

FACTUAL HISTORY

OWCP accepted that appellant, then a 35-year-old clerk, sustained a right supraspinatus tear and a right rotator cuff tear in the performance of duty on October 11, 2007. It authorized surgery and he underwent an arthroscopic subacromial decompression of the right shoulder performed by Dr. John Ternes, a Board-certified orthopedic surgeon, on June 18, 2008. Appellant received appropriate compensation benefits.² Thereafter, Dr. Ternes released him to work without restrictions effective September 11, 2008.³

On April 3, 2009 appellant, through counsel, filed a claim for a schedule award.⁴

In an October 9, 2008 report, Dr. Ternes indicated that appellant was seen for a follow up of his June 18, 2008 right shoulder surgery. Appellant reported that he had returned to full-duty work and felt intermittent discomfort at the subacromial area of his shoulder with overhead reaching and lifting. Dr. Ternes found that appellant's right shoulder revealed well-healed arthroscopic portals. Appellant had subjective tenderness on palpation of the subacromial area, but no biceps tendon tenderness. His right shoulder range of motion was forward flexion to 170 degrees, abduction to 180 degrees, 90 degree external rotation to 90 degrees, 90 degree internal rotation to 35 degrees, and external rotation with arm at side to 50 degrees. Appellant had a negative impingement sign in his shoulder. On strength testing in all directions, his strength rated a five out of five and equal to his opposite side. Appellant had no anterior, inferior, or posterior instability of his shoulder. Dr. Ternes concluded that appellant had reached maximum medical improvement and opined that he had a 20 percent permanent impairment of the right arm "based on his decreased range of motion and residual discomfort." He released appellant to work without restrictions.

On January 9, 2009 Dr. Ternes reported that appellant's right shoulder had a 90 degrees internal rotation to 40 degrees and reiterated his opinion that appellant had a 20 percent permanent impairment of the right upper extremity.

In an April 8, 2009 letter, OWCP notified appellant of the deficiencies of his schedule award claim. It afforded him 30 days to submit additional evidence, including a medical report containing a detailed description of his permanent impairment based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

² By decision dated August 4, 2008, OWCP made a preliminary determination that appellant had received an overpayment of compensation in the amount of \$652.86 because he received compensation for temporary total disability for the period June 7 to 13, 2008 while he worked full time. In an October 8, 2008 letter, it administratively terminated collection of the overpayment of compensation since the general cost of collection of at least \$2,256.00 was greater than the overpayment amount of \$652.86.

³ Appellant, through counsel, filed additional claims (Form CA-2a) alleging that he sustained a recurrence of disability on October 23, 2008 and June 18, 2009. By decisions dated January 20, 2009 and January 20, 2010, OWCP denied the claims on the basis that the medical evidence was insufficient to establish that he sustained a recurrence of his accepted right shoulder conditions.

⁴ Appellant, through counsel, filed claims for wage-loss compensation (Form CA-7) for intermittent periods commencing March 15, 2009. By decision dated June 1, 2009, OWCP denied the claims on the basis that the medical evidence was insufficient to establish that he was disabled during the periods claimed.

On April 28, 2009 an OWCP medical adviser reviewed the evidence of record and explained that Dr. Ternes' 20 percent impairment rating had no basis and did not follow the A.M.A., *Guides*. The medical adviser found that based upon the findings of Dr. Ternes and the fifth edition of the A.M.A., *Guides* appellant had a five percent permanent impairment of the right upper extremity.

By decision dated April 30, 2009, OWCP granted appellant a schedule award for five percent permanent impairment to the right upper extremity for 15.6 weeks of compensation for the period October 29, 2008 through February 15, 2009.

On January 25, 2010 appellant, through counsel, requested an oral hearing before an OWCP hearing representative and submitted a December 9, 2008 report from Dr. Ternes who reiterated his findings and medical opinions.

In a September 25, 2009 report, Dr. Ternes had indicated that the rating guide he used to determine appellant's permanent impairment was "the *North Carolina Industrial Commission Rating Guide* last updated on February 5, 2009." After reviewing the fifth edition of the A.M.A., *Guides*, he found that appellant's impairment rating was mostly determined by his change of motion in the shoulder. Dr. Ternes determined that, based on Figure 16-40, appellant had a one percent upper extremity impairment based on flexion. Based on Figure 16-46, appellant had a three percent upper extremity impairment based on internal rotation. Dr. Ternes concluded that appellant had a four percent permanent impairment of the right upper extremity, which he noted that was comparable to the rating determined by the medical adviser.

In an April 6, 2010 letter, appellant, through counsel, filed a petition to withdraw his request for an oral hearing.⁵

By decision dated May 4, 2010, an OWCP hearing representative accepted appellant's request for withdrawal of the hearing.

In a June 24, 2010 report, Dr. Ternes stated that it was medical opinion that appellant's status regarding his shoulder was unchanged from his previous evaluations and that his permanent impairment rating from this injury and his permanent work restrictions continued to be in effect.

On October 22, 2010 Dr. Martin Fritzhand, a Board-certified urologist, conducted a physical examination of appellant and found that forward flexion of the right shoulder was diminished to 100 degrees, with extension diminished to 30 degrees. Abduction of the shoulder was diminished to 90 degrees, with adduction diminished to 20 degrees. External rotation of the shoulder was normal to 90 degrees, with internal rotation diminished to 30 degrees. There was tenderness noted on palpation of the right trapezius musculature. Muscle strength was well-preserved and there was no evidence of muscle atrophy. Dr. Fritzhand indicated that under the sixth edition of the A.M.A., *Guides*, Table 15-5,⁶ if motion loss was present in a right rotator cuff

⁵ On April 7, 2010 appellant, through counsel, filed a notice of occupational disease (Form CA-2) alleging that he developed cervical spondylosis due to factors of his federal employment.

⁶ Table 15-5, page 401-05, of the sixth edition of the A.M.A., *Guides* is entitled *Shoulder Regional Grid*.

injury, impairment could alternatively be assessed using section 15.7. Utilizing Table 15-34,⁷ he indicated that appellant's flexion resulted in a three percent permanent impairment, his extension resulted in one percent, his abduction three percent, adduction one percent, external rotation zero percent and internal rotation four percent. Dr. Fritzhand concluded that appellant had a total of 12 percent permanent impairment to the right upper extremity. He also provided an impairment rating based on a diagnosis of cervical radiculopathy.

On February 12, 2013 an OWCP medical adviser found a discrepancy in the range of motion findings of Dr. Ternes and Dr. Fritzhand. She indicated that an inconsistency in the findings could have been the result of a worsening of the accepted conditions and recommended a second opinion evaluation to determine the nature and extent of appellant's right shoulder condition. The medical adviser noted that an impairment rating based on a cervical diagnosis was not correct as appellant had no accepted cervical conditions.

OWCP referred appellant to Dr. Harrison Latimer, a Board-certified orthopedic surgeon, for a second opinion evaluation. On June 5, 2013 Dr. Latimer conducted a physical examination and reviewed appellant's medical history and a statement of accepted facts. Upon examination, he found that appellant had full, active, assisted range of motion of the right shoulder and full range of motion of the cervical spine without any radicular symptoms. Dr. Latimer indicated that appellant was "very hesitant with testing of his shoulder as far as scapulohumeral rhythm [was] concerned but he ha[d] no winging of the scapula." Appellant had global mild weakness in the right shoulder in all directions to rotator cuff testing. He had no anterior, posterior, or inferior instability of the shoulder. Appellant had a normal axillary musculocutaneous, radial, median, ulnar, motor and sensory examination, and a normal vascular examination. Dr. Latimer concluded that appellant's right shoulder condition had resolved. He indicated that appellant did not have a complete rotator cuff rupture, but an impingement, tendinopathy, and at most partial tear with no evidence of any tearing when the tendon surface was visualized arthroscopically. Utilizing the sixth edition of the A.M.A., *Guides*, Dr. Latimer determined that appellant's condition fell under rotator cuff injury partial thickness tear and was a class 1 diagnosis. He assigned a grade modifier 2 for Functional History (GMFH) because appellant was able to perform activities with modification unassisted, but required over-the-counter medications and some narcotic medicines. Dr. Latimer assigned a grade modifier 2 for Physical Examination (GMPE) due to reproducible symptoms and demonstrated bursal tendinopathy lesion by magnetic resonance imaging (MRI) scan and arthroscopic examination. He assigned a grade modifier 2 for Clinical Studies (GMCS) based on appellant's MRI scan and surgical findings. Based on Table 15-5,⁸ Dr. Latimer determined that the grade modifiers moved appellant up to a class 1E injury, resulting in a five percent permanent impairment of the right upper extremity. He opined that appellant reached maximum medical improvement in March 2009, approximately nine months after his shoulder surgery.

On July 3, 2013 Dr. H.P. Hogshead, an OWCP medical adviser, reviewed the medical evidence of record and concurred with Dr. Latimer that appellant had reached maximum medical improvement effective March 2009. He concurred with Dr. Latimer's class 1E diagnosis of

⁷ Table 15-34, page 475, of the sixth edition of the A.M.A., *Guides* is entitled *Shoulder Range of Motion*.

⁸ See *supra* note 6.

partial thickness tear based on Table 15-5 of the sixth edition of the A.M.A., *Guides* and found that, as appellant previously received payment for a five percent permanent impairment of the right upper extremity, he was not entitled to an additional schedule award.

By decision dated July 15, 2013, OWCP denied appellant's claim for increased schedule award, indicating that the medical adviser recommended a five percent permanent impairment of the right upper extremity less any award previously paid. Appellant previously received a schedule award for five percent permanent impairment of the right upper extremity and, therefore, the medical evidence did not support an increase in the impairment already compensated.

On July 19, 2013 appellant, through counsel, requested an oral hearing before an OWCP hearing representative. A telephonic hearing was held before an OWCP hearing representative on December 17, 2013.

By decision dated March 12, 2014, the hearing representative affirmed the July 15, 2013 schedule award decision.

LEGAL PRECEDENT

The schedule award provisions of FECA⁹ provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized 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 OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.¹⁰ For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.¹¹

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).¹² Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.¹³ The net adjustment formula is (GMFH - CDX) + (GMPE -

⁹ 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

¹⁰ See *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000). See also 5 U.S.C. § 8107.

¹¹ See *D.T.*, Docket No. 12-503 (issued August 21, 2012); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); see also Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

¹² A.M.A., *Guides* (6th ed., 2009), p.3, section 1.3, *International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement*.

¹³ *Id.* at 494-531.

CDX) + (GMCS - CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.¹⁴

It is appellant's burden to submit sufficient evidence to establish the extent of permanent impairment.¹⁵

ANALYSIS

OWCP accepted that appellant sustained a right supraspinatus tear and a right rotator cuff tear in the performance of duty on October 11, 2007. Appellant underwent right shoulder surgery on June 18, 2008 and returned to work without restrictions effective September 11, 2008. In an April 30, 2009 award of compensation, OWCP granted him a schedule award for five percent permanent impairment to the right upper extremity. As previously noted, it is appellant's burden to submit sufficient evidence to establish the extent of permanent impairment.

OWCP properly referred appellant to Dr. Latimer for a second opinion examination to determine the extent and degree of any permanent impairment. On June 5, 2013 Dr. Latimer found that appellant had full active assisted range of motion of the right shoulder. He indicated that appellant was "very hesitant with testing of his shoulder as far as scapulohumeral rhythm [was] concerned but he ha[d] no winging of the scapula." Appellant had global mild weakness in the right shoulder in all directions to rotator cuff testing. He had no anterior, posterior, or inferior instability of the shoulder. Appellant had a normal axillary musculocutaneous, radial, median, ulnar, motor and sensory examination, and a normal vascular examination. Dr. Latimer concluded that appellant's right shoulder condition had resolved. He indicated that appellant did not have a complete rotator cuff rupture, but an impingement, tendinopathy, and at most partial tear with no evidence of any tearing when the tendon surface was visualized arthroscopically. Utilizing the sixth edition of the A.M.A., *Guides*, Dr. Latimer determined appellant's condition fell under rotator cuff injury partial thickness tear and was a class 1 diagnosis. He assigned a grade modifier 2 for GMFE because appellant was able to perform activities with modification unassisted, but required over-the-counter medications and some narcotic medicines. Dr. Latimer assigned a grade modifier 2 for GMPE due to reproducible symptoms and demonstrated bursal tendinopathy lesion by MRI scan and arthroscopic examination. He assigned a grade modifier 2 for GMCS based on appellant's MRI scan and surgical findings. Based on Table 15-5, Dr. Latimer determined that the grade modifiers moved appellant up to a class 1E injury, resulting in a five percent permanent impairment of the right upper extremity. He opined that appellant reached maximum medical improvement in March 2009.

In accordance with its procedures, OWCP properly referred the evidence of record to its medical adviser, Dr. Hogshead, who reviewed the clinical findings of Dr. Latimer on July 3, 2013 and determined that appellant had a five percent permanent impairment of the right upper extremity under the sixth edition of the A.M.A., *Guides*. Dr. Hogshead concurred with Dr. Latimer's class 1E diagnosis of partial thickness tear based on Table 15-5 of the sixth edition

¹⁴ See *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

¹⁵ See *Annette M. Dent*, 44 ECAB 403 (1993).

of the A.M.A., *Guides*. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Hogshead found that (2-1) + (2-1) + (2-1) resulted in a net grade modifier of 3, resulting in an impairment class 1, grade E, equaling a five percent permanent impairment of the right upper extremity. He discussed how he arrived at his conclusion by listing specific tables and pages in the A.M.A., *Guides*. Dr. Hogshead properly interpreted Table 15-5 to find that appellant qualified for five percent permanent impairment to the right upper extremity. Thus, the Board finds that OWCP properly relied upon the opinion of its medical adviser in denying appellant's claim for an additional schedule award.

Regarding appellant's impairment for the accepted right shoulder conditions, Dr. Fritzhand selected range of motion measurements. The A.M.A., *Guides* provide that, under specific circumstances, range of motion may be selected as an alternative approach in rating upper extremity impairment and cautions that an impairment rating that is calculated using range of motion stands alone and may not be combined with a diagnosis-based impairment.¹⁶ However, section 15.7a indicates that range of motion should be measured after a warm up, that the maximum range of motion should be measured at least three times and that the maximum measurement is used to determine range of motion measurement.¹⁷ There is no indication that the range of motion measurements reported by Dr. Fritzhand followed the procedure outlined in the A.M.A., *Guides*.¹⁸ As such, his opinion is of reduced probative value.¹⁹

The Board has held that when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides* or does not discuss how he or she arrives at the degree of impairment based on physical findings, his or her opinion is of diminished probative value in establishing the degree of impairment and OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.²⁰ The Board finds that the medical adviser in this case properly applied the standards of the A.M.A., *Guides*. The medical adviser's opinion is the weight of medical evidence and supports that appellant does not have a greater right upper extremity impairment than the five percent previously awarded.

In his October 22, 2010 report, Dr. Fritzhand provided an impairment rating based on a diagnosis of cervical radiculopathy. OWCP has not accepted a cervical condition in this case. Therefore, this report has no probative value regarding appellant's permanent impairment under

¹⁶ Section 15.3b, page 407, of the sixth edition of the A.M.A., *Guides* is entitled *Adjustment Grid: Physical Examination*. Section 15.3b of the A.M.A., *Guides* indicates that range of motion may be used to determine an impairment rating "only when specified by the regional grid or in the rare case when DBIs [diagnosis-based impairments] are not applicable.... If it is clear to the evaluator that a restricted range of motion has an organic basis, [three] measurements should be obtained and the greatest range measured should be used for the determination of impairment." *Id.*

¹⁷ A.M.A., *Guides* 464 (6th ed. 2009).

¹⁸ *See supra* note 16.

¹⁹ *See H.R.*, Docket No. 13-1264 (issued December 3, 2013).

²⁰ *L.M.*, Docket No. 12-868 (issued September 4, 2012); *see John L. McClanic*, 48 ECAB 552 (1997).

the sixth edition of the A.M.A., *Guides* and he has failed to establish a claim for an additional schedule award.²¹

There is no probative medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has more than a five percent permanent impairment to the right upper extremity. Accordingly, appellant has not established that he is entitled to a schedule award greater than that previously awarded.²²

On appeal, counsel contends that OWCP's decision was contrary to fact and law. For the reasons stated above, the Board finds that counsel's arguments are not substantiated.

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 sustained more than a five percent permanent impairment to the right upper extremity, for which he received a schedule award.

²¹ See *Richard A. Neidert*, 57 ECAB 474 (2006) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

²² FECA provides for reduction of compensation for subsequent injury to the same body member. It provides that schedule award compensation is reduced by the compensation paid for an earlier injury where the compensation in both cases are for impairment of the same member or function and where it is determined that the compensation for the later disability in whole or part would duplicate the compensation payable for the preexisting disability. 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

ORDER

IT IS HEREBY ORDERED THAT the March 12, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 15, 2014
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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