United States Department of Labor
Employees' Compensation Appeals Board

J.G., Appellant	)	
and	)	**Docket No. 12-410**
	)	**Issued: September 7, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Chillicothe, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 21, 2011 appellant filed a timely appeal from a September 14, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 her burden of proof to establish that she has more than a three percent permanent impairment of the left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On July 21, 2010 appellant, then a 50-year-old clerk, filed a claim for occupational disease, alleging that she developed a left shoulder condition due to her employment. The claim

[1] 5 U.S.C. § 8101 *et seq.*

was accepted on August 31, 2010 for adhesive capsulitis of the left shoulder and left shoulder impingement syndrome.

On March 21, 2011 appellant requested a schedule award.

In an April 5, 2011 development letter to Dr. Lisa Snyder, appellant's treating physician Board-certified in pain medicine, OWCP requested that a medical evaluation be conducted to determine whether appellant sustained a compensable permanent impairment. Dr. Snyder was requested to provide a date of maximum medical improvement, a description of appellant's permanent impairment, as well as an impairment rating, pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

In a report dated April 12, 2011, Dr. Snyder reviewed appellant's history of injury and diagnosed impingement syndrome, acromioclavicular (AC) joint injury, left shoulder partial anterior and posterior labral tears and a partial supraspinatus tear. She noted that appellant had reached maximum medical improvement on March 14, 2011. Using Table 15-5, Table 15-7 and Table 15-8 of the sixth edition of the A.M.A., *Guides*, Dr. Snyder determined that the resulting impairment rating to be one percent for impingment syndrome, zero percent for AC joint disease, two percent for anterior and posterior labral tears and one percent for supraspinatus tear. She then added the impairment ratings to obtain a total of four percent impairment finding. Dr. Snyder also conducted range of motion examination and found appellant's left shoulder's condition as follows: 170 degrees abduction, 40 degrees adduction, 165 degrees forward flexion, 80 degrees external rotation, 80 degrees internal rotation and 50 degrees shoulder extension.

Dr. Snyder's medical findings were then forwarded to the district medical adviser (DMA) for review. In his July 7, 2011 letter, the DMA disagreed with Dr. Snyder's findings, stating that, because appellant had loss of motion, Table 15-5 should not have been used, as Table 15-5 could only be used for cuff tears with normal motion. He stated that appellant's impairment should have been assessed under Table 15-34, based upon loss of motion and rated a three percent permanent impairment of her left shoulder.

By decision dated September 14, 2011, OWCP granted appellant a schedule award for a three percent permanent impairment of the left upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing federal regulations[2] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[3] For decisions after

[2] 20 C.F.R. § 10.404.

[3] *Id*. at § 10.404(a).

February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[4] For decisions issued after May 1, 2009, the sixth edition will be used.[5]

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).[6] 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).[7] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[8]

In the sixth edition, diagnosis-based impairment (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.[9]

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

> "If a patient has [two] 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 [AC] joint is not rated."[10]

The A.M.A., *Guides* again explain 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.

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

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

[6] A.M.A., *Guides* (6th ed. 2008) 3, section 1.3, The ICF, Disability and Health: A Contemporary Model of Disablement.

[7] *Id*. at 385-419.

[8] *Id*. at 411.

[9] *Id*. at 387.

[10] *Id*.

> Typically, [one] diagnosis will adequately characterize the impairment and its impact on [activities of daily living]."[11]

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."[12] In a case where there are DBIs in other regions of the upper extremity, the values are combined.[13] 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 tendon pathology, the default impairment value can be modified according to the clinical studies adjustment table.[14]

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."[15]

Thus, the A.M.A., *Guides* do 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. It must be understood, however, that in most cases only one diagnosis in a region will be appropriate.

ANALYSIS

OWCP requested that Dr. Snyder provide an evaluation of appellant's permanent impairment of the left upper extremity. Dr. Snyder evaluated the degree of appellant's

[11] *Id*. at 389.

[12] *Id*.

[13] *Id*. at 390.

[14] *Id.*

[15] *Id*. at 419.

impairment pursuant to the sixth edition of the A.M.A., *Guides*. For impingement syndrome, she applied Table 15-5 to obtain a default level one and obtained a grade modifier 1 for the functional history adjustment and a grade modifier 0 from the physical examination adjustment. Using the grade modifier formula, Dr. Snyder obtained a net adjustment value of -1. She properly concluded that the impingement syndrome evaluation yielded a one percent upper extremity impairment rating.

For the AC joint injury, she applied the Table 15-5, which yielded a grade zero impairment rating.

For the left shoulder partial anterior and posterior labral tears, Table 15-5 yielded a class 1 impairment rating. The functional history and physical examination tables provided a -1 net adjustment. Because the default level for a grade 1 labral region is 3, the impairment rating is properly determined to be two percent after the -1 adjustment.

For the partial supraspinatus tear, Table 15-5 yielded a class 1 impairment rating with default level of 1. The functional history and physical examination tables yielded a default level of -1, from which the physician properly determined that the impairment rating to be one percent.

Dr. Snyder added all the impairment ratings together; but, as noted above, if more than one diagnosis is applicable for a region of an extremity, only one diagnosis, the highest causally-related impairment rating should be used. The evaluator is expected to choose the most significant diagnosis and to rate only that diagnosis using the DBI method. Only in rare cases may the examiner combine multiple impairments within a region, with supporting medical rationale. Because Dr. Snyder did not support her combination of rating with written justification she needed to choose the highest impairment rating for the different diagnoses of the left shoulder. In this case, the highest rating was given for appellant's labral tears, which was two percent.

The DMA stated that, according to the A.M.A., *Guides* sixth edition, Table 15-5 did not apply in appellant's case because she had loss of motion, because "cuff tears with normal motion can only be used by [Table] 15-5." In fact, the A.M.A., *Guides* note: "if motion loss is present, this impairment may alternatively be assessed using [s]ection 15.7, [r]ange of [m]otion [i]mpairment; and the range of motion impairment stands alone and is not combined with diagnosis impairment." In the current case, it was appropriate to assess appellant's impairment rating using both the diagnosis approach under Table 15-5 as well as the range of motion stand alone approach under Table 15-34, to determine the greater rating.[16]

The DMA calculated appellant's impairment rating using the stand alone range of motion approach. He utilized the physical examination findings from Dr. Snyder's April 12, 2011 report of 170 degrees abduction, 40 degrees adduction, 165 degrees forward flexion, 80 degrees external rotation, 80 degrees internal rotation and 50 degrees extension. Under Table 15-34, appellant did not suffer motion loss, except in her forward flexion, which corresponded to a modifier 1, which in turn yields a three percent impairment of upper extremity.

[16] *See A.B.*, Docket No. 12-262 (issued June 22, 2012).

As the impairment rating under the range of motion approach yielded a greater impairment finding than the rating obtained under the diagnosis-based approach, appellant's permanent impairment was properly rated solely based upon loss of motion. OWCP properly found appellant's impairment rating to be three percent of the upper extremity.

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.[17]

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she has more than a three percent permanent impairment of the left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the September 14, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 7, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

[17] On appeal, appellant argued that her right shoulder impairment under a different claim was given a rating of 13 percent in October 2008 and that she felt the 3 percent determination on the left shoulder was too low. The Board notes that her right shoulder impairment was calculated under the fifth edition of the A.M.A., *Guides*, which used a different rating system and is no longer in use.