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Workers' Compensation Board

State of New York

EMPLOYER: EXCELLUS INC

Case No.
G301
9590

Carrier ID No. LH-22-000007 W417380
January 31, 2025

***1** Date of Accident 03/07/2022

MEMORANDUM OF BOARD PANEL DECISION RULING

The carrier requests review of the Workers' Compensation Law Judge (WCLJ) decision filed on February 27, 2024. The claimant filed a timely rebuttal.

ISSUES

The issues presented for administrative review are:

1. Whether the claim should be amended to include the right shoulder;

2. Whether the claimant is at maximum medical improvement (MMI); and

3. Whether the record supports the schedule loss of use (SLU) finding and award.

FACTS

This claim is established for right elbow and right wrist due to a work-related accident/occupational injury on March 7, 2022. The average weekly wage is set at $887.85.

By a medical narrative dated March 7, 2022, the claimant was seen at WellNow Urgent Care. In the narrative, the treating provider [PA Cassandra Piccione] noted the claimant presented with pain in the right upper extremity that had been ongoing for approximately two months. The claimant denied acute injury but recalled that she works from home and did a lot of typing and mouse clicking with her right hand and index finger. The claimant reported her pain radiated from her right index finger and to the right wrist and right dorsal forearm and dorsal lateral elbow. The provider diagnosed possible carpal tunnel syndrome. The claimant also noted that the pain starts in her wrist and radiates up into the shoulder occasionally; but that the pain is mostly in the wrist and elbow. The provider diagnosed cervical radiculopathy versus possible carpal tunnel and cubital tunnel syndromes, right wrist pain, and right elbow pain.

By medical narrative dated March 16, 2022, claimant's treating provider, PA Michael Paolini noted the claimant presented with right upper extremity numbness. The claimant reported that her work required her to be on a computer all day. The claimant further reported that she began experiencing numbness, pain, and tingling in her right arm.

On May 3, 2022, a Electrodiagnostic Study (EMG) was performed. The study revealed right median neuropathy at wrist level compatible with carpal tunnel syndrome.

By medical narrative dated May 5, 2022, claimant's treating provider, FNP Peter Kelley noted the claimant presented for a follow-up for right upper extremity numbness diagnosed the claimant with right carpal tunnel syndrome and right lateral epicondylitis.

By medical narrative dated November 21, 2022, claimant's treating provider, Dr. Michael Cicchetti noted the claimant presented for right shoulder and right arm pain, numbness, and tingling. The doctor noted a history that the claimant works as an advocacy associate for Univera for over 20 years, The claimant denied specific injury, and related her symptoms to repetitive work. The doctor noted that the claimant returned to work full duty in August despite pain and numbness in the right arm. The doctor diagnosed pain and stiffness in the right shoulder, numbness and tingling in the right arm, right arm pain, right shoulder adhesive capsulitis, and cervical radiculitis. An MRI was recommended for the right shoulder.

***2** By notice of decision filed on February 3, 2023, the WCLJ found prima facie medical evidence (PFME) for the right shoulder and cervical spine. MRI studies for the right shoulder and cervical spine were granted on a diagnostic basis.

By notice of decision filed on April 21, 2023, the WCLJ directed the claimant to produce clarifying medical evidence on the neck and right shoulder.

By C-4.3 (Doctor's Report of MMI/Permanent Partial Impairment) dated May 25, 2023, the claimant's treating provider, Dr. Timothy McGrath noted the claimant presented for a schedule loss of use evaluation for the right shoulder, right elbow, and right wrist. He diagnosed the claimant with brachial plexus disorder, cervical radiculopathy, right shoulder impingement, right carpal tunnel syndrome, and right elbow lateral epicondylitis. Dr. McGrath noted that the claimant presented with symptoms and radiographic findings consistent with neurogenic thoracic outlet syndrome, likely cervical radiculopathy, mild right impingement syndrome with possible adhesive capsulitis and right lateral epicondylitis.

On physical exam, he noted, for the right shoulder: forward flexion at 95 degrees both actively and passively; 95 degrees abduction both actively and passively; external rotation at 90/90 is 30 degrees with severe discomfort; and 20 degrees of internal rotation. For the left, he noted 170 flexion, 70 degrees external rotation, and 50 degrees internal rotation. For the right elbow, he noted full range of motion (ROM) with positive Tinel's at the median nerve, ulnar nerve and radial tunnel. For the right wrist, he noted 45 degrees in extension, and 40 degrees in flexion. Positive Tinel's sign was noted on the right side. For the left wrist, he noted 70 degrees extension and 80 degrees flexion.

He further opined that the claimant had reached MMI and pursuant to the 2018 Guidelines had a 72.5% SLU to the right shoulder [based upon flexion, abduction, and internal rotation deficits], 0% SLU to the right elbow, and a 10% SLU to the right hand based upon the EMG and clinical findings of carpal tunnel syndrome.

The carrier's consultant, Dr. James Faulk, an orthopedic surgeon, submitted an IME-4 (Independent Examiner's Report of Medical Examination) dated June 26, 2023. Dr. Faulk noted receiving a history of the claimant working fulltime for the employer, where she sat at a computer, looking at three monitors. She stated that this required her to turn her head from side to side to look at the different monitors. She typed on a keyboard. She worked there for eight years but had worked from home the last three years. She states she went out of work from April 11, 2022, to August 1, 2022.

On physical exam, for the right shoulder he noted: forward flexion at 35/40/49; 54/51/56 for abduction; 30/26/30 for extension; 62/65/60 for external rotation; and was able to internally rotate her right arm to touch her lateral hip. On the left side, he noted 129/125/115 flexion; 109/104/107 abduction; 59/56/59 extension; and 62/60/64 external rotation. Pronation and Supination were normal. Flexion of the right elbow was 75/76/71 compared to 130. For extension on the right elbow, she lacked 15/20/6 compared to the left elbow where she lacked 10 degrees. In her right wrist, he noted dorsiflexion 35/40/43 compared to 60/55/59 on the left wrist. He noted volar flexion at 15/19/20 compared to 50/61/55 on the left side.

***3** Dr. Faulk diagnosed the claimant with nerve irritation or compression involving the right upper extremity suggested at the wrist by the EMG, and limited ROM at the right shoulder, probably from capsulitis with associated limited ROM of the right elbow and right wrist. He further opined that the claimant had reached MMI [but not pre-injury status], as treatment had been unsuccessful, and surgery was not being recommended.

Based on the guidelines, he opined a 10% SLU of the right hand based upon Chapter 4.3 [Carpal Tunnel Syndrome]. He found the right wrist and right elbow were idiopathic and not related to the claimant's work, but noted based on his exam, a 20% SLU [due to limits in dorsiflexion and volar flexion] was warranted for the right wrist. For the right elbow, he noted based on his exam, a 45% SLU was warranted due to the mild loss in extension, and the deficits in flexion. No opinion was provided for the right shoulder for SLU or causation.

By decision filed July 25, 2023, the WCLJ found prima facie medical evidence (PFME) for the neck, right shoulder, brachial plexus disorder, and neurogenic thoracic outlet syndrome. He further directed the carrier to obtain a consultant's report (IME) by the next hearing.

The carrier's consultant, Dr. Faulk, an orthopedic surgeon, submitted an IME-4 (Independent Examiner's Report of Medical Examination) dated August 29, 2023. Dr. Faulk diagnosed the claimant with altered sensation right upper extremity involving the fingers of the entire hand and EMG evidence of carpal tunnel syndrome, not objectively confirmed; limited ROM probably from adhesive capsulitis of the right shoulder and associated limitation on ROM of the right elbow and right wrist. No firm diagnosis has been confirmed; possible thoracic outlet syndrome and brachial plexus problems, but not confirmed. He noted that,

"while thoracic outlet syndrome and brachial plexus disorder can cause some similar symptoms, her clinical presentation with loss of range of motion in the shoulder, elbow, and wrist are generally not associated with thoracic outlet syndrome, and I do not think the clinical presentation fits that. In addition, there has never been EMG evidence of definite brachial plexus problems .... I do not find any causal relationship to a brachial plexus injury or a thoracic outlet syndrome. I do not find any injury to her right shoulder that would be causally related to her job. Adhesive capsulitis is much more common in women, and there is no history of injury of the right shoulder in her job."

By decision filed September 5, 2023, the WCLJ noted that both sides had evidence of permanency, but the issue of MMI remained due to the additional sites of injury. The carrier was granted an additional opportunity to obtain clarifying medical on permanency and the additional sites.

By decision filed December 8, 2023, the WCLJ noted that the additional sites: neck, right shoulder, thoracic outlet syndrome, and brachial plexopathy were being held in abeyance. The parties were granted an extension to depose Drs. Cicchetti, McGrath and Faulk.

***4** At a deposition held on October 26, 2023, testimony was taken from Dr. McGrath. He testified as follows. The claimant first presented to him with complaints of pain, numbness and tingling to the right side. The claimant was diagnosed with right carpal tunnel syndrome which was confirmed by EMG. He also diagnosed a right shoulder impingement with right upper extremity neurogenic thoracic outlet syndrome/ brachial plexus. The claimant was further felt to have some cervical pathology by Buffalo Spine & Sorts. The doctor stated that based on persistent exam findings and complaints of shoulder limitation and range of motion, he felt the claimant had an impingement in the rotator cuff. He noted the claimant had an MRI of the left shoulder

on April 3, 2023, which was negative for tears but revealed some mild supraspinatus tendinosis and subacromial bursitis. He noted that he felt the claimant also had thoracic outlet syndrome/brachial plexus based upon continued distal nerve symptoms, positive Wright's maneuver, with limited shoulder range of motion. He stated these findings are provocative for thoracic outlet syndrome. The doctor conceded that the EMG was negative for the condition but noted that the test is not 100%. He opined that the claimant had a cervical condition based upon the symptomology and that she was referred to a spine specialist.

The doctor further stated that the carpal tunnel syndrome was confirmed by EMG and that the condition was contributing to some of the claimant's symptoms but not all. He believed that the claimant also had a separate neck issue, a separate shoulder issue and a separate elbow issue which he felt to be lateral epicondylitis. He noted that these conditions commonly develop with "ergonomic or postural-related issues for clerical work and prolonged desk work and typing. The individuals get rounded forward shoulder postural with tight muscles that can compress the brachial plexus. And then can further develop additional shoulder issues.' He noted the conditions do not develop specifically from the act of typing itself, but the posture held when typing. Essentially, if the claimant had poor anterior shoulder posture while doing clerical work, the condition is likely to develop.

The doctor confirmed that he gave a 72.5% for the right shoulder based upon the deficits in range of motion. He found no schedule for the elbow because even though there were deficits, he did not feel the deficits were "functionally impairing loss of range of motion."

On cross-examination, he confirmed that he felt the claimant was at MMI. He noted that it was hard to predict whether the claimant would have any further improvement. He noted a 10% SLU was given for the carpal tunnel syndrome, which was noted to be mild by EMG. With regards to causation, he noted he would defer to Dr. Cicchetti on an opinion for the neck. For the diagnosis for thoracic outlet syndrome, he said he would defer to the doctor partially, as he does believe the claimant had continuously shown clinical evidence of the condition.

***5** At a deposition held on November 2, 2023, testimony was taken from Dr. Cicchetti. He testified as follows. He first examined the claimant on November 21, 2022. The claimant presented with complaints of right shoulder pain and stiffness, right arm pain, pain at the elbow and numbness and tingling into the right hand. He received a history of no direct injury but rather repetitive use as work where the claimant was working on a computer typing all day. He noted that sitting in front of a computer, looking at three monitors and turning her head side to side while typing on a keyboard is a reasonable and likely cause of her symptoms. He noted that the repetitive nature of this ergonomical posture can certainly cause her symptoms. The EMG revealed evidence of mild right carpal tunnel syndrome, but he felt based on the constellation of her symptoms she also may have had a neck problem. He was also suspicious of a possible frozen shoulder and lateral epicondylitis condition that was contributing to her symptoms. The MRI of the right shoulder that was performed was negative for tears but did not rule out a frozen shoulder.

The doctor confirmed that there was a low suspicion for a brachial plexus injury or thoracic outlet syndrome, as he felt that more likely the claimant's symptoms were being caused by a frozen shoulder and a neck problem. He noted that a brachial plexus injury is more caused by direct trauma and would have been more likely to have been seen on the EMG. He noted that the neck needed an MRI before he could confirm or deny that the neck was a contributing factor to the symptoms the claimant was having.

He was questioned whether the claimant could have full ROM with a frozen shoulder initially. The doctor stated that frozen shoulder has three stages. On the first stage, the individual has no restricted range of motion. They just have pain. This can last anywhere from four to five months. In stage two, the claimant develops range of motion limitation which he calls the freezing stage which can last anywhere from nine months to two years. The last stage, the thawing stage, the condition begins to resolve or get better.

At a deposition held on January 9, 2024, testimony was taken from Dr. Faulk. He testified as follows. He performed an independent medical exam on the claimant on June 26, 2023, and August 29, 2023. The claimant presented with a burning type of pain that involved her right upper extremity that radiated down into her hand and into the tips of each finger. She further

reported stiffness and limits in ROM in the shoulder, elbow and wrist. He noted on exam, she had significant loss of motion in all planes of the shoulder as well as loss of motion in the elbow and wrist. He noted that he did not see any sign of symptom magnification, as her symptoms and exams were consistent. Based on his exams, he formed a working diagnosis of: altered sensation of the right upper extremity involving the fingers of the entire hand and EMG evidence of carpal tunnel syndrome but not objectively confirmed; limited range of motion probably from adhesive capsulitis of the right shoulder and associated limitation of motion of the right elbow and wrist; possible thoracic outlet syndrome and brachial plexus problems.

***6** The doctor explained that the cause of her elbow condition could be from the claimant not using her arm normally. He noted that the carpal tunnel syndrome was confirmed by EMG, but that the condition did not explain the symptoms in the pinky. He stated that usually when an individual has numbness in all fingers there may be an ulnar nerve problem as well. He noted that while the EMG was negative for ulnar nerve entrapment; that does not 100% rule out an ulnar problem. He noted that the claimant's symptoms could also be explained by thoracic outlet syndrome, but that the diagnosis is usually made when the doctors cannot pin the symptoms on anything else. He stated that usually, when there are a number of symptoms, like in the claimant's case, where they are having difficulties pinning the symptoms to a specific cause, they say the condition is idiopathic [meaning no known cause]. He noted that adhesive capsulitis can be idiopathic and in fact, appears commonly in middle aged women. He conceded that it was a possibility that the claimant's posture while typing may have been responsible for her condition but felt that it was more idiopathic.

Dr. Faulk after being read the claimant's cervical spine MRI, acknowledged that the claimant did appear to have a cervical spine problem, albeit not as severe as the herniation was small. He opined that the neck condition did not explain the claimant's significant loss of motion in the shoulder, elbow, or wrist; but that it did explain the symptoms in the trapezius.

At a deposition held on January 18, 2024, testimony was taken from Dr. Cicchetti. He testified as follows. He has previously been concerned that the claimant may have a neck condition that was contributing to her symptomology. Since he last testified, the claimant had undergone an MRI of the cervical spine. He noted that the findings on the MRI did not correlate with the claimant's symptoms, and that based on the findings it was unlikely that her neck or cervical radiculopathy was the cause of her symptoms. Based on this, he felt it was much more likely that the claimant's symptoms were caused by adhesive capsulitis in the right shoulder. He noted that carpal tunnel was confirmed by the EMG, which was a separate diagnosis from the right shoulder. The doctor confirmed that the diagnostic workup did not reveal thoracic outlet syndrome or a brachial plexus injury, and he therefore did not believe that the claimant had the conditions.

On cross-examination, the doctor confirmed that the diagnostic testing ruled out a cervical nerve root injury, thoracic outlet syndrome and brachial plexus.

At a hearing held on February 22, 2024, the WCLJ denied amending the claimant's claim to include the neck, brachial plexus, or thoracic outlet syndrome. The WCLJ did find that the record supported amendment to include the right shoulder based upon the credible opinions of Drs. Cicchetti and McGrath.

The WCLJ noted that a 72.5% SLU is warranted to the right shoulder pursuant to the credible opinion of Dr. McGrath whom he felt provided an opinion consistent with the guidelines. The WCLJ further noted that no contrary opinion on the right shoulder SLU had been provided by the carrier. With regards to the hand and elbow, the WCLJ found both Drs. Faulk and Cicchetti credible but noted that pursuant to Table 5.5, special consideration 8, the claimant would only be entitled to an additional 10% to be added to her right shoulder schedule.

***7** The WCLJ's determination to disallow the claim for the back was memorialized in a decision filed on February 27, 2024.

LEGAL ANALYSIS

The carrier contends that the WCLJ's February 27, 2024, decision should be reversed. The carrier argues that the medical evidence does not support amending the claim to include the right shoulder, as Dr. Faulk indicated that the injury was idiopathic and barred under WCL 28. [The carrier cites to Matter of Bates v. Marine Midland Bank, 256 A.D.2d 948 (N.Y. App. Div. 1998) 682 N.Y.S2d 282)]. In addition, the carrier argues that the finding of MMI is premature, as the providers have indicated that the adhesive capsulitis condition is likely to improve. Alternatively, the carrier argues that the claimant should have been deemed to have a 40% SLU to the right arm at most and a 10% SLU to the right hand.

In rebuttal, the claimant contends that the February 27, 2024, decision should be affirmed. Notably no appeal was filed regarding the denial of the neck, brachial plexus, or thoracic outlet syndrome claims. As such, the Board Panel will not be addressing these additional sites.

Right Shoulder

In evaluating the medical evidence presented, the Board is not bound to accept the testimony or reports of any one expert, either in whole or in part, but is free to choose those it credits and reject those it does not credit (see Matter of Morrell v Onondaga County, 238 AD2d 805 [1997], lv denied 90 NY2d 808 [[1997]; Matter of Wood v Leaseway Transp. Corp., 195 AD2d 622 [1993]). Thus, questions of credibility, reasonableness, and relative weight to be accorded to conflicting evidence are questions of fact that come within the exclusive province of the Board (see Matter of Berkley v Irving Trust Co., 15 AD3d 750 [2005]).

Workers' Compensation Law (WCL) § 2 (15) defines an occupational disease as "a disease resulting from the nature of employment and contracted therein." To establish an occupational disease, the claimant must demonstrate "a recognizable link between his or her condition and a distinctive feature of his or her employment" (Matter of Garcia v MCI Interiors, Inc., 158 AD3d 907, 908 [2018] [internal quotation marks and citations omitted]; see Matter of Mack v County of Rockland, 71 NY2d 1008, 1009 [1988]; Matter of Corina-Chernosky v Dormitory Auth. of State of N.Y., 157 AD3d 1067, 1068 [2018]). "Significantly, the Board's decision regarding whether a medical condition is present and should be classified as an occupational disease 'is a factual determination that will not be disturbed if supported by substantial evidence' (Matter of Scott v Bimbo Bakeries USA, Inc., 171 AD3d 1421, 1422 [2019]; see Matter of Yanas v Bimbo Bakeries, 134 AD3d 1321, 1321 [2015])." Matter of Glowcznski v. Suburban Restoration Co., Inc., 174 AD3d 1236 (2019).

Evidence that a repetitive action is a distinct feature of a claimant's employment together with medical evidence of the necessary causal link will support a claim for an occupational disease (see Matter of Aldrich v St. Joseph's Hosp., 305 AD2d 908 [2003]).

***8** With regards to the case cited to by the carrier, Matter of Bates v. Marine Midland Bank, 256 A.D.2d 948 (N.Y. App. Div. 1998) 682 N.Y.S2d 282)], there the Court held that the claimant had failed to identify a specific feature of their work [cradling a phone was not enough] that was linked to the development of their condition. The Court noted that the condition must derive from the very nature of the employment rather than an environmental condition. The Court further noted that whether the condition or feature of the work environment cannot be found to be an occupational disease, that even if the claim cannot be established as an occupational disease, the Board should consider whether the claim can be established as an accident (Matter of Steinhauser v Ontario County, 289 AD2d 851 [2001]). Specifically, the,

"Board should consider whether the record supports a finding that the claimant's injury resulted from the claimant's repetitive motions while performing his or her work in some ergonomically incorrect manner which would demonstrate that the injury resulted from "unusual environmental conditions or events assignable to something extraordinary at his workplace" (Matter of Mazayoff v A.C.V.L. Cos., Inc., 53 AD3d 890 [2008] [internal quotations and citations omitted])."

Here, while the carrier is correct, and the claimant's poor posture/ or a work environment in general cannot be utilized to establish a claim for an occupational disease, however, the Board Panel notes that the carrier accepted this claim for the right elbow and right wrist [under the same occupational/poor posture theory] as a repetitive accident.

Moreover, the Board Panel finds sufficient evidence to support amending the claim for a repetitive right shoulder accident. (See Matter of Mazayoff v A.C.V.L. Cos., Inc., 53 AD3d 890 [2008] [internal quotations and citations omitted]; Matter of Jones v Consolidated Edison Co. of N.Y., Inc., 130 AD3d 1106 [2015], where the Court held that where the medical evidence contributed the claimant's cradling of a phone while working on a computer, i.e. his posture was sufficient to support establishment of a work related repetitive injury; and Matter of Steinhauser v Ontario County, 289 AD2d 851 [2001]).

In addition, the Board Panel is not persuaded that Dr. Faulk's opinion of the right shoulder condition being idiopathic is more credible than the claimant's providers. Notably, Dr. Faulk conceded that the condition may have been caused by the repetitive poor posture [particular the turning of the head] from the claimant while performing her clerical duties at work. Furthermore, both Drs. McGrath and Cicchetti agree that the claimant's poor ergonomic posture while working on a computer typing and looking at three monitors likely led to the development of the claimant's right shoulder condition. As such, the Board Panel finds that claimant's providers' knowledge of "prolonged computer usage" and the claimant's posture while working was to support establishment.

WCL 28

***9** Under WCL § 28, the right to claim compensation for an occupational disease is not time barred if the claim is filed no more than two years after the date of disablement and after the claimant knew or should have known that the disease is or was caused by the employment (Matter of Patterson v Long Is. Jewish Med. Ctr., 296 AD2d 774 [2002]). Therefore, to determine the applicability of WCL § 28 to an occupational disease claim, three pieces of information generally are necessary: (1) the date of disablement, (2) the date on which the claimant knew or should have known that the condition was related to employment, and (3) the date on which the claim was filed.

Here, accident was set at March 7, 2022, which is also notably the first medical report in the Board file. Notably, PFME was first found by a decision filed on February 3, 2023, which is well within two years if the date of disablement set. As such, WCL is not applicable herein.

MMI

Pursuant to the Board's NYS Workers' Compensation Guidelines for Determining Impairment (First Edition, November 22, 2017), evaluation of permanent disability occurs when there is a permanent impairment remaining after the claimant has reached MMI.

The 2018 New York State Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity (Guidelines) define maximum medical improvement (MMI) as:

"[A] medical judgment that (a) the claimant has recovered from the work injury to the greatest extent that is expected and (b) no further improvement is reasonably expected. The need for palliative care or symptomatic treatment does not preclude a finding of MMI. In cases that do not involve surgery or fractures, MMI cannot be determined prior to 6 months from the date of injury or disablement, unless otherwise agreed to by the parties."

"The mere assertion of the possibility of future surgery is not a bar to MMI. The appropriateness of surgical intervention should be evaluated in light of applicable Medical Treatment Guidelines. A claimant must not only qualify for surgery but also have specific plans for surgery, including an active request for pre-authorization, if required. Judges may evaluate the credibility of the claimant or provider who asserts the possibility of future surgery, based on such factors as history of treatment, prior requests for surgery, etc. If MMI is deferred because of surgery, the claim will be followed to ensure that surgery occurs, and the claim is reconsidered following post-surgical rehabilitation" (Matter of White Glove Placement Inc., 2020 NY Wrk Comp G2005665). In evaluating the medical evidence presented, the Board is not bound to accept the testimony or reports of any one expert, either

in whole or in part, but is free to choose those it credits and reject those it does not credit (see Matter of Morrell v Onondaga County, 238 AD2d 805 [1997], lv denied 90 NY2d 808 [1997]; Matter of Wood v Leaseway Transp. Corp., 195 AD2d 622 [1993]). Thus, questions of credibility, reasonableness, and relative weight to be accorded to conflicting evidence are questions of fact that come within the exclusive province of the Board (see Matter of Berkley v Irving Trust Co., 15 AD3d 750 [2005]).

***10** In its application for review, the carrier has argued that because the claimant has adhesive capsulitis and is symptomatic, the claimant cannot be at MMI because it had not been two years from the time the claimant was diagnosed, to the time the doctors found MMI. Under the 2018 Guidelines, where a claimant has been diagnosed with adhesive capsulitis or frozen shoulder, Special consideration, section 5.5 #7 provides that,

"frozen shoulder and adhesive capsulitis (with or without surgery): if the condition is asymptomatic give a schedule loss of use of the arm. If extremely painful and all modalities of treatment exhausted, consider classification after two years."

Here, first and foremost, all of the providers have indicated the claimant has reached MMI. In addition, the Board Panel notes that the Guidelines do not state that classification is required where a claimant is symptomatic, the Guidelines merely instruct that the provider consider whether classification is appropriate. Here, the only doctor to give an opinion on permanency for the right shoulder opined that the claimant was amenable to a schedule. No questions were posed to the doctor whether classification would have been more appropriate and moreover, the carrier failed to obtain its own opinion on the matter. As such, the Board Panel finds no merit to the carrier's argument, and that the WCLJ properly found the claimant at MMI.

SLU Versus Classification for the Right Shoulder

In evaluating the medical evidence presented, the Board is not bound to accept the testimony or reports of any one expert, either in whole or in part, but is free to choose those it credits and reject those it does not credit (see Matter of Morrell v Onondaga County, 238 AD2d 805 [1997], lv denied 90 NY2d 808 [[1997]; Matter of Wood v Leaseway Transp. Corp., 195 AD2d 622 [1993]). Thus, questions of credibility, reasonableness, and relative weight to be accorded to conflicting evidence are questions of fact that come within the exclusive province of the Board (see Matter of Berkley v Irving Trust Co., 15 AD3d 750 [2005]).

Here, as stated previously the Board Panel finds that the claimant was properly deemed entitled to a schedule rather than a classification award for the right shoulder, based upon the only opinion provided [by Dr. McGrath] for permanency of the right shoulder. After independent review of the medical record, Dr. McGrath opined that the claimant had a 72.5% SLU to the right shoulder based upon the ROM deficits found. The Board Panel notes that while Dr. McGrath is the only opinion on schedule loss of use and it was therefore proper to credit his ROM findings, the overall schedule found must still be within the Guidelines. Here, Dr. McGrath failed to proportionally adjust his ROM findings in accordance with the values at/below those depicted in the table and failed to proportionally adjust the values for the contralateral side.

More specifically, the Impairment Guidelines Table 5.4(a) of the Shoulder provides in pertinent part: "schedule loss of use percentages for ranges of motion values above/below those depicted here should be adjusted proportionally." The Impairment Guidelines further instruct that "when evaluating the level of permanent residual physical deficit, the medical provider should consider contralateral extremity where appropriate and expected/normal values."

***11** Turning to the schedule loss of use for loss of forward flexion and abduction, Dr. McGrath documented 95 degrees. The Board Panel further finds that abduction to 95 degrees is a deficit of 85 degrees. The Guidelines advise that the range of motion findings are proportionally adjusted, and this results in a 37.4% schedule loss of use (40% divided by 90 degrees is .4444 and this multiplied by the 85-degree deficit).

However, the Board Panel notes that the claimant did not report an history of a left shoulder injury to any of her providers, and therefore, the value must be proportionally adjusted to address the measurements taken for the left shoulder. For the left shoulder, Dr. McGrath noted 170 degrees of flexion and abduction. The Board Panel finds that abduction to 170 degrees is an

adjustment of .94. Adjusting for the contralateral limb, warrants a 35.12% schedule for the flexion/abduction deficits (37.4% multiplied by 94).

Table 5.4(a) of the 2018 Guidelines also indicates: "Do not add mild deficits of internal and external rotation to avoid cumulative values. May add 10-15% for marked deficits of rotation and muscle atrophy, not to exceed ankylosis." Here, the claimant's internal and external rotation measurements are moderate to marked and marked. However, Dr. McGrath's C-4.3 noted that there was no atrophy found on exam. As such, the Board Panel finds that no additional values may be added for the deficits found for rotation.

In addition, the Board Panel finds that special consideration, section 5.5 #8 would not be applicable, based upon the schedule awarded. Special consideration #8 provides that where a high schedule is given,

"the schedule given is focused on the highest valued part of the extremity. In case of a high schedule for one given part of the extremity calculate first for the major loss in part involved. For example, amputation at the wrist equals 100% loss of use of the hand or equals 80% loss of use of the arm. If there are additional deficits of the elbow and/or shoulder add 10% to the 80% loss of use of the arm and the final schedule would be 90% loss of use of the arm."

Here, based on the proportional adjustments made, the claimant does not have a high schedule, and therefore special consideration #8 would not be applicable.

Right Elbow SLU

With regards to the right elbow, the claimant was found to have lateral epicondylitis by Drs. McGrath and Cicchetti. Dr. Faulk did not provide any diagnosis for the right elbow. The Impairment Guidelines section 4.5, special consideration #3, provides "medial and lateral epicondylitis are usually given a schedule, but if it becomes chronic, severe and disabling, consider classification." Here, both Drs. McGrath and Dr. Faulk found a schedule loss of use was appropriate.

Row "A" in "table 4.4" labeled "extension" identifies full ROM as flexion to zero degrees. Flexion to 45 degrees, a mild deficit, constitutes a 25.00% loss, flexion to 90 degrees, a moderate deficit, constitutes a 50.00% loss, flexion to 125 degrees, a marked deficit, constitutes an 85.00% loss.

***12** Row "B" in "table 4.4" labeled "flexion" identifies full ROM as extension to 150 degrees. Extension to 125 degrees, a mild deficit, constitutes a 7.50% loss, extension to 90 degrees, a moderate deficit, constitutes a 33.33% loss, extension to 45 degrees, a marked deficit, constitutes an 66.66% loss, and ankylosis, which is defined as full extension at zero degrees, constitutes a 90.00% loss.

Turning to the flexion and extension deficits, the Board Panel finds Dr. McGrath's measurements to be the most credible for the right elbow. Dr. McGrath found 135 degrees for flexion. Flexion to 135 degrees is a deficit of 15 degrees. The Guidelines advise that the range of motion findings are proportionally adjusted, and this results in a 4.5% schedule loss of use (7.5% divided by 25 degrees is .003 and this multiplied by the 15-degree deficit). Full ROM was found for flexion on the left elbow, and therefore no additional adjustment is needed. For extension, Dr. McGrath found lacking 10 degrees on both the right and left side, and therefore, no additional value would be added.

Right Hand/Wrist SLU

With regards to the right hand, all of the claimant's providers have opined that the claimant has right carpal tunnel syndrome which was confirmed by EMG. No other diagnosis has been opined for the right hand or wrist. Special consideration, section

3.5 #6 provides that, "carpal tunnel syndrome: Schedule one-year post decompression if asymptomatic. If symptoms persist and become severe and disabling, consider classification. [For values see Nerve Section 10.3A]."

Section 10.3A provides, "carpal tunnel syndrome with or without decompression is usually given a schedule loss of the hand, which usually averages 10-20% loss of use. If symptoms persist and condition becomes disabling, consider classification."

Here, both Dr. McGrath and Dr. Faulk have opined that the claimant would be entitled to a 10% SLU to account for the diagnosis of carpal tunnel syndrome. While it is acknowledged that Dr. Faulk provided an additional 20% SLU for ROM deficits at the wrist, the Board Panel finds that this was inappropriate, as the doctor did not diagnosis a separate diagnosis from carpal tunnel syndrome. (See Matter of Blue v New York State Off. of Children & Family Servs., 206 AD3d 1126 (2022), instructs the higher value for the conditions to be used when there are multiple diagnoses for the same body site. (See Albany Marble Inc, 2024 NY Wrk Comp G2098201).

Therefore, the Board Panel, upon review of the record and based upon the preponderance of the evidence, sufficient evidence to support amending the claim to include the right shoulder. The claimant has reached MMI based upon the uncontroverted opinions of all providers. In addition, the Board Panel finds that the claimant is entitled to a 35.12% SLU to the right shoulder, a 4.5% SLU to the right elbow, and a 10% SLU to the right hand entitling the claimant to 148.01 weeks of benefits.

CONCLUSION

***13** ACCORDINGLY, the WCLJ's decision filed February 27, 2024, is MODIFIED, to find a 35.12% SLU to the right shoulder, a 4.5% SLU to the right elbow. The attorney fee is adjusted to $11,757.52, based upon the money moving. No further action.

All Concur.

Renee L. Delgado
Linda Hull
Arelis Tavares

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