United States Department of Labor
Employees' Compensation Appeals Board

B.B., Appellant	)	
and	)	**Docket No. 13-991**
	)	**Issued: July 26, 2013**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Baton Rouge, LA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 26, 2013 appellant filed a timely appeal from a January 23, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) granting him a schedule award. 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 has more than an 11 percent permanent impairment of the left upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On October 15, 2010 appellant, then a 58-year-old maintenance mechanic, filed a traumatic injury claim alleging that on October 8, 2010 he injured his left shoulder in the

[1] 5 U.S.C. § 8101 *et seq.*

performance of duty. OWCP accepted the claim for a contusion of the left shoulder and upper arm, a left shoulder sprain, a closed left acromioclavicular dislocation and a foreign body granuloma of a left muscle.

On November 10, 2010 Dr. Alan C. Schroeder, a Board-certified orthopedic surgeon, performed an open acromioclavicular joint resection and an excision of a presumed lipoma. On March 9, 2011 he performed an arthroscopoic subacromial decompression with a distal clavicle excision and debridement of the left shoulder. On April 19, 2011 appellant returned to modified employment.

In a report dated September 12, 2011, Dr. Schroeder noted that appellant continued to experience pain with reduced left shoulder strength and motion. He measured left shoulder passive external rotation of 30 degrees, abduction of 90 degrees and forward flexion of over 120 degrees. Dr. Schroeder measured right shoulder passive external rotation of 40 degrees, abduction of 90 degrees and forward flexion of 30 degrees. He opined that appellant had reached maximum medical improvement.

On December 6, 2011 appellant filed a claim for a schedule award. In an impairment evaluation dated April 16, 2012, Dr. M. Stephen Wilson, an orthopedic surgeon, discussed his continued complaints of left shoulder pain, decreased strength and reduced motion. He measured range of motion of the left shoulder and found tenderness to palpation and crepitation with motion. Dr. Wilson concluded that appellant had a 12 percent permanent impairment due to loss of range of motion of the left shoulder pursuant to Table 15-34 on page 475 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

On May 31, 2012 OWCP's medical adviser reviewed Dr. Wilson's report and recommended that OWCP refer appellant for a second opinion examination. He noted that the A.M.A., *Guides* provided, "If the opposite extremity is neither involved nor previously injured, it must be used to define normal for that individual; any losses should be made in comparison to the opposite normal extremity." The medical adviser indicated that Dr. Schroeder measured motion in the uninjured right upper extremity that, if used as the baseline, would result in "no net impairment under Table 15-34 for flexion, abduction or external rotation of the affected left shoulder."

By letter dated June 21, 2012, OWCP referred appellant to Dr. Brett Rothaermel, a Board-certified physiatrist, for a second opinion examination regarding the extent of any left upper extremity impairment. In a report dated July 11, 2012, Dr. Rothaermel noted that appellant continued to complain of pain and loss of motion following shoulder surgeries. On examination, he found normal range of motion of the right shoulder and "suboptimal effort on manual muscle testing of the entire left upper extremity." Dr. Rothaermel related that appellant moved his left shoulder easily when removing his shirt, but "on range of motion direct observation and assessment, [he] is noted to be grimacing throughout range of motion." He utilized the diagnosis-based assessment method under the A.M.A., *Guides* as he was "concerned about range of motion reliability." Dr. Rothaermel identified the diagnosis as class 1 acromioclavicular joint disease status post distal clavicle resection using Table 15-5 on page 403, which yielded a default value of 10 percent. He found that appellant had a grade 2 modifier for

Functional History (GMFH) based on his Disabilities of the Arm, Shoulder and Hand (*Quick*DASH) score of 42.5 and interference with activities. Dr. Rothaermel further found a grade 1 modifier due to Physical Examination (GMPE) for mild loss of motion with no atrophy and a grade 1 modifier for Clinical Studies (GMCS) due to postsurgical changes and edema. He applied the net adjustment formula, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) or (2-1) + (1-1) + (1-1) = 1, to find a grade D or 11 percent impairment of the left upper extremity.

On August 27, 2012 OWCP's medical adviser reviewed Dr. Rothaermel's report and concurred with his impairment rating.

By decision dated January 23, 2013, OWCP granted appellant a schedule award for an 11 percent permanent impairment of the left upper extremity. The period of the award ran for 34.32 weeks from July 11, 2012 to March 8, 2013.

On appeal, appellant argues that he continued to experience pain, stiffness and reduced motion in his left arm such that he required further treatment from Dr. Schroeder.

LEGAL PRECEDENT

The schedule award provision of FECA[2] and its implementing federal regulations[3] 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.[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 GMFH, GMPE and GMCS.[6] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

ANALYSIS

OWCP accepted that appellant sustained contusions of the left shoulder and arm, left shoulder sprain, a closed left acromioclavicular dislocation and a foreign body granuloma on the left due to an October 8, 2010 employment injury. On November 10, 2010 appellant underwent

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *Id.* at § 10.404(a).

[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).

[6] A.M.A., *Guides* 494-531.

a resection of the acromioclavicular joint and on March 9, 2011 he underwent a distal clavicle excision and subacromial decompression.

On September 12, 2011 Dr. Schroeder opined that appellant had reached maximum medical improvement. He measured range of motion for both the right and left shoulders.

In an impairment evaluation dated April 16, 2012, Dr. Wilson applied Table 15-34 of the sixth edition of the A.M.A., *Guides* and determined that appellant had a 12 percent left upper extremity impairment due to loss of range of motion of the left shoulder. OWCP's medical adviser reviewed his report and noted that the range of motion measurements by Dr. Schroeder in his September 12, 2011 report showed reduced motion of both shoulders. He asserted that the range of motion for the unaffected right side should have been used as a baseline for determining loss of motion. The A.M.A., *Guides* provides that if the opposite extremity is neither involved nor previously injured, it must be used to define normal for the individual. Any losses should be made in comparison to the opposite normal extremity.[7] Dr. Wilson did not provide range of motion measurements for the right side. As he did not compare the loss of range of motion measurements for the left upper extremity to the opposite extremity, his report is of diminished probative value as it does not conform to the A.M.A., *Guides*.[8]

On July 11, 2012 Dr. Rothaermel, an OWCP referral physician, reviewed appellant's history of injury, shoulder surgeries and discussed his current complaints of left shoulder pain and reduced motion. On examination, he found a lack of effort on manual muscle testing and unreliable range of motion measurements. Using the diagnosis-based impairment rating, Dr. Rothaermel identified a class 1 impairment due to acromioclavicular joint disease after a distal clavicle resection using the shoulder regional grid set forth in Table 15-5 which yielded a default value of 10 percent.[9] After determining the impairment class and default grade, he considered whether there were any applicable grade adjustments for functional history, physical examination and clinical studies. Dr. Rothaermel found a grade modifier of two for functional history based on appellant's *Quick*DASH score, a grade modifier of one for or physical examination based on his mild motion loss and a grade modifier of one for clinical studies due to his postsurgical changes. He utilized the net adjustment formula, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) or (2-1) + (1-1) + (1-1) = 1, to move the default value one place to the right for an 11 percent left upper extremity impairment. On August 27, 2012 OWCP's medical adviser concurred with Dr. Rothaermel's impairment rating. The Board finds that the opinions of Dr. Rothaermel and the medical adviser establish that appellant has no more than an 11 percent left upper extremity impairment.

On appeal, appellant asserts that he continues to require medical treatment for his injury and experiences pain, stiffness and loss of motion of the left arm. The issue, however, is the degree of any permanent impairment rather than the need for medical treatment. It is appellant's

[7] *Id.* at 461.

[8] *See D.J.*, Docket No. 11-1611 (issued June 25, 2012).

[9] The diagnosis-based impairment method is the method of choice for calculating upper extremity impairments under the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides* 387.

burden to submit medical evidence supporting the degree of permanent impairment.[10] He has not submitted any medical evidence showing a greater impairment that conforms to the A.M.A., *Guides*.

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 no more than an 11 percent permanent impairment of the left upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the January 23, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 26, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[10] *See D.H.*, 58 ECAB 358 (2007); *Annette M. Dent*, 44 ECAB 403 (1993).