United States Department of Labor
Employees' Compensation Appeals Board

M.M., Appellant	)	
and	)	**Docket No. 13-1136**
	)	**Issued: June 10, 2014**
U.S. POSTAL SERVICE, POST OFFICE, St. Louis, MO, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 10, 2013 appellant, through her attorney, filed a timely appeal from a February 25, 2013 schedule award decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.

ISSUE

The issue is whether appellant has more than seven percent impairment of her right arm, for which she received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] Appellant, a 53-year-old mail processor clerk, has an accepted claim for a right shoulder strain. She underwent a magnetic resonance imaging (MRI) scan of her right shoulder on June 20, 2007, which demonstrated a near to complete rupture of the supraspinatus tendon and diffuse atrophy of the supraspinatus muscle, mild tendinopathy of the infraspinatus tendon and moderate acromial joint changes and joint effusion.

On April 4, 2008 appellant underwent arthroscopic repair of the right shoulder with subacromial decompression, distal clavicle excision and rotator cuff repair. She underwent a computerized tomography (CT) scan on August 6, 2008, which demonstrated that her tendons were not well defined. On October 3, 2008 appellant underwent an arthroscopy of the right shoulder with repair of the rotator cuff and subacromial decompression.

In 2009, appellant claimed a schedule award. By decision dated July 9, 2009, OWCP granted a schedule award for seven percent impairment of the right arm.

On August 23, 2009 appellant requested reconsideration. She submitted an August 14, 2009 report from Dr. D.R. Bassman, an attending Board-certified orthopedic surgeon, who reviewed the treatment of appellant and advised that he would rate impairment at 30 percent due to pain, discomfort and loss of strength. Dr. Bassman did not make any reference to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

By decision dated September 29, 2009, OWCP denied modification of the prior decision. If found that Dr. Bassman did not provide an impairment rating under the A.M.A., *Guides*.

In a report dated November 24, 2009, Dr. Jody T. Jachna, a Board-certified orthopedic surgeon, examined appellant's right shoulder. He noted that she was unable to lift her arm more than 30 degrees in flexion or abduction, but had a full passive range of motion. Dr. Jachna found a positive impingement sign. He stated that appellant was unable to support her arm at all and that a recent arthrogram did not reveal any full thickness tear of the rotator cuff; but an MRI scan of the cervical spine showed multiple levels of degenerative joint disease with stenosis at C4-5 and neuroforaminal stenosis at C5-6. Dr. Jachna diagnosed right-sided shoulder prior rotator cuff tear with repair with significant residual weakness of the rotator cuff.

Appellant requested an additional schedule award. In letter dated April 5, 2010, OWCP requested that she submit additional medical evidence to support greater impairment. On May 19, 2010 Dr. Bassman provided range of motion findings for appellant's right shoulder. He listed abduction of 10 degrees, forward flexion of 10 degrees, internal rotation of 80 degrees, external rotation of 20 degrees and backward flexion of 10 degrees. Dr. Bassman stated, "The disability therefore established by these figures would leave [appellant] with a [permanent partial disability] rating of 75 percent of the right shoulder."

[2] Docket No. 07-2329 (issued March 13, 2008). The Board affirmed determinations by OWCP that appellant did not meet her burden of proof to establish her claim. On September 25, 2007 OWCP accepted her claim.

Dr. David H. Garelick, an OWCP medical adviser, reviewed the medical evidence on June 21, 2010. He noted that the diagnostic tests revealed that appellant's rotator cuff was intact and that passive motion was full; therefore, it was possible that the loss of active motion represented a lack of full effort on her behalf. Dr. Garelick recommended a functional capacity evaluation to determine if appellant was using full effort.

On May 19, 2010 Dr. Bassman noted appellant's complaints of increased right shoulder pain. He diagnosed strain/tear of the rotator cuff on the right.

Appellant underwent a functional capacity evaluation on August 4, 2010, which demonstrated the presence of variable levels of physical effort on her part. She demonstrated minor inconsistency to the reliability or accuracy of her subjective reports of pain. The functional capacity evaluation demonstrated that appellant had right shoulder range of motion of flexion of 60 degrees, extension of 40 degrees, abduction of 75 degrees, external rotation of 60 degrees and internal rotation of 40 degrees. Appellant's right scapular strength was two of five in all planes. She demonstrated less than full effort in grip testing and low effort on the right. Appellant's heart rate also demonstrated questionable effort.

In a note dated July 28, 2010, Dr. Bassman found normal motor strength in appellant's right shoulder.

In a September 20, 2010 report, Dr. Garelick reviewed the medical evidence and noted that the functional capacity evaluation demonstrated submaximal effort on appellant's part. He found that the reported range of motion measurements were not reliable. Therefore, the medical evidence did not support greater than seven percent impairment as previously awarded.

By decision dated September 30, 2010, OWCP denied appellant's claim for an additional schedule award.

Appellant requested an oral hearing before an OWCP hearing representative that was held on February 11, 2011.

In a decision dated May 2, 2011, the hearing representative affirmed the denial of an additional schedule award. She found that the weight of the medical evidence did not establish greater impairment.

Appellant requested reconsideration on September 6, 2011. She submitted a CT scan of the right upper extremity, which demonstrated postoperative changes in the right shoulder, positive os acromial suspected and no definite labral or full thickness rotator cuff tear. Appellant also submitted a right shoulder arthrogram and report dated August 30, 2011 from Dr. Matthew Bradley, a Board-certified surgeon, who noted her history of injury and stated that she continued to have an inability to abduct or flex her shoulder. Dr. Bradley provided range of motion including active flexion of the shoulder to 30 degrees, active abduction of 25 degrees, external rotation to 70 and internal rotation "to the abdomen with the arm fully adducted." He stated that appellant's passive range of motion was flexion 160, abduction to 155, external rotation to 75 degrees and internal rotation to the abdomen. Dr. Bradley found that she had normal strength in her internal and external rotators about the shoulder and zero of five strength of her supraspinatus muscle.

In a report dated December 26, 2011, Dr. Sanjai Shukla, a medical adviser, reviewed the medical record. He noted that Dr. Bradley reported a full passive range of motion of the right shoulder with negative impingement testing. Further, the CT scan was negative for a recurrent tear of the rotator cuff. Dr. Shukla found no basis for an increase in appellant's permanent impairment rating beyond the seven percent previously awarded. The medical adviser noted that this percentage was the maximum award for a full thickness rotator cuff tear with residual loss.

By decision dated February 8, 2012, OWCP denied appellant's claim for an additional schedule award.

Appellant requested reconsideration on April 14, 2012. In reports dated March 2 and 30, 2012, Dr. Bradley stated that she never gained the ability to abduct or flex her right shoulder postoperatively following surgery. He stated that appellant had excellent passive range of motion without any other findings except that she was unable to actively abduct or flex her shoulder to any degree. Dr. Bradley suggested that nerve damage was a possibility and noted that she was scheduled for nerve conduction and electromyogram (EMG) testing. He stated that appellant's range of motion was unchanged and that she had no strength in her deltoids. A March 21, 2012 EMG report stated, "The recruitment pattern is incomplete in the right deltoid and biceps muscle, more pronounced in the right deltoid muscle since [appellant] was unable to give complete efforts secondary to restricted range of motion." The report noted that appellant's abnormal findings were chronic in nature and that she had almost frozen shoulder for several years. Dr. Bradley stated, "At this point, I feel that any recovery of nerve function or motor function is very unlikely as EMG clearly demonstrates no ability for motor recruitment of [appellant's] deltoid muscles."

On May 27, 2012 Dr. Shukla reviewed the medical record and stated that EMG demonstrated incomplete recruitment of the deltoid since appellant was unable to give complete effort secondary to restricted range of motion. He noted, "Incomplete motor unit activation is observed in EMG's when a patient's efforts are voluntarily reduced because of pain, fear or malingering. Incomplete recruitment is not a sign of muscle denervation." Dr. Shukla noted that appellant's physical examination demonstrated a full passive range of motion and the MRI scan demonstrated an intact rotator cuff. He stated that the medical evidence did not establish greater impairment.

In a decision dated June 13, 2012, OWCP denied appellant's claim for an additional schedule award.

Appellant requested reconsideration on June 30, 2012. She submitted a functional capacity evaluation of June 29, 2012 obtained by Maria Ross, a physical therapist.

On August 25, 2012 Dr. Christopher Gross, a medical adviser, reviewed the medical record and found that the testing showed no consistency in maximum voluntary effort and demonstrated that appellant was not at maximum medical improvement. He recommended additional evaluation by Dr. Bradley to address the possibility of impending adhesive capsulitis.

In a decision dated September 19, 2012, OWCP denied appellant's claim for an additional schedule award.

Appellant requested reconsideration on November 13, 2012. On October 26, 2012 Dr. Bradley stated that her EMG demonstrated nerve injuries. He found that appellant's physical examination was unchanged and reported active flexion to 30 and active abduction to 30. Dr. Bradley listed her passive range of motion as 140 degrees of abduction, 150 degrees of flexion and 50 degrees of external rotation. He found motor strength testing of zero out of five of the supraspinatus, one out of five of the deltoids with only some very slight recruitment of the middle fibers of the deltoid. Dr. Bradley stated that appellant had reached maximum medical improvement. He stated, "I have assigned [appellant] a partial permanent disability rating at 75 percent as it relates to her right upper extremity as she has very, very minimal amount of function of her shoulder not allowing her to place her hand in any appropriate position in space to allow for any meaningful work."

On February 18, 2013 Dr. Garelick reviewed the record and found that Dr. Bradley's impairment rating was arbitrary. He was unable to correlate the extent of impairment with any table in the sixth edition of the A.M.A., *Guides*.

By decision dated February 25, 2013, OWCP denied modification of the September 19, 2012 decision. It found that Dr. Bradley's October 26, 2012 report was not in accordance with the A.M.A., *Guides*.

LEGAL PRECEDENT

The schedule award provision of FECA[3] and its implementing regulations[4] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of loss of use, of scheduled members or functions 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 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[5]

In addressing upper extremity impairments, the sixth edition requires identification of 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). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[6]

[3] 5 U.S.C. §§ 8101-8193, 8107.

[4] 20 C.F.R. § 10.404.

[5] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009). *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 Award and Permanent Disability Claims*, Chapter 2.808.6a (January 2010).

[6] A.M.A., *Guides* 411.

ANALYSIS

On July 9, 2009 appellant received a schedule award for seven percent impairment of the right arm. She subsequently contended that she sustained greater impairment due to her right shoulder strain. Appellant underwent surgery on April 4 and October 3, 2008. The Board finds that she has not submitted sufficient medical evidence to establish greater impairment.

The medical evidence submitted to the record from appellant's physicians does not provide an adequate discussion of the physical findings or how her impairment was rated applying the sixth edition of the A.M.A., *Guides*. Moreover, the physicians do not affirmatively address whether she is at maximum medical improvement. Dr. Bassman originally provided a rating of 30 percent impairment as a result of pain, discomfort and loss of strength but he made no reference to how his rating was prepared utilizing Chapter 15 of the Shoulder Regional Grid at Table 15-5 and applicable grade modifiers. His subsequent reports provided findings on examination and, on May 19, 2010, he increased the impairment rating to 75 percent of the right shoulder. Again, Dr. Bassman failed to address how this rating was made in compliance with the protocols of the sixth edition of the A.M.A., *Guides*. Thereafter, on July 28, 2010, he reported normal motor strength. For this reason, Dr. Bassman's impairment ratings are of diminished probative value.

Dr. Jachna provided findings pertaining to appellant's right shoulder. He noted that a recent arthrogram did not reveal a full thickness tear of the rotator cuff; but that an MRI scan showed cervical degenerative disc disease. Dr. Jachna did not provide any impairment rating. This report is not sufficient to establish greater permanent impairment than the seven percent awarded in 2009.

Dr. Bradley examined appellant in 2011 and provided findings on range of motion. However, he did not provide a rating of impairment under the sixth edition of the A.M.A., *Guides*. Dr. Shukla, the medical adviser, noted that the findings on examination were unchanged from prior reports and that clinical studies showed an intact rotator cuff and full passive range of motion. In early 2012, Dr. Bradley again provided treatment records, noting that appellant had problems pertaining to the deltoid muscle. He did not state whether she was at maximum medical improvement regarding her right shoulder or address impairment with reference to the A.M.A., *Guides*. On October 26, 2012 Dr. Bradley stated that appellant's nerve studies demonstrated injury and he noted reduced motor strength testing. He did not address how this correlated with the normal motor strength testing previously noted by Dr. Bassman in July 2010 or whether she was at maximum medical improvement. Dr. Bradley did not specifically address appellant's cooperation or effort on range of motion testing or make reference to the A.M.A., *Guides* when providing a 75 percent rating to her right shoulder.

It is well established that it is the responsibility of the evaluating physician to explain in writing why a particular method was used to assign an impairment rating.[7] It is also well established that ratings that do not address how the extent of impairment was determined under the applicable edition of the A.M.A., *Guides*, are of reduced probative value.[8] In this case,

[7] *See Peter C. Belkind*, 56 ECAB 580, 584-85 (2005). *See also Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

[8] *See Derrick C. Miller*, 54 ECAB 266 (2002); *James Kennedy, Jr.*, 40 ECAB 620 (1989).

appellant's physicians did not adequately explain the method by which their impairment ratings were completed; they did not address whether appellant had achieved maximum medical improvement or demonstrated sufficient cooperation on range of motion testing. None of the physicians referenced the sixth edition of the A.M.A., *Guides*. The Board finds that appellant has not submitted sufficient medical evidence to establish that she sustained additional impairment.

CONCLUSION

The Board finds that appellant has not established greater than seven percent impairment to her right arm.

ORDER

IT IS HEREBY ORDERED THAT the February 25, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 10, 2014
Washington, DC

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

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