United States Department of Labor
Employees' Compensation Appeals Board

P.J., Appellant	)	
and	)	**Docket No. 12-871**
	)	**Issued: September 14, 2012**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Milwaukee, WI, 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 March 13, 2012 appellant filed a timely appeal from November 21, 2011 and February 23, 2012 merit decisions 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 schedule award issue.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has more than an eight percent impairment of the left arm for which he received a schedule award.

FACTUAL HISTORY

On June 28, 2010 appellant, then a 53-year-old cook, filed a traumatic injury claim alleging that on June 25, 2010 he injured his left shoulder after he lifted a case of cans. OWCP

[1] 5 U.S.C. § 8101 *et seq.*

accepted his claim for left shoulder and upper arm sprain and left rotator cuff tear. Appellant underwent authorized left shoulder rotator cuff repair, left shoulder arthroscopy surgery and left biceps tenodesis arthroscopy. He received wage-loss compensation benefits.

On August 9, 2011 appellant, through counsel, requested a schedule award.

In an August 12, 2011 report, Dr. William N. Grant, a Board-certified internist, noted appellant's accepted diagnoses for left shoulder sprain and rotator cuff tear and reviewed his medical history. He provided an accurate history of injury that appellant heard a "pop" in his left shoulder and experienced severe pain when he lifted a heavy case at work. Dr. Grant noted that appellant underwent surgery to repair a torn rotator cuff. He related appellant's complaints of constant painful paresthesia to his left shoulder and inability to lift his left arm above his left shoulder without experiencing pain. Appellant also experienced difficulty performing any activities of daily living using his left shoulder. Examination of the left shoulder revealed tenderness to palpation over the left deltoid muscle and limited range of motion of the left shoulder. Dr. Grant also observed that appellant had lost over 75 percent of strength of his right arm. He diagnosed left shoulder sprain and left rotator cuff tear and concluded that appellant reached maximum medical improvement on August 12, 2011.

Utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (6th ed. 2009) (hereinafter, A.M.A., *Guides*), Dr. Grant opined that appellant had 2 percent impairment due to the left shoulder sprain, 5 percent impairment due to the left shoulder rotator cuff tear and 13 percent impairment due to his brachial plexus injury, which resulted in a total left upper extremity impairment of 20 percent. For his left shoulder sprain, he determined that appellant had a class 1 diagnosis according to Table 15-5.[2] Dr. Grant utilized a grade modifier based on Functional History (GMFH) of 2 because appellant had a *Quick*DASH score of 46.[3] He utilized a grade modifier based on Physical Examination (GMPE) of 2 due to his moderate decreased range of motion.[4] Dr. Grant applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX)[5] and found that appellant had a net adjustment formula of 2. He concluded that appellant had two percent upper extremity impairment for the left shoulder sprain. For his left shoulder rotator cuff rupture, Dr. Grant determined that appellant had a class 1 diagnosis according to Table 15-5.[6] He utilized grade modifiers of 2 based on functional history[7] and physical examination,[8] which resulted in a net adjustment of 2. Dr. Grant found that appellant had five percent impairment upper extremity impairment for the left shoulder rotator cuff syndrome. For appellant's brachial plexus injury, he determined that

[2] A.M.A., *Guides* 401.

[3] *Id.* at 406.

[4] *Id.* at 408.

[5] *Id.* at 411.

[6] *Id.* at 403.

[7] *Id.* at 406.

[8] *Id.* at 408.

appellant had a class 1 diagnosis according to Table 15-20.[9] Dr. Grant utilized grade modifiers of 2 based on functional history[10] and physical examination.[11] He applied the net adjustment of 2 and found that appellant had 13 percent upper extremity impairment for brachial plexus injury. Dr. Grant combined the impairment ratings to conclude that appellant had a total impairment rating of 20 percent for the left upper extremity.

On October 7, 2011 OWCP referred appellant's schedule award claim to a district medical adviser. In an October 10, 2011 report, Dr. David H. Garelick, a Board-certified orthopedic surgeon and district medical adviser, noted that appellant sustained a work-related left shoulder rotator cuff tear and underwent an arthroscopic acromioplasty, rotator cuff repair and biceps tenodesis. He noted that Dr. Grant rated 20 percent impairment for the left upper extremity based largely on a reported brachial plexus injury, but stated that there was no objective evidence, such as an electromyography (EMG) study, supporting such a nerve injury. Dr. Garelick stated that Dr. Grant appeared to have based his impairment rating on appellant's subjective complaints of paresthesias in the left shoulder and not objective findings on examination. He advised OWCP to disregard Dr. Grant's rating.[12] Dr. Garelick reviewed the findings of Dr. Grant and noted full active forward elevation, abduction, and rotation and mild weakness with external rotation against resistance. He also noted mild atrophy of the infraspinatus.

Utilizing the sixth edition of the A.M.A., *Guides*, Dr. Garelick reported that appellant had a default of five percent impairment for his rotator cuff tear according to Table 15-5, page 403. He stated there was no change to this award based on the net adjustment formula. Dr. Garelick noted that there was no schedule award category for biceps tenodesis, but he recommended an additional three percent left upper extremity impairment for a biceps tendon dislocation and subluxation.[13] He combined the values according to page 604 of the A.M.A., *Guides* and concluded that appellant had an eight percent impairment of the left upper extremity. Dr. Garelick found that appellant reached maximum medical improvement on March 28, 2011 when he was discharged from Dr. Wichman's care.[14]

[9] *Id.* at 434.

[10] *Id.* at 406.

[11] *Id.* at 408.

[12] Dr. Garelick also stated that he reviewed the schedule award recommendation of Dr. Marck Wichman, a Board-certified orthopedic surgeon, for 12 percent left upper extremity impairment and noted that it was unclear what tables in the A.M.A., *Guides* Dr. Wichman relied on.

[13] *Id.* at 404.

[14] Appellant also submitted July 16, 2010 diagnostic reports by Dr. Benjamin George Broghammer, a Board-certified diagnostic radiologist, which revealed mild C4-C5 to space narrowing with anterior and posterior osteophytes and minimal C3-C4 space narrowing in his cervical spine. Dr. Broghammer also observed minimal degenerative changes identified in the acromioclavicular (AC) joint, but found no evidence of fracture or dislocation. He diagnosed mild degenerative change to the C4-C5 with minimal degenerative change at the C3-C4 level. Dr. Broghammer also submitted clinic notes from a chiropractor.

On November 21, 2011 OWCP granted a schedule award for an eight percent impairment of the left arm based on Dr. Garelick's report. The award ran for a period March 28 to September 18, 2011 for 24.96 weeks.

On December 20, 2011 appellant requested reconsideration of his schedule award.

In a January 2, 2012 report, Dr. Wichman reviewed appellant's records and noted that he underwent a repair of a large rotator cuff tear and biceps tenodesis. He reported that appellant reached maximum medical improvement on March 29, 2011. Dr. Wichman observed active assisted forward elevation of 160 degrees with active forward elevation of approximately 120 degrees. Active external rotation also demonstrated mild-to-moderate persistent weakness. Dr. Wichman stated that appellant had 12 percent permanent impairment of the shoulder, 10 percent permanent impairment secondary to the rotator cuff dysfunction and 2 percent impairment due to the biceps tendinopathy.

On February 7, 2012 OWCP referred Dr. Wichman's January 2, 2012 report to the district medical adviser for review. In a February 13, 2012 report, Dr. Garelick stated that he reviewed appellant's chart for the purpose of determining the extent of impairment to the left upper extremity. He noted that Dr. Wichman reiterated that appellant had 10 percent permanent impairment for his rotator cuff dysfunction and 2 percent for the biceps tendinopathy, which totaled 12 percent permanent impairment of the left upper extremity. Dr. Garelick was unsure on what table Dr. Wichman based his impairment rating because the most appellant could be rewarded for a rotator cuff injury was seven percent. He concluded that appellant had eight percent permanent impairment of the left upper extremity as explained in his October 10, 2011 report.

In a decision dated February 23, 2012, OWCP denied modification of its November 21, 2011 decision finding insufficient medical evidence to support an increase in the eight percent impairment rating already compensated.

LEGAL PRECEDENT

The schedule award provision of FECA[15] and its implementing federal regulations[16] 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. The method used in making such a determination is matter that rests within the sound discretion of OWCP.[17] 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.[18] As

[15] 5 U.S.C. § 8107.

[16] 20 C.F.R. § 10.404.

[17] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1998).

[18] *Id.* at § 10.404; *Ronald R. Kraynak*, 53 ECAB 130 (2001).

of May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used to calculate schedule awards.[19]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator identifies the impairment class for the diagnosed code (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[20] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[21]

OWCP procedures provide that, 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 in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[22] In determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[23]

ANALYSIS

Appellant's claim was accepted for left shoulder sprain, upper arm sprain and left rotator cuff tear. He underwent left shoulder rotator cuff repair and arthroscopy and left biceps tenodesis arthroscopy. On November 21, 2011 OWCP granted a schedule award for an eight percent impairment of the left arm. By decision dated February 23, 2012, it denied modification of the schedule award for eight percent permanent impairment of the left upper extremity. The Board finds that this case is not in posture for decision as to the degree of appellant's left upper extremity impairment and will be remanded to OWCP for further development.

In an August 12, 2011 report, Dr. Grant provided an accurate history of injury and noted that appellant underwent surgery to repair a torn rotator cuff. Upon examination, he observed tenderness to palpation over the left deltoid muscle and limited range of motion of the left shoulder. Dr. Grant diagnosed left shoulder sprain and rotator cuff tear and concluded that appellant reached maximum medical improvement on August 12, 2011. He opined that according to the sixth edition of the A.M.A., *Guides* appellant had 2 percent impairment due to his left shoulder sprain, 5 percent impairment due to the left shoulder rotator cuff tear and 13 percent impairment due to the brachial plexus injury, which resulted in a total left upper extremity impairment of 20 percent. Dr. Grant determined that appellant had a class 1 diagnosis according to Table 15-5.[24] He utilized grade modifiers based on functional history of 2 because

[19] FECA Bulletin No. 09-03 (issued March 15, 2009); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[20] A.M.A., *Guides* 385-419.

[21] *Id.* at 411.

[22] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[23] *Peter C. Belkind*, 56 ECAB 580 (2005).

[24] A.M.A., *Guides* 401.

appellant had a *Quick*DASH score of 46[25] and based on physical examination of 2 due to his decreased range of motion.[26] Dr. Grant applied the net adjustment formula of 2 to determine that appellant had 2 percent upper extremity impairment for left shoulder sprain. For appellant's left shoulder rotator cuff rupture, he determined that appellant had a class 1 diagnosis according to Table 15-5.[27] Dr. Grant utilized grade modifiers based on functional history of 2[28] and physical examination of 2,[29] which resulted in a net adjustment of 2, and a total impairment rating of 5 percent impairment for the left shoulder rotator cuff syndrome. For appellant's brachial plexus injury, he determined that appellant had a class 1 diagnosis according to Table 15-20.[30] Dr. Grant utilized grade modifiers based on functional history of 2[31] and physical examination of 2.[32] He applied the net adjustment of 2 and found that appellant had 13 percent upper extremity impairment for brachial plexus injury. Dr. Grant combined the impairment ratings to conclude that appellant had a total impairment rating of 20 percent for the left upper extremity.

The Board finds that this report is not sufficient to establish appellant's degree of permanent impairment as Dr. Grant did not provide an adequate impairment rating based on the A.M.A., *Guides.* The Board notes that Dr. Grant awarded 13 percent impairment for appellant's brachial plexus injury, however, as explained by Dr. Garelick, Table 15-20 of the A.M.A., *Guides*, allows up to a 13 percent impairment for brachial plexus sensory deficit, only if the sensory deficit is objectively verified. There is no evidence from Dr. Grant that appellant's sensory deficits were objectively verified, by EMG or other objective testing. The Board finds that the record does not support 13 percent impairment for appellant's brachial plexus injury. Accordingly, Dr. Grant's awards of five percent for left rotator cuff tear and two percent for left shoulder sprain only total seven percent impairment rating for the left upper extremity.

Appellant also submitted a January 2, 2012 report by Dr. Wichman who related that appellant underwent a repair of a large rotator cuff tear and biceps tenodesis and opined that appellant reached maximum medical improvement on March 29, 2011. Dr. Wichman observed active assisted forward elevation of 160 degrees with active forward elevation of approximately 120 degrees. He stated that appellant had 12 percent permanent impairment of the shoulder, 10 percent permanent impairment secondary to the rotator cuff dysfunction and 2 percent impairment due to the biceps tendinopathy. The Board finds, however, that Dr. Wichman did not explain how he rated impairment based on the appropriate formula or grade modifiers

[25] *Id.* at 406.

[26] *Id.* at 408.

[27] *Id.* at 403.

[28] *Id.* at 406.

[29] *Id.* at 408.

[30] *Id.* at 434.

[31] *Id.* at 406.

[32] *Id.* at 408.

previously described.[33] He failed to mention the sixth edition of the A.M.A., *Guides* or the tables used to identify the impairment class for appellant's diagnosed conditions. Dr. Wichman provided a conclusory impairment rating of 24 percent without fully explaining how he arrived at that percentage. Accordingly, his report is insufficient to establish the extent of permanent impairment.

The Board also finds that the reports of Dr. Garelick, OWCP's medical adviser, are insufficient because he failed to adequately explain how he reached the conclusion that appellant had eight percent permanent impairment of the left arm. Dr. Garelick reported that appellant had five percent impairment for his rotator cuff tear and recommended an additional three percent left upper extremity impairment for biceps tendon dislocation and subluxation, which totaled an eight percent impairment of the left upper extremity. While he identified a default award of five percent for appellant's rotator cuff tear, he failed to identify any grade modifiers based on GMFH, GMPE and GMCS[34] or apply the net adjustment formula.[35] As noted, under the sixth edition, for upper extremity impairments, the evaluator identifies the impairment class for the diagnosed code and adjusts the condition by grade modifiers.[36] Moreover, Dr. Garelick recommended an additional three percent left upper extremity impairment for biceps tendon dislocation and subluxation but did not adequately address the evidence to support his findings or identify any grade modifiers. Therefore, the Board finds that the opinion of the medical adviser requires further clarification on the issue of appellant's left upper extremity impairment.[37]

The record fails to contain a medical opinion that fully comports with the A.M.A., *Guides* as to appellant's left upper extremity impairment. The Board finds that the case is not in posture for decision. The case will be remanded to OWCP for further development. Following such further development as OWCP deems necessary, it should issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision as to the extent of appellant's left upper extremity impairment.

[33] *Supra* note 19.

[34] *Id.*

[35] *Id.* at 411.

[36] *Supra* note 19.

[37] *See S.O.*, Docket No. 12-161 (issued June 4, 2012).

ORDER

IT IS HEREBY ORDERED THAT the February 23, 2012 and November 21, 2011 decisions of the Office of Workers' Compensation Programs be set aside and the case remanded to OWCP for proceedings consistent with this decision of the Board.

Issued: September 14, 2012
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