**United States Department of Labor**
**Employees' Compensation Appeals Board**

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| **G.G., Appellant** | ) | |
| **and** | ) | **Docket No. 14-0359** |
| | ) | **Issued: June 22, 2015** |
| **U.S. POSTAL SERVICE, POST OFFICE, Boston, MA, Employer** | ) | |

*Appearances:*
*Ron Watson*, for the appellant
*No appearance,* for the Director

Oral Argument July 9, 2014

# DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

## ***JURISDICTION***

On December 2, 2013 appellant, through his representative, filed a timely appeal from a June 28, 2013 schedule award 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 seven percent permanent impairment of the right upper extremity, for which he received a schedule award.

## ***FACTUAL HISTORY***

On December 27, 2002 appellant, then a 41-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on December 26, 2002 he sustained a right shoulder injury

[1] 5 U.S.C. § 8101 *et seq.*

when he slipped on ice. By decision dated February 13, 2003, OWCP accepted the claim for right shoulder sprain.

On May 5, 2010 appellant filed a recurrence claim (Form CA-2a) alleging a return/increase of disability. By decision dated October 7, 2010, OWCP accepted his recurrence claim; the claim was expanded to include complete right rotator cuff rupture.

OWCP authorized surgery for right shoulder arthroscopy and biceps tendon repair on November 15, 2010. On December 16, 2010 appellant underwent right shoulder arthroscopy with extensive debridement, lysis of adhesions, biceps tenodesis, subacromial decompression with acromioplasty, rotator cuff repair and distal clavicle excision performed by Dr. James D. O'Holleran, a Board-certified orthopedic surgeon.

OWCP approved a subsequent February 3, 2011 surgery resulting from a postoperative infection. On that date, appellant underwent a right shoulder arthroscopy with extensive debridement, complete synovectomy, loose body removal and subacromial decompression. On February 8, 2011 he underwent an additional surgery for drainage of a pus collection in the subcutaneous tissues anteriorly. Appellant returned to full-time work on July 11, 2011.

On January 11, 2012 appellant filed a claim for a schedule award (Form CA-7).

In support of his schedule award claim, appellant submitted a December 28, 2011 medical report from his treating physician, Dr. Byron V. Hartunian, a Board-certified orthopedic surgeon. In his report, Dr. Hartunian provided details regarding appellant's medical history and findings on physical examination. He diagnosed acromioclavicular (AC) joint disease of the right shoulder, rotator cuff injury with full-thickness rotator cuff tear status post repair of the right shoulder and biceps tendon tear status post tenodesis of the right shoulder. Using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[2] Dr. Hartunian opined that appellant had a total 22 percent impairment of the upper right extremity. According to the Shoulder Regional Grid Table 15-5 for an AC joint injury or disease, he placed appellant in a class 1 for status post distal clavicle resection.[3] Physical examination was processed as a grade modifier 2 because there were moderate palpatory findings consistently documented and supported by the observed abnormalities. Functional history was processed as a grade modifier 1, mild problem, because appellant had some difficulty performing stressful activities. Clinical studies were processed as a grade modifier 2 because diagnostic testing revealed moderate AC joint arthrosis. Applying the net adjustment formula, Dr. Hartunian calculated a net adjustment of 2 yielding a class 1, grade E impairment of 12 percent for the upper right extremity.

Dr. Hartunian noted that the rotator cuff tear was a separate ratable category per Table 15-5.[4] He opined that the symptoms appellant experienced since the injury and surgery at the rotator cuff were separate from those caused by the AC joint dysfunction and affected

[2] A.M.A., *Guides* (2009).

[3] *Id.* at 403, Table 15-5.

[4] *Id.*

activities of daily living in a different way. Specifically, Dr. Hartunian noted that strength in abduction was affected as opposed to the pain localized at the AC joint during overhead activities. Upon placing this condition in class 1 and providing findings for functional history, clinical studies and physical examination, he calculated a seven percent impairment of the upper right extremity for the rotator cuff tear. Dr. Hartunian further found that the biceps tendinitis and weakness in biceps strength was a separate ratable category per Table 15-5 because the pain and weakness affected different activities of daily living, specifically lifting objects directly in front of him as opposed to overhead activities.[5] He placed appellant's condition in a class 1 category and calculated a five percent impairment of the upper right extremity for biceps tendon.

Dr. Hartunian concluded that using the Combined Values Chart of the A.M.A., *Guides,* the impairment ratings of 12 percent, 7 percent and 5 percent must be combined for a total 22 percent impairment of the right upper extremity. The date of maximum medical improvement (MMI) was noted as June 2011.

On September 6, 2012 OWCP routed Dr. Hartunian's report, a statement of accepted facts and the case file to Dr. Morley Slutsky, an OWCP medical adviser Board-certified in occupational medicine, for an opinion on permanent impairment of the upper right extremity.

In a September 6, 2012 report, Dr. Slutsky noted that there were a number of diagnoses which could be rated in appellant's claim. He argued that Dr. Hartunian improperly rated multiple conditions when only one diagnosis could be used, that which produced the greatest potential impairment in accordance with section 15.2(e) and 15.3(f) of the A.M.A., *Guides*.[6] Dr. Slutsky also noted that appellant's bicep pathology was not ratable as clinical examination did not reveal tendon dislocation or subluxation. He found that the diagnosis of AC joint arthrosis status post distal clavicle resection had the greatest potential for impairment and agreed with Dr. Hartunian's 12 percent impairment rating for this injury. Dr. Slutsky concluded, however, that appellant was only entitled to a 12 percent impairment of the upper right extremity.

By letter dated December 26, 2012, OWCP informed appellant that Dr. Slutsky, the medical adviser, provided a 12 percent impairment rating of the upper extremity as opposed to the 22 percent impairment rating provided by Dr. Hartunian. It provided appellant with a copy of Dr. Slutsky's report and advised him to obtain a supplemental report from his treating physician which would support further consideration of the additional 10 percent impairment difference.

In a December 31, 2012 supplemental report, Dr. Hartunian reviewed Dr. Slutsky's report and disagreed with his conclusion that only one diagnosis could be used to calculate appellant's impairment of the upper right extremity. While he agreed with Dr. Slutsky that the AC joint arthrosis status post clavicle excision was the highest ratable condition, he argued that ratings for the rotator cuff and biceps tendon tear should be combined due to the complex nature of the injuries. Dr. Hartunian noted that Dr. Slutsky's reference to section 15.3(f) of the A.M.A.,

[5] *Id.* at 402.

[6] *Id.* at 390 and 419.

*Guides* failed to note that in rare cases, the examiner may combine multiple impairment ratings within a single region if the most impairing diagnosis does not adequately reflect the losses. When uncertain about which method to choose or whether diagnoses are duplicative, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[7] Thus, Dr. Hartunian argued that the residual symptoms of the rotator cuff injury caused significant reduction in strength in abduction with overhead lifting as opposed to the localized pain at the AC joint caused by overhead lifting, warranting an additional seven percent upper extremity impairment for the rotator cuff. He further argued that the biceps tendinitis condition affected appellant's activities of daily living differently from the other two injuries where the condition affected appellant's strength and caused pain in the arm when lifting objects in front of him below shoulder level. This accounted for an additional five percent impairment of the upper extremity. Dr. Hartunian also stated that Dr. Slutsky incorrectly found that the bicep pathology was not ratable because there was no dislocation or subluxation present. He noted that appellant's operative report indicated that his tendon was dislocated from its original position. Dr. Hartunian concluded that appellant was entitled to a 22 percent impairment of the upper right extremity.

On March 20, 2013 OWCP referred appellant, a statement of accepted facts, the case file, a medical conflict statement, and a series of questions to Dr. Kenneth Glazier, a Board-certified orthopedic surgeon, for an impartial referee medical examination to resolve the conflict on permanent impairment between Dr. Hartunian (reports dated December 28, 2011 and December 31, 2012) and Dr. Slutsky (report dated September 7, 2012).

In an April 16, 2013 medical report, Dr. Glazier provided a medical history and findings on physical examination. He stated that appellant had constant pressure discomfort in the right shoulder and symptoms increased after a full day of work as a letter carrier. Dr. Glazier noted a stabbing pain in the biceps area with very heavy lifting, pain reaching across his body to pick up stacks of mail and weakness and discomfort when using the right arm at and above shoulder height for any repetitive-type activities. Appellant further complained of difficulty and avoided using his right arm to reach overhead, out to the side and across his body.

Dr. Glazier agreed with Dr. Slutsky's assessment that only the highest rated diagnosis should be used based on the A.M.A., *Guides.* He argued, however, that the more appropriate diagnosis was the rotator cuff tear given the lack of symptoms and findings at the AC joint. Dr. Glazier referenced page 389 of the A.M.A., *Guides* which noted that the reliability of the diagnosis is essential and mostly consistent with the clinical history and findings at the time of the impairment assessment. He stated that there was no evidence of ongoing problems either by history or examination at the AC joint and based his rating on the rotator cuff tear given appellant's symptoms and examination. Using Table 15-5, Dr. Glazier calculated seven percent right upper extremity impairment based on appellant's rotator cuff injury.[8]

[7] *Id.* at 419.

[8] *Id.* at 403.

On May 7, 2013 OWCP routed Dr. Glazier's report to Dr. Robert Y. Pick, an OWCP medical adviser and Board-certified orthopedic surgeon, for an opinion on the referee physician's impairment rating.

In a May 26, 2013 report, Dr. Pick agreed with Dr. Glazier's seven percent upper extremity impairment rating. He stated that the impairment rating was based on the rotator cuff because it was the salient and major issue in the case as opposed to the AC joint.

By decision dated June 28, 2013, OWCP granted appellant a schedule award claim for seven percent permanent impairment of the right upper extremity, finding that the weight of the medical evidence rested with Dr. Glazier's referee report. The date of maximum medical improvement was noted as July 11, 2011. The award covered a period of 21.84 weeks from July 11 to December 10, 2011.

## ***LEGAL PRECEDENT***

The schedule award provision of FECA and its implementing regulations 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.[9] 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.[10]

The A.M.A., *Guides* provide a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[11] 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. After the Class of Diagnosis (CDX) is determined for the diagnosed condition (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).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Under Chapter 2.3, evaluators are

[9] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[10] *K.H.*, Docket No. 09-341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

[11] A.M.A., *Guides*, *supra* note 2 at 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[12] *Id.* at 385-419.

[13] *Id.* at 411.

directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[14]

The A.M.A., *Guides* emphasize, however, that in most cases only one diagnosis in a region will be appropriate:

> If a patient has two significant diagnoses, for instance, rotator cuff tear and biceps tend[i]nitis, the examiner should use the diagnosis with the highest causally related impairment rating for the impairment calculation. Thus, when rating rotator cuff injury/impairment or glenohumeral pathology/surgery, incidental resection arthroplasty of the AC joint is not rated.[15]

However the A.M.A., *Guides* also provide the exception to this rule:

> If there are multiple diagnoses at maximum medical improvement, the examiner should determine if each should be considered or if the impairments are duplicative. If there are multiple diagnoses within a specific region, then the most impairing diagnosis is rated because it is probable this will incorporate the functional losses of the less impairing diagnoses. When uncertain about which method to choose or whether diagnoses are duplicative, the evaluator should calculate the impairment using different alternatives.

The evaluating physician must explain in writing the rationale for combining impairments.[16]

Thus, the A.M.A., *Guides* do not strictly prohibit calculating regional impairment using multiple diagnoses. Such a case is considered rare and the evaluating physician has the burden to justify combining regional impairments by explaining how the most impairing diagnosis does not incorporate the functional losses of the less impairing diagnoses. It must be understood, however, that in most cases only one diagnosis in a region will be appropriate.[17]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[18]

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[14] *Id*. at 23-28.

[15] *Id.* at 387.

[16] *Id.* at 419.

[17] *D.A.*, Docket No. 12-841 (issued August 3, 2012).

[18] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims,* Chapter 2.808.6 (February 2013).

## *ANALYSIS*

OWCP accepted appellant's claim for sprain of right shoulder and upper arm, postoperative infection and complete rotator cuff rupture. It approved surgery for right shoulder arthroscopy with extensive debridement, rotator cuff repair, biceps tendon repair and distal clavicle excision. The issue is whether appellant has more than a seven percent permanent impairment of the right upper extremity, for which he received a schedule award. The Board finds this case is not in posture for decision.

In a December 28, 2011 medical report, Dr. Hartunian, appellant's treating physician, calculated a 22 percent impairment of the upper right extremity by combining rating values of 12 percent impairment of the AC joint status post distal clavicle resection, 7 percent impairment of the rotator cuff tear and 5 percent impairment of the biceps tendon. He opined that the impairment ratings should be combined because the symptoms for each injury were different and affected activities of daily living differently.

OWCP properly routed Dr. Hartunian's report, a statement of accepted facts, and the case file to Dr. Slutsky, an OWCP medical adviser, for review and a determination on whether appellant sustained a permanent partial impairment to the upper right extremity. In his September 6, 2012 report, Dr. Slutsky disagreed with Dr. Hartunian's impairment rating, finding that appellant only sustained 12 percent permanent impairment of the upper right extremity for the AC joint status post distal clavicle resection. He argued that the A.M.A., *Guides* provide that only the diagnosis with the greatest potential impairment could be used when multiple conditions existed. Dr. Slutsky stated that the diagnosis of AC joint status post distal clavicle resection produced the greatest potential impairment at 12 percent. He further stated that appellant's bicep pathology was not ratable as clinical examination did not reveal tendon dislocation or subluxation.

By letter dated December 26, 2012, OWCP provided appellant with Dr. Slutsky's report to afford him an opportunity to have Dr. Hartunian comment on the medical adviser's lesser impairment rating.

In a December 31, 2012 supplemental report, Dr. Hartunian disagreed with Dr. Slutsky's findings and provided support for his opinion. He referred to section 15.3(f) of the A.M.A., *Guides* which noted that in rare cases, the examiner could combine multiple impairment ratings within a single region if the most impairing diagnosis did not adequately reflect the losses.[19] While he agreed with Dr. Slutsky that the AC joint arthrosis status post clavicle excision was the highest ratable condition, Dr. Hartunian argued that ratings for the rotator cuff and bicep tendon tear should be combined due to the complex nature of the injuries. He stated that the residual symptoms of the rotator cuff injury caused significant reduction in strength in abduction with overhead lifting as opposed to the localized pain at the AC joint with overhead lifting. This warranted an additional seven percent impairment for the rotator cuff. Dr. Hartunian further argued that the biceps tendinitis condition affected appellant's activities of daily living differently from the other two injuries. He stated that this condition affected appellant's strength and caused pain in the arm when lifting objects in front of him below shoulder level, resulting in

[19] *Supra* note 16.

an additional five percent impairment of the upper extremity. Dr. Hartunian also argued that Dr. Slutsky incorrectly stated that the bicep pathology was not ratable because there was no dislocation or subluxation present. Dr. Hartunian noted that appellant's operative report indicated that his tendon was dislocated from its original position. He concluded that appellant was entitled to a 22 percent impairment of the upper right extremity.

OWCP determined a conflict existed between Dr. Hartunian, appellant's treating physician, and Dr. Slutsky serving as the medical adviser, and referred the case to Dr. Glazier for an impartial medical examination to resolve the conflict regarding the extent of permanent impairment.

In his April 16, 2013 report, Dr. Glazier agreed with Dr. Slutsky's assessment that only the highest rated diagnosis should be used but argued that the more appropriate diagnosis was the rotator cuff tear given the lack of symptoms and findings at the AC joint. He stated that there was no evidence of ongoing problems either by history or examination at the AC joint and based his rating on the rotator cuff tear given appellant's symptoms and examination. Using Table 15-5, Dr. Glazier calculated seven percent right upper extremity impairment of the rotator cuff.[20] On May 26, 2013 Dr. Pick, an OWCP medical adviser, reviewed Dr. Glazier's findings and agreed with his assessment of seven percent permanent impairment of the right upper extremity for the rotator cuff.

The Board finds that Dr. Glazier's opinion is of reduced probative value. Dr. Glazier opined that the rotator cuff tear was the more appropriate diagnosis to use based on appellant's symptoms and examination but failed to identify the particular finding that justified that conclusion. His general findings are not specific enough to clearly visualize permanent partial impairment, or lack thereof.[21] Dr. Glazier further noted that there was no evidence of ongoing problems either by history or examination at the AC joint yet failed to address Dr. Hartunian's December 28, 2011 report which noted findings on physical examination as well as a history of issues related to this condition. Furthermore, he appears to contradict himself as he states that there are no symptoms related to the AC joint while also noting that appellant felt stabbing pain in the biceps area with very heavy lifting, pain reaching across his body to pick up a stack of mail, complaints with overhead activities and weakness and discomfort when using his right arm at and above shoulder height for repetitive-type activities. Dr. Glazier also failed to address Dr. Hartunian's December 31, 2012 supplemental report which provided detailed reasoning regarding why the ratings for the AC joint, rotator cuff and bicep tendon injuries should be combined. The conflict in medical evidence between the opinions of Dr. Slutsky and Dr. Hartunian is well defined in their reports. Dr. Hartunian contends that appellant's unusual medical history and array of symptoms requires that a schedule award include multiple diagnoses. Dr. Slutsky finds that appellant's symptoms and impairment are accurately reflected in a single diagnosis. This is a medical question. Dr. Glazier's impartial medical examination

[20] *Supra* note 8.

[21] *Id.*

report does not explain or resolve this conflict. The Board has consistently held that a medical opinion not fortified by rationale is of limited probative value.[22]

Given the inadequacy of Dr. Glazier's April 16, 2013 report, OWCP should either request a clarification or assign the file to a different referee examiner. 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 a decision.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the June 28, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision.[23]

Issued: June 22, 2015
Washington, DC

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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

[22] *A.D.*, 58 ECAB 149 (2006).

[23] Michael E. Groom, Alternate Judge, participated in the original decision but was no longer a member of the Board effective December 27, 2014.