United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	**Docket No. 14-515**
	)	**Issued: July 22, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Cleveland, OH, Employer	)	

Appearances:
Alan J. Shapiro, 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 December 30, 2013 appellant, through her attorney, filed a timely appeal from the December 12, 2013 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 this case.

ISSUE

The issue is whether appellant has more than a five percent permanent impairment of her left arm, for which she received a schedule award.

FACTUAL HISTORY

OWCP accepted that on February 7, 2007 appellant, then a 50-year-old clerk, sustained an acute left shoulder strain, left rotator cuff tear, left shoulder impingement syndrome, left elbow sprain and cervical spine sprain due to pushing and pulling mail containers. She received

[1] 5 U.S.C. §§ 8101-8193.

disability compensation on the daily and periodic rolls. On December 13, 2007 appellant underwent authorized left shoulder surgery, including arthroscopic rotator cuff repair, arthroscopic subacromial decompression and arthroscopic glenohumeral debridement.

On March 27, 2013 appellant filed a claim for a schedule award due to her accepted work injuries.

In an April 24, 2013 report, Dr. John L. Dunne, an attending osteopath Board-certified in preventive medicine, reported the findings of his physical examination of appellant. Appellant's cervical range of motion was normal with some tightness across the tops of the shoulders. Dr. Dunne noted that range of motion of appellant's left shoulder was assessed *via* goniometer. Flexion was measured at 150 degrees, extension at 20 degrees, abduction at 120 degrees, adduction at 40 degrees, external rotation at 60 degrees and internal rotation at 40 degrees, all with relatively poor quality of motion and scapular dyskinesia with end-point pain. Dr. Dunne noted that rotator cuff testing was grade 5/5 for all groups and that there was a normal sensory examination of the left shoulder. He found that appellant reached maximum medical improvement in December 2009 and noted that, under Table 17-2 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009), she did not have any impairment due to her cervical strain. Dr. Dunne concluded that appellant had 14 percent permanent impairment of her right arm. He stated:

> "Chapter 15 on the upper extremity best assesses the impairment of the rotator cuff tear, sprain, surgical repair *via* a stand-alone range of motion method and Table 15-34 which totaled a 14 percent range of motion impairment of the right shoulder. Table 15-35 assigns a 14 percent impairment of the upper extremity to be a [g]rade [m]odifier 2. The functional history per Table 15-7 is a [g]rade [m]odifier 1 so no grade adjustment is necessary for a final 14 percent impairment of the left upper extremity for sprain of the shoulder and upper arm, rotator cuff tear, other affectations of shoulder not elsewhere classified.
>
> "The left elbow shows a full range of motion to 0 degrees of extension and 145 degrees of flexion, easily able to touch the shoulder and 80 degrees supination and pronation. Referencing the elbow regional grid, Table 15-4, soft tissues [c]lass 0, zero percent impairment.
>
> "Final: 14 percent impairment for sprain shoulder and upper arm, rotator cuff, [zero] percent impairment sprain of the neck. [Zero] percent impairment sprain of the elbow and forearm for a total of a 14 percent impairment of the left upper extremity."

In a May 17, 2003 report, Dr. Morley Slutsky, a Board-certified preventive medicine physician serving as an OWCP medical adviser, reviewed the medical evidence of record, including the April 24, 2013 report of Dr. Dunne. He noted that diagnosis-based impairment ratings were preferred under the sixth edition of the A.M.A., *Guides*, but that the range of motion method of rating impairment could be used in some circumstances. Dr. Slutsky found that Dr. Dunne had documented only one motion per shoulder joint movement, which was not consistent with the validity criteria in section 15.7 of the A.M.A., *Guides* for measuring range of

motion. He discussed these standards noting that three active range of motion measurements must be taken per joint motion, that each of the measurements must be within 10 degrees of the calculated average and that the maximum observed measurement per joint motion was to be used to determine the final calculated range of motion impairment.

Dr. Slutsky provided a diagnosis-based impairment rating for appellant's left arm and concluded that she had five percent permanent impairment. Under Table 15-5 on page 403, appellant had a diagnosis-based impairment of rotator cuff injury (full-thickness tear) which fell under Class 1 with a default value of five percent. Dr. Slutsky noted that she had a grade modifier 1 for functional history (ongoing left shoulder pain and dysfunction), a grade modifier 0 for physical examination (invalid range of motion testing and no other objective findings) and a grade modifier 2 for clinical studies (diagnostic testing showed full-thickness rotator cuff tear). He applied the Net Adjustment Formula to find that there was no adjustment from the default value of a five percent impairment of appellant's left arm.

In an August 7, 2013 decision, OWCP granted appellant a schedule award for a five percent permanent impairment of her left arm. The award ran for 15.6 weeks from December 2, 2009 to March 21, 2010.

In a September 12, 2013 report, Dr. Dunne discussed Dr. Slutsky's May 17, 2003 report and stated that the range of motion findings he provided on May 17, 2013 were based on the average of the three goniometer readings in active motion "as prescribed since the [f]ourth [e]dition of the A.M.A., *Guides* and carried through in the [f]ifth and [s]ixth [e]ditions." He noted that the range of motion findings should be considered valid and stated:

> "To satisfy [Dr. Slutsky's] criticism though, I invited [appellant] back in for another examination of her shoulder range of motion on July 25, 2013. [A]fter a brief shoulder warm-up, goniometer measurements of left versus right shoulder range of motion were taken in an active manner, three trials. Active assisted range of motion was also done as was passive range of motion. The results varied by less than [five degrees] and were all accompanied by end-stage pain. These values differed by less than 10 percent from the original report.
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> "[I]t is my opinion that the initial range of motion measurements stand as valid, and if [Dr. Slutsky] wishes to review the raw data as well as my written notes of the history, past medical and surgical history, related injuries, social and family history of [appellant], I would be happy to provide that at [Dr. Slutsky's] request provided the injured worker agrees to the release of this private work product which does not enter into the final official report.
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> "Having established the validity of the range of motion loss impairment involving the left shoulder of the injured worker, I disagree with [Dr. Slutsky's] assignment to the shoulder [diagnosis-based impairment] full rotator cuff tear as the

documented objective findings of abnormal motion cannot be accounted for in any of the shoulder regional grid rotator cuff tear assignments."[2]

In a November 22, 2013 report, Dr. Slutsky reviewed Dr. Dunne's September 12, 2013 report. He noted that it was incorrect for Dr. Dunne to use the average of the three range of motion readings for each shoulder joint motion, rather than the maximum range of motion value. Dr. Slutsky stated:

> "Dr. Dunne offered to provide all the [range of motion] measurements to the [U.S. Department of Labor]. I suggest the [U.S. Department of Labor] ask for this information and to provide them to me for review in consideration of the claimant's final impairment calculations.
>
> "If this information is not obtained then the final [left upper extremity] remains [five] percent. As noted in my previous report the impairment is based upon the preferred 'diagnosis'[-]based impairment method and rated the most impairing diagnosis in the left shoulder region (full-thickness rotator cuff tear with residual dysfunction). Dr. Dunne used the less preferred [range of motion] method with invalid left shoulder [range of motion] measurements … to arrive at a final rating of 14 percent [left upper extremity]."

In a December 12, 2013 decision, OWCP affirmed its August 7, 2013 decision. It found that appellant did not establish more than five percent permanent impairment of her left arm. OWCP found that Dr. Slutsky's assessment was in accordance with the standards of the sixth edition of the A.M.A., *Guides*.

LEGAL PRECEDENT

The schedule award provision of FECA[3] and its implementing regulations[4] 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 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.[5] For OWCP decisions issued on or after

[2] Dr. Dunne suggested that he used the average of the three range of motion readings for each shoulder joint motion, rather than the maximum range of motion value. Further, the A.M.A., *Guides* provide that range of motion is factored under Table 15-8 in consideration of the adjustment for physical examination at pages 407 and 408.

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] *Id*.

May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.[6]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401. After the Class of Diagnosis (CDX) is determined from the Shoulder Regional Grid (including identification of a default grade value), the Net Adjustment Formula is applied using the grade modifier for Functional History (GMFH), grade modifier for Physical Examination (GMPE) and grade modifier for Clinical Studies (GMCS). The Net Adjustment Formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[7]

While section 15.2 of the sixth edition of the A.M.A., *Guides* provides that "[d]iagnosis-based impairment is the primary method of evaluation for the upper limb," Table 15-5 also provides that, if motion loss is present for a claimant who has a rotator cuff injury, impairment may alternatively be assessed using section 15.7 (range of motion impairment). Such a range of motion impairment stands alone and is not combined with a diagnosis impairment.[8]

Section 15.7 of the sixth edition of the A.M.A., *Guides* provides:

> "Range of motion should be measured after a "warm up," in which the individual moves the joint through its maximum range of motion at least [three] times. The range of motion examination is then performed by recording the active measurements from [three] separate range of motion efforts. Measurements should be rounded up or down to the nearest number ending in 0…. All measurements should fall within 10 [degrees] of the mean of these three measurements. The maximum observed measurement is used to determine the range of motion impairment."[9]

It is well-established that proceedings under FECA are not adversarial in nature, and while the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[10]

ANALYSIS

OWCP accepted that appellant sustained an acute left shoulder strain, left rotator cuff tear, left shoulder impingement syndrome, left elbow sprain and cervical spine sprain due to

[6] *See* FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5th ed. 2001) is used.

[7] *See* A.M.A., *Guides* 401-11 (6th ed. 2009).

[8] *Id.* at 387, 405, 475-78.

[9] *Id.* at 464.

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

pushing and pulling mail containers. On December 13, 2007 she underwent left shoulder surgery for arthroscopic rotator cuff repair, arthroscopic subacromial decompression and arthroscopic glenohumeral debridement. In an August 7, 2013 decision, OWCP granted appellant a schedule award for five percent permanent impairment of her left arm. The award was based on the opinion of Dr. Slutsky, a Board-certified preventive medicine physician serving as an OWCP medical adviser.

In rating five percent impairment of her left arm, Dr. Slutsky carried out a diagnosis-based method of rating left arm impairment, noting that under Table 15-5 on page 403 of the sixth edition of the A.M.A., *Guides*, appellant had a diagnosis-based impairment of rotator cuff injury (full-thickness tear) which fell under class 1 with a default value of five percent. He disagreed with a 14 percent left arm impairment rating devised by Dr. Dunne, an attending osteopath and Board-certified family practitioner. Dr. Slutsky stated that Dr. Dunne did not properly perform the range of shoulder motion testing within the standards of the sixth edition of the A.M.A., *Guides*.[11] He recommended that an attempt be made to obtain the raw data from Dr. Dunne's range of shoulder motion testing so that the data could be evaluated and considered as a possible alternative means of rating appellant's left arm impairment.

The Board notes that while section 15.2 of the sixth edition of the A.M.A., *Guides* provides that "[d]iagnosis-based impairment is the primary method of evaluation for the upper limb," Table 15-5 also provides that, if motion loss is present for a claimant who has a rotator cuff injury, impairment may alternatively be assessed using section 15.7 (range of motion impairment).[12] In order to conduct a full evaluation of appellant's left arm impairment, the Board finds that the case should be remanded to OWCP to obtain the raw data from Dr. Dunne's range of shoulder motion testing. If the data is obtained, it should be evaluated and considered under the relevant standards of the A.M.A., *Guides.* After developing the evidence in accordance with the Board's decision, OWCP shall issue an appropriate decision regarding appellant's left arm impairment.

CONCLUSION

The Board finds that the case is not in posture for decision as to whether appellant has more than a five percent permanent impairment of her left arm.

[11] *See supra* note 9.

[12] *See supra* note 8.

ORDER

IT IS HEREBY ORDERED THAT the December 12, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: July 22, 2014
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