United States Department of Labor
Employees' Compensation Appeals Board

T.T., Appellant	)	
	)	**Docket No. 13-258**
and	)	**Issued: April 17, 2013**
DEPARTMENT OF HOMELAND SECURITY, FEDERAL AVIATION ADMINISTRATION, Corapolis, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 10, 2012 appellant, through his attorney, filed a timely appeal from a November 7, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 the case.

ISSUE

The issue is whether appellant has more than five percent permanent impairment of the left upper extremity for which he received a schedule award.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On June 5, 2008 appellant, then a 49-year-old civil aviation security specialist filed a traumatic injury claim alleging that on May 30, 2008 he injured his left shoulder while participating in mandatory training sessions at work. On October 24, 2008 OWCP accepted left shoulder cuff tear, labral tear, impingement and synovitis. It authorized arthroscopic surgery which was performed on July 1, 2008.

Appellant submitted a June 12, 2008 magnetic resonance imaging (MRI) scan of the left shoulder which revealed a high grade partial thickness articular sided tear of the critical zone of the central cuff, moderate subacromial subdeltoid bursitis, joint effusion, probable type 4 superior labral tear from anterior to posterior (SLAP), sequelae of prior anterior dislocation and moderate to advanced joint arthrosis. He was treated by Dr. Mark Rodosky, a Board-certified orthopedist, who on July 1, 2008 performed a left shoulder arthroscopic SLAP repair, arthroscopic rotator cuff repair, arthroscopic subacromial decompression with acromioplasty, extensive debridement of glenohumeral arthritis with microfracture and synovectomy of glenohumeral joint. Dr. Rodosky diagnosed left shoulder type 2 SLAP lesion, articular sides partial thickness rotator cuff tear, subacromial impingement, glenohumeral osteoarthritis and glenohumeral joint synovitis. In reports dated September 2, 2008 to January 14, 2009, he noted that appellant was improving and could resume all activities without restriction on January 14, 2009.

On March 16, 2009 appellant filed a claim for a schedule award. He submitted a February 24, 2009 report from Dr. Michael J. Platto, a Board-certified orthopedist, which provided a comprehensive summary of appellant's treatment. Dr. Platto diagnosed left shoulder pain, status post superior labrum tear, partial thickness rotator cuff tear, subacromial impingement, osteoarthritis, synovitis, status post left shoulder arthroscopic SLAP lesion repair, rotator cuff repair, subacromial decompression, acromioplasty, debridement of glenohumeral arthritis and synovectomy on July 1, 2008. He opined that pursuant to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[2] (A.M.A., *Guides*) appellant had five percent left upper extremity impairment for loss of range of motion.

On March 20, 2009 Dr. Platto's report and the case record were referred to OWCP's medical adviser, who, concurred with Dr. Platto's findings that appellant sustained five percent impairment of the left upper extremity in accordance with the A.M.A., *Guides*.

In a decision dated April 22, 2009, OWCP granted appellant a schedule award for five percent permanent impairment of the left upper extremity. The period of the schedule award was from February 23, to June 12, 2009.

Appellant continued to submit reports from Dr. Rodosky dated May 4 to 18, 2009 who noted an MRI scan arthrogram of the left shoulder revealed a partial thickness tear. Dr. Rodosky recommended a subacromial injection.

On July 25, 2012 appellant requested reconsideration. He submitted a May 30, 2012 report from Dr. Platto who based his upper extremity impairment rating on left shoulder range of

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

motion measurements. Dr. Platto reported left shoulder active range of motion (ROM) results as follows: 145 degrees flexion, 43 degrees extension, 132 degrees abduction, 22 degrees adduction, 50 degrees internal rotation and 90 degrees external rotation. With regard to the right shoulder active range of motion results as follows: 165 degrees flexion, 43 degrees extension, 155 degrees abduction, 22 degrees adduction, 58 degrees internal rotation and 90 degrees external rotation. Dr. Platto diagnosed left rotator cuff injury, partial thickness tear according to Table 15-5, page 402 of the A.M.A., *Guides* (6th ed. 2009). In explaining his impairment rating, he referenced an asterisk next to the diagnoses which refers to page 405 and states that, if range of motion loss is present, then impairment may alternatively be assessed using section 15-7, Range of Motion Impairment. Dr. Platto noted that he had calculated both a diagnosis-based impairment (DBI) and a ROM impairment in accordance with Chapter 15 (The Upper Extremities), A.M.A., *Guides*. However, Dr. Platto considered the DBI rating inappropriate because there were significant deficits of active and passive left shoulder ROM and it provided a greater impairment. Applying Table 15-34, A.M.A., *Guides* 475, he found nine percent left arm impairment due to loss of shoulder ROM. Dr. Platto referred to Figure 15-34 for shoulder range of motion and determined that flexion of 145 degrees would equal a three percent impairment, extension of 43 degrees would equal zero percent impairment, abduction of 132 degrees would equal a three percent impairment, adduction of 22 degrees would equal one percent impairment, external rotation of 90 degrees would equal zero percent impairment and internal rotation of 55 degrees would equal two percent impairment.[3] He added the range of motion values and indicated that would result in a nine percent permanent impairment. Dr. Platto also referred to Table 15-35 and explained that the range of motion deficit qualified for a grade 1 modifier[4] and a *Quick*DASH score of 29 which equated to a functional history grade modifier of 1, therefore no adjustment was made.

On November 5, 2012 OWCP's medical adviser reviewed Dr. Platto's May 30, 2012 impairment rating and found five percent impairment of the left arm. He applied the sixth edition of the A.M.A., *Guides* and opined that the diagnosis-based impairment was the preferred rating method for the upper extremities. The medical adviser noted that the range of motion method should be only used when no other approach was available and only used as an alternative to the diagnosis-based rating when there were no diagnosis-based ratings available and referenced Section 15.2, page 387 of the A.M.A., *Guides*. He further noted that page 481, step 12 provides that only if no other approach is available to rating may impairment be calculated based on range of motion. The medical adviser noted that appellant's most impairing diagnosis was left shoulder partial thickness rotator cuff tear with residual loss of function. He noted that, pursuant to Section 15.2, Diagnosis-Based Impairment, Table 15-5, Shoulder Regional Grid, Ligament/Bone/Joint, for the diagnosed rotator cuff injury, partial thickness tear, appellant was a class 1 rating for residual dysfunction, with a default rating of three percent upper extremity impairment. The medical adviser noted that, pursuant to the Adjustment Grid: Functional History, Table 15-7, appellant was assigned a grade modifier 1, with no functional modifications to achieve self-care activities. With regard to physical examination adjustment, appellant was assigned a grade modifier 1 for loss of range of motion. With regard to the clinical studies adjustment, he was assigned a grade modifier 4 as the diagnostic studies confirmed the

[3] A.M.A., *Guides* 475.

[4] *Id.* at 477.

diagnoses of a rotator cuff tear, labral tears as well as other pathology. The medical adviser noted that the adjustments were for functional history grade modifier 1, physical examination grade modifier 1, clinical studies was a grade modifier of 4 for a net adjustment of +2. This resulted in a grade E and five percent arm impairment.

In a decision dated November 7, 2012, OWCP denied appellant's claim for an additional schedule award.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations,[6] 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, FECA 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[9]

ANALYSIS

OWCP accepted left shoulder cuff tear, left labral tear, impingement and synovitis and authorized arthroscopic surgery which was performed on July 1, 2008. Appellant's attending physician, Dr. Platto submitted a May 30, 2012 report noting appellant's history of injury and medical history. He diagnosed left rotator cuff injury, partial thickness tear according to Table 15-5, page 402 of the A.M.A., *Guides* (6th ed. 2009). Dr. Platto noted that he had calculated both a diagnosis-based impairment and a ROM impairment in accordance with Chapter 15, A.M.A., *Guides*. However, he considered the DBI rating inappropriate because there were significant deficits of active and passive left shoulder ROM and ROM provided a greater impairment. In explaining his calculation, Dr. Platto referenced an asterisk next to the diagnoses ("Rotator cuff injury, partial thickness tear*") which referred to page 405 and provides that if motion loss is present impairment may alternatively be assessed using section 15-7, Range of Motion Impairment. He noted that the range of motion impairment stands alone and is not combined with diagnoses impairment.

Applying Table 15-34, A.M.A., *Guides* 475, Dr. Platto found nine percent left arm impairment due to loss of shoulder ROM. He referred to Figure 15-34 for shoulder range of motion and determined that flexion of 145 degrees would equal a three percent impairment,

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

[8] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[9] FECA Bulletin No. 09-03 (issued March 15, 2009).

extension of 43 degrees would equal zero percent impairment, abduction of 132 degrees would equal a three percent impairment, adduction of 22 degrees would equal one percent impairment, external rotation of 90 degrees would equal zero percent impairment and internal rotation of 55 degrees would equal two percent impairment.[10] Dr. Platto added the range of motion values and indicated that it would result in a nine percent permanent impairment. He also referred to Table 15-35 and explained that the range of motion deficit qualified for a grade 1 modifier[11] and a *Quick*DASH score qualified for function modifier of 1 such that no adjustment was made. Dr. Platto noted that appellant reached maximum medical improvement and was permanent and stationary.

The Board has carefully reviewed OWCP's medical adviser's report dated November 5, 2012, and finds this report deficient. While the medical adviser found five percent impairment of the left arm for a diagnosis-based impairment, he did not adequately distinguish the impairment finding of Dr. Platto.[12] He opined that the diagnosis-based impairment was the preferred rating method for the upper extremities under the sixth edition of the A.M.A., *Guides*. The medical adviser noted that, pursuant to Section 15.2, Diagnosis-Based Impairment, Table 15-5, Shoulder Regional Grid, Ligament/Bone/Joint, for the diagnosed rotator cuff injury, partial thickness tear, appellant was a class 1 rating for residual dysfunction, with a default rating of three percent arm impairment. He noted that appellant was assigned a grade 1 modifier for functional history, a grade 1 modifier for physical examination and a grade 4 modifier for clinical studies for a net adjustment of +2. This resulted in a grade E and five percent arm impairment. However, the medical adviser incorrectly noted that the range of motion method should be only used when no other approach was available and only used as an alternative to the diagnoses-based rating when there were no diagnoses based ratings available. The Board notes that the A.M.A., *Guides* notes: "Rotator cuff injury, partial thickness tear, refers to page 405 and provides that if motion loss is present impairment may alternatively be assessed using section 15-7, Range of Motion Impairment." The A.M.A., *Guides* note that range of motion impairment stands alone and is not combined with diagnosis-based impairment. The range of motion calculation would provide appellant with greater impairment than that which would be calculated using the diagnosis-based impairment. While the medical adviser noted provisions in the A.M.A., *Guides* that express a preference for a diagnosis-based rating, the rating grid for appellant's shoulder diagnosis specifically allows alternative impairment assessment using range of motion.[13]

In view of this, OWCP should further develop the medical evidence as appropriate to determine the extent of appellant's impairment of the left upper extremity. The Board has held that proceedings under FECA are not adversary in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, OWCP shares

[10] A.M.A., *Guides* 475.

[11] *Id.* at 477.

[12] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

[13] The Board has recognized use of range of motion as a stand-alone alternative where the diagnosis grid allows the use of range of motion to assess impairment. *See K.W.*, Docket No. 12-1281 (issued January 9, 2013); *S.E.*, Docket No. 12-953 (issued October 12, 2012); *F.R.*, Docket No. 10-701 (issued November 12, 2010).

responsibility in the development of the evidence. It has the obligation to see that justice is done. Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[14]

The Board, therefore, finds that this case must be remanded for an OWCP medical adviser to review the range of motion impairment rating and render an updated evaluation. Following this and any other further development as deemed necessary, OWCP shall issue an appropriate merit decision on appellant's schedule award claim.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the November 7, 2012 decision of the Office of Workers' Compensation Programs is set aside and remanded for further proceedings consistent with this decision of the Board.

Issued: April 17, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

[14] *John W. Butler*, 39 ECAB 852 (1988).