22, 2007 decision, the Office affirmed its prior decisions regarding appellant's left arm impairment. It determined that the January 1, 2007 report of Dr. Luallin and the July 20, 2007 report of Dr. Parmar did not show that appellant has more than a nine percent permanent impairment of his left arm. The Office cited Dr. Zimmerman's October 5, 2007 report in discounting Dr. Luallin's range of motion findings.

On December 20, 2007 Dr. Lowry Jones, Jr., an attending Board-certified orthopedic surgeon, indicated that appellant had an 8 percent impairment due to loss of strength in his left arm and a 10 percent impairment for his isolated distal clavicle resection. Regarding the range of motion of appellant's left shoulder, he stated, "He showed maximum passive flexion to 110

[5] This measurement would actually equal three percent impairment as it falls halfway between the designated values for impairment in Figure 16-40. *See* A.M.A., *Guides* 476, Figure 16-40; *see* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b (June 2003); *Carolyn E. Sellers*, 50 ECAB 393, 394 (1999).

[6] Dr. Parmar did not provide a measurement for internal rotation.

[7] Dr. Zimmerman also indicated that appellant could not receive impairment ratings for both range of motion and strength losses. *See* A.M.A., *Guides* 526, Table 17-2.

degrees with a fixed end point. Dr. Jones showed maximum abduction measured with a goniometer, again at 85 degrees with fixed end point. He has fixed external rotation limited to 10 degrees of external on the left side as compared to his 45 degrees of external rotation in a adducted position on his right side.[8] Dr. Jones concluded that using the Combined Values Chart to combine these various impairments meant that appellant had a 26 percent permanent impairment of his left arm.

On February 16, 2008 Dr. Zimmerman stated that the range of motion measurements of appellant's left shoulder were not valid as it was unclear whether Dr. Jones obtained active (rather than passive) measurements as required by the A.M.A., *Guides*. He also indicated that Dr. Jones did not adequately explain why appellant had eight percent impairment due to loss of strength in his left arm.

In a February 28, 2008 decision, the Office affirmed its prior decisions regarding appellant's left arm impairment. It indicated that the December 20, 2007 report of Dr. Jones did not show that he had more than a nine percent permanent impairment of his left arm.

## ***LEGAL PRECEDENT***

The schedule award provision of the Act[9] and its implementing regulations[10] 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 regulations as the appropriate standard for evaluating schedule losses.[11]

The period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of his employment injury and maximum medical improvement means that the physical condition of the injured member has stabilized and will not improve further.[12]

It is well established that proceedings under the Act are not adversarial in nature, and while the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[13]

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[8] Dr. Jones concluded that these values equaled 11 percent impairment under the standards of the A.M.A., *Guides*.

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404 (1999).

[11] *Id*.

[12] *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989); *Neil Papkin*, 39 ECAB 239, 243 (1987).

[13] *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

## ***ANALYSIS***

The Office accepted that appellant sustained employment-related bilateral shoulder tendinitis and bilateral shoulder impingement. On September 9, 2005 Dr. Parmar, an attending Board-certified orthopedic surgeon, performed a subacromial decompression, distal clavicle excision and debridement of the superior labrum and a partial thickness tear of the articular surface of the rotator cuff. In a December 21, 2006 decision, the Office granted appellant a schedule award for a nine percent permanent impairment of her left arm. In October 22, 2007 and February 28, 2008 decisions, it determined that appellant had not shown entitlement to greater schedule award compensation for his left arm.

The record contains a July 20, 2007 report in which Dr. Parmar concluded that appellant had a 27 percent impairment of his left arm. The Board notes that the Office correctly found that Dr. Parmar did not adequately explain in his July 20, 2007 report why appellant had four percent impairment for decreased strength in his left shoulder under the standards of the A.M.A., *Guides*.[14] The Office also correctly noted that Dr. Parmar improperly found in this report that appellant had a 10 percent impairment rating for the resection arthroplasty of his left acromion. The A.M.A., *Guides* does not provide for such a diagnosis-based rating.[15] However, Dr. Parmar did properly find that appellant had a 10 percent impairment of his left arm due to his isolated distal clavicle excision.[16] He found range of left shoulder motion losses which were lower than those previously found and it should be noted that range of motion losses cannot be combined with diagnosis-based losses (such as the 10 percent rating based on the clavicle excision). Therefore, Dr. Parmar's findings at best show that appellant would have 10 percent impairment due to his clavicle excision.

In a December 20, 2007 report, Dr. Jones, an attending Board-certified orthopedic surgeon, concluded that appellant had a 26 percent permanent impairment of his left arm. The Office correctly questioned the validity of the range of motion measurements of appellant's left shoulder obtained on December 20, 2007 by Dr. Jones. They were not valid as it does not appear that Dr. Jones obtained active range of motion measurements as required by the A.M.A., *Guides*.[17] The Office also properly indicated that Dr. Jones did not adequately explain why appellant had an eight percent impairment due to loss of strength in his left arm. Dr. Jones did properly find that appellant had a 10 percent impairment of his left arm due to his isolated distal clavicle excision and at best his report would show that he had this level of impairment.

Therefore, as appellant would at least be entitled to a 10 percent impairment rating due to his clavicle excision, there is some evidence that he has more than a 9 percent permanent

[14] It is unclear whether Dr. Parmar carried out manual muscle testing in accordance with the A.M.A., *Guides* and applied the relevant standards. A.M.A., *Guides* 510, Table 16-35. The Board notes that even if a decreased loss of strength rating were established it could not be combined with a range of motion or diagnosis-based rating loss. *See* A.M.A., *Guides* 526, Table 17-2.

[15] *See* A.M.A., *Guides* 506, Table 16-27.

[16] *Id.*

[17] *See id.* at 476.

impairment of his left arm. Moreover, there is medical evidence which suggests that appellant has an even greater impairment of his left arm based on limited left shoulder motion alone.[18] On January 1, 2007 Dr. Luallin, a Board-certified orthopedic surgeon who served as an Office referral physician, determined that appellant had a 15 percent impairment based on limited active motion of his left shoulder, including a 4 percent impairment for 124 degrees of flexion, a 1 percent impairment for 38 degrees of extension, a 4 percent impairment for 90 degrees of abduction, a 1 percent impairment for 22 degrees of adduction, a 1 percent impairment for 32 degrees of external rotation and a 4 percent impairment for 30 degrees of internal rotation.

The Board notes that the Office improperly discounted the range of motion findings of Dr. Luallin.[19] The Office found, based on a report of an Office medical adviser, that the findings were invalid because appellant had been deemed to have reached maximum medical improvement and the findings of Dr. Parmar (obtained about six months after those of Dr. Luallin) showed lesser range of motion losses. Maximum medical improvement means that the physical condition of the injured member has stabilized and will not improve further but reaching maximum medical improvement does not preclude that the impairment of a given member might worsen.[20] Moreover, the Office did not adequately explain why it felt that Dr. Parmar's findings presented a more accurate picture of range of motion impairment than those of Dr. Luallin.

The Office had specifically referred appellant to Dr. Luallin for further evaluation. As noted above, it shares responsibility in the development of the evidence.[21] The record contains evidence which shows that appellant has impairment of his left arm which is some degree greater than the nine percent impairment for which he has been compensated. Therefore, the case should be remanded to the Office for further development to be followed by an appropriate decision regarding the permanent impairment of his left arm.

## ***CONCLUSION***

The Board finds that the case is not in posture regarding whether appellant met his burden of proof to establish that he has more than a nine percent permanent impairment of his left arm, for which he received a schedule award. The case is remanded to the Office for further development.

[18] The A.M.A., *Guides* does not allow the combination of range of motion and diagnosis-based losses. *See* A.M.A., *Guides* 526, Table 17-2. If appellant's impairment based on limited motion alone were higher than 10 percent, the evaluator would base appellant's impairment on a limited motion rating rather than a diagnosed-based rating.

[19] However, the Office properly found that Dr. Luallin did not adequately explain why appellant had 13 percent impairment for strength loss in his left arm under the A.M.A., *Guides*.

[20] *See supra* note 12 and accompanying text.

[21] *See supra* note 13 and accompanying text.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the Office of Workers' Compensation Programs' February 28, 2008 and October 22, 2007 decisions are set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: February 18, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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