

sprain and upper arm, sprain rotor cuff tendinitis, and bursae and tendon left arm. Appellant returned to work on March 8, 2008 in a light-duty position with work restrictions.

On September 28, 2010 appellant filed a claim for a schedule award. In an October 25, 2010 letter, OWCP advised him of the medical information necessary to establish permanent impairment.

In a January 28, 2011 report, Dr. John P. Byrne, a Board-certified orthopedic surgeon, noted appellant's primary diagnoses as rotator cuff tendinitis with subacromial bursitis, impingement and acromioclavicular arthrosis. Based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*), he opined that appellant had 15 percent permanent impairment under Table 15-5 for class 1 impingement syndrome rotator cuff injury and acromioclavicular joint disease taking into account appellant's pain and limited mobility. Examination findings revealed pain at 100 degrees forward flexion, 15 degrees internal rotation and 15 degrees extension.

In an April 13, 2011 report, an OWCP medical adviser reviewed the medical record and Dr. Byrne's January 28, 2011 report. He noted that Dr. Byrne did not provide the absolute extent of the range of motion and failed to provide a percentage for abduction. The medical adviser stated that the range of motion model was not applicable for determining appellant's impairment. He stated that the diagnosis-based impairment using the shoulder regional grid under Table 15-5 was applicable. The medical adviser noted that Dr. Byrne found that appellant had class 1 impairment for impingement. Based on Table 15-5 for impingement syndrome, the default value would be three percent. The medical adviser noted that multiple diagnoses, such as appellant's acromioclavicular joint disease, rotator cuff tendinitis and subacromial bursitis, could not be used when applying the shoulder regional grid for impairment purposes. Rather the predominant impairment factor would prevail, which would allow the maximum impairment under class 1 impairment for impingement syndrome with a default impairment of three percent within a range of one to five percent permanent impairment of the upper extremity. The medical adviser determined that the appropriate impairment, based on Dr. Byrne's report, was five percent impairment of the left arm. He further opined that maximum medical improvement was reached on January 7, 2009, one year from the date of injury.

By decision dated July 15, 2011, OWCP granted appellant a schedule award for five percent impairment of the left upper extremity. The award covered 15.6 weeks of compensation for the period January 7 to April 26, 2009.

LEGAL PRECEDENT

The schedule award provision of FECA² and its implementing regulations³ 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

² *Id.* at § 8107.

³ 20 C.F.R. § 10.404.

making such a determination is a matter that rests within the sound discretion of OWCP.⁴ 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.⁵ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁶

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), Physical Examination (GMPE) and Clinical Studies (GMCS).⁷ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).⁸

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.⁹

ANALYSIS

OWCP accepted that appellant sustained left shoulder sprain and upper arm, sprain rotor cuff tendinitis, and bursae and tendon left arm. Appellant subsequently filed a claim for a schedule award. By decision dated July 15, 2011, OWCP granted five percent permanent impairment to the left upper extremity.

In a January 28, 2011 report, Dr. Byrne opined that appellant had 15 percent permanent impairment. While he indicated that appellant had class 1 impairment for impingement syndrome under Table 15-5, he provided no rationale or calculations for his impairment rating. The Board notes that under Table 15-5 the default value for class 1 impairment for impingement syndrome is three percent with a maximum of five percent. This percentage can be moved up or down dependent upon grade modifiers. Dr. Byrne, however, did not explain how he determined 15 percent impairment. The Board notes that he appeared to take into account appellant's other primary impairing diagnoses of rotator cuff tendinitis with subacromial bursitis and acromioclavicular arthrosis. Table 15-5, pages 401-05 of the A.M.A., *Guides* provides the upper extremity impairment ratings for diagnoses of the shoulder region. Typically, one diagnosis will adequately characterize the impairment and its impact on activities of daily living. Selection of

⁴ *Linda R. Sherman*, 56 ECAB 127 (2004); *Daniel C. Goings*, 37 ECAB 781 (1986).

⁵ *Ronald R. Kraynak*, 53 ECAB 130 (2001).

⁶ 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).

⁷ A.M.A., *Guides* 494-531.

⁸ *Id.* at 521.

⁹ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

the optimal diagnosis requires judgment and experience. If more than one diagnosis can be used, the one allowing for the highest impairment rating should be used. This will generally be the more specific diagnosis.¹⁰ Dr. Byrne calculated impairment from the primary impairing diagnosis of impingement syndrome; the other diagnoses should not have been taken into account. No other reports from him provided an impairment rating under the sixth edition of the A.M.A., *Guides*. Dr. Walter's rating is of limited probative value regarding permanent impairment as he did not adequately explain how he arrived at his rating under the A.M.A., *Guides*.¹¹

The medical adviser determined that appellant had five percent permanent impairment of the left arm attributable to the impingement syndrome. He referred to Table 15-5 and provided the maximum impairment of five percent permanent impairment for class 1 impairment for impingement syndrome. The Board notes that diagnosis-based impairment is the primary method of evaluation for the upper extremity.¹² Table 15-5, page 402 of the A.M.A., *Guides* gives a default impairment rating of three percent for the diagnosis of impingement syndrome with residual symptoms, functional with normal motion. This default rating, classified as mild, can be modified slightly based on a claimant's functional history, physical findings and clinical studies. The medical adviser considered appellant's findings and opined that predominant impairing factor of impingement syndrome would allow for the maximum impairment of five percent. Appellant has not submitted any medical evidence consistent with the A.M.A., *Guides*, indicating that he has greater than five percent impairment of the left upper extremity. Accordingly, the Board finds that appellant has no greater than five percent impairment of the left upper extremity.

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 he has more than a five percent impairment of the left upper extremity for which he received a schedule award.

¹⁰ A.M.A., *Guides* 389.

¹¹ See *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).

¹² A.M.A., *Guides* 387 (6th ed. 2009).

ORDER

IT IS HEREBY ORDERED THAT the July 15, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 18, 2012
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