United States Department of Labor
Employees' Compensation Appeals Board

D.D., Appellant	)	
and	)	**Docket No. 13-512**
	)	**Issued: July 19, 2013**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, Milwaukee, WI, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On December 26, 2012 appellant filed a timely appeal of an October 26, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant sustained more than three percent permanent impairment of the left upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On August 27, 2010 appellant, then a 58-year-old transportation security officer, sustained left shoulder pain while in the performance of duty. He did not stop work. OWCP

[1] 5 U.S.C. § 8101 *et seq.*

accepted appellant's traumatic injury claim for left acromioclavicular sprain, adhesive capsulitis, and disorder of bursae and tendons.

Appellant underwent arthroscopic debridement of labrum and biceps tendon, synovectomy, subacromial decompression and excision of distal clavicle on January 13, 2011. He filed a schedule award claim on May 18, 2012 and submitted medical evidence.[2]

In a July 15, 2011 report, Dr. Dennis J. Andersen, a Board-certified orthopedic surgeon, related that appellant experienced difficulty lifting items after the January 13, 2011 surgery. On examination, he observed palpable biceps stump and anterior shoulder pain. In a June 10, 2012 report, Dr. Andersen detailed that appellant exhibited the following range-of-motion (ROM) measurements for the left shoulder: 160 degrees of flexion, 150 degrees of abduction, 40 degrees of internal rotation, and 80 degrees of external rotation. Citing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[3] he stated that these findings coincided with impairment ratings of one percent, one percent, three percent, and zero percent, respectively. In addition, on a scale from 1 to 10, appellant indicated that his pain was at 3, which amounted to a separate five percent rating.[4] Dr. Andersen added these values and determined that appellant sustained 10 percent permanent impairment of the left upper extremity.

On October 1, 2012 Dr. David H. Garelick, an OWCP medical adviser and Board-certified orthopedic surgeon, reviewed the medical file and disagreed with Dr. Andersen's impairment rating. He pointed out that appellant's left shoulder ROM was nearly normal and that the objective evidence did not show signs of infection, weakness or impingement. Applying Table 15-5 (Shoulder Regional Grid: Upper Extremity Impairments) of the A.M.A., *Guides*,[5] (sixth edition) Dr. Garelick assigned an impairment class 3 with a grade C, resulting in a default impairment rating of three percent due to biceps tendon dislocation. The medical adviser found that the net adjustment formula did not change the default rating. He listed July 15, 2011 as the date of maximum medical improvement.

By decision dated October 26, 2012, OWCP granted a schedule award for three percent permanent impairment of the left upper extremity for the period July 15 to September 18, 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 of or loss of use of scheduled members or functions of the body.[6] However, FECA does not

[2] Appellant previously filed a schedule award claim on June 28, 2011, which OWCP denied by decision dated May 29, 2012.

[3] *See* A.M.A., *Guides*, *infra* note 5.

[4] Dr. Andersen did not identify the edition of the A.M.A., *Guides* or any specific pages or tables.

[5] A.M.A., *Guides* 404.

[6] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

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.[7]

The A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF). For upper extremity impairments, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[8] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[9]

ANALYSIS

OWCP accepted that appellant sustained left acromioclavicular sprain, adhesive capsulitis, and disorder of bursae and tendons while in the performance of duty on August 27, 2010. Thereafter, appellant filed a claim for a schedule award and furnished medical evidence. In a July 15, 2011 report, Dr. Andersen specified that appellant exhibited left shoulder flexion of 160 degrees, abduction of 150 degrees, internal rotation of 40 degrees, and external rotation of 80 degrees, which coincided with ratings of one percent, one percent, three percent and zero percent, respectively. He also noted, on a scale from 1 to 10, that appellant complained of pain at 3, which amounted to a separate rating of five percent. Adding these values, Dr. Andersen calculated a final impairment rating of 10 percent.

According to OWCP procedures, an attending physician's impairment rating report must include a detailed description of the impairment and a rationalized opinion as to the percentage of permanent impairment under the A.M.A., *Guides*.[10] For impairment ratings calculated on and after May 1, 2009, the sixth edition applies.[11] In this case, while Dr. Andersen cited the A.M.A., *Guides* in his report, he did not identify the edition or refer to any specific pages or tables. Because he did not show that he utilized the proper edition of the A.M.A., *Guides* and did not provide a rationalized opinion, his report was of limited probative value regarding the extent of appellant's left upper extremity impairment.

[7] *K.H.*, Docket No. 09-341 (issued December 30, 2011).

[8] *R.Z.*, Docket No. 10-1915 (issued May 19, 2011).

[9] *J.W.*, Docket No. 11-289 (issued September 12, 2011).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6(a) (February 2013).

[11] *Id.* at Chapter 2.808.5(a).

On the other hand, the Board finds that Dr. Garelick's opinion constitutes the weight of the medical evidence. The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[12] In his October 1, 2012 report, Dr. Garelick reviewed the medical file. He found that the totality of the evidence showed excellent left shoulder ROM and the absence of any infection, weakness or impingement. Properly applying Table 15-5 of the sixth edition of the A.M.A., *Guides*, Dr. Garelick assigned a class 3 with a grade C, resulting in an impairment rating of three percent on account of biceps tendon dislocation. In view of this rationalized medical opinion, the Board finds that OWCP properly denied appellant's claim.[13]

Appellant contends on appeal that he sustained 10 percent permanent impairment of the left upper extremity per Dr. Andersen's July 15, 201 report. The Board has already addressed the deficiencies of this report.

Appellant may request an increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in increased impairment.

CONCLUSION

The Board finds that appellant did not sustain more than three percent permanent impairment of the left upper extremity.

[12] *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *James Mack*, 43 ECAB 321, 329 (1991).

[13] *See Linda Beale*, 57 ECAB 429 (2006) (it is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment and OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides*).

ORDER

IT IS HEREBY ORDERED THAT the October 26, 2012 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: July 19, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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