United States Department of Labor
Employees' Compensation Appeals Board

G.T., Appellant	)	
and	)	**Docket No. 11-1336**
	)	**Issued: February 7, 2012**
U.S. POSTAL SERVICE, NEW YORK PRIORITY MAIL PROCESSING CENTER, Bethpage, NY, Employer	)	

Appearances:
Thomas S. Harkins, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 10, 2011 appellant, through his attorney, filed a timely appeal of a December 7, 2010 Office of Workers' Compensation Programs' (OWCP) merit decision granting a schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c)(1) 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 arm for which he received a schedule award.

On appeal counsel argued that the medical evidence represented by Dr. Jonathan B. Ticker, a Board-certified orthopedic surgeon, established that appellant had 24 percent impairment of his right upper extremity.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On August 21, 2002 appellant, then a 56-year-old equipment operator, filed a traumatic injury claim alleging that on August 20, 2002 he injured his right shoulder while pulling a brake. X-rays demonstrated degenerative changes of the glenohumeral joint. OWCP accepted appellant's claim for right shoulder sprain on September 11, 2002.

A magnetic resonance imaging (MRI) scan on October 24, 2002 demonstrated 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. Ticker diagnosed right impingement syndrome with glenohumeral degenerative arthritis and a lipoma of his shoulder. 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 also diagnosed borderline carpal tunnel syndrome. Appellant underwent computerized tomography (CT) scan on March 21, 2006 which demonstrated extensive osteoarthritic degeneration of the glenohumeral and AC joints. OWCP authorized surgery on March 6, 2006. Dr. Ticker performed a right proximal humerus hemiarthroplasty, biceps tenodesis and distal clavicle excision on July 27, 2006. He found right glenohumeral osteoarthritis, AC joint osteoarthritis and biceps tendinitis with degeneration.

OWCP accepted appellant's claim for recurrence of disability beginning on July 26, 2006 on September 5, 2006.

Dr. Ticker found that appellant had reached maximum medical improvement on September 28, 2007. He completed a report on October 31, 2008 and listed appellant's range of motion as 140 degrees of forward flexion, 30 degrees of external rotation and internal rotation to L3, as well as abduction of 70 degrees, 45 degrees of external rotation and 30 degrees of internal rotation with 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 applied the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[2] and found three percent impairment due to lack of flexion, five percent impairment of loss of abduction, one percent impairment each for extension, adduction and external rotation as well as four percent impairment of loss of internal rotation. In addition to impairment ratings for loss of range of motion, he found that appellant had 24 percent impairment due to the total shoulder implant including that distal clavicle excision and biceps surgery. Dr. Ticker concluded that appellant had 39 percent impairment of his right upper extremity.

Appellant requested a schedule award on June 8, 2010. OWCP requested additional information on June 23, 2010. In a progress note dated July 16, 2010, Dr. Ticker stated that appellant had 120 degrees of forward flexion and 30 degrees of external rotation. He found 5-/5 strength. Dr. Ticker reviewed x-rays and found the implant in good position with minimal lucency around the stem. He stated that he reviewed the sixth edition of the A.M.A., *Guides*[3]

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

[3] A.M.A., *Guides*, 6th ed. (2009).

and found no change in the impairment rating of 24 percent. In a letter dated August 9, 2010, OWCP requested a supplemental report from Dr. Ticker providing citations to the appropriate tables and pages of the A.M.A., *Guides*. It allotted him 21 days to reply. Dr. Ticker did not respond.

OWCP referred appellant for a second opinion evaluation with 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, as well as 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[4] and found that he could also utilize the range of motion provisions to reach an impairment rating of 50 percent.[5] Dr. Varriagle completed an addendum on November 3, 2010 and provided additional range of motion figures including flexion of 150 degrees, extension of 40 degrees, external and internal rotation of 30 degrees. He noted mild weakness of internal and external rotation with no tenderness. Dr. Varriagle stated that based on range of motion 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. He concluded that appellant had 14 percent impairment under the sixth edition of the A.M.A., *Guides* due to loss of range of motion.[6] 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.

On November 22, 2010 OWCP's medical adviser, Dr. Henry J. Magliato, a Board-certified orthopedic surgeon, reviewed Dr. Varriagle's report. He found that Dr. Ticker did not provide any citations to the appropriate edition of the A.M.A., *Guides* to support that appellant had 14 percent impairment of the right arm due to loss of range of motion.

By decision dated December 7, 2010, OWCP granted appellant a schedule award for 14 percent impairment of his right upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA[7] and its implementing regulations[8] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or 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

[4] *Id.* at 405, Table 15.5.

[5] *Id.* at 406, Table 15.7.

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

[7] 5 U.S.C. §§ 8101-8193, 8107.

[8] 20 C.F.R. § 10.404.

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 degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[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 A.M.A., *Guides* also provide that, if motion loss if present, some impairments may alternatively be assessed[11] using section 15.7, range of motion impairment.[12]

ANALYSIS

OWCP accepted appellant's claim for right shoulder sprain. On July 27, 2006 appellant's physician, Dr. Ticker, performed an authorized right proximal humerus hemiarthroplasty, biceps tenodesis and distal clavicle excision.[13] The sixth edition of the A.M.A., *Guides* provides two methods to evaluate appellant's permanent impairment of the right upper extremity, the preferred method through the diagnosis-based estimates.[14] Under this method, Drs. Ticker and Varriagle found that appellant had at least 24 percent impairment of the right upper extremity due to shoulder arthroplasty.[15] While neither physician provided a detailed explanation of how the respective impairment ratings of 24 and 50 percent were reached, the record contains evidence that appellant has more than 14 percent impairment.

Dr. Magliato negated the diagnosis-based impairment rating by Dr. Ticker on the grounds that he did not provide citations to the A.M.A., *Guides* to support his conclusion. He did not mention that Dr. Ticker relied on the default value for a shoulder arthroplasty of 24 percent in reaching his impairment rating. Dr. Magliato also failed to discuss or consider the diagnosed-based impairment rating received from Dr. Varriagle of 50 percent when evaluating appellant's

[9] 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).

[10] A.M.A., *Guides* 411.

[11] *Id.* at 405.

[12] *Id.* at 461.

[13] Consistent with OWCP procedures, any impairment resulting from an authorized surgery, even if the underlying condition is not an accepted condition, may for the basis of a compensation claim. *D.B.*, 58 ECAB 354 (2007). Furthermore, the Board has long held that preexisting impairments to the scheduled member are to be included when determining entitlement to a schedule award. *Carol A Smart*, 57 ECAB 340 (2006).

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

[15] *Id.* at 405, Table 15-5.

permanent impairment for schedule award purposes. He concluded that Dr. Varriagle, the OWCP second opinion physician, had established an impairment rating of 14 percent based on loss of range of motion without attempting to ascertain how Dr. Varriagle reached the much higher impairment rating of 50 percent. The Board finds that this case requires additional development of the medical evidence. Proceedings before OWCP are not adversarial in nature and OWCP is not a disinterested arbiter; in a case where OWCP "proceeds to develop the evidence and to procure medical evidence, it must do so in a fair and impartial manner."[16] On remand, OWCP should request a supplemental report from Dr. Varriagle comporting with the A.M.A., *Guides* and explaining how he reached the diagnosis-based estimate of 50 percent impairment. OWCP should also determine if and why Dr. Varriagle believes that range of motion assessment is most appropriate in this case. After this and such other development as OWCP deems necessary, OWCP should issue a *de novo* decision with regard to appellant's schedule award claim.

CONCLUSION

The Board finds this case is not in posture for decision due to deficiencies in the medical evidence.

[16] *Walter A. Fundinger, Jr.*, 37 ECAB 200, 204 (1985).

ORDER

IT IS HEREBY ORDERED THAT the December 7, 2010 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this decision of the Board.

Issued: February 7, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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