United States Department of Labor
Employees' Compensation Appeals Board

C.M., Appellant	)	
and	)	**Docket No. 11-1282**
	)	**Issued: December 20, 2011**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Kansas City, MO, Employer	)	

Appearances:
Edward L. Daniel, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 2, 2011 appellant, through her representative, filed a timely appeal from the February 14, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied modification of her 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 over the merits of this case.

ISSUE

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

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On September 23, 2008 appellant, a 49-year-old tax examining technician, sustained an injury in the performance of duty when she slipped and fell on a wet floor. OWCP accepted her claim for adhesive capsulitis of the right shoulder, adhesive capsulitis of the right knee and contusion of the right knee. On January 13, 2009 appellant underwent a right shoulder arthroscopic superior labrum anterior-posterior (SLAP) repair, rotator cuff debridement and subacromial decompression acromioplasty. On August 13, 2009 she underwent another right shoulder arthroscopic labral repair, chondroplasty of the humeral head and subacromial decompression and acromioplasty.

Appellant filed a claim for a schedule award. Her evaluating physician, Dr. M. Stephen Wilson, found a 25 percent right upper extremity impairment due to profound loss of shoulder motion.[2] Adjusting for a severe functional history, as shown by appellant's *Quick*DASH score of 77.3, he increased appellant's rating to 26 percent.

An OWCP medical adviser noted that an impairment rating based on range of motion is a stand-alone rating and, therefore, could not be adjusted for functional history. He reported that appellant's basic rating of 14 percent was acceptable.[3] In a supplemental report, OWCP's medical adviser explained that Dr. Wilson's impairment rating due to range of motion was acceptable as a stand-alone rating: "The rating due to range of motion restrictions will be accepted."

On September 9, 2010 OWCP issued a schedule award for a 14 percent impairment of appellant's right upper extremity. It found that the weight of the medical evidence rested with its medical adviser because he correctly applied the applicable standards to Dr. Wilson's examination findings.

Appellant requested reconsideration and submitted a supplemental report from Dr. Wilson, who explained that he based his rating solely on loss of motion as a stand-alone rating. Dr. Wilson showed how appellant's impairment due to loss of shoulder motion totaled 25 percent, and he explained how this was adjusted to 26 percent for severe functional history. Appellant's representative argued that a conflict in medical opinion was created between Dr. Wilson, who found a 26 percent impairment, and OWCP's medical adviser, who approved a 14 percent impairment.

OWCP accepted this argument and referred appellant to Dr. M. Scott Beall, Jr., a Board-certified orthopedic surgeon, for an impartial medical evaluation. Dr. Beall noted the accepted right shoulder diagnosis and appellant's surgical procedures. He explained that it was somewhat difficult to come up with an impairment rating because the diagnosis of adhesive capsulitis "does

[2] Dr. Wilson reported 80 degrees flexion (nine percent impairment), 26 degrees extension (two percent impairment), 88 degrees abduction (three percent impairment), 16 degrees adduction (one percent impairment), 24 degrees internal rotation (6 percent impairment) and 41 degrees external rotation (four percent impairment).

[3] At one point in his calculations, Dr. Wilson mistakenly stated that the impairment values for loss of shoulder motion totaled 14 percent. The impairments he reported actually totaled 25 percent, which he thereafter correctly noted when adjusting for functional history.

not in itself fall into the diagnosis-based impairment method." Dr. Beall explained, however, that the range of motion impairment method did not appear appropriate: "Range of motion actively is certainly limited but the passive range of motion is significantly better and without major muscle wasting, solely using the range of motion method does not appear to be appropriate to her condition."

In Dr. Beall's opinion, the most appropriate diagnosis at surgery was SLAP tear, which would be a traumatic injury and which could well be the result of her fall and surgical corrections. He explained that appellant would fall into the "labral lesions, including SLAP tears" category. Dr. Beall felt that appellant had the highest rating in that category, so he rated her right upper extremity impairment at 13 percent.[4]

In a decision dated February 14, 2011, OWCP denied modification of appellant's schedule award. It found that Dr. Beall's report represented the weight of the medical evidence.

On appeal, appellant's representative argues that OWCP did not refer the case to its medical adviser following receipt of the impartial medical specialist's opinion to assess whether the examination was sufficient to resolve the conflict.

LEGAL PRECEDENT

FECA authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body.[5] Such loss or loss of use is known as permanent impairment. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides.*[6]

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.[7] When there exist opposing medical reports of virtually equal weight and rationale, and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[8]

[4] The highest rating in the category "Labral lesions, including SLAP tears" is five percent. American Medical Association, *Guides to the Evaluation of Permanent Impairment* 404 (6th ed. 2009).

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404. For impairment ratings calculated on and after May 1, 2009, OWCP should advise any physician evaluating permanent impairment to use the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

[7] 5 U.S.C. § 8123(a).

[8] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

ANALYSIS

Diagnosis-based impairment is the primary method of evaluation for the upper limbs. The diagnosis and specific criteria determine the impairment class. This is adjusted by such nonkey factors as functional history, physical examination and clinical studies.[9] The first step in determining an impairment rating is to choose the diagnosis that is most applicable for the region being assessed. Selection of the optimal diagnosis requires judgment and experience. If more than one diagnosis can be used, the highest causally related impairment rating should be used; this will generally be the more specific diagnosis. Typically, one diagnosis will adequately characterize the impairment and its impact on activities of daily living. In the event that a specific diagnosis is not listed in the diagnosis-based impairment grid, the examiner should identify a similar listed condition to be used as a guide to the impairment calculation. The rationale for this decision should be described.[10]

While diagnosis-based impairment is the method of choice for calculating impairment, some diagnosis-based impairment grids refer to the range of motion section when that is the more appropriate mechanism for grading the impairment. Range of motion is to be used as a stand-alone rating when other grids refer the evaluator to that section or when no other diagnosis-based sections are applicable. The final range of motion impairment may be adjusted for functional history in certain circumstances. If active motion differs significantly from passive range of motion, the examiner should note the difference and provide a pathological explanation (*e.g.*, abduction weakness after a rotator cuff tear prevents full motion against gravity). The examiner is permitted to disallow the rating for loss of active range of motion if there is not a pathoanatomic or physiological correlate, and there is suboptimal effort or symptom magnification. Sound clinical knowledge and measurement techniques are necessary for appropriate impairment evaluation and rating using range of motion.[11]

If the opposite extremity is neither involved nor previously injured, it must be used to define normal for that individual. Any losses should be made in comparison to the opposite normal extremity.[12]

Table 15-5, page 401 of the A.M.A., *Guides*, is the shoulder regional grid. It provides diagnosis-based upper extremity impairment values for various shoulder diagnoses. Nearly all of the listed diagnoses note that if motion loss is present, the impairment may alternatively be assessed using the range of motion section.[13] Appellant's evaluating physician, Dr. Wilson, used the alternative range of motion method, and his reference to the profoundness of appellant's motion loss indicated the reason. Reporting his measurements, but not always rounding them to

[9] A.M.A., *Guides* 387.

[10] *Id*. at 389.

[11] *Id*. at 461.

[12] *Id*.

[13] *Id*. at 405.

the nearest 10 degrees,[14] Dr. Wilson determined, after a small adjustment for functional history, that appellant had a 26 percent right upper extremity impairment due to motion loss. He did not compare the loss to the opposite extremity.

OWCP's medical adviser agreed with Dr. Wilson's use of the alternative range of motion method. Because of an error in Dr. Wilson's report, the medical adviser misinterpreted the rating as 14 percent. He also erroneously explained that range of motion impairment could not be adjusted for functional history,[15] but he made clear that Dr. Wilson's rating due to range of motion was acceptable. The Board therefore finds no conflict in opinion arose between the two physicians.

Because there was no real conflict to resolve, Dr. Beall cannot be considered an impartial medical specialist under section 8123(a) of FECA. His status, instead, is that of an OWCP second opinion physician. Dr. Beall explained that the range of motion method might not be appropriate, for reasons he explained. He chose instead to use the diagnosis-based impairment method. Noting that the accepted condition of adhesive capsulitis was not listed in the shoulder regional grid at page 401 of the A.M.A., *Guides*, he chose instead, with reasons, the diagnosis of SLAP tear, for which appellant underwent surgical repair. The default impairment value for a SLAP tear is three percent of the upper extremity, with a maximum impairment value of five percent. Without following the procedure for adjusting the default value through grade modifiers, Dr. Beall stated that he believed appellant had the highest rating in the category.

The Board finds that a conflict in medical opinion exists between appellant's evaluating physician, Dr. Wilson, and OWCP's second opinion physician, Dr. Beall, on which method should be used to rate appellant's right upper extremity impairment. Dr. Wilson chose the alternative and permissible range of motion method, while Dr. Beall chose the diagnosis-based impairment method, which is generally the method of choice. As the decision is one that rests within the sound discretion of the evaluating physician, the Board will set aside OWCP's February 14, 2011 decision and remand the case for referral to an impartial medical specialist under section 8123(a) of FECA. The impartial medical specialist, or referee physician, shall examine appellant consistent with the A.M.A., *Guides*, determine which evaluation method is more appropriate and shall provide sound reasoning to support both the choice of method and the calculation of impairment under specific tables. After such further development of the evidence as might become necessary, OWCP shall issue an appropriate final decision on appellant's entitlement to a schedule award.

Appellant's argument on appeal is moot, as Dr. Wilson is not considered an impartial medical specialist.

[14] *Id*. at 461.

[15] As noted earlier: "The final [range of motion] impairment may be adjusted for functional history in certain circumstances." *Id*.

CONCLUSION

The Board finds that this case is not in posture for decision. Further development of the medical opinion evidence is warranted.

ORDER

IT IS HEREBY ORDERED THAT the February 14, 2011 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with the Board's opinion.

Issued: December 20, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

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