

On June 29, 2009 appellant, then 53-year-old special agent, filed a traumatic injury claim alleging that he sustained injuries in the performance of duty on June 12, 2009 when a ladder he was climbing collapsed. OWCP initially accepted a closed left radial neck fracture of the elbow on August 6, 2009. In addition, it subsequently accepted cervical strain, left shoulder impingement, and left carpal tunnel syndrome. Appellant underwent a left carpal tunnel release on January 21, 2010 and left shoulder arthroscopic surgery with excision of the distal clavicle on September 13, 2010.

In a report dated March 30, 2011, Dr. Tiffany Shay Alexander, Board-certified in occupational medicine, provided results upon examination. She opined that appellant had a 20 percent left upper extremity impairment under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). In a report dated October 24, 2011, Dr. Arthur Harris, an OWCP medical adviser, reviewed Dr. Alexander's findings and opined that, under the sixth edition of the A.M.A., *Guides*, appellant had a 10 percent left upper extremity permanent impairment. He indicated that the impairment was based on impairments to the shoulder, elbow, and wrist.

By decision dated September 26, 2012, OWCP issued a schedule award for a 10 percent permanent impairment to the left upper extremity. The period of the award was 31.2 weeks from March 30, 2011.

On November 26, 2012 appellant requested reconsideration and submitted an October 9, 2012 report from Dr. Jacob Tauber, a Board-certified orthopedic surgeon, who provided results on examination, indicating that appellant had some intermittent left hand and wrist pain, and the pain was associated with numbness and tingling. Dr. Tauber also noted occasional left elbow pain. He opined that appellant had a 21 percent left upper extremity impairment under the A.M.A., *Guides* (sixth edition). Dr. Tauber opined that appellant had a 10 percent impairment under Table 15-5 for the distal clavicle resection. In addition, he found an additional three percent impairment under Table 15-5 for left shoulder impingement syndrome. As to the elbow, Dr. Tauber stated that there was a three percent impairment under Table 15-4 for the radial neck fracture.

In a report dated April 1, 2013, Dr. Harris reviewed the report from Dr. Tauber. He opined that appellant had a 15 percent left arm permanent impairment. Dr. Harris stated that, under Table 15-5, appellant would have an 11 percent impairment for distal clavicle resection, adjusting for a grade modifier for clinical studies. He found no additional impairment under Table 15-5 was warranted, as the A.M.A., *Guides* indicated only one diagnosis should be used for the diagnosis-based regional grids. In addition, Dr. Harris found Dr. Tauber's findings were not consistent with a five percent impairment under Table 15-23, noting examination results and the absence of abnormalities on diagnostic studies. He opined that a two percent impairment was appropriate under Table 15-23. The date of maximum medical improvement was reported as the date of Dr. Tauber's report.²

² The date of the report was October 9, 2012, although Dr. Harris reported the date as October 19, 2012.

By decision dated April 25, 2013, OWCP denied appellant's request for reconsideration. The Board reviewed this decision, and issued an order remanding case.³ The Board noted that appellant had submitted new medical evidence and OWCP should issue an appropriate decision on a claim for an increased schedule award.

In a decision dated January 22, 2014, OWCP issued a schedule award for an additional 5 percent for a total of 15 percent permanent impairment to the left upper extremity. The period of the award was 15.60 weeks commencing October 19, 2012.

Appellant requested a review of the written record by an OWCP hearing representative. In a decision dated August 5, 2014, the hearing representative found that appellant had not established more than a 15 percent left upper extremity impairment.

LEGAL PRECEDENT

5 U.S.C. § 8107 provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.⁴ Neither FECA nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.⁵ For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition.⁶

With respect to a shoulder impairment, the A.M.A., *Guides* provide a regional grid at Table 15-4. The Class of Diagnosis (CDX) is determined based on specific diagnosis, and then the default value for the identified CDX is determined. The default value (grade C) may be adjusted by using grade modifiers for Functional History (GMFH, Table 15-7), Physical Examination (GMPE, Table 15-8), and Clinical Studies (GMCS, Table 15-9). The adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).⁷

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.⁸ In Table 15-23, grade modifiers levels (ranging from zero to four) are described for the categories test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The

³ Docket No. 13-1781 (issued February 4, 2014).

⁴ 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found at 20 C.F.R. § 10.404(a).

⁵ A. George Lampo, 45 ECAB 441 (1994).

⁶ FECA Bulletin No. 09-03 (March 15, 2009).

⁷ The net adjustment is up to +2 (grade E) or -2 (grade A).

⁸ A.M.A., *Guides* 448-50.

default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.⁹

ANALYSIS

In the present case, OWCP has issued schedule awards for permanent impairment to the left arm resulting from a June 12, 2009 employment incident. It issued a schedule award for a 10 percent left upper extremity impairment on September 26, 2012 and an additional five percent impairment was awarded by decision dated January 22, 2014.

Appellant submitted a March 30, 2011 report from Dr. Alexander, with an opinion as to the impairment under the fifth edition of the A.M.A., *Guides*. As noted above, schedule awards after May 1, 2009 must be based on the sixth edition. The report from Dr. Alexander is therefore of little probative value in determining the percentage of permanent impairment. In an October 9, 2012 report, Dr. Tauber opined that appellant had a 21 percent left upper extremity impairment under the sixth edition. OWCP received an April 1, 2013 report from Dr. Harris opining that appellant had a 15 percent left arm impairment. In reviewing these reports, the Board finds that the weight of the evidence rests with Dr. Harris.

As to an impairment to the left shoulder, both Dr. Tauber and Dr. Harris identified Table 15-5. For status post distal clavicle resection, the default (grade C) impairment for Class of Diagnosis 1 is 10 percent.¹⁰ Dr. Tauber opined that appellant had a 10 percent impairment. In this case, Dr. Harris adjusted the impairment to a grade D impairment of 11 percent, using a grade modifier 2 for clinical studies.¹¹ As noted above, the default impairment may be adjusted based on grade modifiers and application of the formula noted.

Dr. Tauber found an additional impairment of three percent under Table 15-5 for left shoulder impingement syndrome. As noted by Dr. Harris, this is contrary to specific instructions in the A.M.A., *Guides* regarding diagnosis-based impairments. When there are two diagnoses evaluated under the same table, “the examiner should use the diagnosis with the highest causally related impairment rating for the impairment calculation.”¹² Therefore, Dr. Harris properly used only the diagnosis for the distal clavicle resection under Table 15-5.

As to the left elbow, both Dr. Tauber and Dr. Harris found a three percent impairment based on Table 15-4. This table is also a diagnosis-based regional grid. For an elbow fracture with residual symptoms, the grade C impairment is three percent.¹³ Neither Dr. Tauber or Dr. Harris indicated that an adjustment to the default value was warranted.

⁹ *Id.*

¹⁰ *Id.* at 403, Table 15-5.

¹¹ *Id.* at 410, Table 15-9. A grade modifier 2 is for a moderate problem with clinical studies confirming the diagnosis.

¹² *Id.* at 387; *see also C.P.*, Docket No. 11-117 (issued August 10, 2011).

¹³ *Id.* at 399, Table 15-4.

For the impairment due to carpal tunnel, the Board again finds that it is Dr. Harris who represents the weight of the evidence. Dr. Tauber reported a five percent impairment under Table 15-23, without further explanation. A five percent impairment represents a grade modifier 2 under this table, but such a finding requires test findings and “significant intermittent symptoms.”¹⁴ Dr. Tauber provided only brief findings as to the left wrist without discussing significant symptoms or test findings. In addition, a grade modifier 2 is proper for decreased sensation. Although he briefly refers to numbness, the A.M.A., *Guides* state that decreased sensation “means decreased two-point discrimination (greater than six millimeter) for compression involving the median or ulnar nerve...”¹⁵ Dr. Tauber did not provide detailed findings that would establish decreased sensation. Dr. Harris explained that grade modifier 1 was appropriate based on the lack of test findings and the examination of Dr. Tauber. A grade modifier 1 results in a default impairment of two percent under Table 15-23.

The Board accordingly finds that Dr. Harris properly applied the A.M.A., *Guides* in this case and his opinion represents the weight of the evidence. The number of weeks of compensation for a schedule award is determined by the compensation schedule at 5 U.S.C. § 8107(c). For complete loss of use of the arm, the maximum number of weeks of compensation is 312 weeks. Since appellant’s impairment was 15 percent, he was entitled to 15 percent of 312 weeks, or 46.80 weeks of compensation. He properly received a combined 46.80 weeks of compensation from the September 26, 2012 and January 22, 2014 schedule award decisions. The period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from residuals of the employment injury.¹⁶

On appeal, appellant states that OWCP misinterpreted Dr. Tauber’s report. For the reasons discussed above, the Board finds that Dr. Tauber’s report did not establish more than a 15 percent permanent impairment of the left upper extremity. Appellant may request at any time an increased schedule award based on new medical evidence showing progression of an employment-related condition resulting in an increased impairment.

CONCLUSION

The Board finds that the evidence does not establish more than a 15 percent left upper extremity permanent impairment.

¹⁴ *Id.* at 449, Table 15-23.

¹⁵ *Id.* at 446.

¹⁶ *Albert Valverde*, 36 ECAB 233, 237 (1984).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 5, 2014 is affirmed.

Issued: March 2, 2015
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