United States Department of Labor
Employees' Compensation Appeals Board

A.L., Appellant	)	
and	)	**Docket No. 10-596**
	)	**Issued: November 30, 2010**
U.S. POSTAL SERVICE, AIRPORT MAIL FACILITY, Denver, CO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On December 30, 2009 appellant filed a timely appeal from a December 15, 2009 decision of the Office of Workers' Compensation Programs regarding a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant established that he sustained more than a nine percent permanent impairment of the right upper extremity, for which he received a schedule award.

On appeal, appellant asserts there is a conflict of medical opinion between his physician and an Office medical adviser regarding the appropriate percentage of permanent impairment.

FACTUAL HISTORY

The Office accepted that on July 20, 2007 appellant, then a 63-year-old mail handler, sustained bilateral shoulder sprains and a right rotator cuff tear when unloading trays onto a

conveyor belt.[1] On November 9, 2007 appellant underwent an open rotator cuff repair of the right shoulder, with subacromial decompression, debridement of the labrum, biceps tendon and rotator cuff. The Office approved surgery.

On January 28, 2009 appellant claimed a schedule award. He submitted a December 30, 2008 impairment rating from Dr. Craig Anderson, an attending physician Board-certified in occupational medicine, who found that appellant had reached maximum medical improvement. Appellant was able to perform all self-care activities. Referring to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, "A.M.A., *Guides*"), Dr. Anderson found a nine percent impairment of the right upper extremity due to restricted motion.[2] He opined that according to Table 16-35,[3] appellant also had an 11 percent impairment of the right upper extremity due to weakness in the rotator cuff complicated by thin tissue quality that lessened the effectiveness of the surgical repair. Dr. Anderson combined these impairments to total a 19 percent permanent impairment of the right upper extremity.

The Office asked an Office medical adviser to provide an impairment rating according to the fifth edition of the A.M.A., *Guides*. In a February 4, 2009 report, the Office medical adviser reviewed the record and found that appellant had reached maximum medical improvement as of December 30, 2008. He explained that according to section 16.8, page 508 of the A.M.A., *Guides*, restricted motion could not be considered with weakness because the physical limitation prevented application of maximal force. The Office medical adviser excluded Dr. Anderson's 11 percent impairment rating for weakness. He concluded that appellant had a nine percent impairment of the right arm due to restricted motion.

By decision dated February 6, 2009, the Office granted appellant a schedule award for a nine percent impairment of the right upper extremity.

In February 26 and March 2, 2009 letters, appellant requested a review of the written record. He submitted a February 17, 2009 report from Dr. Anderson, explaining that section 16.8 of the A.M.A., *Guides* did not apply to his case as restricted motion did not prevent him from applying maximal force. Dr. Anderson also opined that thin tissue quality in the rotator cuff constituted an anatomic defect meriting a rating for loss of strength.[4]

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[1] An August 27, 2007 magnetic resonance imaging (MRI) scan of the right shoulder showed a full thickness tear of the supraspinatus tendon.

[2] Dr. Anderson found a one percent upper extremity impairment due to extension limited to 35 degrees, a three percent impairment for flexion at 145 degrees, a two percent impairment for abduction at 138 degrees and a three percent impairment for internal rotation at 45 degrees.

[3] Table 16-35, page 510 of the fifth edition of the A.M.A., *Guides* is entitled "*Impairment of the Upper Extremity Due to Strength Deficit From Musculoskeletal Disorders Based on Manual Muscle Testing of Individual Units of Motion of the Shoulder and Elbow*."

[4] In a February 23, 2009 report, Dr. Fallinger opined that permanent weakness was very common following surgical repair of a "very large, retracted supraspinatus tear" even though the tendon had healed.

By decision dated June 24, 2009, an Office hearing representative remanded the case for the medical adviser to review Dr. Anderson's February 17, 2009 report and calculate impairment according to the sixth edition of the A.M.A., *Guides* in effect as of May 1, 2009.[5]

In a June 29, 2009 report, the Office medical adviser reviewed Dr. Anderson's February 17, 2009 report. Referring to the sixth edition of the A.M.A., *Guides*, he selected Diagnosis Class 1 for the full thickness rotator cuff tear. The Office medical adviser discounted Dr. Anderson's range of motion measurements as they did not meet the three trial and averaging requirements under section 15.7 of the sixth edition of the A.M.A., *Guides*. Referring to Table 15-8, page 408,[6] he selected a functional history grade modified (GMFH) of one as Dr. Anderson found no deficits in self-care. The Office medical adviser selected a physical examination grade modifier (GMPE) of zero, as the range of motion measurements provided by Dr. Anderson were not valid under the sixth edition of the A.M.A., *Guides*. Also, loss of strength was considered subjective and not included as a grade modifier on physical examination. Referring to Table 16-9, page 410,[7] the medical adviser selected a clinical studies grade modifier (GMCS) of two, classifying the thin rotator cuff as a moderate postsurgical pathology. He found that no net adjustment was necessary, resulting in the default grade of C. Referring to the upper extremity rating grid for the shoulder at Table 15-5, pages 401 to 405, the Office medical adviser found a five percent impairment of the right upper extremity, less than the nine percent previously awarded.

In an August 4, 2009 letter, the Office requested that Dr. Anderson submit an impairment rating according to the sixth edition of the A.M.A., *Guides*. Dr. Anderson provided an August 26, 2009 impairment rating for the right upper extremity, referencing the sixth edition of the A.M.A., *Guides*. Appellant completed Table 15-37, page 483, the Activities of Daily Living Questionnaire, noting some difficulty with showering, dressing and lifting. Dr. Anderson obtained range of motion measurements for the right shoulder using the three trial method of the sixth edition of the A.M.A., *Guides*. He provided the following percentages of impairment for restricted motion: three percent for flexion at 130 degrees; one percent for extension at 30 degrees; three percent for abduction at 120 degrees; two percent for external rotation at 45 degrees. Dr. Anderson added these percentages to total a nine percent impairment of the right upper extremity for limited motion. He then diagnosed a Class 1 rotator cuff tear according to Table 15-5, the shoulder regional grid. Dr. Anderson selected a functional history (GMFH) modifier of two as appellant had difficulty dressing. He noted physical examination (GMPE) and clinical studies (GMCS) modifiers of two, due to persistent objective pathologies of the rotator cuff tissue. This resulted in a net adjustment of three and a final grade of E. Dr. Anderson calculated a final right upper extremity impairment of seven percent.

[5] Appellant submitted several undated letters on July 21 and September 2, 2009, questioning the schedule award calculation, the Office's application of the A.M.A., *Guides* and the compensation claim process.

[6] Table 15-8, page 408 of the sixth edition of the A.M.A., *Guides* is entitled "*Physical Examination Adjustment: Upper Extremities.*"

[7] Table 15-9, page 410 of the sixth edition of the A.M.A., *Guides* is entitled "*Clinical Studies Adjustment: Upper Extremities.*"

By decision dated September 16, 2009, the Office found that appellant had not established that he sustained more than the nine percent upper extremity impairment for which he received a schedule award.

In letters dated September 10 to October 3, 2009, appellant requested reconsideration. He submitted two undated statements asserting that the Office improperly discounted Dr. Anderson's opinion about section 16.8a of the fifth edition of the A.M.A., *Guides*.

By decision dated December 15, 2009, the Office denied modification of the September 16, 2009 decision on the grounds that the evidence submitted did not establish that appellant had more than a nine percent impairment of the right arm. It accorded the weight of the medical evidence to the Office medical adviser. The Office explained that appellant's contentions regarding the fifth edition of the A.M.A., *Guides* were no longer relevant as the sixth edition was applicable to rating impairment on and after May 1, 2009.

LEGAL PRECEDENT

The schedule award provisions of the Federal Employees' Compensation Act[8] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. The Act, 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 mater which rests in the sound discretion of the Office. 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[9]

For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[10] Initial schedule award decisions issued on or after May 1, 2009 will be based on the sixth edition of the A.M.A., *Guides*, even if the amount of the award was calculated prior to that date. A claimant who has received a schedule award under a previous edition may make a claim for an increased award, which should be calculated according to the sixth edition.[11]

[8] 5 U.S.C. §§ 8101-8193.

[9] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[10] FECA Bulletin No. 09-03 (issued March 15, 2009); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[11] *Id. See also T.B.*, Docket No. 09-1903 (issued April 15, 2010) (the Board held that in a claim for an increased schedule award due to worsening of an accepted impairment, the Office medical adviser must utilize the edition of the A.M.A., *Guides* in effect at the time the Office issues a decision on the augmented schedule award).

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 and Health (ICF).[12] Under the sixth edition, the evaluator identifies 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).[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

After obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for a rationalized opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*.[14]

ANALYSIS

The Office accepted that appellant sustained bilateral shoulder sprains and a right rotator cuff tear, requiring surgical repair on November 29, 2007. Appellant claimed a schedule award on January 28, 2009. To obtain an impairment rating, the Office forwarded the medical record to an Office medical adviser for review.

An Office medical adviser submitted a February 4, 2009 report following the assessment formula of the fifth edition of the A.M.A., *Guides* then in effect. He utilized the December 30, 2008 clinical findings of Dr. Anderson, an attending physician Board-certified in occupational medicine, who found a 19 percent impairment of the right upper extremity due to restricted motion and weakness. The Office medical adviser allowed a nine percent impairment due to restricted motion. On February 6, 2009 the Office granted appellant a schedule award for a nine percent impairment of the right upper extremity, based on the Office medical adviser's interpretation of Dr. Anderson's findings. Dr. Anderson then submitted additional reports indicating a greater percentage of permanent impairment.

On June 29, 2009 the Office remanded the case for recalculation of the schedule award according to the sixth edition of the A.M.A., *Guides* then in effect. In a June 29, 2009 report, the Office medical adviser applied the sixth edition of the A.M.A., *Guides* to Dr. Anderson's clinical findings. He identified an impairment class of Grade 1 for the rotator cuff tear, selected a GMFH of one, a GMPE of zero as Dr. Anderson's range of motion measurements were not performed according to sixth edition of the A.M.A., *Guides* criteria and a GMCS of two for moderate objective pathology. The Office medical adviser found that no net adjustment was necessary, mandating a default grade of C. According to the shoulder grid at Table 15-5, this resulted in a five percent impairment of the right upper extremity.

Dr. Anderson submitted an August 26, 2009 impairment rating according to the sixth edition of the A.M.A., *Guides*. He concurred with the Office medical adviser's selection of a

[12] A.M.A., *Guides* (6th ed., 2008), page 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): *A Contemporary Model of Disablement*."

[13] A.M.A., *Guides* (6th ed. , 2008), page 494-531.

[14] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

Grade 1 impairment class, but selected a GMFH of two as appellant had some difficulty with activities of daily living, a GMPE of two for restricted motion and a GMPE of two for persistent objective pathologies. Dr. Anderson calculated a net adjustment of three, resulting in a Grade E, indicating a seven percent upper extremity impairment.

The Board finds that both Dr. Anderson and the Office medical adviser properly used the tables and grading formulae of the sixth edition of the A.M.A., *Guides*.[15] Both physicians provided rationale supporting the impairment ratings offered. The Office medical adviser found a five percent right upper extremity impairment, whereas Dr. Anderson found a seven percent impairment. The reports of both physicians establish that appellant does not have more than the nine percent impairment of the right arm as previously awarded. As the physicians agree on the critical issue in the case, the difference in opinion regarding the percentage of impairment does not require appointment of an impartial medical examiner under section 8123(a) as both ratings are less than that awarded in the case.[16]

CONCLUSION

The Board finds that appellant has not established that he sustained more than a nine percent impairment of the right upper extremity, for which he received a schedule award.

[15] *P.B.*, 61 ECAB ___ (Docket No. 10-103, issued July 23, 2010).

[16] 5 U.S.C. § 8123(a).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 15, 2009 is affirmed.

Issued: November 30, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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