

FACTUAL HISTORY

OWCP accepted that on September 14, 2012 appellant, then a 54-year-old sheet metal mechanic, sustained a right biceps tear due to taking a heavy box from a rack and setting it down to the floor. He did not stop work at the time of his September 14, 2012 injury.

In a September 21, 2012 report, Dr. Brian A. Levings, an attending osteopath, stated that appellant presented with a right shoulder injury sustained on September 14, 2012 when he felt a pop while trying to get something off of a high shelf at work. Dr. Levings diagnosed biceps tendon tear of the right arm.

On September 27, 2012 Dr. Levings performed right shoulder surgery, including arthroscopy, subacromial decompression, distal clavicle excision, arthroscopic rotator cuff repair, biceps tenodesis, and extensive debridement of the biceps, rotator cuff, and labrum. The procedures were authorized by OWCP.

In a March 25, 2013 report, Dr. Levings stated that appellant was seen six months status post right shoulder surgery. He reported that appellant was “doing well” with “[n]o complaints.” Dr. Levings indicated that no medications were noted and reported examination findings for the right shoulder, including full flexion and abduction, good strength with internal and external rotation, and negative empty can and O’Brien tests. He recommended that appellant continue with his home exercise and indicated that he could work full duty without restriction.

OWCP requested that Dr. Levings provide an impairment rating for appellant’s right arm under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009). In a July 25, 2013 report, Dr. Levings stated that appellant presented on September 21, 2012 with a right shoulder injury sustained on September 14, 2012 when he felt a pop while trying to get something off of a high shelf at work. Appellant underwent a magnetic resonance imaging scan test on September 21, 2012 which showed full-thickness tear of the supraspinatus and subscapularis and some biceps instability and he underwent a right shoulder arthroscopic biceps tenodesis, subscapularis repair, and rotator cuff repair on September 27, 2012. Dr. Levings noted that appellant “proceeded nicely” with his postoperative course and rehabilitation into maximum medical improvement and was released from care on March 25, 2013. He stated, “According to the [A.M.A., *Guides*] is 20 percent [sic] for his right upper extremity.”

On July 17, 2014 appellant filed a claim (Form CA-7) for a schedule award due to his accepted injury.

On March 4, 2014 Dr. Henry Mobley, a Board-certified internist serving as an OWCP medical adviser, stated that he had reviewed Dr. Levings’ July 15, 2013 impairment evaluation. He indicated that the report did not meet the requirements of OWCP’s regulations for a probative schedule award determination because it was not clear how the impairment rating was derived from the standards of the sixth edition of the A.M.A., *Guides*. Dr. Mobley recommended that an impairment evaluation be obtained from a Board-certified specialist (preferably an orthopedic surgeon or physical medical and rehabilitation physician) who is familiar with the sixth edition of the A.M.A., *Guides*.

In March 2014, OWCP referred appellant and the case record to Dr. Shawn Smith, a Board-certified physical medical and rehabilitation physician, for examination and an opinion on his right arm impairment. In a report dated April 10, 2014, Dr. Smith detailed appellant's medical history, including the nature of his September 14, 2012 work injury and subsequent treatment, and reported the findings of his examination on that date. He described appellant's right arm surgery in September 2012 and indicated that he continued to have weakness in his right bicipital muscle as well as pain in his right shoulder at times.² Dr. Smith stated that appellant's right shoulder showed fairly well-preserved range of motion with 60 degrees of adduction, 135 degrees of abduction, 155 degrees of flexion, 60 degrees of extension, 90 degrees of internal rotation, and 45 degrees of external rotation. Appellant had a positive Popeye's sign with dissection of the biceps proximally on the right with minimal weakness. Dr. Smith noted that he had tenderness in the right shoulder acromioclavicular joint and weakness in the supraspinatus muscle at 3 to 4/5, but that he otherwise had good strength throughout his right shoulder. Appellant had no focal numbness or weakness and no hyperhidrosis or contracture. Dr. Smith diagnosed right full thickness rotator cuff tear with mild residual impairment range of motion and pain, and right bicipital tendon tear status post repair with some residual weakness. He stated that Table 15-5 of the sixth edition of the A.M.A., *Guides* provided for diagnosis-based impairments for these two injuries. Dr. Smith concluded that appellant had an eight percent permanent impairment of his right arm and stated:

"The patient has a complete rotator cuff tear with residual loss which is a [c]lass 1 impairment. Grade [m]odifier [a]djustments are 1 for [f]unctional [h]istory, 1 for [p]hysical [e]xam[ination], 1 for [c]linical [s]tudies with a *QuickDASH* score of 28. This results in a Net Adjustment Score of 0 or a [g]rade C, which provides for five percent impairment according to the same table.

"The bicipital tendon dislocation is a [c]lass 1 impairment with [g]rade [m]odifiers of 1 for [f]unctional [h]istory, 1 for [p]hysical [e]xam[ination], [and] 1 for [c]linical [s]tudies with the same *QuickDASH* score. This results in an additional Net Adjustment Score of 0 or [g]rade C [and] it provides for three percent. In this case, I think both should be provided to accurately reflect the injuries to the arm, elbow, and shoulder. This results in a total of eight percent partial permanent impairment for the right upper extremity....

"As a result, I concur with the date of maximum medical improvement of [July 15, 2013] with a total of eight percent partial permanent impairment of the right shoulder...."³

In an April 30, 2014 report, Dr. Mobley, again serving as an OWCP medical adviser, stated that he had reviewed Dr. Smith's April 10, 2014 impairment evaluation. He provided a summary of how Dr. Smith had rated appellant's right arm impairment under Table 15-5 on pages 401 to 405 of the sixth edition of the A.M.A., *Guides*. Dr. Mobley noted that Dr. Smith's

² Appellant reported a previous rotator cuff tear in his right shoulder in 2009 which had previously been repaired with no residual deficits.

³ Dr. Smith indicated that appellant's right rotator cuff tear from 2009 did not appear to contribute any additional impairment.

combination of rotator cuff and bicep impairments “better represents [appellant’s] impairment than one” and agreed with Dr. Smith’s assessment that appellant had an eight percent right arm impairment.

In a May 29, 2014 decision, OWCP granted appellant a schedule award for an eight percent permanent impairment of his right arm. The award ran for 24.96 weeks from April 10 to October 1, 2014 and was based on the April 10, 2014 report of Dr. Smith and the April 30, 2014 report of Dr. Mobley.

LEGAL PRECEDENT

The schedule award provision of FECA⁴ and its implementing regulations⁵ 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 to all claimants, good administrative practice necessitates 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 the implementing regulations as the appropriate standard for evaluating schedule losses.⁶ For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.⁷

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401. After the Class of Diagnosis (CDX) is determined from the Shoulder Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier Functional History (GMFH), grade modifier Physical Examination (GMPE) and grade modifier Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).⁸ It is well established that, in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment,

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404 (1999).

⁶ *Id.*

⁷ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

⁸ See A.M.A., *Guides* (6th ed. 2009) 401-11. Table 15-5 also provides that, if motion loss is present for a claimant who has undergone a shoulder arthroplasty, impairment may alternatively be assessed using section 15.7 (range of motion impairment). Such a range of motion impairment stands alone and is not combined with a diagnosis impairment. *Id.* at 405, 475-78.

preexisting impairments of the body are to be included.⁹ There is no basis for including subsequently acquired conditions.¹⁰

ANALYSIS

OWCP accepted that on September 14, 2012 appellant sustained a right biceps tear due to taking a heavy box from a rack and setting it down to the floor. On September 27, 2012 Dr. Levings, an attending osteopath, performed right shoulder surgery, including arthroscopy, subacromial decompression, distal clavicle excision, arthroscopic rotator cuff repair, biceps tenodesis, and extensive debridement of the biceps, rotator cuff, and labrum. The procedures were authorized by OWCP. Appellant filed a claim for a schedule award due to his accepted injury. On May 29, 2014 OWCP granted him a schedule award for an eight percent permanent impairment of his right arm based on the April 10, 2014 report of Dr. Smith, a Board-certified orthopedic surgeon serving as an OWCP referral physician, and the April 30, 2014 report of Dr. Mobley, a Board-certified internist serving as an OWCP medical adviser.

The Board finds that appellant did not submit sufficient medical evidence to establish that he has more than an eight percent permanent impairment of his right arm, for which he received a schedule award.

In a report dated April 10, 2014, Dr. Smith properly determined that appellant had an eight percent permanent impairment of his right arm under the standards of the sixth edition of the A.M.A., *Guides*. He detailed appellant's medical history, including the nature of his September 14, 2012 work injury and subsequent treatment, and reported the findings of his examination on that date. Dr. Smith diagnosed right full thickness rotator cuff tear with mild residual impairment range of motion and pain, and right bicipital tendon tear status post repair with some residual weakness. He stated that Table 15-5 (Shoulder Regional Grid) of the sixth edition of the A.M.A., *Guides*¹¹ provided for diagnosis-based impairments for these two injuries. Dr. Smith noted that appellant's complete right rotator cuff tear with residual loss which was a class 1 impairment and that the grade modifier adjustments were 1 for functional history, 1 for physical examination, and 1 for clinical studies with a *QuickDASH* score of 28. This resulted in a Net Adjustment Score of 0 or a grade C which provided for five percent right arm impairment according to the same table.¹² Dr. Smith further indicated that appellant's right bicipital tendon dislocation was a class 1 impairment with grade modifiers 1 for functional history, 1 for physical examination, and 1 for clinical studies with a *QuickDASH* score of 28. This resulted in a Net Adjustment Score of 0 or grade C and an additional right arm impairment of three percent. Dr. Smith properly indicated that combining the five percent impairment (rotator cuff tear) and the three percent impairment (biceps rupture) provided the best assessment of appellant's right arm

⁹ *D.F.*, 59 ECAB 288 (2007); *Kenneth E. Leone*, 46 ECAB 133 (1994).

¹⁰ *R.G.*, Docket No. 13-220 (issued May 9, 2013).

¹¹ A.M.A., *Guides* 401-05, Table 15-2.

¹² See *supra* note 8 for a description of the application of grade modifiers and the net adjustment formula.

and shoulder.¹³ On April 30, 2014 Dr. Mobley produced a report in which he explained why he was in agreement with Dr. Smith's impairment rating.

On appeal, appellant asserted that his right arm impairment was represented by a 20 percent impairment rating provided in a July 15, 2013 report of Dr. Levings. However, the July 15, 2013 report is of limited probative value on the extent of appellant's right arm impairment because the impairment rating it provides is not derived in accordance with the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses.¹⁴ With respect to appellant's right arm impairment, Dr. Levings merely stated, "According to the [A.M.A., *Guides*] is 20 percent [sic] for his right upper extremity." He did not provide any explanation of how his impairment rating was derived under the specific standards of the sixth edition of the A.M.A., *Guides*.

For these reasons, appellant did not show that he has more than an eight percent permanent impairment of his right arm. He 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 did not meet his burden of proof to establish that he has more than an eight percent permanent impairment of his right arm, for which he received a schedule award.

¹³ The Board notes that Dr. Smith also considered appellant's preexisting right shoulder condition, including an apparent 2009 rotator cuff tear, in arriving at his impairment rating. *See supra* note 9.

¹⁴ *See James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).

ORDER

IT IS HEREBY ORDERED THAT the May 29, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 6, 2015
Washington, DC

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

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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