United States Department of Labor
Employees' Compensation Appeals Board

L.D., Appellant **and** **DEPARTMENT OF THE AIR FORCE, 402nd AIRCRAFT MAINTENANCE GROUP, ROBINS AIR FORCE BASE, GA, Employer**	)	**Docket No. 11-338** **Issued: September 9, 2011**

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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 23, 2010 appellant timely appealed the July 19, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied modification of a November 16, 2009 schedule award. Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

ISSUE

The issue is whether appellant has greater than 24 percent impairment of the right upper extremity.

[1] 5 U.S.C. §§ 8101-8193 (2006).

[2] The record on appeal contains evidence received after OWCP issued its July 19, 2010 decision. The Board is precluded from considering evidence that was not in the case record at the time OWCP rendered its final decision. 20 C.F.R. § 501.2(c)(1) (2010).

FACTUAL HISTORY

Appellant, a 65-year-old retired aircraft production control supervisor, injured his right upper extremity in the performance of duty on September 28, 2004.[3] OWCP accepted his claim for right shoulder rotator cuff tear and shoulder impingement tendinitis with secondary adhesive capsulitis. Appellant has undergone two OWCP-approved surgical procedures to repair his right rotator cuff. He received appropriate wage-loss compensation for periods of temporary total disability. Appellant has also received multiple schedule awards. On November 3, 2005 OWCP granted an award for 12 percent impairment of the right upper extremity.[4] Appellant received an award for an additional 5 percent on July 19, 2007, for a total right upper extremity impairment of 17 percent.[5]

On July 2, 2009 appellant filed a claim (Form CA-7) for an additional schedule award. His physician, Dr. Malone, provided an April 6, 2009 rating of 26 percent impairment of the right upper extremity.[6] This rating was prepared in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (2001). Effective May 1, 2009, OWCP adopted the sixth edition of the A.M.A., *Guides* (2008). Although Dr. Malone expressed his willingness to recalculate appellant's impairment under the sixth edition of the A.M.A., *Guides*, he did not submit a supplemental report. OWCP, therefore, referred appellant to an orthopedic specialist.

In a report dated August 25, 2009, James S. Mason, M.D., found 13 percent impairment of the right upper extremity under the sixth edition of the A.M.A., *Guides* (2008). He noted that appellant had undergone two surgeries to repair his right rotator cuff, most recently in January 2007. Dr. Mason also noted that an October 2008 magnetic resonance imaging scan revealed another right rotator cuff tear. Due to an unrelated medical condition, appellant was not a suitable candidate for additional surgery, and therefore, he had reached maximum medical improvement with respect to his right shoulder condition. Dr. Mason cited Table 15-5 (Shoulder Regional Grid), A.M.A., *Guides* 403 (2008) as the basis for appellant's upper extremity

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[3] Appellant fell to the floor when the chair he was seated in broke.

[4] The 2005 award was based on the September 2, 2005 evaluation of Dr. K. Scott Malone, appellant's attending physician, and the district medical adviser's (DMA) October 17, 2005 report. The 12 percent impairment rating was for loss of motion in the right shoulder.

[5] The 2007 award was based on Dr. Malone's June 26, 2007 impairment rating, with which the DMA concurred. Both physicians agreed that appellant had 17 percent impairment due to loss of motion in the right shoulder. Because appellant had already received a schedule award for the right upper extremity, OWCP adjusted the July 2007 award to reflect the 12 percent impairment previously awarded.

[6] The overall impairment rating included components for distal clavicle resection arthroplasty (10 percent) and loss of shoulder motion (18 percent). Dr. Malone reported right shoulder active ROM results as follows: 80 degrees flexion, 24 degrees extension, 80 degrees abduction, 26 degrees adduction, 45 degrees internal rotation and 40 degrees external rotation.

impairment rating. He characterized appellant's diagnosis-based impairment as class 1, grade E, which reportedly represented 13 percent upper extremity impairment.[7]

Dr. Guillermo M. Pujadas, the DMA, reviewed the record on October 20, 2009.[8] He indicated that the diagnosis-based impairment rating method was less favorable, resulting in only 10 percent upper extremity impairment. Instead of relying on the diagnosis-based impairment method, the DMA calculated 24 percent impairment due to loss of motion in the right shoulder. The range of motion (ROM) rating was based on Dr. Malone's April 6, 2009 physical examination findings, which the DMA applied to Table 15-34 (Shoulder Range of Motion), A,M.A., *Guides* 475 (2008).[9] Lastly, the DMA noted that appellant had already received awards totaling 17 percent impairment for loss of motion in the right shoulder. He subtracted the prior ratings from the current 24 percent ROM impairment, and advised that appellant be awarded an additional 7 percent impairment of the right upper extremity.

In a decision dated November 16, 2009, OWCP found that appellant had 24 percent impairment of the right upper extremity. Because appellant had previously received combined awards totaling 17 percent, OWCP granted an additional 7 percent impairment. The award covered a period of 21.84 weeks from April 6 to September 5, 2009.

On June 11, 2010 appellant requested reconsideration. He argued that OWCP should have paid him an additional 13 percent based on Dr. Mason's August 25, 2009 report.

OWCP referred the case to its DMA, Dr. Howard "H.P." Hogshead, requesting that he review Dr. Mason's August 25, 2009 report.[10] In a June 21, 2010 report, the DMA indicated that Dr. Pujadas' 24 percent rating and Dr. Mason's 13 percent rating were both valid under the A.M.A., *Guides* (6th ed. 2008).[11]

By decision dated July 19, 2010, OWCP denied modification of the November 16, 2009 schedule award. It noted that prior to its latest award appellant had already been compensated for 17 percent impairment of the right upper extremity. OWCP explained that had it accepted Dr. Mason's August 25, 2009 rating of 13 percent, appellant would not have received the additional 7 percent award.

[7] Dr. Mason also provided right shoulder ROM measurements as follows: 90 degrees forward flexion, 90 degrees abduction, 60 degrees external rotation and internal rotation to approximately L5.

[8] Dr. Pujadas is a Board-certified orthopedic surgeon.

[9] The DMA further explained that Dr. Malone's 26 percent rating under the fifth edition of the A.M.A., *Guides* represented a combination of impairments for loss of motion and distal clavicle arthroplasty, which was not an acceptable approach under the sixth edition of the A.M.A., *Guides* (2008). The DMA did not specifically mention Dr. Mason's August 25, 2009 report.

[10] Dr. Hogshead is a Board-certified orthopedic surgeon.

[11] Dr. Hogshead (DMA) also noted that Dr. Mason's August 25, 2009 ROM values were different than those previously relied upon by Dr. Pujadas (DMA).

LEGAL PRECEDENT

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[12] FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[13] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).[14]

FECA and its implementing regulations provide for the reduction of compensation for subsequent injury to the same scheduled member.[15] Benefits payable under 5 U.S.C. § 8107(c) shall be reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[16]

ANALYSIS

The Board finds that appellant has not established that he has greater than 24 percent impairment of the right upper extremity.

Prior to the latest schedule award, appellant had already received two awards totaling 17 percent impairment of the right upper extremity. Appellant mistakenly believed that Dr. Mason recommended an "additional" 13 percent impairment of the right upper extremity. Contrary to appellant's belief, Dr. Mason did not find an "additional" 13 percent impairment. Instead, he found that appellant's total right upper extremity impairment was 13 percent, which was less than what appellant had already received. If OWCP had relied upon Dr. Mason's August 25, 2009 impairment rating, appellant would not have received an additional seven percent impairment of the right upper extremity.

Dr. Hogshead (DMA) indicated that Dr. Mason's 13 percent rating was "appropriate [and] consistent" with the A.M.A., *Guides* (6th ed. 2008), however, the DMA was mistaken. Under the sixth edition of the A.M.A., *Guides*, impairments of the upper extremities are covered by Chapter 15. Section 15-2, entitled diagnosis-based impairment, indicates that "[d]iagnosis-

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[12] For a total loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

[13] 20 C.F.R. § 10.404.

[14] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.* Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (January 2010).

[15] 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

[16] 20 C.F.R. § 10.404(c)(1), (2).

based impairment is the primary method of evaluation of the upper limb."[17] The initial step in the evaluation process is to identify the impairment class by using the corresponding diagnosis-based regional grid. Dr. Mason's diagnosis-based impairment rating under Table 15-5 (Shoulder Regional Grid), A.M.A., *Guides* 403 appears to have been based upon appellant's distal clavicle resection. Dr. Mason characterized it as a class 1, grade E impairment, for which he assigned 13 percent upper extremity impairment. However, a class 1, grade E impairment under Table 15-5 -- acromioclavicular (AC) joint injury, status post distal clavicle resection -- represents 12 percent upper extremity impairment, not 13 percent.

While diagnosis-based impairment is the preferred method of evaluation, Table 15-5 also provides an alternative to the diagnosis-based impairment method where loss of motion is present. That alternative is a ROM impairment rating under section 15.7, A.M.A., *Guides* 459, 475 (2008). Unfortunately, Dr. Mason did not provide complete right shoulder ROM measurements. He did not measure appellant's extension or adduction, and his measurement for internal rotation was unclear.[18] If one applies Dr. Mason's limited ROM measurements to Table 15-34, A.M.A., *Guides* 475 (2008), appellant would have seven percent impairment of the right upper extremity for loss of shoulder motion.[19] Dr. Pujadas' (DMA) reliance on Dr. Malone's April 6, 2009 examination findings proved most advantageous for appellant. Dr. Malone reported 80 degrees flexion (9 percent), 24 degrees extension (2 percent), 80 degrees abduction (6 percent), 26 degrees adduction (1 percent), 45 degrees internal rotation (2 percent), and 40 degrees external rotation (4 percent), which represented 24 percent impairment under Table 15-34, A.M.A., *Guides* 475 (2008).

The Board finds that Dr. Pujadas' October 20, 2009 impairment rating conforms to the A.M.A., *Guides* (6th ed. 2008), and thus, represent the weight of the medical evidence regarding the extent of appellant's right upper extremity impairment. Appellant has not submitted any credible medical evidence indicating he has greater than 24 percent impairment of the right upper extremity. Because appellant had already been awarded 17 percent impairment of the right upper extremity, OWCP properly offset the latest rating of 24 percent, and awarded only an additional 7 percent impairment.[20]

CONCLUSION

Appellant has not established that he has greater than 24 percent impairment of the right upper extremity.

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[17] Section 15.2, A.M.A., *Guides* 387 (2008).

[18] *See supra* note 7.

[19] Ninety (90) degrees forward flexion (3 percent), 90 degrees abduction (3 percent), and 60 degrees external rotation (1 percent). It is not entirely clear what level of impairment corresponds to Dr. Mason's finding of "internal rotation to approximately L5."

[20] *See* 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

ORDER

IT IS HEREBY ORDERED THAT the July 19, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 9, 2011
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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