United States Department of Labor
Employees' Compensation Appeals Board

T.U., Appellant	)	
and	)	**Docket No. 10-1663**
	)	**Issued: April 19, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Mead, WA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On June 2, 2010 appellant filed a timely appeal from a December 7, 2009 decision of the Office of Workers' Compensation Programs which granted appellant a schedule award. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

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

FACTUAL HISTORY

On December 10, 2005 appellant, then a 48-year-old rural carrier, filed a (Form CA-2), occupational disease claim, alleging that he sustained a partially torn rotator cuff and impingement syndrome from performing repetitive duties with his right arm. The Office

[1] 5 U.S.C. § 8101 *et seq.*

accepted disorder of the bursae and tendons of the right shoulder, complete rupture of the right rotator cuff and sprain of the right shoulder and upper arm.

The Office authorized surgery. On November 30, 2005 Dr. Christopher J. Lang, a Board-certified orthopedic surgeon, performed a right shoulder arthroscopic subacromial decompression and right shoulder intra-articular arthroscopic debridement of the torn labrum and rotator cuff. He diagnosed right shoulder chronic impingement syndrome, right shoulder superior labral tear and right shoulder partial thickness articular surface rotator cuff tear. Appellant returned to full-time regular duty on November 20, 2006.

On March 8, 2009 appellant filed a claim for a schedule award. On March 12, 2009 the Office requested that he submit a report from a treating physician addressing the extent of permanent partial impairment in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2]

In a June 2, 2009 report, Dr. William M. Shanks, a Board-certified orthopedic surgeon, diagnosed rotator cuff tendinitis and impingement syndrome of the right shoulder. Appellant was status postoperative subacromial decompression and debridement of the right shoulder with a finding of degenerative labral tear. Dr. Shanks noted findings on examination that included tenderness over the anterior aspect of the right shoulder, flexion to 160 degrees on the right and 180 degrees on the left, extension to 40 degrees on the right and 70 degrees on the left, abduction was 120 degrees on the right and 180 degrees on the left, adduction was 30 degrees on the right compared to 45 degrees on the left, abduction was 90 degrees, internal rotation was 40 degrees on the right and 90 degrees on the left and external rotation was 80 degrees on the right and 110 on the left. He further noted mild weakness of external rotation of the right shoulder and sensation was intact in the upper extremities. In a pain disability questionnaire, appellant noted difficulty with pain control and with overhead activity involving the right arm that interfered with recreational activity. Dr. Shanks noted that appellant fell within Class 1 or 2 concerning activities of daily living. Using the diagnosis-based impairment rating for impingement syndrome or partial thickness tear of the rotator cuff, appellant was a category 1 using the modifier, according the activities of daily living, pursuant to Table 15-5, page 402 of the A.M.A., *Guides*. Dr. Shanks noted that, under Table 15-8, appellant qualified for a grade 1 modifier due to the limitations of active range of motion with no acute trauma. He rated him as Class 2 with 14 percent impairment of the right arm.

In a July 9, 2009 report, an Office medical adviser noted that it was unclear how Dr. Shanks determined that appellant had Class 2 right shoulder impairment pursuant to the A.M.A., *Guides.* Dr. Shanks noted that with diagnosed-based impairment, key factors are used to calculate impairment and class is determined by the key factor. He failed to provide a detailed narrative describing his evaluation to support his determination that appellant had 14 percent impairment of the right arm. The Office medical adviser requested that Dr. Shanks provide a supplemental report.

The Office requested that Dr. Shanks clarify his rating. In a September 22, 2009 statement, Dr. Shanks noted that the Office disputed every schedule award rating he had

[2] A.M.A., *Guides* (6th ed. 2009).

provided. He advised that he stood by his original report, would provide no further clarification and would not perform schedule award evaluations for the Office.

The Office referred appellant, together with the case record and a statement of accepted facts, to Dr. Clarence Fossier, a Board-certified orthopedic surgeon, for a second opinion. In a November 4, 2009 report, Dr. Fossier reviewed appellant's history and described his findings on examination. Range of motion for forward flexion was measured at 150 degrees on the right and 160 degrees on the left, abduction was measured at 90 degrees bilaterally, internal rotation was measured at 80 degrees on the right and 90 degrees on the left and external rotation was 90 degrees bilaterally. Dr. Fossier diagnosed impingement syndrome with partial tear of the right rotator cuff and labrum treated surgically. He advised that appellant reached maximum medical improvement in December 2006. Dr. Fossier noted appellant lost 10 degrees of flexion, abduction, external and internal rotation on the right side and complained of difficulty sleeping on his right side and with overhead motions. He opined that appellant had five percent impairment of the right arm in accordance with the A.M.A., *Guides.* The impairment rating was based on a diagnosis of rotator cuff injury, partial tear thickness with residual loss, but functional within normal motion, which represented a Class 1 impairment based on a history of painful injury. The default grade C, for the class of diagnosis (CDX) was three percent impairment of the upper extremity. Dr. Fossier advised that appellant scored 27 on the *Quick*Dash questionnaire functional assessment tool, which represented a grade 2 modifier (Grade Modifier for Functional History - GMFH).[3] He also found a grade 1 modifier based on appellant's physical examination, which was essentially normal (Grade Modifier for Physical Examination - GMPE). Dr. Fossier opined that using the net adjustment formula appellant had five percent impairment of the upper extremity.

The Office referred Dr. Fossier's report to an Office medical adviser. In a December 2, 2009 report, the Office medical adviser concurred with Dr. Fossier's rating but noted a mathematic error. He explained that appellant's impairment rating was based on a diagnosis of partial-thickness tear of the rotator cuff, which represented Class 1 impairment with a default grade of C. The default grade C, for the class of diagnosis (CDX) was three percent impairment based on the shoulder grid, Table 15-5, page 402 of the A.M.A., *Guides*. The Office medical adviser noted that appellant scored 27 on the *Quick*Dash functional assessment tool, which represented a grade 3 modifier (GMFH). In calculating the modifier, he noted the raw score of 27 divided by 11 (the number of questions answered) for an average of 2.45. This figure was multiplied by 25 to obtain the final score of 61.25, not 49.25 as noted by Dr. Fossier. The Office medical adviser found a grade 1 modifier based on appellant's physical examination findings which were essentially normal (GMPE). In order to determine the final impairment under the sixth edition, he applied the Net Adjustment Formula (NAF): GMFH (3) minus CDX (1) plus GMPE (1) minus CDX (1). Based on the formula, the net adjustment modifier was two. The Office medical adviser explained that the plus two net adjustment modifier allowed for adjustment from grade C, the default, to grade E, which represented five percent impairment of the upper extremity and which was consistent with Dr. Fossier's rating. He opined that appellant

[3] Dr. Fossier noted that using the *Quick*Dash formula, the raw score was 27 divided by 11 (the number of questions answered) for an average of 2.45. This number is multiplied by 25 to obtain a final score of 49.25. Pursuant to Table 15-7, page 406 of the A.M.A., *Guides* the GMFH was a grade 2.

had five percent impairment to the right arm and that maximum medical improvement was reached on November 4, 2009.

In a decision dated December 7, 2009, the Office granted appellant a schedule award for five percent permanent impairment to the right upper extremity. The period of the award was from November 4, 2009 to February 21, 2010.

LEGAL PRECEDENT

The schedule award provision of the Act[4] and its implementing regulations[5] 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, the Act 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.[6] Effective May 1, 2009, schedule awards are determined in accordance with the A.M.A., *Guides* (6th ed. 2008).[7]

ANALYSIS

Appellant's claim was accepted by the Office for a disorder of the bursae and tendons of the right shoulder, complete rupture of the right rotator cuff and sprain of the right shoulder and upper arm and rotator cuff. The Office authorized arthroscopic surgery on the right shoulder which was performed on November 30, 2005 for repair of a partial-thickness rotator cuff tear. The Board finds that the medical evidence of record establishes five percent impairment to appellant's right upper extremity.

Under the sixth edition of the A.M.A., *Guides*, impairments of the upper extremities are covered by Chapter 15 section 15-2, entitled Diagnosis-Based Impairment, provides that diagnosis-based impairment is the primary method of evaluation of the upper limb.[8] The initial step in the evaluation process is to identify the impairment class by using the corresponding diagnosis-based regional grid. Dr. Fossier utilized the Shoulder Regional Grid, Table 15-5, A.M.A., *Guides*, page 402, and identified a Class 1 impairment based on rotator cuff injury, partial-thickness tear, with residual loss that was functional with normal motion. He noted that appellant had a history of painful injury warranting a Class 1 designation. Under Table 15-5, the default grade C, for such a Class 1 partial-thickness tear is three percent upper extremity impairment.

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *See id.*; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Example 1 (January 2010).

[8] A.M.A., *Guides* 387, section 15.2.

After determining the impairment class and default grade, Dr. Fossier addressed whether there were any applicable grade adjustments for so-called nonkey factors or modifiers. These include adjustments for functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS). The grade modifiers are used in the Net Adjustment Formula to calculate a net adjustment.[9] The final impairment grade is determined by adjusting the grade up or down from the default value C by the calculated net adjustment. Dr. Fossier identified two modifiers; one based on the functional history (GMFH) and the other based on physical examination (GMPE). For the functional history, he assigned a grade modifier 2 based on appellant *Quick*Dash score of 27.[10] However, the Board notes that, in calculating the modifier, Dr. Fossier incorrectly found that the raw score of 27 divided by 11 (the number of questions answered) for an average of 2.45 multiplied by 25 was 49.25. Rather, the final score was 61.25. This would equate to a functional modifier of grade 3 instead of 2 as made by Dr. Fossier, who also found a grade 1 modifier based on appellant's physical examination findings which were essentially normal.[11] Applying the net adjustment formula resulted in a net modifier of plus two, which resulted in a grade adjustment from the default grade of C to E. The corresponding upper extremity impairment for a Class 1, grade E rotator cuff partial-thickness tear is five percent.[12] The medical adviser noted that his calculation was consistent with Dr. Fossier's rating.

The Board finds that the Office medical adviser properly applied the A.M.A., *Guides* to the findings presented by Dr. Fossier in rating impairment to appellant's right arm. Both, Dr. Fossier and the Office medical adviser, agreed that appellant had five percent impairment under the A.M.A., *Guides*. The weight of medical evidence establishes that appellant has no more than five percent right arm impairment.

Appellant submitted a June 2, 2009 report from Dr. Shanks, who noted that appellant sustained a 14 percent impairment of the right upper extremity pursuant to the A.M.A., *Guides*. Dr. Shanks opined that appellant was a Class 2 with 14 percent impairment of the right upper extremity pursuant to the A.M.A., *Guides*. However, the Board notes that it was unclear how he determined that appellant had a Class 2 right shoulder impairment pursuant to the A.M.A., *Guides*. Table 15-5, page 402, of the A.M.A., *Guides* provides that impingement syndrome and rotator cuff tear are a Class 1 impairment. Similarly, final impairment grade within a class is calculated using the grade modifiers; however, a grade modifier will allow movement within a class but does not permit movement into a different class.[13] The Office requested that Dr. Shanks provide a supplemental report explaining his rating but, he stood by his initial report and provided no further clarification. The Board finds that he did not properly follow the

[9] Net Adjustment = (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). Section 15.3d, A.M.A., *Guides* 411.

[10] *Id.* at 406, Table 15-7.

[11] *Id.* at 408, Table 15-8.

[12] *Id*. at 402, Table 15-5.

[13] *See id*. at 387.

A.M.A., *Guides*. An attending physician's report is of diminished probative value where the A.M.A., *Guides* were not properly followed.[14]

On appeal, appellant asserts that he is entitled to 14 percent impairment of the right arm as set forth by Dr. Shanks. He contended that Dr. Shanks was the only physician to examine him and that Dr. Fossier's report contained a mathematical error. As noted, it was unclear how Dr. Shanks determined appellant's impairment under the A.M.A., *Guides* and he refused to clarify his opinion. The mathematical error in Dr. Fossier's report was harmless as it did not result in the impairment rating being lowered. There is no medical evidence of record, in conformance with the A.M.A., *Guides*, supporting greater impairment than five percent.

CONCLUSION

The Board finds that appellant has five percent impairment of the right upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the December 7, 2009 decision of the Office of Workers Compensation Programs is affirmed.

Issued: April 19, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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

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

[14] *See Paul R. Evans, Jr.*, 44 ECAB 646 (1993); *John Constantin*, 39 ECAB 1090 (1988) (a medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).