United States Department of Labor
Employees' Compensation Appeals Board

D.A., Appellant	)	
and	)	**Docket No. 12-841**
	)	**Issued: August 3, 2012**
U.S. POSTAL SERVICE, BULK MAIL CENTER, Pittsburgh, PA, Employer	)	

Appearances:
Felix J. De Guilio, Esq., for the appellant
Office of Solicitor, for the Director

Oral Argument June 27, 2012

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 2, 2012 appellant, through his representative, filed a timely appeal from the December 30, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP), which found that he was not entitled to a greater schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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 has more than a 12 percent impairment of his right upper extremity as a result of his October 26, 2007 shoulder injury, for which he received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On October 26, 2007 appellant, a 55-year-old mail handler, sustained a traumatic injury in the performance of duty when he was struck by a piece of rolling stock equipment. OWCP accepted his claim for sprain of the shoulder and upper arm; rotator cuff, right; and contusion of the shoulder and upper arm, right. On February 19, 2008 appellant underwent a right rotator cuff repair, acromioplasty and distal clavicle resection.

In August 2008, appellant told his surgeon, Dr. Gregory L. Hung, a Board-certified orthopedic surgeon, that he recently noticed some discomfort in the biceps muscle. In November 2008, Dr. Hung diagnosed a recent acute rupture of the long head of the biceps tendon.

On January 5, 2009 Dr. Hung examined appellant and found full active range of right shoulder motion with very mild tenderness to palpation of the proximal end of the biceps.

Appellant filed a schedule award claim for permanent physical impairment. OWCP advised him that all impairment evaluations be made according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[2]

Dr. William J. Hennessey, a Board-certified physiatrist, evaluated appellant's impairment. He related the history of appellant's right rotator cuff tear, the surgical repair and the right proximal biceps tendon tear in approximately May 2008, which he described as work related. Dr. Hennessey noted that appellant use to handle 70-pound bags, which caused right elbow flexor discomfort and burning. Although appellant had a good result from his rotator cuff tear, there was still some lack of motion and strength. After recovering sufficiently to resume gainful employment, he again handled 70-pound bags, at which point he developed a right biceps tear.

Stating that he was applying the sixth edition of the A.M.A., *Guides*, Dr. Hennessey found a two percent impairment of the right upper extremity due to lack of shoulder abduction, a one percent impairment due to lack of flexion, and a three percent impairment due to lack of internal rotation, for a six percent total impairment due to motion loss. He found a 22 percent impairment due to strength deficits associated with the right rotator cuff injury. Dr. Hennessey assigned a 10 percent rating for the distal clavicle resection. He found a five percent impairment from weakness and right elbow flexion due to the complete detachment of the long head of his biceps tendon. Using the A.M.A., *Guides*' Combined Values Chart, Dr. Hennessey determined that appellant had a 35 percent total impairment of his right upper extremity.

Dr. Craig M. Uejo, Board-certified in occupational medicine and an OWCP medical consultant, reviewed Dr. Hennessey's impairment evaluation.[3] He explained that the sixth edition of the A.M.A., *Guides* allowed two methods for rating appellant's impairment: the

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

[3] The sixth edition of the A.M.A., *Guides* credits Dr. Uejo as a reviewer. Dr. Uejo's qualifications include being an associate editor of the new edition of *The AMA Guides Casebook* and associate editor for *The Guides Newsletter*.

diagnosis-based impairment (DBI) method, based on the primary diagnosis involved, and the range of motion method, based on motion loss to the involved joint. He further explained that the A.M.A., *Guides* does not allow combining these two methods, as done by Dr. Hennessey.

Noting that several right shoulder conditions could be considered for rating impairment, Dr. Uejo found that acromioclavicular joint disease with distal clavicle resection provided the highest rating. Table 15-5, page 403, showed that the default impairment value for such a diagnosis and criterion was 10 percent. As appellant's functional history was mild, his physical examination negative and his clinical studies moderate, there was no net adjustment to the default DBI rating.

Dr. Uejo explained that although range of motion could be used as a stand-alone method for rating the impairment, Dr. Hennessey's findings were inconsistent with those of Dr. Hung, who found full active range of motion 11 months following surgery.[4] The findings were therefore considered invalid. Dr. Uejo recommended the DBI method as the more reliable and objective measure of appellant's impairment.

In a February 1, 2010 decision, OWCP issued a schedule award for a 10 percent impairment of appellant's right upper extremity.

On September 16, 2010 Dr. Hennessey noted that appellant suffered a large right rotator cuff tear that required a surgical repair, acromioplasty and distal clavicle resection. Postoperatively, appellant developed a painful restriction of range of motion medically termed adhesive capsulitis and subsequently he further developed a right biceps tendon tear.

Dr. Hennessey rated appellant's diagnosed conditions under the sixth edition of the A.M.A., *Guides*. He offered a nine percent rating for rotator cuff tear, nine percent for adhesive capsulitis and six percent for biceps tendon tear. For each rating, Dr. Hennessey determined there should be no grade modifier adjustments. He added the three ratings together for a total impairment of 24 percent.

An OWCP medical adviser reviewed the record and determined that appellant had a 12 percent impairment of his right upper extremity. Of the applicable diagnoses, he found that acromioclavicular joint disease resulting in distal clavicle resection had the potentially greatest impairment rating. The default impairment value for a class 1 injury was 10 percent. The medical adviser found no adjustment for functional history and subtracted 1 percent for physical examination, as the findings for range of motion were inconsistent. He added 3 percent for clinical studies because an imaging study revealed a full rotator cuff tear and labral tear. The medical adviser concluded that appellant had a final impairment rating of 12 percent.

In a March 17, 2011 decision, OWCP issued a schedule award for an additional 2 percent impairment of appellant's right upper extremity, for a total schedule award of 12 percent paid.

[4] This was consistent with physical therapy records from July 2008, which recorded range of motion within normal limits.

Dr. Hennessey again explained that appellant had three different diagnoses at his right shoulder and that each of these is assigned an upper extremity impairment rating. He objected to OWCP's decision because he was a Board-certified, published and experienced musculoskeletal physician who examined appellant, while OWCP's medical adviser and claims examiner did not. Dr. Hennessey reiterated the 24 percent rating.

In a June 21, 2011 decision, OWCP denied modification of its March 17, 2011 decision.

On reconsideration, Dr. Hennessey challenged OWCP to point out where the A.M.A., *Guides* stated that only one diagnosis should be used and on which page it specifically stated that it was medically inappropriate to use more than one diagnosis. He could find no language that a patient could not be rated for more than one diagnosis.

In an August 29, 2011 decision, OWCP denied appellant's request for reconsideration.

Appellant again requested reconsideration, indicating that Dr. Hennessey stated that, as per section 16.1c of the A.M.A., *Guides*, multiple impairments are to be combined. As he did have more than one diagnosis, "it was absolutely completely medically appropriate of me with The A.M.A., *Guides* to rate [appellant] for more than one diagnosis." Dr. Hennessey added that page 389 of the A.M.A., *Guides* did not indicate that only one diagnosis was permitted. "This is a significantly erroneous interpretation by a nonphysician [of] a book by physicians for physicians."

An OWCP medical adviser subsequently pointed to specific pages and excerpts in the A.M.A., *Guides* stating that only the most significant or most impairing regional diagnosis should be rated.

In a December 30, 2011 decision, OWCP denied modification of appellant's schedule award.

On appeal, appellant's representative argues that OWCP's acceptance of a rating based on only one diagnosis is a violation of *James Massenburg*,[5] which is binding authority. He argued that full and fair compensation required rating all of appellant's impairments, including his biceps tendon tear. If multiple impairments are not to be combined, he questioned why the sixth edition of the A.M.A., *Guides* has a Combined Values Chart and that Chapter 5.2e of the A.M.A., *Guides* did not apply to appellant's circumstances. Appellant's representative urges the Board to find that appellant is entitled to the 24 percent rating provided by Dr. Hennessey.

LEGAL PRECEDENT

Section 8107 of FECA[6] authorizes the payment of schedule awards for the loss or permanent impairment of specified members, functions or organs of the body. FECA does not specify how the percentage of impairment shall be determined. For consistent results and to

[5] 29 ECAB 850 (1978).

[6] 5 U.S.C. § 8107.

ensure equal justice for all claimants, OWCP has adopted the A.M.A., *Guides* as the standard for determining the percentage of impairment. The Board has long concurred in such adoption.[7]

Regulations implementing FECA provide as follows: "OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*."[8] For impairment ratings calculated on and after May 1, 2009, OWCP should advise any physician evaluating permanent impairment to use the sixth edition of the A.M.A., *Guides*.[9]

The sixth edition of the A.M.A., *Guides* explains that impairment evaluations require medical knowledge; therefore, mostly doctors who are qualified in allopathic or osteopathic medicine or chiropractic medicine use the A.M.A., *Guides* to evaluate impairment. "It must be emphasized, however, that even though the A.M.A., *Guides* is mainly written by medical doctors for medical doctors and others permitted to do impairment evaluations, nonphysician evaluators may analyze an impairment evaluation to determine if it was performed in accordance with the A.M.A., *Guides*."[10]

OWCP procedures require that the file contain competent medical evidence that describes the impairment in sufficient detail for the claims examiner to visualize the character and degree of impairment and that gives a percentage of impairment based on a specific diagnosis. The attending physician should make the evaluation whenever possible. After obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment. The percentage should be computed in accordance with the sixth edition of the A.M.A., *Guides*. As a matter of course, the medical adviser should provide rationale for the percentage of impairment specified. The claims examiner, in turn, should review the medical adviser's findings.[11] The Board has jurisdiction to review the final decision of OWCP.[12]

ANALYSIS

Because regulations require OWCP to evaluate the degree of permanent impairment according to the standards set forth in the sixth edition of the A.M.A., *Guides*, and because there

[7] *Danniel C. Goings*, 37 ECAB 781 (1986) (the Board approved OWCP's adoption of a new standard, based on the second edition of the A.M.A., *Guides*, published in 1984, for evaluating schedule awards in hearing loss cases, which new standard was made applicable to original schedule award decisions made after February 24. 1986); *Leisa D. Vassar*, 40 ECAB 1287 (1989) (the Board found that it was proper for OWCP to adopt the most current edition of the A.M.A., *Guides*, published in 1988, as a standard for making schedule award decisions effective March 8, 1989).

[8] 20 C.F.R. § 10.404.

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

[10] A.M.A., *Guides* 23 (6th ed. 2009).

[11] *Supra* note 9.

[12] 20 C.F.R. § 501.2(c).

has been some misunderstanding in this case about how to apply the sixth edition, the Board will begin by reviewing the sixth edition's methodology.

In the sixth edition, DBI is the primary method of evaluation for the upper extremity. A grid listing relevant diagnoses is provided for each region of the upper extremity: the digit region, the wrist region, the elbow region and the shoulder region. A regional impairment will be defined by class and grade. The class is determined first by using the corresponding regional grid. The grade is initially assigned the default value for that class. This value may be adjusted slightly using "nonkey" grade modifiers such as functional history, physical examination and clinical studies.[13]

This process is repeated for each separate diagnosis in each limb involved. The A.M.A., *Guides* emphasizes, however, that in most cases only one diagnosis in a region will be appropriate:

> "If a patient has 2 significant diagnoses, for instance, rotator cuff tear and biceps tend[i]nitis, the examiner should use the diagnosis with the highest causally related impairment rating for the impairment calculation. Thus, when rating rotator cuff injury/impairment or glenohumeral pathology/surgery, incidental resection arthroplasty of the [acromioclavicular] joint is not rated."[14]

The A.M.A., *Guides* explains that the first step in determining an impairment rating is to choose the diagnosis that is most applicable for the region being assessed. Selection of the optimal diagnosis requires judgment and experience:

> "If more than one diagnosis can be used, the highest causally-related impairment rating should be used; this will generally be the more specific diagnosis. Typically, one diagnosis will adequately characterize the impairment and its impact on [activities of daily living]."[15]

The A.M.A., *Guides* repeats the single-diagnosis methodology for rating regional impairment: "The evaluator should select the most accurate diagnosis and identify the class containing that diagnosis."[16] In a case where there are DBIs in other regions of the upper extremity, the values are combined.[17] But when calculating the DBI of a single region, such as the shoulder: "The evaluator is expected to choose the most significant diagnosis and to rate only that diagnosis using the DBI method that has been described." If clinical studies confirm more than one of the following symptomatic diagnoses -- rotator cuff tear, labral lesion or biceps

[13] A.M.A., *Guides* 387 (6th ed. 2009).

[14] *Id*.

[15] *Id*. at 389.

[16] *Id*.

[17] *Id*. at 390.

tendon pathology, the default impairment value can be modified according to the Clinical Studies Adjustment Table.[18]

In discussing how to combine impairments, the A.M.A., *Guides* notes the rationale for using the single-diagnosis methodology:

> "If there are multiple diagnoses at [maximum medical improvement], the examiner should determine if each should be considered or if the impairments are duplicative. If there are multiple diagnoses within a specific region, then the most impairing diagnosis is rated because it is probable this will incorporate the functional losses of the less impairing diagnoses. In rare cases, the examiner may combine multiple impairments within a single region if the most impairing diagnosis does not adequately reflect the losses. When uncertain about which method to choose or whether diagnoses are duplicative, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.
>
> "The evaluating physician must explain in writing the rationale for combining impairments."[19]

Thus, the A.M.A., *Guides* does not strictly prohibit calculating regional impairment using multiple diagnoses. Such a case is considered rare and the evaluating physician has the burden to justify combining regional impairments by explaining how the most impairing diagnosis does not incorporate the functional losses of the less impairing diagnoses. In most cases, however, only one diagnosis in a region will be appropriate.

With these principles in mind, the Board will now review the impairment rating offered by Dr. Hennessey, appellant's evaluating physiatrist. After it became clear that he had been following the protocols of the fifth edition of the A.M.A., *Guides*, which were not applicable, Dr. Hennessey rated appellant's impairment under the sixth edition. He offered a nine percent rating for rotator cuff tear, but he did not explain how he arrived at that percentage. According to the Shoulder Regional Grid, Table 15-5, pages 402-03, the highest impairment rating anyone may receive for a rotator cuff tear is seven percent, so it does not appear that Dr. Hennessey properly followed the protocols of the sixth edition.

Dr. Hennessey offered a nine percent rating for adhesive capsulitis, but that diagnosis is not listed in the Shoulder Regional Grid. He described this condition as a painful restriction of range of motion. The A.M.A., *Guides* states, however, that range of motion *"is used primarily as a physical examination adjustment factor and only to determine actual impairment values when a grid permits its use as an option."*[20] (Emphasis in the original.) When it is permitted, it

[18] *Id*.

[19] *Id*. at 419.

[20] *Id*. at 387.

may be selected as an alternative approach, but an impairment rating that is calculated using range of motion may not be combined with a DBI. It stands alone as a rating.[21]

For most of the diagnoses listed in the Shoulder Regional Grid, if motion loss is present, range of motion impairment may alternatively be assessed using section 15.7, but again, it stands alone and is not combined with a DBI.[22]

Dr. Hennessey did not explain how he used the sixth edition to calculate a nine percent impairment for this painful restriction of motion. The Board notes that OWCP has not accepted appellant's claim for the condition of adhesive capsulitis. Further, if appellant suffered from the condition in the first months of recovering from his February 2008 surgery, the condition appears to have resolved later that year. Physical therapy notes in July 2008 noted normal range of motion, and 11 months after the surgery Dr. Hung, the orthopedic surgeon, examined appellant and found full active range of right shoulder motion. This is rather a moot point, however, as Dr. Hennessey's 9 percent rating for restricted motion, which must stand alone, does not establish that appellant has more than a 12 percent impairment of his right upper extremity.

Dr. Hennessey also offered a six percent rating for biceps tendon tear. OWCP has not accepted appellant's claim for this medical condition either and the Shoulder Regional Grid does not list such a diagnosis. It provides impairment values for the diagnosis of biceps tendon dislocation/subluxation, but the highest impairment rating for that diagnosis stands at five percent. Like the rating for adhesive capsulitis, Dr. Hennessey's rating for biceps tendon tear does not show that appellant has more than a 12 percent impairment of his right upper extremity.

Dr. Hennessey added his three DBIs for a total impairment of 24 percent. The A.M.A., *Guides* prohibits such a combination in the absence of a medical explanation demonstrating how the most impairing of the three diagnoses does not adequately reflect appellant's losses. Dr. Hennessey did not sufficiently explain why combining multiple regional impairments was necessary and why there was no pathomechanical overlap. He simply insisted that it was entirely appropriate for him to do so as per section 16.1c of the A.M.A., *Guides*.

There is no section 16.1c in the sixth edition of the A.M.A., *Guides*. Section 16 of the fifth edition in 2001 allowed combining different types of impairment in a given unit -- for example, abnormal motion, sensory loss and partial amputation of a finger[23] -- but that methodology has been superseded. Appellant's impairment must be rated according to the protocols of the current edition of the A.M.A., *Guides*, which address the upper extremities in Chapter 15.

The Board finds that Dr. Hennessey's 24 percent rating carries no probative weight. As Dr. Hennessey points out, he is a Board-certified physiatrist or musculoskeletal physician. He is published and experienced and he physically examined appellant. No other party in this matter holds that status. Nonetheless, this does not mean that Dr. Hennessey has properly evaluated

[21] *Id*. at 390.

[22] *Id*. at 405 (annotation at the bottom of Table 15-5).

[23] A.M.A., *Guides* 438 (5th ed. 2001).

appellant's right upper extremity impairment under the sixth edition of the A.M.A., *Guides*. Knowledge of key concepts and philosophy underlying the sixth edition, along with a thorough understanding of the appropriate chapters of the A.M.A., *Guides*, are essential for a credible impairment rating.[24]

Dr. Hennessey's reports may serve as competent medical evidence describing appellant's impairment in sufficient detail for others to visualize the character and degree of impairment so that a credible rating may be accomplished to satisfy appellant's burden of proof to establish his entitlement to a schedule award. Dr. Uejo, the specialist in occupational medicine and an OWCP medical consultant, correctly noted that one diagnosis -- acromioclavicular joint disease, status post distal clavicle resection -- provided the highest impairment rating for appellant.[25]

The default impairment value for that diagnosis and criterion is 10 percent. As the Board indicated earlier, this default impairment value may be adjusted slightly, up or down 2 percent, depending on appellant's functional history, physical examination and clinical studies. OWCP's medical adviser adjusted the default value to 12 percent. In this appeal, an analysis of each "nonkey" adjustment is unnecessary because, in the end, OWCP has awarded appellant the highest rating possible for the most impairing of his right shoulder diagnoses. He can receive no more under the single-diagnosis methodology of the sixth edition.

As appellant's schedule award is consistent with the protocols of the sixth edition of the A.M.A., *Guides*, the Board will affirm OWCP's December 30, 2011 decision denying modification of that award.

In *James Massenburg*,[26] the evaluating physician reported left foot and great toe pain, a limp, the use of an orthotic, tenderness and swelling and loss of motion. An x-ray revealed degenerative and traumatic arthritis. The physician was of the opinion that the claimant had sustained a contusion and subsequently developed traumatic arthritis, which was responsible for the current signs and symptoms. He offered a total body rating of 20 percent.

OWCP's deputy medical director noted total body impairment was not relevant to impairment as set forth in the then-applicable edition of the A.M.A., *Guides*. He therefore assigned a percentage loss to each impairment reported by the evaluating physician and then applied the Combined Values Chart to calculate a 13 percent impairment of the left foot.

The Board affirmed, holding that the weight of the medical evidence rested with the rating offered by the deputy medical director, who applied the A.M.A., *Guides* insofar as

[24] A.M.A., *Guides* 23 (6th ed. 2009).

[25] According to Table 15-5, page 401-05 of the A.M.A., *Guides*, the highest rating appellant can receive for nonspecific shoulder pain post acute injury or surgery, not otherwise specified, is 1 percent; for shoulder sprain or strain, 2 percent; for shoulder contusion or crush injury, 3 percent; for partial-thickness rotator cuff tear, 5 percent; for labral lesions, including superior labral tear from anterior to posterior (SLAP tear), 5 percent; for biceps tendon dislocation/subluxation, 5 percent; for full-thickness rotator cuff tear, 7 percent; and for acromioclavicular joint injury or disease, status post distal clavicle resection, 12 percent.

[26] *Supra* note 5.

applicable to the findings of the evaluating physician. The Board noted: "The use of the A.M.A., *Guides*, insofar as applicable, has been recognized by [OWCP] and Board as an appropriate standard for evaluating percentage loss of use of a scheduled member of the body under the schedule award provisions of [FECA]."[27]

The Board decided *Massenburg* in 1978. That the A.M.A., *Guides* at that time permitted combining multiple regional impairments in no way binds OWCP or prevents it from adopting and applying the A.M.A., *Guides'* current methodology, as embodied in the sixth edition. As the A.M.A., *Guides* explains, the sixth edition defines an innovative new international standard for assessing impairment. A consistent, well-designed methodology was adopted and applied to each chapter to enhance the relevancy of impairment ratings, improve internal consistency, promote greater precision and standardize the rating process. The goal is to provide an impairment rating guide that is authoritative, fair and equitable to all parties. The A.M.A., *Guides* recognizes that the process of defining impairment or the complexities of human function is not perfect; however, the sixth edition standardizes the rating process, improves accuracy and provides a solid basis for future editions of the A.M.A., *Guides*.[28]

Appellant's representative may disagree. He may feel that rating impairment on the basis of only one diagnosis is unfair. But regulations require OWCP to apply the standards set forth by the A.M.A., *Guides* in the sixth edition of the A.M.A., *Guides*. In much more recent cases -- those reviewing ratings under the sixth edition -- the Board has consistently affirmed the application of the single-diagnosis methodology for rating regional impairment.[29] OWCP has applied the sixth edition of the A.M.A., *Guides* insofar as possible to the findings reported by the evaluating physician. As in *Massenburg*, the Board will affirm OWCP's decision.

The sixth edition of the A.M.A., *Guides* provides a Combined Values Chart because it allows the combination of impairments under certain circumstances, such as when there are impairments to different regions of the upper extremity. It does not follow that the mere inclusion of the chart in the sixth edition means that all impairments must be combined notwithstanding the A.M.A., *Guides*' current philosophy and instructions to the contrary.

The Board interprets the second paragraph of section 15.2e, page 390, as simply illustrative of the fundamental DBI methodology that the examiner should use the diagnosis with the highest causally related impairment rating for the impairment calculation. It does not, in the Board's opinion, restrict that methodology to the single situation in which a shoulder is found to have a rotator cuff tear, a SLAP tear or other labral lesion and biceps tendon pathology. The A.M.A., *Guides* suggests no reason for restricting the methodology and such a reading is inconsistent with repeated instructions on how to calculate a DBI.

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[27] *Id.* at 853.

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

[29] *E.g.*, *V.B.*, Docket No. 11-2099 (issued June 13, 2012) (where OWCP accepted both bilateral carpal tunnel syndrome and bilateral upper extremity tendinitis, the Board found that OWCP properly awarded schedule compensation based on the former, as it was the most impairing diagnosis); *B.W.*, Docket No. 11-2146 (issued May 2, 2012) (bilateral carpal tunnel syndrome and de Quervain's disease); *A.H.*, Docket No. 11-2010 (issued April 13, 2012) (bilateral carpal tunnel syndrome and tenosynovitis).

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that the weight of the evidence fails to establish that appellant has more than a 12 percent impairment of his right upper extremity as a result of his October 26, 2007 shoulder injury, for which he received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the December 30, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 3, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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