United States Department of Labor
Employees' Compensation Appeals Board

M.F., Appellant	)	
and	)	**Docket No. 10-2024**
	)	**Issued: May 20, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Charlottesville, VA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 3, 2010 appellant filed a timely appeal of a May 18, 2010 Office of Workers' Compensation Programs' merit decision granting a schedule award. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

ISSUE

The issue is whether appellant has more than eight percent impairment of his left upper extremity for which he received a schedule award.

On appeal appellant argued that the medical evidence supported 10 percent impairment of his left upper extremity.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On October 13, 2005 appellant, then a 40-year-old city letter carrier, filed an occupational disease claim alleging that he sustained a complete tear of his left rotator cuff due to his employment duties. He underwent a magnetic resonance imaging (MRI) scan on October 12, 2004 which demonstrated a small focal avulsion of the distal supraspinatus tendon, infraspinatus tendinosis, partial tear of the subscapularis tendon and partial tear of the biceps tendon. The Office accepted appellant's claim for nontraumatic left rotator cuff tear on January 18, 2006. It accepted the additional conditions of bicipital tenosynovitis and tendinosis of the underlying infraspinatus tendon on the left on March 9, 2006. Dr. Mark Miller, an orthopedic surgeon, performed a left shoulder arthroscopy with subscapularis repair, arthroscopic biceps tenodesis and subacromial decompression on March 27, 2006.

Appellant filed a claim for compensation and requested a schedule award on April 7, 2009. He submitted a report dated March 30, 2009 from a physical therapist, finding that appellant had four percent impairment of his left arm based on loss of range of motion under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment.*[2] Dr. Alfred A. Durham, a Board-certified orthopedic surgeon, completed a note on June 22, 2009 and stated that appellant had reached maximum medical improvement. He found 175 degrees of forward flexion in the left shoulder as well as 170 degrees of abduction and good internal rotation with 30 degrees of external rotation. Dr. Durham reported pain when maximum forward flexion was reached.

On March 23, 2010 the Office referred appellant for a second opinion evaluation to determine the extent of permanent impairment. In a report dated April 21, 2010, Dr. William C. Andrews, a Board-certified orthopedic surgeon, noted appellant's history of injury and found that he had difficulty with overhead activities and in placing his arm behind his back. He found that appellant had reached maximum medical improvement. Dr. Andrews listed range of motion as 80 degrees of external rotation, 60 degrees of internal rotation, abduction of 150 degrees. He found slight weakness in the left upper extremity with pain at the extremes of motion and markedly positive impingement sign. Dr. Andrews found no sensory changes, no atrophy or ankylosis. He found class 1 impairment with grade modifiers of 2 for functional history, 2 for physical examination and awarded a grade D of seven percent impairment due to rotator cuff injury with residual loss. In regard to biceps tendon, Dr. Andrews found a class 1 injury with a functional history grade modifier of 1, physical examination modifier of 1 for a grade C impairment of three percent. Based on the sixth edition of the A.M.A., *Guides,* he found that appellant had 10 percent impairment due to the diagnoses of shoulder biceps tendinitis and rotator cuff tear.[3]

The Office referred the medical evidence to the district medical adviser on May 4, 2010. In report dated May 11, 2010, Dr. Christopher Brigham, Board-certified in occupational medicine, determined that appellant had eight percent impairment of his left upper extremity. He based this rating on the sixth edition of the A.M.A., *Guides* finding that a diagnosis-based

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[2] A.M.A., *Guides*, 5th ed. (2001).

[3] A.M.A., *Guides*, 6th ed. (2009).

estimate of rotator cuff injury, full thickness tear with residual loss was the appropriate diagnosis, a class 1 grade C resulting in five percent impairment of the upper extremity.[4] Dr. Brigham found that the functional history adjustment was one as appellant exhibited pain with strenuous activity and required medication to control symptoms.[5] Appellant's physical examination adjustment was one due to mild motion loss.[6] As to appellant's clinical studies, Dr. Brigham found a grade modifier of one as the MRI scan confirmed the diagnosis of partial tear of the biceps tendon.[7] He applied the appropriate formula of the A.M.A., *Guides* to reach a net adjustment of zero for class 1, grade C impairment of five percent of the left upper extremity.

Dr. Brigham also rated impairment based on appellant's loss of range of motion.[8] He found that 160 degrees of flexion was three percent impairment, 150 degrees of abduction was three percent impairment and that 60 degrees of internal rotation was two percent impairment. Dr. Brigham added the loss of range of motion impairments to reach eight percent impairment of the left arm.

By decision dated May 18, 2010, the Office granted appellant a schedule award for eight percent impairment of his left upper extremity.

LEGAL PRECEDENT

The schedule award provision of the Act[9] and its implementing regulations[10] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions 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 matter which rests in the 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 Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[11]

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[4] *Id*. at 403, Table 15-5.

[5] *Id*. at 406, Table 15-7.

[6] *Id*. at 408, Table 15-8.

[7] *Id*. at 410-Table 15-9.

[8] *Id*. at 472, 475, Table 15-34.

[9] 5 U.S.C. §§ 8101-8193, 8107.

[10] 20 C.F.R. § 10.404.

[11] For new decisions issued after May 1, 2009 the Office began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6a (January 2010); Part 3 -- Medical, *Schedule Awards,* Chapter 3.700, Exhibit 1 (January 2010).

The A.M.A., *Guides* provided that in most cases only one diagnosis will be appropriate for rating under the diagnosis-based impairment system.[12] The A.M.A., *Guides* state:

> "If a patient has two significant diagnoses, for instance, rotator cuff tear and biceps tendonitis, the examiner should use the diagnosis with the highest causally-related impairment rating for the impairment calculation."[13]

In addressing upper extremity impairments, the sixth edition requires identifying 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). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14]

ANALYSIS

The Office accepted that appellant sustained left rotator cuff tear, bicipital tenosynovitis and tendinosis of underlying infraspinatus tendon. On March 27, 2006 appellant underwent left shoulder arthroscopy with subscapularis repair, arthroscopic biceps tenodesis and subacromial decompression. His attending physician, Dr. Durham opined that appellant reached maximum medical improvement on June 22, 2009.

The Office referred appellant for a second opinion evaluation with Dr. Andrews who completed a report on April 21, 2010, finding 80 degrees of external rotation, 60 degrees of internal rotation and abduction of 150 degrees. Dr. Andrews determined appellant's diagnosis-based impairments for both shoulder biceps tendinitis and rotator cuff tear. As noted, the A.M.A., *Guides* provide that only one diagnosis is appropriate in most situations. Dr. Andrews did not discuss this aspect of the A.M.A., *Guides* or offer any explanation for his determination that two diagnosis-based impairments should be used to rate appellant's permanent impairment for schedule award purposes. Due to this deficiency in his report, his findings do not comport with the A.M.A., *Guides* and his rating is of reduced probative value.[15]

The Board finds that the Office medical adviser, Dr. Brigham, properly applied the diagnosis-based impairment rating system to Dr. Andrews findings on physical examination. Dr. Brigham concluded that, based on the diagnosis of rotator cuff pathology, appellant had five percent impairment. He then noted that the A.M.A., *Guides* provide that range of motion can be used as a stand-alone rating when appropriate.[16] Dr. Brigham rated appellant with eight percent impairment of his left arm due to loss of range of motion. It is well established that, when a physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment

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[12] A.M.A., *Guides* 387.

[13] *Id.*

[14] *Id*. at 411.

[15] *See J.Q.*, 59 ECAB 366 (2008); *Tara L. Hein*, 56 ECAB 431 (2005).

[16] *Id*. at 461.

and the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings of the physician.[17] The Board finds that the weight of the medical evidence establishes that appellant has eight percent impairment of his left upper extremity for which he received a schedule award. There is no medical evidence in the record which comports with the A.M.A., *Guides* establishing more than eight percent impairment.

On appeal appellant argued that the medical evidence established 10 percent impairment of his left upper extremity. While Dr. Andrews rated 10 percent impairment, he did not comply with the standards of the A.M.A., *Guides* as there was no medical explanation of why two diagnosis-based impairment ratings were appropriate in appellant's situation. Lacking such an explanation, this report is not sufficient to carry the weight of the medical evidence or establish the extent of permanent impairment.

CONCLUSION

The Board finds that appellant has no more than eight percent impairment of his left upper extremity for which he has received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the May 18, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 20, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[17] *Linda Beale*, 57 ECAB 429 (2006).