United States Department of Labor
Employees' Compensation Appeals Board

R.S., Appellant	)	
and	)	**Docket No. 11-850**
	)	**Issued: January 4, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Olathe, KS, Employer	)	

Appearances:
Edward L. Daniel, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On February 17, 2011 appellant, through his representative, filed a timely appeal from the December 8, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP) regarding a 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 met his burden of proof to establish that he has more than a 9 percent permanent impairment of his left arm and a 10 percent permanent impairment of his right arm, for which he received schedule awards.

FACTUAL HISTORY

OWCP accepted that by late 2004 appellant, then a 52-year-old letter carrier, had sustained bilateral shoulder tendinitis and bilateral shoulder impingement due to the performance

[1] 20 C.F.R. § 8101 *et seq.*

of his job duties over time. Appellant performed several left shoulder procedures, including a subacromial decompression, distal clavicle excision and debridement of the superior labrum and a partial thickness tear of the articular surface of the rotator cuff.

In a May 25, 2006 decision, OWCP granted appellant a schedule award for a 10 percent permanent impairment of his right arm. The award was calculated under the standards of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). In a December 21, 2006 decision, OWCP granted him a schedule award for a nine percent permanent impairment of his left arm which was also calculated under the standards of the fifth edition of the A.M.A., *Guides*. In a February 18, 2009 decision,[2] the Board affirmed OWCP's determination that appellant had a nine percent permanent impairment of his left arm.

In a March 31, 2009 report, Dr. Robert Conway, Board-certified in physical medicine and rehabilitation and an OWCP referral physician, reported findings on physical examination of appellant, including range of motion testing of his shoulders. He questioned the validity of appellant's range of arm motion. Dr. Conway opined that appellant did not cooperate sufficiently to provide a reliable examination and stated, "Therefore, in my opinion, given the poor effort, I do not feel that this patient has any ratable impairment."

In an August 4, 2009 report, Dr. John W. Ellis, an attending Board-certified occupational medicine physician, determined that appellant had a 19 percent permanent impairment of his right arm and a 20 percent permanent impairment of his left arm under the sixth edition of the A.M.A., *Guides*.[3] Dr. Ellis applied the range of motion method for evaluating impairment which is found in Chapter 15.7.

In a September 7, 2009 report, Dr. Daniel D. Zimmerman, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, stated that Dr. Ellis' opinion was of limited probative value because he did not adequately follow the procedures detailed in Chapter 15.7 in order to assure the credibility of the range of motion findings.

In a September 22, 2009 decision, OWCP determined that appellant had not shown that he was entitled to additional schedule award compensation. It found that Dr. Zimmerman properly pointed out the deficiencies of Dr. Ellis' evaluation.

In a brief report dated October 15, 2009, Dr. Ellis asserted that his August 19, 2009 was properly prepared in accordance with the relevant standards. However, he did not provide any notable additional explanation of his rating methods.

In a March 3, 2010 decision, OWCP affirmed its September 22, 2009 decision noting that Dr. Ellis had not adequately explained his impairment rating methods.

[2] Docket No. 08-1669 (issued February 18, 2009).

[3] The Board notes that it was appropriate to apply the standards of the sixth edition of the A.M.A., *Guides* at this time. *See infra* note 7.

In a February 15, 2010 report, Dr. Ellis reiterated that appellant had a 19 percent permanent impairment of his right arm and a 20 percent permanent impairment of his left arm by applying the range of motion method for evaluating impairment which is found in Chapter 15.7. Dr. Zimmerman reviewed Dr. Ellis' report and determined that it had the same deficiencies as his prior reports.

In a July 26, 2010 decision, OWCP affirmed its March 3, 2010 decision finding that appellant was not entitled to additional schedule award compensation. It found that the new medical evidence did not establish greater impairment to support a higher level of schedule award compensation.

In a September 27, 2010 report, Dr. Stephen Wilson, an attending Board-certified physical medicine and rehabilitation physician, determined that appellant had a 19 percent permanent impairment of his right arm and a 30 percent permanent impairment of his left arm. Dr. Wilson applied the range of motion evaluation method under Chapter 15.7, but provided limited explanation of how this section was used. In an October 29, 2010 report, Dr. Zimmerman found that Dr. Wilson's report was of limited probative value because he did not properly apply the range of motion testing procedures described in Chapter 15.7.

In a December 8, 2010 decision, OWCP affirmed its July 26, 2010 decision finding that appellant was not entitled to additional schedule award compensation.

LEGAL PRECEDENT

The schedule award provision of FECA[4] and its implementing regulations[5] 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, FECA 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[6] For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.[7]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401.

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999).

[6] *Id*.

[7] *See* FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5th ed. 2001) is used.

In Chapter 15, the sixth edition of the A.M.A., *Guides* stresses that diagnosis-based impairment is the "primary method of evaluation for the upper limb."[8] After the Class of Diagnosis (CDX) is determined from the Shoulder Regional Grid (including identification of a default grade value), the Net Adjustment Formula is applied using the grade modifier for Functional History (GMFH), grade modifier for Physical Examination (GMPE) and grade modifier for Clinical Studies (GMCS). The Net Adjustment Formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[10]

Table 15-5 also provides that, if motion loss is present for a claimant who has undergone a shoulder arthroplasty, impairment may alternatively be assessed using section 15.7 (range of motion impairment). Such a range of motion impairment stands alone and is not combined with a diagnosis-based impairment.[11] The range of motion method involves the taking of active and passive range of motion findings and then comparing of the two types of motion in order to evaluate credibility issues. Range of motion is measured after a "warm up" in which the individual moves the joint through its maximum range of motion at least three times.[12]

ANALYSIS

Appellant received schedule awards for a 9 percent permanent impairment of his left arm and a 10 percent permanent impairment of his right arm. He later claimed that he was entitled to receive greater amounts of schedule award compensation for the permanent impairment of his arms.

The Board finds that appellant did not meet his burden of proof to establish that he has more than a 9 percent permanent impairment of his left arm and a 10 percent permanent impairment of his right arm.

Appellant submitted several reports of Dr. Ellis, an attending Board-certified occupational medicine physician, including those dated August 4, October 15, 2009 and February 15, 2010. These reports contained impairment ratings for appellant's arms which were higher than the 9 percent impairment of the left arm and the 10 percent impairment of the right arm previously found. However, these reports are of limited probative value on the extent of impairment because Dr. Ellis did not adequately explain how his impairment ratings were derived in accordance with the relevant standards of the sixth edition of the A.M.A., *Guides*.

[8] *See* A.M.A., *Guides* 401-11 (6th ed. 2009).

[9] *See id.* at 401-11.

[10] *Id.* at 23-28.

[11] *Id.* at 405, 475-78.

[12] *Id.* at 461-64.

Dr. Ellis evaluated appellant's arm impairment under the range of motion method delineated in Chapter 15.7 of the sixth edition of the A.M.A., *Guides*. But he did not adequately explain why he did not adopt a diagnosis-based evaluation of appellant's impairment under Table 15-5 of the sixth edition of the A.M.A., *Guides*. As noted above, the sixth edition of the A.M.A., *Guides* stresses that diagnosis-based impairment is the "primary method of evaluation for the upper limb," nor did Dr. Ellis show that he complied with the testing regimen of Chapter 15.7 of the A.M.A., *Guides*. The range of motion method involves the taking of active and passive range of motion findings and then comparing the two types of motion in order to evaluate credibility issues. Range of motion is measured after a "warm up" in which the individual moves the joint through its maximum range of motion at least three times. Dr. Ellis did not show that he complied with these procedures which are designed to ensure the credibility of range of motion testing. Dr. Zimmerman, the Board-certified orthopedic surgeon who served as an OWCP medical adviser, properly pointed out the deficiencies of Dr. Ellis' impairment ratings.

Appellant also submitted a September 27, 2010 report in which Dr. Wilson, an attending Board-certified physical medicine and rehabilitation physician, determined that he had a 19 percent permanent impairment of his right arm and a 30 percent permanent impairment of his left arm. Dr. Wilson applied the range of motion evaluation method under Chapter 15.7 but his opinion on impairment also is of limited probative value because it has the same deficiencies as the opinions of Dr. Ellis.

On appeal appellant's representative argued that claimants might have wide variance in range of motion findings and suggested that there was no good reason to question the legitimacy of the range of motion findings obtained by Dr. Ellis. The opinion of Dr. Ellis was found to be of limited probative value regarding the extent of appellant's arm impairment, not because the range of motion findings were found to be invalid. Rather Dr. Ellis did not adequately explain why the primary diagnosis-based impairment method was not appropriate or that the range of motion evaluation section of the sixth edition of the A.M.A., *Guides* (Chapter 15.7) was properly applied. Appellant's representative also argued that Dr. Zimmerman, in his role as OWCP medical adviser, could not resolve a conflict in the medical opinion evidence regarding the extent of appellant's arm impairment. The Board notes that there was no conflict in the medical opinion evidence and Dr. Zimmerman was not called upon to resolve such a conflict. As noted Dr. Ellis did not provide a well-rationalized opinion, under the standards of the relevant edition of the A.M.A., *Guides*, regarding appellant's arm impairment.

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 appellant did not meet his burden of proof to establish that he has more than a 9 percent permanent impairment of his left arm and a 10 percent permanent impairment of his right arm, for which he received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the December 8, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 4, 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