United States Department of Labor
Employees' Compensation Appeals Board

W.H., Appellant	)	
and	)	**Docket No. 13-146**
	)	**Issued: April 12, 2013**
DEPARTMENT OF VETERANS AFFAIRS, AUDIE L. MURPHY MEMORIAL HOSPITAL, San Antonio, TX, Employer	)	

Appearances:
Anthony Rogers, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 29, 2012 appellant, through his representative, filed a timely appeal from an October 16, 2012 decision of the Office of Workers' Compensation Programs (OWCP) denying 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 the case.

ISSUE

The issue is whether appellant has more than 13 percent impairment of his left upper extremity for which he received schedule awards.

FACTUAL HISTORY

On April 20, 2006 appellant, then a 55-year-old materials handler, injured both shoulders and elbows when a refrigerator that he was moving fell. OWCP accepted his claim for bilateral

[1] 5 U.S.C. §§ 8101-8193.

sprain of the shoulders and upper arms and authorized arthroscopic surgery of the left shoulder on August 7, 2009. Appellant underwent manipulation under anesthesia of the left shoulder on February 24, 2010 and a left epicondylectomy on March 21, 2012.

Appellant was treated by Dr. James Key, a Board-certified orthopedic surgeon, who diagnosed severe impingement syndrome, left rotator cuff tear and left wrist sprain. On August 7, 2009 Dr. Key performed an arthroscopic mini arthrotomy with debridement of the left rotator cuff and acromioplasty over the tip of the acromion. On November 19, 2009 appellant presented with severe left shoulder pain. Dr. Key diagnosed adhesive capsulitis and recommended physical therapy. A May 28, 2009 electromyogram (EMG) scan revealed left median sensory and motor neuropathy and right median and bilateral ulnar motor neuropathy. A June 11, 2009 magnetic resonance imaging (MRI) scan of the left shoulder was consistent with impingement syndrome, mild subdeltoid bursitis, a small partial thickness articular surface tear of the mid supraspinatus tendon and a superior labral anterior-posterior **(**SLAP**)** lesion and complex tear of the anterior labrum. A September 23, 2009 left elbow MRI scan revealed mild thickness of both the triceps tendon and common extensor tendon insertions without discrete tear and mild atrophy of the extensor carpi ulnaris muscle without apparent etiology. An October 27, 2009 left shoulder MRI scan showed impingement syndrome and subdeltoid bursitis along with superficial fraying of the subscapularis tendon and the long head of the biceps tendon, without tearing.

On February 24, 2010 Dr. Lisa Wheeler, a chiropractor performed left shoulder manipulation under anesthesia and diagnosed adhesive capsulitis of the left shoulder.

On April 15, 2010 appellant filed a claim for a schedule award. In a March 31, 2010 report, Dr. Helo Chen, an osteopath, noted a history of injury and diagnosed sprain/strain of the bilateral shoulder, left shoulder region disease and left lateral epicondylitis. He noted that appellant had arthroscopic surgery on the left shoulder on August 7, 2009, mini-arthrotomy, debridement of the left rotator cuff and acromioplasty. Dr. Chen noted that appellant was at maximum medical improvement and provided an impairment rating under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] Under Section 15.2, Diagnosis-Based Impairment, Table 15-5, Shoulder Regional Grid, the diagnoses of left rotator cuff repair, SLAP lesion repair and distal clavicle resection, appellant was a class 1 rating, grade C for residual symptoms, functional loss for a default rating of three percent impairment of the left upper extremity. Dr. Chen noted range of motion for the left shoulder was flexion of 130 degrees, extension of 40 degrees, abduction of 155 degrees, adduction of 15 degrees, internal rotation of 50 degrees and external rotation of 60 degrees. He noted that, pursuant to the Adjustment Grid: Functional History (GMFH) Adjustment, Table 15-7, appellant was assigned a grade modifier 1, for Physical Examination (GMPE) Adjustment, he was assigned a grade modifier 1 and for Clinical Studies (GMCS) Adjustment, appellant was assigned a grade modifier 2. Dr. Chen noted that the net adjustment was +1 which resulted in a grade D and four percent arm impairment.

[2] A.MA., *Guides* (6th ed. 2008).

In a February 3, 2011 report, Dr. Michael M. Igzy, an OWCP medical adviser, reviewed Dr. Chen's impairment rating. He noted that the rating specified that a normal range of motion should be present but appellant's range of motion was abnormal based on Dr. Chen's examination. Dr. Igzy stated that, pursuant to the A.M.A., *Guides*, impairment may be assessed with a standalone range of motion rating which was appropriate and yield a higher rating than the diagnosis-based rating. Applying Table 15-34, A.M.A., *Guides* 475, he found 10 percent left arm impairment due to loss of shoulder range of motion. Dr. Igzy referred to Figure 15-34 for shoulder range of motion to find that flexion of 130 degrees was three percent impairment, extension of 40 degrees was one percent impairment, abduction of 160 degrees was three percent impairment, adduction of 15 degrees was one percent impairment, external rotation of 60 degrees did not represent impairment and internal rotation of 50 degrees was two percent impairment.[3] He added the range of motion values to total 10 percent permanent impairment.

In a decision dated April 8, 2011, OWCP granted appellant a schedule award for 10 percent impairment for the left upper extremity. The period of the award was from March 31 to November 4, 2010.

Appellant continued to be treated by Dr. James A. Ghadially, a Board-certified orthopedic surgeon, for left shoulder and elbow pain. In a surgical report dated March 21, 2012, Dr. Ghadially performed left epicondylar slide, distal epicondylectomy and excision of hamartomatous tissue and diagnosed epicondylitis of the left elbow. A July 24, 2012 MRI scan of the left shoulder revealed status post acromioplasty and subacromial decompression, bursal surface fraying of the supraspinatus tendon and intrasubstance tear of the subscapularis tendon and obliquely oriented tearing of the superior labrum.

On July 14, 2012 appellant claimed an additional schedule award. In a June 28, 2012 report, Dr. Chen diagnosed sprain/strain of both shoulders, left shoulder region disease and left lateral epicondylitis. He opined that appellant reached maximum medical improvement on March 31, 2010. Dr. Chen stated that, pursuant to Section 15.2, Diagnosis-Based Impairment, Table 15-5, Shoulder Regional Grid, the diagnoses of left rotator cuff repair, SLAP lesion repair, and impingement syndrome, appellant was a class 1 rating, grade C for residual symptoms, functional loss for a default rating of three percent impairment of the left arm. He noted that pursuant to the Adjustment Grid: Functional History, Table 15-7, appellant was assigned a grade modifier of 1. With regards to physical examination adjustment, appellant was assigned a grade modifier 1 for mild decrease of normal motion of the left shoulder joint. With regards to the clinical studies adjustment, he was assigned a grade modifier 4 as the clinical studies confirmed the diagnoses of a rotator cuff tear, SLAP and other labral lesion. Dr. Chen noted that these adjustments yielded a net adjustment of +3. This resulted in a grade E and five percent upper extremity impairment under Table 15-5.

With regards to the left elbow, Dr. Chen applied the A.M.A., *Guides*, to determine that, based on the accepted left epicondylitis status postsurgical release, appellant was a class 1 rating, grade C for a default rating of five percent impairment of the left arm under Table 15-4 at page 399 of the A.M.A., *Guides*. Pursuant to the Adjustment Grid: Functional History, Table 15-7,

[3] *Id*. at 475.

appellant was assigned a grade modifier 1 for pain symptoms with strenuous vigorous activity and medications to control symptoms. For the Physical Examination Adjustment, Table 15-8, page 408, he was assigned a grade modifier 0. For the Clinical Studies Adjustment, Table 15-9, page 410, appellant was assigned a grade modifier 0. Dr. Chen noted that the adjustments were for functional history grade modifier 1, physical examination grade modifier 0 and clinical studies was 0 for a net adjustment of -2. This resulted in a grade A and three percent arm impairment. Dr. Chen opined that appellant had eight percent combined impairment of the left arm under the A.M.A., *Guides.*

In an August 3, 2012 report, Dr. Ronald Blum, an OWCP medical adviser reviewed the medical evidence and concurred with Dr. Chen's calculations. He opined that appellant had five percent impairment of the left upper extremity for the labral lesion and three percent impairment of the left upper extremity for the lateral epicondylitis, post surgery.

On September 12, 2012 OWCP advised Dr. Blum that appellant was previously granted 10 percent permanent impairment of the left upper extremity. It requested that he clarify the impairment rating in light of the previous schedule award.

In a September 19, 2012 report, Dr. Blum noted that appellant was previously granted 10 percent impairment for the left upper extremity based on loss of motion for the shoulder. He opined that appellant was not entitled to an additional five percent impairment of the left shoulder. Rather the 10 percent previously granted would be subtracted from 5 percent to yield no additional impairment for the left shoulder. Dr. Blum noted that the remaining 3 percent impairment for the left epicondylitis would be combined with the previous range of motion rating of 10 percent impairment to total 13 percent for the left upper extremity. As appellant was previously granted 10 percent impairment of the left arm he had an additional impairment of three percent to the left upper extremity.

In a decision dated October 16, 2012, OWCP granted appellant a schedule award for an additional three percent impairment for the left upper extremity. The period of the award was from July 16 to September 19, 2012.

LEGAL PRECEDENT

The schedule award provision of FECA[4] and its implementing federal 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6]

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id.* at § 10.404(a).

For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[8] It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[9]

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).[10] Under the sixth edition of the A.M.A., *Guides*, for upper extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12]

ANALYSIS

On appeal, appellant contends that he has more than 13 percent permanent impairment of the left upper extremity. OWCP accepted his claim for sprains of both shoulders and arms and authorized arthroscopic surgery on the left shoulder to repair the rotator cuff tear on August 7, 2009 and a left epicondylectomy on March 21, 2012.

In a June 28, 2012 report, Dr. Chen reviewed the medical evidence and properly applied the sixth edition of the A.M.A., *Guides*. For the left shoulder, he determined that, pursuant to Section 15.2, Diagnosis-Based Impairment, Table 15-5, Shoulder Regional Grid, the diagnoses of left rotator cuff repair, SLAP lesion repair and impingement syndrome, appellant was a class 1 rating, grade C impairment, which correlated with findings of residual symptoms, functional loss, for a default rating of three percent impairment of the left upper extremity. Dr. Chen noted that, pursuant to the Adjustment Grid: Functional History, Table 15-7, appellant was assigned a grade modifier 1 for pain symptoms with strenuous vigorous activity and medications to control symptoms. For the physical examination adjustment, appellant was assigned a grade modifier 1 for mild decrease of normal motion of the left shoulder joint. With regards to the clinical studies adjustment, he was assigned a grade modifier 4 as the clinical studies confirmed the diagnoses of a rotator cuff tear, SLAP or other labral lesion. Dr. Chen noted a net adjustment of +3 which resulted in a grade E and five percent arm impairment for the left shoulder. For left lateral epicondylitis, he noted that, under Section 15.2, Diagnosis-Based Impairment, Table 15-4, Elbow Regional Grid, appellant was status postsurgical release, for a class 1 rating, grade C for a default rating of five percent left arm impairment. Under the Functional History Adjustment Grid, Table 15-7, appellant was a grade modifier 1 for pain symptoms with strenuous vigorous activity and medications to control symptoms; for the Physical Examination Adjustment, Table

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

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

[9] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[10] A.M.A., *Guides*, *supra* note 1 at 3, section 1.3, ICF: A Contemporary Model of Disablement.

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

[12] *Id.* at 411.

15-8, page 408, he was a grade modifier 0 and for the Clinical Studies Adjustment, Table 15-9, page 410, appellant was a grade modifier 0. Dr. Chen noted a net adjustment of -2 which resulted in a grade A and three percent arm impairment. He found a total left arm impairment of eight percent.

Dr. Blum reviewed the medical record and concurred with Dr. Chen's impairment rating for the diagnosed left rotator cuff repair, SLAP lesion repair and impingement syndrome, pursuant to the Shoulder Regional Grid, Table 15-5, A.M.A., *Guides*, page 403, finding five percent impairment of the left arm.[13] Similarly, he concurred with Dr. Chen in his rating of impairment for the diagnosed left lateral epicondylitis, status postsurgical release, pursuant to the Elbow Regional Grid, Table 15-4, A.M.A., *Guides*, finding three percent impairment of the left arm. Dr. Blum noted that appellant was previously rated 10 percent impairment of the left arm based on left shoulder range of motion which was greater than the 8 percent diagnosis-based estimate.[14] The 3 percent impairment attributable to the left elbow condition, a different region of the arm, was combined with the 10 percent impairment attributable to loss of range of motion to the shoulder, which yielded a total impairment of 13 percent for the left arm. As appellant was previously granted a schedule award for 10 percent impairment of the left upper extremity, he was entitled to an additional 3 percent.

The Board finds that the medical adviser properly applied the A.M.A., *Guides* to rate impairment to appellant's left shoulder and left elbow based on the examination by Dr. Chen. Dr. Blum reviewed the medical evidence and determined that appellant had an additional three percent impairment for the left upper extremity under the sixth edition of the A.M.A., *Guides*. There is no medical evidence of greater impairment under the A.M.A., *Guides*.

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 has an additional 3 percent impairment of the left upper extremity, for a total 13 percent impairment, for which he received a schedule award.

[13] As noted, *infra*, Dr. Blum previously found that assessing range of motion impairment for the shoulder provided appellant greater impairment for the shoulder region than did use of diagnosis-based impairment under Table 15-5. Table 15-5 specifically allows for assessing impairment for lost range of motion but specifically advises that "a range of motion impairment stands alone and is not combined with diagnosis impairment." A.M.A., *Guides* 405.

[14] *See* 5 U.S.C. § 8108 (the period of compensation payable under the schedule award provision of FECA is reduced by the period of compensation paid under the schedule for an earlier injury if compensation in both cases is for disability for the same member or function and OWCP finds that compensation payable for the later disability would in whole or in part duplicate the compensation payable for the preexisting disability).

ORDER

IT IS HEREBY ORDERED THAT the October 16, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 12, 2013
Washington, DC

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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

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