United States Department of Labor
Employees' Compensation Appeals Board

V.Z., Appellant	)	
and	)	**Docket No. 14-1012**
	)	**Issued: November 5, 2014**
DEPARTMENT OF THE NAVY, NAVAL AIR WARFARE CENTER WEAPONS DIVISION, China Lake, CA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 27, 2014 appellant filed a timely appeal from a November 22, 2013 decision of the Office of Workers' Compensation Programs (OWCP) regarding a 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 established that he sustained more than 25 percent impairment of the right arm, for which he received a schedule award.

On appeal, appellant contends that OWCP should have relied on the impairment rating provided by his attending physician and not the rating offered by a second opinion physician as interpreted by an OWCP medical adviser.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on May 3, 2011 appellant, then a 56-year-old electronics engineer, sustained adhesive capsulitis of the right shoulder due to driving a truck loaded with heavy equipment over a bumpy road and then striking his shoulder in a doorway.[2] Under OWCP File No. xxxxxx372, it previously accepted a right rotator cuff tear occurring on September 18, 2008. Appellant underwent arthroscopic partial repair of the rotator cuff tear on June 2, 2009. On April 7, 2010 Dr. George F. Hatch, III, an attending Board-certified orthopedic surgeon, performed a right latissimus dorsi tendon transfer.[3]

In reports dated May 20, 2011 to March 8, 2012, Dr. Hatch noted appellant's complaints of increased right shoulder pain following the May 3, 2011 injury. He diagnosed right shoulder impingement, improved with physical therapy.[4]

In a March 9, 2012 report, Dr. Stephen Lombardo, an attending Board-certified orthopedic surgeon, found that appellant had reached maximum medical improvement. He found abduction and forward flexion of the right shoulder less than 150 degrees, external rotation at 70 degrees and internal rotation at 0 degrees. Dr. Lombardo also noted 4/5 weakness in forward flexion, internal and external rotation. He stated that appellant had "lost 80 percent of his function of his glenohumeral joint" according to the fifth edition of the A.M.A., *Guides*.

In a May 8, 2012 report, Dr. Hatch also found that appellant had reached maximum medical improvement. He noted identical ranges of motion and strength measurements to those found by Dr. Lombardo on March 9, 2012.[5]

On September 7, 2012 appellant claimed a schedule award. In a September 18, 2012 letter, OWCP advised appellant to obtain an impairment rating from Dr. Lombardo utilizing the sixth edition of the A.M.A., *Guides*. Appellant submitted a copy of Dr. Hatch's March 8, 2012 report. As he did not provide the impairment rating requested on March 20, 2013, OWCP referred him for a second opinion to Dr. Alice N. Martinson, a Board-certified orthopedic surgeon, who reviewed the medical record and a statement of accepted facts provided by OWCP. In her March 20, 2013 report, Dr. Martinson concurred that appellant had reached maximum

[2] OWCP File No. xxxxxx112.

[3] In a March 14, 2011 report, Dr. Hatch opined that appellant's right shoulder was permanent and stationary. He found 36 percent impairment of the right arm according to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*) for weakness and restricted motion.

[4] July 26, 2011 x-rays of the right shoulder showed a Hill-Sachs deformity of the superior lateral aspect of the right humeral head not present on April 7, 2010 studies, and osteophytes at the acromioclavicular joint and humeral head. A November 1, 2011 arthrogram of the right shoulder showed postoperative changes and a 3.5 centimeters "[f]ull-thickness tearing or stripping of the supraspinatus to infraspinatus with medial restriction from the greater tuberosity and repair."

[5] By a May 11, 2012 decision, OWCP denied appellant's request to continue seeing Dr. Hatch as his office was beyond a 50-mile radius from his zip code area. In an August 9, 2012 letter, appellant requested an oral hearing. He requested that OWCP approve Dr. Lombardo as his attending physician. On August 27, 2012 appellant withdrew his request for an oral hearing.

medical improvement. On examination of the right shoulder, she found 80 degrees flexion, 40 degrees abduction, 10 degrees extension, 30 degrees internal rotation and 0 degrees adduction and external rotation. Dr. Martinson diagnosed a "[m]arked loss of shoulder strength and motion following an irreparable rotator cuff tear and latissimus dorsi transfer." Referring generally to Table 15-34 of the sixth edition of the A.M.A., *Guides*,[6] she rated 32 percent impairment of the right upper extremity due to loss of range of motion.

On July 3, 2013 Dr. Arthur S. Harris, an OWCP medical adviser, reviewed Dr. Martinson's report and found that appellant had reached maximum medical improvement as of her March 20, 2013 examination. He then applied the sixth edition of the A.M.A., *Guides* to her clinical findings. Referring to Table 15-34, Dr. Harris found nine percent impairment of the right upper extremity for shoulder flexion limited to 80 degrees, four percent impairment for internal rotation of the shoulder at 30 degrees, six percent impairment for abduction limited to 40 degrees, two percent impairment for shoulder adduction at 0 degrees, two percent impairment for external rotation at 0 degrees and two percent impairment for shoulder extension limited to 10 degrees. He added these percentages to total 25 percent impairment of the right arm. Dr. Harris explained that Dr. Martinson did not provide a breakdown of her impairment calculations supporting a greater percentage of impairment. He indicated that, although appellant had a postsurgical diagnosis, the range of motion method was the more appropriate means of evaluating appellant's specific deficits.

By decision dated November 22, 2013, OWCP granted appellant a schedule award for 25 percent impairment of the right upper extremity, based on Dr. Martinson's opinion as reviewed by the medical adviser.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound 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. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[8] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[9]

In addressing upper extremity impairments, the sixth edition requires identifying the impairment class for Class of Diagnosis (CDX), which is then adjusted by grade modifiers based

[6] Table 15-34, page 475 of the sixth edition of the A.M.A., *Guides* is entitled "Shoulder Range of Motion."

[7] 5 U.S.C. § 8107.

[8] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[11]

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.[12]

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 zero…. 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."[13]

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.[14]

ANALYSIS

OWCP accepted that appellant sustained adhesive capsulitis of the right shoulder due to a May 3, 2011 incident, preceded by a right rotator cuff tear sustained on September 18, 2008. Appellant underwent arthroscopic partial rotator cuff repair and a right latissimus dorsi tendon transfer. On March 14, 2011 Dr. Hatch, an attending Board-certified orthopedic surgeon, found 36 percent impairment of the right upper extremity due to weakness and limited motion according to the fifth edition of the A.M.A., *Guides*. Dr. Lombardo, an attending Board-certified orthopedic surgeon, opined that on March 9, 2012 appellant had a permanent impairment of the right arm under the fifth edition of the A.M.A., *Guides*.

Appellant claimed a schedule award on September 7, 2012. OWCP advised him by September 18, 2012 letter to submit an impairment rating from his attending physician utilizing the sixth edition of the A.M.A., *Guides*. As appellant did not submit such rating, OWCP obtained a second opinion from Dr. Martinson, a Board-certified orthopedic surgeon, who found

[10] A.M.A., *Guides* 385-419; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[11] *Id.* at 411.

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

[13] *Id*. at 464.

[14] *Dorothy L. Sidwell*, 36 ECAB 699 (1985).

32 percent impairment of the right arm due to restricted shoulder motion according to Table 15-34. Dr. Harris reviewed Dr. Martinson's report and concurred with her clinical findings, but found that applying the individual grading criteria under Table 15-34 to the ranges of motion observed resulted in 25 percent impairment. He concurred that the range of motion rating method was more appropriate than the diagnosis-based method in appellant's case. OWCP issued its November 22, 2013 schedule award for 25 percent impairment of the right upper extremity, based on the reviews by Dr. Harris of Dr. Martinson's clinical findings.

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).[15] In this case it is not apparent that Dr. Martinson obtained range motion in compliance with section 15.7. The case should be remanded to OWCP to obtain further information from Dr. Martinson as to the protocol outlined at page 464, 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 right upper extremity impairment.

On appeal, appellant contends that OWCP should have accorded the weight of the medical evidence to his attending physicians and not to Dr. Martinson. The Board notes that Dr. Hatch and Dr. Lombardo relied on the fifth edition of the A.M.A., *Guides* which was no longer in effect as of May 1, 2009. The case will be remanded for additional development regarding Dr. Martinson's range of motion findings.

CONCLUSION

The Board finds that the case is not in posture for decision as to whether appellant has more than 25 percent impairment of the right upper extremity, for which he received a schedule award.

[15] A.M.A., *Guides* 387, 405, 475-78.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 22, 2013 is set aside, and the case remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: November 5, 2014
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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