

unspecified left shoulder and upper arm sprain, temporary aggravation of preexisting right knee osteoarthritis, degenerative tearing of right knee medial meniscus, left shoulder acromioclavicular (AC) joint ligament sprain and temporary aggravation of primary localized left shoulder osteoarthritis. It authorized left shoulder surgery, which included a distal clavicle excision (Mumford procedure) performed on December 8, 2010.² Appellant previously injured his left shoulder on March 1, 2001 and had authorized surgery in April 2002.³ He also received a September 2003 schedule award for 22 percent impairment of the left upper extremity.⁴

With respect to the April 26, 2010 employment injury, appellant filed a claim for a schedule award (Form CA-7) on August 8, 2011. OWCP granted an award for 24 percent impairment of the right lower extremity.⁵ With regard to appellant's left upper extremity, it denied any additional schedule award by decision dated March 9, 2012. The denial was based on the finding of no greater permanent impairment.

In August 2011, appellant's surgeon determined that appellant had reached maximum medical improvement and referred him to Dr. Edwin C. Fulton, a Board-certified orthopedic surgeon, for further evaluation regarding the extent of permanent impairment. Dr. Fulton examined appellant on September 15, 2011 and found 17 percent left arm impairment. His overall rating included a combination of impairments for shoulder impingement (four to five percent), partial rotator cuff tear (four to five percent) and AC joint injury (four to seven percent). In support of his upper extremity rating, Dr. Fulton referenced Table 15-5, Shoulder Regional Grid, A.M.A., *Guides* 402-03 (6th ed. 2008).

On February 23, 2012 the DMA, Dr. Christopher R. Brigham, an OWCP medical adviser Board-certified in occupational medicine, reviewed the record. He took issue with Dr. Fulton's impairment rating, noting that the A.M.A., *Guides* allowed only one diagnosis within a region, whereas appellant's physician based his rating on three separate diagnoses within the shoulder region. The DMA also noted that Dr. Fulton had not considered appellant's prior schedule award for 22 percent left upper extremity impairment.

Citing Table 15-5, A.M.A., *Guides* 403 (6th ed. 2008), Dr. Brigham found 12 percent left upper extremity impairment based on AC joint injury, status post distal clavicle resection.⁶ He

² Dr. Stephen D. Brown, a Board-certified orthopedic surgeon, performed the December 8, 2010 arthroscopic procedure. His postoperative diagnoses included partial rotator cuff tear of the supraspinatus, AC disease and multiple loose bodies.

³ On April 16, 2002 Dr. Thomas R. Dennis performed an arthroscopic subacromial decompression, arthroscopic Mumford procedure and limited debridement of the left glenohumeral joint and labral tear.

⁴ The September 3, 2003 award included a combination of left shoulder impairments for glenohumeral labral tear (11 percent) and AC joint arthritis (11 percent). OWCP's district medical adviser (DMA) calculated the upper extremity impairment under the then-applicable fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (2001).

⁵ OWCP had authorized a September 30, 2010 right knee partial medial meniscectomy and chondroplasty. The 24 percent right lower extremity impairment rating was for primary knee joint arthritis, class 2. See Table 16-3, Knee Regional Grid, A.M.A., *Guides* 509, 511 (6th ed. 2008).

⁶ The default rating (C) was 10 percent; however, Dr. Brigham calculated a net adjustment of +2 which resulted in a final rating (E) of 12 percent.

explained that appellant's left shoulder distal clavicle resection (Mumford procedure) represented the greatest impairing condition. As such, the impairment rating should be based on that particular diagnosis. Dr. Brigham further noted that the A.M.A., *Guides* provided an alternative rating based on range of motion (ROM); however, Dr. Fulton had not provided any such measurements in his September 15, 2011 report. He noted that because the current rating 12 percent was less than the prior award 22 percent, appellant was not entitled to an additional schedule award.

Appellant requested reconsideration and submitted a July 9, 2012 supplemental report from Dr. Fulton, who stated that his prior assessment was consistent with the A.M.A., *Guides*. Dr. Fulton disagreed with Dr. Brigham that a single diagnosis was required. He indicated that the current rating was based on a new injury which would be in addition to the prior assessment of 22 percent impairment. If Dr. Fulton were to choose a single diagnosis under Table 15-5, it would be for "rotator cuff tear tendon rupture, class 1 grade E at 13 [percent]."

OWCP forwarded Dr. Fulton's supplemental report to Dr. Morley Slutsky, an OWCP medical adviser Board-certified in occupational medicine. In a report dated August 9, 2012, Dr. Slutsky found three percent left upper extremity impairment under Table 15-5, A.M.A., *Guides* 403 (6th ed. 2008). The rating was for AC joint injury.

By decision dated October 12, 2012, OWCP reviewed the merits of appellant's left upper extremity schedule award, but denied modification. It found that the medical evidence did not establish permanent impairment in excess of the previous 22 percent. Consequently, OWCP determined that appellant was not entitled to an additional schedule award.

LEGAL PRECEDENT

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.⁷ FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.⁸ Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).⁹

FECA and its implementing regulations provide for the reduction of compensation for subsequent injury to the same scheduled member.¹⁰ Benefits payable under 5 U.S.C. § 8107(c)

⁷ For a total or 100 percent loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

⁸ 20 C.F.R. § 10.404 (2011).

⁹ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (January 2010).

¹⁰ 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

shall be reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.¹¹

ANALYSIS

Appellant injured his left shoulder at work on April 26, 2010 and underwent approved surgery on December 8, 2010. He had previously injured his left shoulder in March 2001 and had approved surgery on April 16, 2002. Both arthroscopic surgeries involved a distal clavicle excision (Mumford procedure). As a result of his March 1, 2001 employment injury, appellant received a schedule award for 22 percent impairment of the left arm. In August 2011, he filed a claim for a schedule award with respect to his April 26, 2010 employment injuries. In a September 15, 2011 report, Dr. Fulton rated an overall 17 percent left upper extremity impairment based on a combination of shoulder impairments, which included impingement, partial rotator cuff tear and AC joint injury. Dr. Brigham, stated that Dr. Fulton's rating methodology of combining multiple shoulder diagnoses did not comport with the A.M.A., *Guides*. He found 12 percent impairment based on appellant's postdistal clavicle resection. In response, Dr. Fulton provided a July 9, 2012 supplemental report stating that, based on a single diagnosis of rotator cuff tear tendon rupture, appellant had 13 percent left upper extremity impairment.

Dr. Fulton's impairment ratings are not consistent with the A.M.A., *Guides* (6th ed. 2008). The evidence fails to establish greater impairment to appellant's arm than previously awarded. The current shoulder-related left upper extremity rating is less than the September 3, 2003 award of 22 percent. The mere fact that appellant sustained a new left shoulder injury on April 26, 2010 does not, by itself, establish greater impairment. Apart from stating that he sustained a new injury in April 2010, Dr. Fulton did not support greater impairment to the left upper extremity.

The Board finds that Dr. Brigham properly determined that appellant had 12 percent impairment of the left upper extremity. Dr. Brigham correctly noted that the diagnosis-based impairment rating methodology generally requires a single shoulder region diagnosis.¹² Where more than one diagnosis can be used, the highest causally-related impairment rating should be used.¹³ He identified appellant's status as post December 8, 2010 distal clavicle excision (Mumford procedure) that represented the greatest impairment. Under Table 15-5, A.M.A., *Guides* 403 (6th ed. 2008), an AC joint injury, status post distal clavicle resection represents a

¹¹ 20 C.F.R. § 10.404(c)(1) and (c)(2).

¹² See section 15.2, A.M.A., *Guides* 387 (6th ed. 2008).

¹³ Section 15.2a, A.M.A., *Guides* 389 (6th ed. 2008).

class 1 impairment with a default (grade C) upper extremity rating of 10 percent. Dr. Brigham calculated a net adjustment of +2 which resulted in a final rating (grade E) of 12 percent.¹⁴

In his July 9, 2012 supplemental report, Dr. Fulton indicated that based on a single shoulder region diagnosis of rotator cuff tear tendon rupture appellant had 13 percent left upper extremity impairment. The December 8, 2010 operative report noted a partial rotator cuff tear which Dr. Fulton correctly listed in his September 15, 2011 report. Under Table 15-5, A.M.A., *Guides* 402-03 (6th ed. 2008), a partialthickness rotator cuff tear represents a maximum upper extremity impairment of 5 percent; not 13 percent as Dr. Fulton indicated. Even a full-thickness rotator cuff tear represents only a maximum seven percent upper extremity impairment under Table 15-5. Dr. Fulton provided inadequate explanation for his 13 percent upper extremity rating. Accordingly, his opinion is of diminished probative value.

Dr. Brigham's February 23, 2012 finding of 12 percent left upper extremity impairment is consistent with the A.M.A., *Guides* (6th ed. 2008) and thus, represents the weight of the current medical evidence. Appellant has already received a schedule award for 22 percent due to shoulder-related left upper extremity impairment. Because the current medical evidence does not establish a greater impairment than previously awarded, OWCP properly denied an additional 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

Appellant has not established that he has greater than 22 percent impairment of the left upper extremity.

¹⁴Br. Brigham assigned grade 2 modifiers for Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). Net Adjustment (GMFH 2 - CDX 1) + (GMPE 2 - CDX 1) + (GMCS 2 - CDX 1). See section 15.3d, A.M.A., *Guides* 409-12 (6th ed. 2008).

ORDER

IT IS HEREBY ORDERED THAT the October 12, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 3, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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