

December 16, 2010 appellant underwent a left clavicle open reduction with internal fixation. He received wage-loss compensation benefits.

In a May 11, 2011 report, Dr. Thomas W. Harris, an orthopedic surgeon specializing in sports medicine, reviewed appellant's history of injury and medical treatment, noting that he was post left clavicle open reduction and internal fixation. He utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (6th ed. 2009) (A.M.A., *Guides*). On examination, the left shoulder showed a well-healed incision with no evidence of rotator cuff atrophy and tenderness to palpation over the greater tuberosity in the area of the supraspinatus tendon. Dr. Harris found that the joint capsule was nontender, although appellant had tenderness to palpation along the long head of the biceps tendon. Appellant had mild tenderness to palpation in the area of the upper trapezius, levator, and rhomboid muscle group and the acromioclavicular joint was nontender to palpation. Left shoulder range of motion findings included: 45 degrees of extension; 160 degrees of flexion; 60 degrees internal rotation, 65 degrees external rotation; abduction of 160 degrees; and adduction of 50 degrees. Dr. Harris found that appellant reached maximum medical improvement on May 11, 2011 and was capable of working his usual and customary job without restrictions. After surgery, appellant had continued loss of motion and mild weakness. Dr. Harris referred to Table 15-5 of the A.M.A., *Guides* to rate 10 percent left arm impairment.² Dr. Harris explained that the A.M.A., *Guides* did not address the specific condition or procedure that appellant underwent; however, the closest condition would be an acromioclavicular joint injury with residual loss of motion and strength. On July 14, 2011 appellant submitted a Form CA-7 requesting a schedule award.

On August 17, 2011 Dr. Christopher R. Brigham, a Board-certified orthopedic surgeon and OWCP medical consultant, noted appellant's treatment and history. He reviewed Dr. Harris' report and opined that appellant had an eight percent impairment of the arm. Dr. Brigham explained that Dr. Harris based his impairment upon loss of motion and weakness. He stated that it was appropriate to rate impairment due to loss of motion but the A.M.A., *Guides* did not allow ratings based on weakness. Dr. Brigham noted that evaluation of impairment due to the clavicle fracture was based upon section 15.2, Diagnosis-Based Impairment and section 15.2e, Shoulder.³ He referred to Table 15-5, Shoulder Regional Grid, the section on Ligament/Bone/Joint⁴ and advised that for the diagnosis "fracture" there was a class 1 rating for "residual symptoms, consistent objective findings and/or, functional with normal motion." This yielded a default rating of three percent arm impairment. Dr. Brigham noted that section 15.3a, Adjustment Grid -- Functional History and Table 15-7, Functional History Adjustment -- Upper Extremity,⁵ appellant was assigned grade modifier 1; and the functional history was consistent with "pain/symptoms with strenuous/vigorous activity; + /- medication to control symptoms." He referred to section 15.3b, Adjustment Grid -- Physical Examination and Table 15-8, Physical Examination on Adjustment -- Upper Extremities,⁶ and noted that appellant was assigned a grade

² A.M.A., *Guides* 403, Table 15-5.

³ *Id.* at 387, 390.

⁴ *Id.* at 405.

⁵ *Id.* at 406.

⁶ *Id.* at 407, 408.

modifier 1, as the physical examination revealed mild motion loss. Dr. Brigham referred to section 15.3; Adjustment Grid -- Clinical Studies and Table 15-9, Clinical Studies Adjustment -- Upper Extremities,⁷ and determined that appellant was assigned a grade modifier 1 as the diagnostic study confirmed the diagnosis. He explained that each grade modifier was 1, which was compared to the diagnosis class of one, yielding no net adjustment from the grade C default impairment of three percent. Dr. Brigham stated that, based upon the nature of the diagnosis, impairment was also evaluated using the range of motion method under section 15.7g, Shoulder Motion and Table 15-34, Shoulder Range of Motion.⁸ He explained that the A.M.A., *Guides* directed that this section was to be used as a stand-alone rating when applicable.⁹ Left shoulder ranges of motion were: flexion of 160 degrees, which corresponded to three percent impairment; extension of 45 degrees, which corresponded to no impairment; abduction of 160 degrees, which corresponded to three percent impairment; adduction of 50 degrees, which corresponded to no impairment; internal rotation of 60 degrees, which corresponded to two percent impairment and external rotation of 65 degrees which corresponded to no impairment. Dr. Brigham added the shoulder range of motion impairments to yield eight percent impairment. As this was a higher rating, he opined that appellant had eight percent impairment of the left upper extremity.

By decision dated April 2, 2012, OWCP granted appellant a schedule award for a total of 24.96 weeks of compensation for an eight percent permanent impairment of the left upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA,¹⁰ and its implementing federal regulations,¹¹ 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, FECA 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.¹² For decisions issued after May 1, 2009, the sixth edition will be used.¹³

In addressing upper extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers

⁷ *Id.* at 407, 410, 411.

⁸ *Id.* at 472, 475.

⁹ *Id.* at 461.

¹⁰ 5 U.S.C. § 8107.

¹¹ 20 C.F.R. § 10.404.

¹² *Id.* at § 10.404(a).

¹³ FECA Bulletin No. 09-03 (issued March 15, 2009).

based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).¹⁴ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹⁵

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.¹⁶

ANALYSIS

In a May 11, 2011 report, Dr. Harris determined that appellant had a 10 percent impairment of the left arm. He stated that the A.M.A., *Guides*, did not address appellant's condition and that the closest comparable condition was an acromioclavicular injury with residual loss of motion and strength under Table 15-5, page 403 of the A.M.A., *Guides*. The Board finds that Dr. Harris did not adequately explain how this diagnosis best approximated appellant's condition or how he applied grade modifiers. Dr. Harris did not address why the impairment rating for a fracture in the shoulder region that is set forth on page 405 of the A.M.A., *Guides*, was not applicable. The record establishes that appellant had a fractured clavicle which was surgically impaired and did not have a distal clavicle resection.¹⁷ To the extent that Dr. Harris was attempting to combine a diagnosis-based rating with findings for loss of range of motion, this was not in conformance with the A.M.A., *Guides*. The Board notes that the A.M.A., *Guides* indicate that range of motion is not to be combined with other impairment. The A.M.A., *Guides* explains that diagnosis-based impairment is the method of choice for calculating impairment, while range of motion is used principally as an adjustment factor. When other grids refer the evaluator to the range of motion section or when no other diagnosis-based system is applicable, range of motion impairment serves as a stand-alone rating, one that cannot be combined with a diagnosis-based estimate.¹⁸ Board precedent is well settled that when an attending physician's report gives an estimate of impairment but does not address how the estimate is based upon the A.M.A., *Guides*, OWCP is correct to follow the advice of its medical adviser or consultant where he has properly applied the A.M.A., *Guides*.¹⁹

In an August 17, 2011 report, Dr. Brigham utilized the findings provided by Dr. Harris. He opined that the applicable diagnosis for appellant's surgically repaired left clavicle fracture

¹⁴ A.M.A., *Guides* 494-531; see *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

¹⁵ *Id.* at 411.

¹⁶ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

¹⁷ See A.M.A., *Guides* 403 (the description for an acromioclavicular joint injury which merits a 10 percent default impairment rating, indicates that the patient has undergone a distal clavicle resection or has a type III acromioclavicular joint separation with complete disruption of the joint capsule and coracoclavicular ligaments).

¹⁸ A.M.A., *Guides* 461.

¹⁹ *J.Q.*, Docket No. 06-2152 (issued March 5, 2008); *Laura Heyen*, 57 ECAB 435 (2006).

was the fracture diagnosis in Table 15-5, page 405. It provides a three percent default impairment rating for the arm. The medical adviser noted the applicable grade modifiers, applied the net adjustment formula and determined that there was no net adjustment from the three percent default rating.²⁰ He properly noted that loss of range of motion could not be combined with a diagnosis-based rating. The medical adviser evaluated impairment using the range of motion method according to section 15.7g, Shoulder Motion and Table 15-34, Shoulder Range of Motion.²¹ He explained that this section could be used as a stand-alone rating when other grids referred to this section.²² Using Dr. Harris' range of motion findings, the medical adviser found three percent arm impairment for left shoulder flexion of 160 degrees, three percent impairment for abduction of 160 degrees and two percent impairment for internal rotation of 60 degrees. Adding the range of motion impairment values, Dr. Brigham determined that appellant had an eight percent impairment of the left arm due to limited left shoulder motion. The Board notes that the medical adviser correctly utilized the A.M.A., *Guides* and utilized the range of motion method, which provided for a higher impairment rating of eight percent of the left upper extremity.

Appellant has not submitted any other medical evidence conforming with the A.M.A., *Guides* establishing that he has a greater schedule award.

On appeal, appellant argued that OWCP's medical adviser ignored the categories for extension and external rotation and that he was entitled to the 10 percent provided by Dr. Harris. The medical adviser properly found that those two motion measurements did not merit impairment.²³ As explained, the medical adviser properly applied the A.M.A., *Guides* to the findings of Dr. Harris in calculating appellant's impairment.

The Board notes that appellant retains the right to file a claim for an increased schedule award based on new exposure or on medical evidence indicating that the progression of an employment-related condition, without new exposure to employment factors, has resulted in a greater permanent impairment than previously calculated.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he has greater than eight percent of the left upper extremity.

²⁰ See *supra* notes 3-7 and accompanying text.

²¹ A.M.A., *Guides* 472, 475.

²² *Id.* at 461.

²³ Appellant had extension of 45 degrees but Table 15-34 provides for impairment only when the measurement is 40 percent or less. He had external rotation of 65 degrees but Table 15-34 provides for no impairment when the measurement is over 60 degrees. See *id.* at 475.

ORDER

IT IS HEREBY ORDERED THAT the April 2, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 26, 2013
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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