

FACTUAL HISTORY

On December 17, 2008 appellant, then a 67-year-old property disposal specialist, injured her right arm and shoulder when she slipped on water in a hallway and fell. OWCP accepted the claim for right shoulder rotator cuff tear and paid benefits. Appellant worked limited duty following her injury before returning to full duty.

On October 7, 2009 appellant requested a schedule award. In a September 9, 2009 report, Dr. Alexandra J. Strong, a Board-certified orthopedic surgeon, reported that when she first evaluated appellant on January 6, 2009 for right shoulder pain following the December 17, 2008 work injury, there was decreased strength and a magnetic resonance imaging (MRI) scan was ordered. Appellant was next seen on February 10, 2009. The MRI scan showed a large tear with retraction that involved the supraspinatus, infraspinatus and subscapularis. The biceps tendon was dislocated medially from the bicipital groove. Changes were also noted in the posterior labrum, acromioclavicular (AC) joint arthropathy and some glenohumeral degenerative change. Dr. Strong stated that, when appellant was last evaluated on April 7, 2009, she had good range of motion and the x-rays indicated that her humeral head was high riding. Appellant reported occasional pain and discomfort, for which she took Advil or Tylenol. Dr. Strong stated that appellant had degenerative changes in her glenohumeral joint and that her rotator cuff tear was likely irreparable. Appellant also felt that she was getting rotator cuff arthropathy. Dr. Strong stated that a reverse total shoulder replacement might be indicated if appellant's condition worsened. As appellant reported no significant pain to the point she wanted to undergo surgical intervention, Dr. Strong opined that maximum medical improvement had been reached. Based on Table 15-5 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (hereinafter), Dr. Strong rated appellant with 25 percent impairment of the right upper extremity.

On November 13, 2009 an OWCP medical adviser reviewed Dr. Strong's September 9, 2009 report. He agreed that appellant reached maximum medical improvement as of September 9, 2009; however, Dr. Strong's impairment rating could not be used as it was not supported by sufficient examination findings. The medical adviser advised that, under Table 15-5, Shoulder Regional Grid, pages 401-405 of the A.M.A., *Guides*, appellant had a number of ratable conditions which could be used. He stated that page 387 of the A.M.A., *Guides* indicated that, if there were two significant diagnoses, the diagnosis with the highest impairment rating should be used. Under Table 15-5, a complete rotator cuff tear with normal motion equaled a default impairment of 5 percent; a labral tear and degenerative SLAP lesion with normal motion equaled a default impairment of 3 percent; glenohumeral degenerative joint disease with subluxation or shoulder joint dislocation mild equaled an impairment range of 8 to 12 percent; and an AC joint arthropathy with impingement equaled a default impairment of 3 percent. Since Dr. Strong reported that appellant had good range of motion and very little pain, she opined that the impairment rating most favorable to appellant would be glenohumeral degeneration at the upper level of 12 percent because of the severity of x-ray changes and the high riding humeral head.

By decision dated November 23, 2009, OWCP granted appellant a schedule award for 12 percent right arm impairment. The award ran from September 9, 2009 to May 29, 2010, for a total of 37.44 weeks.

On December 17, 2009 appellant requested a hearing before an OWCP hearing representative. In a January 13, 2010 report, Dr. Strong reiterated her previous contacts with appellant and findings. She concluded that appellant had a massive irreparable rotator cuff tear with degenerative changes indicative of early rotator cuff arthropathy of the shoulder which would require a reverse total shoulder replacement if the arthritis progressed. Based on Table 16-27, Dr. Strong stated that appellant had 20 percent impairment of the upper extremity.

A hearing was held on March 10, 2010. Appellant testified that she had no problems with her right shoulder prior to the December 17, 2008 work injury and that she had no new injuries of the right shoulder after the December 17, 2008. The hearing representative noted that it did not appear that the sixth edition of the A.M.A., *Guides* contained a Table 16-27. He allowed 30 days for Dr. Strong to submit a report explaining any disagreement with the medical adviser's opinion and explaining her impairment percentage.

In an April 14, 2010 report, Dr. Strong opined that, based on Table 15-5, page 401 of the A.M.A., *Guides*, appellant had 20 percent right upper extremity impairment based on massive unreparable rotator cuff tear and a distal clavicle bicep subscapular tear.

By decision dated May 5, 2010, OWCP's hearing representative affirmed the prior decision.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations² 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. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.³ 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.⁴ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁵

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH),

² 20 C.F.R. § 10.404.

³ *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

⁴ *Ronald R. Kraynak*, 53 ECAB 130 (2001).

⁵ 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).

Physical Examination (GMPE) and Clinical Studies (GMCS).⁶ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).⁷

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser proving rationale for the percentage of impairment specified.⁸

ANALYSIS

OWCP accepted that appellant sustained a right shoulder rotator cuff tear due to a December 17, 2008 employment injury. Appellant requested a schedule award and provided a September 9, 2009 report from Dr. Strong, who advised that she reached maximum medical improvement and had 25 percent permanent impairment of the right upper extremity based on Table 15-5 of the A.M.A., *Guides*. Dr. Strong did not fully address the diagnosis upon which her impairment rating was based or explain how she arrived at this rating under Table 15-5.⁹ As she did not explain in her September 9, 2009 report how her impairment rating comported with the A.M.A., *Guides*, it is of limited probative value.¹⁰

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, indicates that diagnosis-based impairment is the primary method of evaluation of the upper limb.¹¹ The initial step in the evaluation process is to identify the impairment class by using the corresponding diagnosis-based regional grid. OWCP's medical adviser, in a November 13, 2009 report, correctly indicated that, when the patient has two or more significant diagnoses, the examiner should use the diagnosis with the highest causally-related impairment rating for the impairment calculation.¹² The medical adviser reviewed Dr. Strong's findings and utilized the Shoulder Regional Grid, Table 15-5 and identified all the impairments based on appellant's diagnosed conditions. As the condition of glenohumeral degenerative joint disease with subluxation or shoulder joint dislocation provided the greatest impairment rating, he selected it for the impairment calculation. The Board notes this properly fits into a class 1 AC joint injury or

⁶ A.M.A., *Guides* 494-531.

⁷ *Id.* at 521.

⁸ See note 5, Chapter 2.808.6(d) (August 2002).

⁹ Discussion of how the A.M.A., *Guides* criteria were applied to medical information that generated the specific rating is required for an impairment rating to be consistent with the A.M.A., *Guides*. A.M.A., *Guides* 28.

¹⁰ *I.F.*, Docket No. 08-2321 (issued May 21, 2009) (an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of diminished probative value in determining the extent of permanent impairment).

¹¹ An opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment. *I.F.*, *id.*

¹² A.M.A., *Guides* 387.

disease, on page 403 of the A.M.A., *Guides*, where there is complete disruption of AC joint capsule and coracoclavicular ligaments, which has a default impairment of 10 percent.

After determining the impairment class and default grade, OWCP's medical adviser considered applicable grade modifiers.¹³ The medical adviser considered the severity of appellant's class 1 condition, noting the severity of x-ray and examination findings and concluded that her impairment should be adjusted from the default impairment of 10 percent to the maximum impairment within class 1 for the impairing diagnosis, 12 percent. OWCP properly awarded appellant compensation for 12 percent impairment of her right arm.

Thereafter, appellant submitted additional reports from Dr. Strong dated January 13 and April 14, 2010. These reports do not establish that she has greater than 12 percent impairment of the right upper extremity. In the January 13, 2010 report, Dr. Strong opined that appellant had 20 percent right upper extremity impairment based on Table 16-27; but, she did not explain the findings on examination or the manner by which the impairment rating was calculated. Moreover, there is no Table 16-27 in the sixth edition of the A.M.A., *Guides*. In her April 14, 2010 report, Dr. Strong opined that appellant had 20 percent impairment of the right upper extremity based on Table 15-5, page 401, for massive unreparable rotator cuff tear and distal clavicle bicep subscapular tear. Again, she did not fully explain how she arrived at this rating under Table 15-5 and explain how or why the medical adviser was incorrect in his 12 percent rating. Dr. Strong did not address what diagnosis-based impairment that she used on page 401. The Board notes that there is no diagnosis-based impairment on page 401 of the A.M.A., *Guides* that provides for 25 percent arm impairment. Thus, appellant has not submitted any evidence, in conformance with the A.M.A., *Guides*, showing that she has greater than 12 percent impairment of the right upper extremity.

On appeal, appellant sets forth her belief as to why Dr. Strong did not provide adequate explanations for her impairment ratings. As noted, medical reports that are not in conformance with the A.M.A., *Guides* are of limited probative value in establishing permanent impairment.¹⁴ For the above-noted reasons, Dr. Strong's reports are insufficient to establish that appellant has any greater impairment than that which OWCP has issued a schedule award.

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

CONCLUSION

The Board finds that appellant has not established that she has more than 12 percent right upper extremity impairment.

¹³ The grades range from A to E, with A representing eight percent upper extremity impairment and E representing 12 percent upper extremity impairment. A.M.A., *Guides* 403, Table 15-5. The net adjustment formula is found at page 411 of the A.M.A., *Guides*.

¹⁴ See *supra* note 10.

ORDER

IT IS HEREBY ORDERED THAT the May 5, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 19, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

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