



No. xxxxxx688. He underwent authorized right shoulder arthroscopy on May 20, 1993, shoulder decompression on June 7, 1993 and right carpal tunnel release on July 8, 1993. OWCP granted appellant a schedule award for 22 percent impairment of the right arm.

OWCP subsequently accepted that appellant sustained left lateral and medial epicondylitis, left carpal tunnel syndrome and bilateral shoulder impingement syndrome as a result of pulling, pushing and lifting at work in his capacity as a letter carrier under OWCP File No. xxxxxx860. Appellant underwent authorized left lateral fasciotomy with ostectomy of the elbow on April 27, 1995 and left carpal tunnel release with decompression and tenosynovectomies on June 13, 1995. In a May 22, 1996 decision, OWCP granted him a schedule award for 24 percent impairment of the left upper extremity. On October 20, 1998 it granted appellant an additional schedule award for 7 percent impairment of the left upper extremity, totaling 31 percent impairment. OWCP combined the File Nos. xxxxxx688 and xxxxxx860 into a master file assigned File No. xxxxxx860.

Appellant underwent debridement and rotator cuff repair of the right shoulder on February 14, 2003 and a subacromial decompression and right rotator cuff repair on December 30, 2003. He also underwent a subacromial decompression and modified Mumford procedure of the left shoulder on August 10, 2004 and rotator cuff repair of the left shoulder on March 28, 2005.

On September 9, 2005 appellant filed a claim (Form CA-7) for an additional schedule award and submitted medical evidence. In an August 23, 2005 medical report, Dr. Behrooz Tohidi, a Board-certified orthopedic surgeon, listed findings on physical examination. He advised that appellant was status post arthroscopic modified Mumford procedure, arthroscopic subacromial decompression and left rotator cuff repair. In a November 15, 2005 report, Dr. Norman Kane, a Board-certified orthopedic surgeon, reviewed appellant's medical records and listed findings on physical examination of the right and left shoulders. He reported that an x-ray of the cervical spine revealed minimal degenerative changes. X-rays of the right and left shoulders revealed suture anchors in the greater tuberosity and superior surface of the glenoid. Dr. Kane advised that appellant was status post multiple surgeries to the left and right shoulders with arthroscopic and open repair of superior labrum anterior or posterior lesions and repair of rotator cuff tears. He opined that appellant's bilateral shoulder conditions had reached permanent and stationary status. Dr. Kane noted appellant's resulting limitations and advised that he had no work-related impairment of either shoulder under the fifth edition of American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

On December 31, 2005 an OWCP medical adviser reviewed the medical record. She determined that, based on the fifth edition of the A.M.A., *Guides*, appellant had 13 percent impairment of the right upper extremity and 3 percent impairment of the left upper extremity. The medical adviser stated that he had no additional impairment since the previous determination. She concluded that appellant reached maximum medical improvement on November 15, 2005.

In a February 3, 2006 decision, OWCP denied appellant's claim for an additional schedule award based on the medical adviser's December 31, 2005 opinion. In a January 22, 2007 decision, an OWCP hearing representative affirmed the February 3, 2006 decision. By

decision dated March 19, 2007, OWCP denied appellant's request for reconsideration of the January 22, 2007 decision on the grounds that the evidence submitted was insufficient to warrant a merit review of its prior decision.

On October 3, 2007 appellant underwent authorized left rotator cuff repair. He underwent authorized right shoulder surgery on January 23, 2009, left wrist surgery on July 19, 2010 and left shoulder surgery on March 16, 2012.

On August 25, 2012 appellant filed a Form CA-7 for an additional schedule award and submitted medical evidence. In a July 27, 2012 report, Dr. Kane advised that appellant had reached maximum medical improvement. He determined that appellant had nine percent impairment of the left upper extremity pursuant to the fifth edition of the A.M.A., *Guides*.

By letter dated September 18, 2012, OWCP requested that Dr. Kane determine the extent of appellant's permanent impairment based on the sixth edition of the A.M.A., *Guides*.

In an October 5, 2012 report, Dr. Kane noted the accepted employment injuries and the results of a right shoulder magnetic resonance imaging scan performed by appellant's primary care physician. On physical examination, he reported that appellant could flex his right shoulder to 130 degrees and left shoulder to 110 degrees. Abduction was to 120 degrees on the right and 110 degrees on the left. External rotation was to 30 degrees on the right and 20 degrees on the left. Appellant had weakness with abduction and external rotation against resistance. Dr. Kane advised that appellant was status post left shoulder arthroscopic debridement and decompression and right shoulder rotator cuff tear. He was also status post rotator cuff arthropathy bilaterally with the most recent surgery performed on March 20, 2012. Dr. Kane noted that he had previously provided a permanent and stationary report concerning impairment of the left shoulder based on the fifth edition of the A.M.A., *Guides*.

On October 23, 2012 an OWCP medical adviser reviewed the medical record. He determined that, under Table 15-34 on page 475 of the sixth edition of the A.M.A., *Guides*, appellant had three percent impairment of the right upper extremity each for loss of shoulder flexion and abduction and two percent impairment for loss of shoulder rotation, resulting in eight percent impairment. Regarding the left upper extremity, the medical adviser utilized the same table and determined that he had three percent impairment each for loss of shoulder flexion and abduction and two percent impairment for loss of shoulder external rotation, resulting in eight percent impairment. He advised that appellant's bilateral shoulder impairment was caused by the accepted employment injuries. The medical adviser further advised that he reached maximum medical improvement on October 5, 2012. He noted that while the statement of accepted facts indicated that appellant had work-related bilateral wrist and left elbow conditions, there was no record of any additional treatment of these conditions. The medical adviser concluded that he did not have any additional impairment to either upper extremity.

In a December 3, 2012 decision, OWCP denied appellant's claim for an additional schedule award based on the medical adviser's October 23, 2012 opinion.

On December 18, 2012 appellant requested an oral hearing. Following an April 11, 2013 telephone hearing, he submitted reports from Dr. Kane. In a May 2, 2013 report, Dr. Kane stated that on physical examination appellant could actively flex and abduct both shoulders to 115 degrees. The neurovascular status of his hand was intact. Dr. Kane reiterated that appellant had weakness with abduction and external rotation against resistance. There was no neurological deficit to the upper extremities. Dr. Kane reiterated his prior right and left shoulder x-ray findings and diagnosed rotator cuff arthropathy of both shoulders. He concluded that there was no change in appellant's status.

In a June 18, 2013 decision, an OWCP hearing representative affirmed the December 3, 2012 decision. The hearing representative found that the medical adviser's October 23, 2012 report constituted the weight of the medical opinion evidence.

### **LEGAL PRECEDENT**

The schedule award provision of FECA<sup>2</sup> and its implementing federal regulations,<sup>3</sup> set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions and organs of the body. 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 for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.<sup>4</sup> The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.<sup>5</sup> Effective May 1, 2009, FECA adopted the sixth edition of the A.M.A., *Guides*<sup>6</sup> as the appropriate edition for all awards issued after that date.<sup>7</sup>

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).<sup>8</sup> The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).<sup>9</sup>

OWCP' procedures provide that, after obtaining all necessary medical evidence, the file should be routed through the medical adviser for an opinion concerning the nature and

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<sup>2</sup> 5 U.S.C. § 8107.

<sup>3</sup> 20 C.F.R. § 10.404.

<sup>4</sup> *Ausbon N. Johnson*, 50 ECAB 304 (1999).

<sup>5</sup> 20 C.F.R. § 10.404; *Mark A. Holloway*, 55 ECAB 321, 325 (2004).

<sup>6</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009).

<sup>7</sup> Federal (FECA) Procedure Manual, Part 3 -- Claims, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

<sup>8</sup> A.M.A., *Guides* at 494-531.

<sup>9</sup> *Id.* at 521.

percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.<sup>10</sup>

### ANALYSIS

OWCP accepted appellant's claim for right carpal tunnel syndrome, right rotator cuff tear, left lateral and medial epicondylitis, left carpal tunnel syndrome and bilateral shoulder impingement syndrome. Appellant received a schedule award for 22 percent impairment to the right upper extremity. On October May 22, 1996 he received a schedule award for 24 percent impairment to the left upper extremity. On October 20, 1998 appellant received an additional schedule award for 7 percent impairment to the left upper extremity, totaling 31 percent impairment. The Board finds that he did not meet his burden of proof to establish that he sustained greater impairment to either upper extremity.

Appellant has failed to submit any evidence by a treating physician finding greater impairment to the right and left upper extremities related to the accepted conditions. Dr. Kane's October 5, 2012 report indicated that appellant's right shoulder could flex to 130 degrees and the left shoulder to 110 degrees. He reported that abduction was to 120 degrees on the right and 110 degrees on the left. Dr. Kane advised that external rotation was to 30 degrees on the right and 20 degrees on the left. He found that appellant had weakness with abduction and external rotation against resistance. Dr. Kane advised that appellant was status post left shoulder arthroscopic debridement and decompression, right shoulder rotator cuff tear and rotator cuff arthropathy bilaterally with the most recent surgery performed on March 20, 2012. He failed to make an impairment rating referring to the sixth edition of the A.M.A., *Guides*. Dr. Kane's reference to his July 27, 2012 impairment rating of nine percent impairment to the left upper extremity under the fifth edition of the A.M.A., *Guides* is of limited probative value as it is not based on the proper edition of the A.M.A., *Guides*. For the stated reasons, the Board finds that his reports are insufficient to establish appellant's claim.

The file was then properly routed to the medical adviser, for an opinion concerning the nature or percentage of permanent impairment in accordance with the A.M.A., *Guides*.<sup>11</sup> On October 23, 2012 he utilized Dr. Kane's October 5, 2012 findings, referenced the sixth edition of the A.M.A., *Guides* and found that appellant had eight percent impairment to each upper extremity and reached maximum medical improvement on October 5, 2012. Utilizing Table 15-34 on page 475 of the A.M.A., *Guides*, the medical adviser determined that appellant's right upper extremity had three percent impairment each for loss of flexion and abduction and two percent impairment for loss of rotation, resulting in eight percent impairment. Regarding the left upper extremity, he utilized the same table and determined that appellant had three percent impairment each for loss of flexion and abduction and two percent impairment for loss of external rotation, resulting in eight percent impairment. The medical adviser stated that appellant's bilateral shoulder impairment was caused by the accepted employment injuries. He

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<sup>10</sup> See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (January 2010). See *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

<sup>11</sup> *Id.*

noted that there was no record of any additional treatment for appellant's work-related bilateral wrist and left elbow conditions. The medical adviser concluded that he did not have any additional impairment to either upper extremity.

The Board finds that the medical adviser's October 23, 2012 report properly applied the October 5, 2012 findings of Dr. Kane to the A.M.A., *Guides* and establishes that appellant has no more than 22 percent permanent impairment of his right upper extremity and 31 percent impairment of his left upper extremity under the sixth edition of the A.M.A., *Guides*.

The Board further finds that Dr. Kane's May 2, 2013 report again failed to make an impairment rating referring to the sixth edition of the A.M.A., *Guides*. Dr. Kane listed essentially normal findings with the exception of 115 degrees each in flexion and abduction of both shoulders. He reiterated that appellant had weakness with abduction and external rotation against resistance and his prior right and left shoulder x-ray findings and diagnosis of bilateral shoulder rotator cuff arthropathy. Dr. Kane concluded that there was no change in appellant's status. As his report does not provide an impairment rating based on the sixth edition of the A.M.A., *Guides*, the Board finds that it lacks probative value and is insufficient to establish appellant's claim.

Appellant also submitted new evidence on appeal. However, the Board lacks jurisdiction to review such evidence for the first time on appeal.<sup>12</sup>

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 failed to establish that he has more than 22 percent impairment of the right upper extremity and 31 percent impairment of the left lower extremity, for which he received schedule awards.

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<sup>12</sup> See 20 C.F.R. § 501.2(c)(1); *Sandra D. Pruitt*, 57 ECAB 126 (2005).

**ORDER**

**IT IS HEREBY ORDERED THAT** the June 18, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 6, 2014  
Washington, DC

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

Patricia Howard Fitzgerald, Judge  
Employees' Compensation Appeals Board

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