United States Department of Labor
Employees' Compensation Appeals Board

P.T., Appellant	)	
and	)	**Docket No. 13-667**
	)	**Issued: August 1, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Omaha, NE, 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
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 30, 2013 appellant filed a timely appeal of a November 27, 2012 merit decision of the Office of Workers' Compensation Programs' (OWCP) which affirmed an August 10, 2012 schedule award decision. 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 appellant's claim for a schedule award.

ISSUE

The issue is whether appellant sustained more than a four percent permanent impairment of his right arm.

FACTUAL HISTORY

This case has previously been before the Board.[2] In a January 23, 2013 decision, the Board found that appellant did not meet his burden of proof to establish a recurrence of disability from October 21 through November 1, 2011 causally related to his February 1, 2011

[1] 5 U.S.C. § 8101 *et seq.*

[2] Docket No. 12-1439 (issued June 23, 2013).

employment injury. The facts and history contained in the prior appeal are incorporated by reference.

OWCP accepted appellant's claim for right rotator cuff syndrome and shoulder allied disorder and surgical repair. On August 26, 2011 Dr. Michael J. Morrison, a Board-certified orthopedic surgeon and treating physician, performed right shoulder arthroscopy with acromioplasty; and rotator cuff repair, right shoulder (mini-deltoid splitting). Following surgery, appellant underwent physical therapy and returned to limited-duty work on November 4, 2011. His work restrictions included: no reaching, lifting or carrying at right shoulder level or overhead. Dr. Morrison returned appellant to regular duty with no restrictions on February 6, 2012.

On April 18, 2012 appellant filed a claim for a schedule award.

In a May 14, 2012 report, Dr. Morrison reviewed appellant's history and treatment. He noted that appellant healed from surgery, underwent physical therapy and was advised on February 6, 2012 that he had reached maximum medical improvement. Dr. Morrison utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (6th ed. 2008) (A.M.A., *Guides*) and referred to the Shoulder Regional Grid for upper extremity impairments, Table 15-5.[3] He selected a class 1 for a rotator cuff injury, full thickness tear, and advised that appellant had some residual weakness, some limited internal rotation but full abduction and flexion. Based upon these factors and the fact that he underwent acromioplasty at the time of his surgery, appellant had seven percent impairment to the right upper extremity.

In a report dated July 5, 2012, an OWCP medical adviser noted appellant's history of injury and referred to the A.M.A., *Guides*. He reviewed Dr. Morrison's reports and selected February 6, 2012 as the date of maximum medical improvement as Dr. Morrison advised that appellant was able to work without restrictions. He noted that Dr. Morrison referred to the Shoulder Regional Grid for rating upper extremity impairments, Table 15-5, the selection of a class 1 rotator cuff injury, full thickness rotator tear and advised that this category varied from three to seven percent. The default C value was five percent impairment. OWCP's medical adviser explained that Dr. Morrison selected seven percent, the E rating from class 1 for a rotator cuff injury with a full thickness tear for residual loss and functional with normal motion, but did not consider the grade modifier tables in arriving at his rating. The medical adviser referred to Table 15-7 for functional history adjustment, noted the grade modifier was zero, as appellant had not reported pain or symptoms that impacted activities.[4] OWCP's medical adviser referred to Table 15-8 for physical examination and determined that the grade modifier would be a one for some limited internal rotation and residual weakness.[5] He referred to Table 15-9 for clinical studies and advised that it could not be used, as the clinical study was the basis for choosing a diagnosis from the shoulder regional grid. After applying the net adjustment formula, he arrived at minus one which reduced the default C value of five percent impairment, one place to the left to total four percent impairment of the right arm.

[3] A.M.A., *Guides* 403.

[4] *Id.* at 406.

[5] *Id.* at 408.

On August 10, 2012 OWCP granted appellant a schedule award for four percent impairment of the right upper extremity. The award covered a period of 12.48 weeks of compensation from February 6 to May 3, 2012.

On August 31, 2012 appellant requested a review of the written record. He argued that his physician's report supported seven percent impairment. Appellant indicated that he continued to have range of motion issues and his shoulder popped.

By decision dated November 27, 2012, OWCP's hearing representative affirmed the August 10, 2012 decision.

LEGAL PRECEDENT

A schedule award can be paid only for a condition related to an employment injury. The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.[6]

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[7] FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[8] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[9] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides*.[10]

In addressing upper extremity impairments, the sixth edition requires identifying 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).[11] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[12]

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

[6] *Veronica Williams*, 56 ECAB 367 (2005).

[7] 5 U.S.C. § 8107.

[8] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[9] 20 C.F.R. § 10.404.

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

[11] A.M.A., *Guides* at 494-531; *see J.B.*, (Docket No. 09-2191, issued May 14, 2010).

[12] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP medical adviser providing rationale for the percentage of impairment specified.[13]

ANALYSIS

OWCP accepted the claim for right rotator cuff syndrome and shoulder allied disorder and surgical repair. Appellant underwent right shoulder arthroscopy with acromioplasty and rotator cuff repair, right shoulder (mini-deltoid splitting) on August 26, 2011.

On April 18, 2012 appellant requested a schedule award and submitted the May 14, 2012 report of Dr. Morrison, who referred to the Shoulder Regional Grid for upper extremity impairments, Table 15-5.[14] He selected class 1 for a rotator cuff injury, full thickness tear. However, his report was not complete. While he opined that appellant was eligible for seven percent impairment to the right arm, he did not fully explain how he arrived at the seven percent rating. The Board notes that the grade C default impairment for this condition is five percent. As noted, once the impairment class has been identified for the diagnosed condition, it is then adjusted by grade modifiers based on functional history, physical examination and clinical studies.[15] Board precedent is well settled that when an attending physician's report provides an estimate of impairment, but does not adequately explain how the A.M.A., *Guides*, were applied. OWCP may rely on the medical adviser or consultant where he or she has properly applied the A.M.A., *Guides*.[16]

OWCP's medical adviser concurred with Dr. Morrison's selection of the Shoulder Regional Grid for upper extremity impairments in Table 15-5.[17] He explained that appellant qualified for class 1 for a rotator cuff injury, full thickness rotator tear, which allowed a rating from three to seven percent. OWCP's medical adviser noted that Dr. Morrison did not address the grade modifier tables in arriving at his seven percent rating, which was the maximum E rating from class 1 for a rotator cuff injury with a full thickness tear with residual loss and functional with normal motion. He applied the applicable grade modifiers finding that, in Table 15-7 for functional history adjustment, the grade modifier was zero, as appellant had not reported pain or symptoms that impacted activities.[18] He referred to Table 15-8 for physical examination and determined that the grade modifier was one for some limited internal rotation and some residual weakness.[19] The medical adviser referred to Table 15-9 for clinical studies and explained that it did not apply as a clinical study was the basis for choosing a diagnosis from the shoulder regional grid.[20] He utilized the net adjustment formula: (GMFH-CDX) + (GMPE-

[13] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[14] *Supra* note 3.

[15] *See supra* note 12.

[16] *J.Q.*, 59 ECAB 366 (2008); *Laura Heyen*, 57 ECAB 435 (2006).

[17] *Supra* note 3.

[18] *Id.* at 406.

[19] *Id.* at 408.

[20] *See id*. at 407 (if a finding is used for placement of a diagnosis within a specific class in a database interface grid, that same finding cannot also be used as a grade modifier).

CDX) + (GMCS-CDX).[21] The medical adviser applied the applicable grade modifiers of zero for functional history and one for physical examination to the class 1 diagnosis. This yielded minus one: (0-1) + (1-1). With a net adjustment of minus one, he moved that rating one place to the left from the default grade C (five percent impairment), to grade B (four percent impairment). The Board finds that the rating of OWCP's medical adviser conforms to the A.M.A., *Guides*. As the report of Dr. Morrison did not fully address how the grade modifiers were applied, his rating of impairment is of reduced probative value.

On appeal, appellant asserts that his physician rated seven percent impairment. As noted, the report from his physician did not fully comport with the A.M.A., *Guides.*

Appellant may request a 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 no more than four percent impairment of his right arm.

ORDER

IT IS HEREBY ORDERED THAT the November 27, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 1, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

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

[21] A.M.A., *Guides* 405-12.