United States Department of Labor
Employees' Compensation Appeals Board

J.E., Appellant	)	
and	)	**Docket No. 10-501**
	)	**Issued: October 20, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Chandler, AZ, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 11, 2009 appellant filed a timely appeal from schedule award decisions of the Office of Workers' Compensation Programs dated July 1, September 3 and October 8, 2009. Pursuant to 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 met his burden of proof to establish that he has more than four percent permanent impairment of the right upper extremity for which he received a schedule award. On appeal he asserts that his permanent impairment should be 12 percent for the right upper extremity, based on the opinion of Dr. Jeffrey S. Levine, an attending Board-certified orthopedic surgeon.

FACTUAL HISTORY

On April 28, 2008 appellant, then a 57-year-old clerk, filed an occupational disease claim alleging that he had right shoulder pain and wrist swelling caused by his employment duties. The Office accepted the conditions of impingement syndrome of the right shoulder region and lesion of the ulnar nerve, right, as employment related, and on October 14, 2008, Dr. Jeffrey S.

Levine, a Board-certified orthopedic surgeon, performed right shoulder rotator cuff and right labral arthroscopic repairs for partial tears and right cubital tunnel decompression. Appellant retired on January 1, 2009.

Appellant filed a schedule award claim on April 6, 2009 and submitted a March 27, 2009 report in which Dr. Levine noted that on examination appellant had full range of motion of the right shoulder with negative impingement and no sign of positive labral loading, good strength and no sensory impairment. Dr. Levine advised that appellant's right shoulder condition was stationery and that, in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[1] he sustained a five percent impairment of the whole person based on ulnar neuropathy. By report dated April 24, 2009, he advised that appellant was doing very well with respect to the right shoulder.

In a June 21, 2009 report, Dr. Leonard A. Simpson, an Office medical adviser who is an orthopedic surgeon, noted his review of the medical record, including the operative report and Dr. Levine's reports dated March 27 and April 24, 2009. He noted that Dr. Levine cited the sixth edition of the A.M.A., *Guides*, but did not state which grid table and adjustment tables he utilized. Dr. Simpson provided an impairment analysis for appellant's right upper extremity based on Dr. Levine's findings and indicated that, under Table 15-5, Shoulder Regional Grid, a rotator cuff injury with partial thickness tear, as had been noted at the time of surgery, with a history of painful injury and residual symptoms without consistent objective findings, resulted in a Class 1 or one percent default rating. In regard to the adjustment modifiers, he stated that, for functional history, utilizing Table 15-7, there would be a grade modifier of zero; for physical examination under Table 15-8, there also would be a grade modifier of zero; and under clinical studies, Table 15-9, there would be a grade modifier of two, and thus the default rating of one would be increased to two for two percent impairment for the right shoulder condition. Dr. Simpson further advised that Dr. Levine did not indicate an ongoing irritation of the ulnar nerve following the surgical decompression with no loss of range of motion or tenderness. Utilizing Table 15-21, upper extremity peripheral nerve impairment, he rated appellant at Class 0 for ulnar pathology above the midforearm, classified between zero and three percent. With regard to the adjustment modifiers, Dr. Simpson rated physical findings as normal for a grade modifier of zero, and also noted a normal functional scale, for a zero grade modifier. He recommended a mean between zero and three percent, or one and a half percent rounded up to a two percent impairment which, when combined with the two percent for shoulder pathology would yield a total four percent right upper extremity impairment, with March 27, 2009 as the date of maximum medical improvement.

By decision dated July 1, 2009, appellant was granted a schedule award for a four percent permanent impairment of the right arm, for 12.48 weeks, to run from March 27 to June 22, 2009. On July 31, 2009 he requested reconsideration and submitted a July 24, 2009 report in which Dr. Levine advised that, utilizing the sixth edition of the A.M.A., *Guides*, appellant should be awarded a 5 percent impairment of the right upper extremity for rotator cuff disease, a 3 percent impairment with respect to his superior labrum, anterior to posterior (SLAP) tear, and a 3 percent impairment for his impingement syndrome, for a total 10 percent right shoulder impairment. Dr. Levine further advised that appellant should be awarded a two percent impairment of the

[1] A.M.A., *Guides* (6th ed. 2008).

upper extremity on the basis of very mild, ongoing symptoms due to a decompression of the ulnar nerve at the level of the elbow, for a combined 11 percent impairment of the right upper extremity.

In an August 21, 2009 report, Dr. Simpson reviewed Dr. Levine's July 24, 2009 report. He noted that Dr. Levine did not cite to the appropriate tables and adjustment grids in reaching his conclusion regarding appellant's right upper extremity impairment. Dr. Simpson advised that, as noted in the A.M.A., *Guides*, it was not uncommon for rotator cuff tear, SLAP, or other labral lesions, and biceps tendon pathology to all be present simultaneously, and stated that the evaluator was to choose the most significant diagnosis and to rate only that diagnosis using the diagnosis-based impairment which could then be modified in accordance with Table 15-9. He reiterated his opinion that appellant was entitled to two percent impairment for right shoulder pathology and two percent impairment for his ulnar condition, for a total four percent right upper extremity impairment. In a merit decision dated September 3, 2009, the Office noted that the Office medical adviser's report was the only evaluation in accordance with the sixth edition of the A.M.A., *Guides* and denied modification of the July 1, 2009 schedule award decision.

On September 30, 2009 appellant requested reconsideration and submitted a September 18, 2009 report in which Dr. Levine stated that, under Table 15-5 of the sixth edition of the A.M.A., *Guides*, appellant should be awarded a 5 percent impairment secondary to a Class 1 rotator cuff injury of the right shoulder, 3 percent impairment due to a Class 1 SLAP tear, and 3 percent impairment, due to Class 1 impingement syndrome, which would translate to 10 percent right upper extremity impairment using the Combined Impairment Rating Table. He further found that, with respect to appellant's ongoing ulnar nerve symptoms, using Table 15-21, he had a Class 1 impairment for a mild sensory deficit that could interfere with activities of daily living, for an additional two percent right upper extremity impairment. In an October 8, 2009 decision, the Office weighed the newly submitted report, found it cumulative and denied appellant's reconsideration request.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[2] and its implementing federal regulations,[3] 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, the Act 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 for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[4] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *Id.* at § 10.404(a).

to calculate schedule awards.[5] For decisions issued after May 1, 2009, the sixth edition will be used.[6]

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).[7] Under the sixth edition, for upper extremity impairments 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).[8] The net adjustment formula is (GMFH-CDX) + (GMPE - CDX) + (GMCS-CDX).[9]

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the Office medical adviser providing rationale for the percentage of impairment specified.[10]

ANALYSIS

The Board notes that, although the Office stated in its October 8, 2009 decision that it was denying appellant's reconsideration request, a careful reading of the case shows that the Office reviewed Dr. Levine's September 18, 2009 findings and discussed reasons that it was not in accordance with the sixth edition of the A.M.A., *Guides*. The Board therefore finds the October 8, 2009 decision to be a decision on the merits of the case.

The Board further finds that appellant is entitled to no more than a four percent impairment of the right upper extremity. It is well established that, when the examining physician does not provide an estimate of impairment conforming to the proper edition of the A.M.A., *Guides*, the Office may rely on the impairment rating provided by a medical adviser.[11] In this case, Dr. Levine advised in a March 27, 2009 report, that in accordance with the sixth edition of the A.M.A., *Guides*, appellant had a five percent impairment of the whole person. The Act, however, does not authorize schedule awards for permanent impairment of "the whole person."[12] Furthermore, the physician did not provide any explanation of how he reached this

[5] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

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

[7] A.M.A., *Guides*, *supra* note 1 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[8] A.M.A., *Guides*, *supra* note 1 at 385-419.

[9] *Id*. at 411.

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

[11] *See J.Q.*, 59 ECAB 366 (2008).

[12] *N.D.*, 59 ECAB 344 (2008).

conclusion or reference any applicable tables or grids. The Office therefore properly referred the medical record to Dr. Simpson, an Office medical adviser, for review.

The only medical reports of record that properly referenced the applicable tables and grids of the sixth edition are those of Dr. Simpson, the Office medical adviser, dated June 21 and August 21, 2009.[13] The sixth edition of the A.M.A., *Guides* provides that upper extremity impairments be classified by diagnosis which is then adjusted by grade modifiers according to the formula described above.[14] Appellant's accepted diagnosed conditions are impingement syndrome of the right shoulder and lesion of the ulnar nerve on the right with a partial rotator cuff tear found at surgery. Regarding the right shoulder injury, Table 15-5 of the sixth edition of the A.M.A., *Guides*, Shoulder Regional Grid, provides that a rotator cuff injury with partial-thickness tear can be classified from Class 0 to Class 4, with Class 1 defined as having a history of painful injury and residual symptoms without consistent objective findings. A finding under Class 1 yields impairments ranging from 1 to 13 percent.[15] By extrapolating the physical findings reported by Dr. Levine of a partial thickness tear with a good surgical result and occasional pain, Dr. Simpson permissibly graded appellant's impairment in the low range of Class 1, for a one percent impairment. He then applied the grade modifiers described in Table 15-5 with analysis provided in Tables 15-7 through 15-9 and the net adjustment formula.[16] Dr. Simpson determined that appellant was not entitled to an additional impairment for functional history (GMFH) or physical examination studies (GMPE) and found that appellant was entitled to an additional two percent impairment for clinical studies (GMCS) under Table 15-9.[17] He then concluded that appellant had a total two percent right upper extremity impairment due to his shoulder injury.

Regarding the ulnar pathology, Dr. Simpson reported that following surgical decompression, appellant had no loss of range of motion or tenderness. Table 15-21, Peripheral Nerve Impairment, provides that ulnar pathology above the mid-forearm can be classified from Class 0 to Class 4.[18] Dr. Simpson permissibly graded appellant's ulnar impairment at Class 1[19] and graded it between one and three percent (a mild to moderate impairment). He found no modifiers and recommended the mean, rounded up to two percent impairment. Dr. Simpson then properly added the shoulder impairment and the ulnar impairment and concluded that appellant had a total four percent right upper extremity impairment.

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

[14] A.M.A., *Guides*, *supra* note 1 at 403.

[15] *Id*. at 509.

[16] *Id*. at 406-11.

[17] *Id*. at 410. Regarding the shoulder, Table 15-9 sates that a grade modifier of 2 (moderate problem) is found when one of the following symptomatic diagnoses is confirmed by clinical studies: rotator cuff tear, superior labrum, SLAP tear or other labral lesion or biceps tendon pathology. *Id*.

[18] *Id*. at 443.

[19] The Board notes that Dr. Simpson's report contains a typographical error as he stated that appellant had Class 0 impairment. A reading of his report, however, clearly indicates that he was discussing Class 1 impairment.

While appellant submitted a September 18, 2009 report from Dr. Levine in which the physician referenced Table 15-5 and advised that appellant had five percent impairment for a rotator cuff injury, three percent impairment for a SLAP tear, and three percent impairment for impingement syndrome, section 15.2e of the sixth edition of the A.M.A., *Guides* provides that it is not uncommon for rotator cuff tear, SLAP, or other labral lesions, and biceps tendon pathology to all be present simultaneously, and the evaluator is expected to choose the most significant diagnosis and to rate only that diagnosis using the diagnosis-based impairment which could then be modified according to Table 15-9.[20] Dr. Levine performed no such evaluation. His report is therefore insufficient to establish that appellant is entitled to an additional right upper extremity schedule award.[21]

CONCLUSION

The Board finds that appellant has a four percent impairment of the right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated October 8, September 3 and July 1, 2009 be affirmed.

Issued: October 20, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[20] A.M.A., *Guides*, *supra* note 1 at 390.

[21] In the September 18, 2009 report, Dr. Levine was in agreement with Dr. Simpson's analysis that appellant had two percent impairment for ulnar pathology.