

**United States Department of Labor
Employees' Compensation Appeals Board**

C.F., Appellant)

and)

U.S. POSTAL SERVICE, POST OFFICE,)
Las Vegas, NV, Employer)

**Docket No. 14-1656
Issued: January 8, 2015**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 25, 2014 appellant filed a timely appeal from an April 7, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant established more than an 11 percent permanent impairment to the right arm, for which she received a schedule award.

FACTUAL HISTORY

On August 20, 2012 appellant, then a 51-year-old city letter carrier, filed an occupational disease claim alleging that she developed a right shoulder and arm conditions due to pitching mail, lifting, and delivering mail. OWCP accepted the claim for right shoulder tendinitis and

¹ 5 U.S.C. § 8101 *et seq.*

right shoulder labrum tear. It authorized a January 17, 2013 right shoulder arthroscopy with adhesion resection, acromioplasty, mumford, and manipulation. This surgery was performed by Dr. Robert J. Grondel, a Board-certified orthopedic surgeon. After her surgery, appellant returned to light duty on February 19, 2013. OWCP paid wage-loss compensation.

In an April 17, 2013 report, Dr. Grondel noted that appellant was three months postsurgery. He advised that appellant had mild tenderness, mild limited range of motion in her right shoulder, and numbness in the right arm. Dr. Grondel recommended that appellant undergo an electromyogram (EMG) and nerve conduction study (NCS). In a May 15, 2013 report, Dr. Leo Germin, a Board-certified neurologist, noted the findings of the EMG and NCS testing and found that there was no evidence of right carpal tunnel syndrome, ulnar neuropathy, atonal or demyelinating sensory motor peripheral neuropathy. He also found that motor unit action potential firing pattern and configuration was within a normal range for all muscles tested.

In a July 29, 2013 report, Dr. Bradley Baker, a Board-certified orthopedic surgeon to whom appellant was referred by Dr. Grondel, noted that appellant was experiencing right shoulder pain despite surgery. He reported normal range of motion with some discomfort at times. Dr. Baker stated that appellant appeared to have reached the maximum improvement and that he did not recommend any additional treatment options.

In an August 30, 2013 report, Dr. Grondel noted that appellant complained of right shoulder pain. He recommended that appellant undergo a functional capacity evaluation and an additional magnetic resonance imaging scan to track her progress. On September 18, 2013 Dr. Alison Nguyen, Board-certified in diagnostic radiology, advised that a right shoulder arthrogram revealed moderate supraspinatus tendinosis with undersurface tendon spurring. The testing did not show a full thickness tear of the rotator cuff.

In an October 4, 2013 report, Dr. Grondel noted reviewing a September 27, 2013 functional capacity evaluation and noted current findings. He advised that appellant was experiencing tenderness, swelling, and limited range of motion. Dr. Grondel assessed right rotator cuff tendinitis, right shoulder pain, right shoulder adhesive capsulitis, right biceps tendinitis and chronic right rotator cuff tear. Dr. Grondel recommended that appellant be placed on permanent disability with limitations. He stated that her case was considered closed. In an accompanying October 4, 2013 duty status report (CA-17), Dr. Grondel reiterated the work restrictions outlined in the functional capacity evaluation. The record contains a September 27, 2013 functional capacity evaluation from a physical therapist. The report concluded that appellant had the ability to perform light work and noted her physical work abilities.

On November 13, 2013 appellant claimed a schedule award. On December 4, 2013 OWCP advised appellant of the type of medical report that she needed to support her claim for a schedule award. In a December 16, 2013 letter, appellant informed OWCP that Dr. Grondel did not provide impairment calculations. Appellant asked that OWCP refer her to a physician who would provide an impairment rating.

On December 30, 2013 OWCP referred appellant, together with the medical record and a statement of accepted facts, to Dr. Aubrey Swartz, a Board-certified orthopedic surgeon, for an opinion regarding permanent impairment. In a January 29, 2014 report, Dr. Swartz noted

appellant's history and reviewed her medical record. He reported his findings on examination and advised that she was status post January 17, 2013 right shoulder surgery. In addressing permanent impairment, Dr. Swartz used the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. Referring to page 403, Table 15-5 for acromioclavicular (AC) joint injury or disease, he found that appellant had a class 1 impairment for Class of Diagnosis (CDX) with a default 10 percent impairment. For a Functional History (GMFH) adjustment under Table 15-7, at page 406, Dr. Swartz advised that appellant had a *QuickDASH* score of 22, suggesting a grade modifier of one. He further explained that she had pain with vigorous activity which also supported a grade one modifier. Using the formula GMFH-CDX (1-1), Dr. Swartz found that there was a net zero grade modifier for functional history. For Physical Examination (GMPE) adjustment, he found that appellant was very tender and had pain with provocative testing, which suggested a grade two modifier under Table 15-8, page 408. Using the formula GMFH-CDX (2-1), he found that there was a grade modifier of one. Dr. Swartz advised that the Clinical Studies (GMCS) adjustment was not applicable for appellant's condition. Dr. Swartz found that appellant had a net adjustment of +1. He indicated that this moved the grade C default rating of 10 percent to grade D which provided 11 percent impairment of the arm. Dr. Swartz advised that appellant's maximum medical improvement (MMI) was January 7, 2014, 12 months postoperative.

On March 22, 2014 an OWCP medical adviser reviewed Dr. Swartz January 29, 2014 report and concurred with his determination that appellant had 11 percent impairment of the right arm.

By decision dated April 7, 2014, OWCP granted appellant a schedule award for 11 percent permanent impairment of the right arm. The period of the award ran from January 7 to September 4, 2014.

On appeal, appellant argued that her impairment rating should have been higher than 11 percent and that OWCP overlooked vital medical evidence.

LEGAL PRECEDENT

The schedule award provisions of FECA 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.²

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

² See *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000). See also 5 U.S.C. § 8107.

and Health (ICF).³ Under the sixth edition, the evaluator identifies the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.⁴ The net adjustment formula is (GMFH-CDX) + (GMPE-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.⁵

ANALYSIS

The Board finds that OWCP properly determined appellant's permanent impairment of her right arm. OWCP accepted the claim for right shoulder tendinitis and right shoulder labrum tear and it authorized a January 17, 2013 right shoulder arthroscopy. It accepted the claim for aggravation of preexisting right knee synovitis and popliteal cyst. After appellant claimed a schedule award, OWCP referred her to Dr. Swartz for an impartial evaluation.

The Board finds that Dr. Swartz applied the appropriate tables and grading schemes of the A.M.A., *Guides*, in determining that appellant has 11 percent permanent impairment to the right arm. He found that the diagnosis-based estimate for AC joint injury or disease, under Table 15-5 (shoulder-region grid), page 403, was a class 1, default position C, which equated to 10 percent permanent impairment. This selection was appropriate because the medical evidence of record specifies that appellant underwent a distal clavicle resection. Dr. Swartz then explained that he assigned a grade modifier 1 for functional history, under Table 15-7, page 406, and a grade modifier 2 for physical examination, according to Table 15-8, page 408. He found that clinical studies were not applicable. Using the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), he found that (1-1) + (2-1) + (n/a) resulted in a net grade modifier +1. This moves the default grade C impairment to grade D which results in 11 percent permanent impairment of the right arm. In a March 22, 2014 report, an OWCP medical adviser concurred with Dr. Swartz' determination. 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 an 11 percent permanent impairment of the right arm.

On appeal, appellant argued that her impairment rating should have been higher than 11 percent and that OWCP overlooked vital evidence and had not sufficiently considered her pain and the way that the injury affected her ability to engage in everyday activities. As previously stated, OWCP calculates schedule awards in conformance with the sixth edition of the A.M.A., *Guides*. In this case, there is no other probative medical evidence that calculates an impairment rating using the sixth edition of the A.M.A., *Guides*. Furthermore, the Board has held that factors such as limitations on daily activities have no bearing on the calculation of a schedule award.⁶

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

⁴ *Id.* at 494-531.

⁵ *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

⁶ *Kimberly M. Held*, 56 ECAB 670 (2005).

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 she sustained more than 11 percent permanent impairment to the right upper extremity, for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the April 7, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 8, 2015
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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