

performance of duty. He did not initially stop work. On July 19, 2006 OWCP accepted appellant's claim for left bicipital tendinitis.

On October 19, 2006 appellant underwent an authorized left shoulder arthroscopy with arthroscopic decompression of the rotator cuff, bursectomy and acromioplasty, which was performed by Dr. Steve Barnes, an orthopedic surgeon. He received appropriate compensation benefits.

On February 22, 2007 appellant requested a schedule award. By decision dated March 21, 2007, OWCP granted him a schedule award for an additional eight percent permanent impairment of the left arm due to his shoulder condition. The award covered a period of 24.96 weeks from February 22 to August 15, 2007.² On May 9, 2008 appellant elected disability retirement.

On July 17, 2012 appellant underwent a second authorized left shoulder arthroscopy with acromioclavicular (AC) spur excision, impingement release and shaving partial rotator cuff tear, which was performed by Dr. Bill Barnes, a Board-certified orthopedic surgeon.

On October 31, 2012 appellant requested an increased schedule award. He provided an October 29, 2012 report from Dr. Barnes who concurred with the October 16, 2012 impairment rating performed by Keith Blankenship, a physical therapist. Dr. Barnes noted that appellant qualified for a 10 percent default upper extremity impairment pursuant to Table 15-5³ for an AC joint injury/disease, a distal clavicle resection, class 1 and there was a net modifier adjustment of +1, which moved the default adjustment "one place higher in the impairment range of 8-9-10-11-12 percent for an 11 percent upper extremity rating."⁴ He noted that, since appellant had previously received an impairment of eight percent for the shoulder region, it would be subtracted from the current rating of 11 percent. Dr. Barnes opined that appellant qualified for an additional impairment to the left upper extremity of three percent.

OWCP requested that its medical adviser review the medical evidence and provide an impairment rating utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) (6th ed. 2009).

In a November 16, 2012 report, OWCP's medical adviser noted appellant's history, including his prior schedule awards and utilized the A.M.A., *Guides* and concurred that the impairment evaluation was valid. The medical adviser noted that this was diagnosis based for an AC joint resection. He explained that appellant received a prior award of eight percent for the

² The record reflects that appellant previously received schedule awards for eight percent impairment of his left arm for radial nerve compression, strain and mononeuritis under claim No. xxxxxx098 and for two percent left arm impairment due to a neck strain under claim No. xxxxxx206.

³ A.M.A., *Guides* 403.

⁴ An attached worksheet noted that appellant's diagnosis of AC joint injury and resection was a class 1 diagnosis (CDX). It found a Functional History grade modifier (GMFH) of 2 based on a moderate *QuickDASH* score of 43. The Physical Examination grade modifier (GMPE) was 1, and the Clinical Studies grade modifier (GMCS) was not applicable. Using the net adjustment formula (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX), yielded a +1 net adjustment to the default grade C.

left shoulder based upon loss of motion. Thus, the eight percent would be subtracted from the already awarded 11 percent rating for the same region of the arm warranting an additional award of 3 percent permanent impairment of the left upper extremity. The medical adviser noted that appellant reached maximum medical improvement on October 16, 2012.

By decision dated January 7, 2013, OWCP granted appellant an additional schedule award for three percent impairment of the left arm.⁵ The award covered a period of 9.36 weeks from October 16 to December 20, 2012.

LEGAL PRECEDENT

The schedule award provision of FECA,⁶ and its implementing federal regulations,⁷ 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.⁸ For decisions issued after May 1, 2009, the sixth edition will be used.⁹

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 based on GMFH, GMPE and GMCS.¹⁰ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).¹¹

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to its 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.¹²

⁵ The decision inadvertently indicated that appellant had 11 percent total left arm impairment. As indicated, *see supra* note 2, appellant's schedule awards for all regions of the left arm totaled 21 percent permanent impairment upon issuance of the January 7, 2013 award.

⁶ 5 U.S.C. § 8107.

⁷ 20 C.F.R. § 10.404.

⁸ *Id.* at § 10.404(a).

⁹ FECA Bulletin No. 09-03 (issued March 15, 2009).

¹⁰ A.M.A., *Guides* 494-531; *see J.B.*, (Docket No. 09-2191, issued May 14, 2010).

¹¹ A.M.A., *Guides* 411.

¹² *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

ANALYSIS

OWCP accepted appellant's claim for left bicipital tendinitis. On October 19, 2006 appellant underwent a left shoulder arthroscopy with arthroscopic decompression of the rotator cuff, bursectomy and acromioplasty. On July 17, 2012 he underwent a left shoulder arthroscopy with an AC spur excision, impingement release and shave of the partial rotator cuff tear.

Both the treating physician and OWCP's medical adviser were in agreement with regard to the extent of impairment.

On October 29, 2012 Dr. Barnes, appellant's surgeon, concurred with an October 16, 2012 impairment evaluation prepared by a physical therapist. This evaluation reviewed appellant's history and his current left shoulder findings and complaints. Under the diagnosis-based impairment rating, appellant had a class 1 diagnosis for an AC joint injury and a distal clavicle resection in the shoulder regional grid set forth in Table 15-5, page 403 of the A.M.A., *Guides*. This yielded a default (grade C) value of 10 percent.¹³ 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. After determining the grade modifiers and applying the net adjustment formula, there was a net adjustment of plus one.¹⁴ This moved the default grade value one place to the right to grade D for 11 percent arm impairment for the left shoulder region.

On November 16, 2012 OWCP's medical adviser concurred with this evaluation. He noted that since appellant had previously received a schedule award for 8 percent impairment of the shoulder region, it would be subtracted from the current rating of 11 percent. The medical adviser opined that appellant qualified for an additional impairment to the left upper extremity of three percent.

The Board finds that the opinions of Dr. Barnes and OWCP's medical adviser establish that appellant has no more than 11 percent left arm impairment attributable to the shoulder region. As, appellant previously received an award of eight percent for this region, he is only entitled to an additional impairment of three percent. His total left arm impairment, for all regions, is 21 percent. Appellant has not submitted any other medical evidence conforming with the A.M.A., *Guides* establishing that he has greater impairment.

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.

¹³ 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.

¹⁴ See *supra* notes 4, 10.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he sustained more than 21 percent impairment of the left upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the January 7, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 19, 2013
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board