United States Department of Labor
Employees' Compensation Appeals Board

J.G., Appellant	)	
and	)	**Docket No. 13-1198**
	)	**Issued: December 19, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Jackson, MS, Employer	)	

Appearances:
Henry Zuber, III, Esq., 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 April 18, 2013 appellant, through his attorney, filed a timely appeal from the March 1, 2013 Office of Workers' Compensation Programs' (OWCP) 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 this case.

ISSUE

The issue is whether appellant sustained more than 10 percent permanent impairment of his arm, for which he received a schedule award.

FACTUAL HISTORY

On September 19, 2003 appellant, then a 42-year-old city letter carrier, filed an occupational disease claim alleging a left shoulder/rotator cuff tear in the performance of duty. On October 7, 2003 he underwent left shoulder repair of a chronic rotator cuff tear, clavicle

[1] 5 U.S.C. § 8101 *et seq.*

resection and acromioplasty, which was performed by Dr. Jim Kyle Hudson, a Board-certified orthopedic surgeon. On November 6, 2003 OWCP accepted appellant's claim for left shoulder rotator cuff tear. Appellant received compensation benefits. In a report dated April 15, 2004, Dr. Hudson released appellant to regular duty and provided an impairment rating of 10 percent to the left arm. On April 22, 2004 appellant requested a schedule award.

By decision dated May 21, 2004, OWCP granted appellant a schedule award for 10 percent impairment of the left upper extremity. The award covered a period of 31.2 weeks from April 15 to November 19, 2004.

On April 5, 2011 Dr. Donnis Harrison, a Board-certified orthopedic surgeon, performed a left arthroscopic revision, subacromial decompression and partial acromioplasty, removal of foreign body and biceps tenodesis. OWCP authorized the surgery. Appellant returned to modified full-time work on July 13, 2011.

In a September 7, 2011 report, Dr. Harrison noted appellant's status and reported examination findings. He assessed rotator cuff sprain and set forth work restrictions.

On October 20, 2011 appellant filed a claim for an additional schedule award.

By letter dated October 31, 2011, OWCP requested that appellant's treating physician provide an impairment rating utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*) (6th ed. 2009). It advised him that the rating should be expressed in terms of percentage of loss of use of the affected member or function of the body and not the body as a whole.

On November 22, 2011 OWCP received a copy of Dr. Harrison's September 7, 2011 report, which advised that appellant had a 15 percent impairment to the upper extremity; or nine percent whole person impairment. Dr. Harrison stated that maximum medical improvement was reached on September 7, 2011.

In a December 12, 2011 report, Dr. H.P. Hogshead, an OWCP medical adviser, noted that arthroscopic surgery of the left shoulder was performed on October 7, 2003 and April 5, 2011. He explained that appellant had an excellent result for the distal clavicle excision based upon the physical examination and range of motion findings. Dr. Hogshead noted that Dr. Harrison did not explain how he applied the A.M.A., *Guides* to rate 15 percent impairment of the left arm.

By decision dated December 21, 2011, OWCP denied appellant's claim for an additional impairment. It found that medical evidence did not support greater impairment then already compensated. On February 14, 2012 appellant requested reconsideration.

By decision dated March 20, 2012, OWCP denied modification of its December 21, 2011 decision.

On December 20, 2012 appellant's representative requested reconsideration and submitted additional evidence. He argued that Dr. Harrison's reports supported that appellant had more than 10 percent impairment of the left arm.

In a report dated December 7, 2012, Dr. Harrison asserted that his impairment rating had complied with the A.M.A., *Guides.* Regarding appellant's "diagnosis of biceps tendon instability, dislocation and undergoing a biceps tenodesis surgery," he had significant pain and moderate-to-severe pain when performing activities of daily living, requiring the assistance of his other arm. Dr. Harrison stated that this resulted in "a Grade D, [c]lass 1 with a GMFH [c]lass 2 equals 1 score." The physical examination rating equaled 2, secondary to strength and pain with function with the CDX-1 equals a net of 2. Dr. Harrison opined that this resulted in 13 percent impairment. Regarding the partial rotator cuff repair and previous surgery, he noted that appellant's examination resulted in a class 1 CMFH-1 equals 0, giving him a Grade C, which yielded nine percent impairment. Dr. Harrison combined the two ratings to determined that appellant had 22 percent left arm impairment. As he thought this was "extreme," he lowered the rating to 15 percent. Dr. Harrison explained that appellant had an excellent return to function following his surgery but he still had significant pain and difficulty with overhead activities despite an excellent range of motion. He noted that appellant still had functional impairment requiring assistance with his left arm when doing activities which resulted in a higher impairment rating per the A.M.A., *Guides.*

In a February 20, 2013 report, Dr. Hogshead reviewed Dr. Harrison's December 7, 2012 report. He stated that Dr. Harrison used biceps tendinopathy to support a class 1E or 13 percent permanent impairment. Dr. Harrison also used partial thickness rotator cuff and chose class 1E to rate nine percent impairment. He stated that the two conditions were combined and arbitrarily reduced to 15 percent arm impairment. Dr. Harrison explained that tenodesis of the biceps tendon with arthroscopic surgery did result in a 13 percent impairment. Under Table 15-5, at page 402, a class 1 and grade E impairment was a five percent impairment. For a partial thickness rotator cuff tear, Dr. Hogshead also referred to Table 15-5 of the A.M.A., *Guides*.[2] This qualified for a maximum of five percent permanent impairment. As the A.M.A., *Guides* provide that only one condition per region can be included in the assessment, it should be the condition with greater value. Dr. Hogshead concluded that the medical evidence did not support an impairment rating greater than 10 percent of the left upper extremity.

By decision dated March 1, 2013, OWCP denied modification of the March 20, 2012 decision. It found that the evidence did not support that appellant had greater than 10 percent to the left upper extremity as previously awarded.

LEGAL PRECEDENT

The schedule award provision of FECA[3] and its implementing federal regulations,[4] 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

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

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[5] For decisions issued after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[6] For decisions issued after May 1, 2009, the sixth edition will be used.[7]

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).[8] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the 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.[10]

ANALYSIS

In a May 21, 2004 decision, OWCP granted appellant a schedule award for 10 percent permanent impairment of the left arm. Appellant sought an increased award in 2011. He subsequently provided an undated report from Dr. Harrison, who found 15 percent impairment of the left arm. Dr. Harrison did not explain how he arrived at this rating under the A.M.A., *Guides*.

In a December 7, 2012 report, Dr. Harrison advised that his 15 percent impairment rating complied with the A.M.A., *Guides.* The Board notes, moreover, that he did not cite to any specific tables or pages in the A.M.A., *Guides* to support his rating. While Dr. Harrison noted certain grades and classes of diagnoses and referenced certain grade modifiers, it is unclear how he applied the physical examination findings to the A.M.A., *Guides.* He did not clearly identify a diagnosis from a particular regional grid table or explain how he applied the grade modifiers in the net adjustment formula pursuant to the procedure set forth in the A.M.A., *Guides*. Dr. Harrison combined ratings for biceps tendon instability and for a partial rotator cuff tear. The A.M.A., *Guides* provide that if there are multiple diagnoses within a specific region, only the most impairing diagnosis should be rated.[11] Dr. Harrison further noted that, while appellant had a combined 22 impairment rating, he reduced this to 15 percent, as the higher rating was on the "extreme" side. He did not explain how this reduction complied with the A.M.A., *Guides*.

[5] *Id*. at § 10.404(a).

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

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

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

[9] *Id*. at 411.

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

[11] A.M.A., *Guides* 419.

OWCP has adopted the A.M.A., *Guides* to provide for consistent results and to ensure equal justice under the law for all claimants. In view of Dr. Harrison's failure to clearly follow the A.M.A., *Guides*, his opinion on permanent impairment is of diminished probative value. This evidence does not establish that appellant has greater left arm impairment.[12]

Board precedent is well settled that when an attending physician's report gives an estimate of impairment but does not address how the estimate is based upon the A.M.A., *Guides*, OWCP may follow the advice of its medical adviser or consultant where he has properly applied the A.M.A., *Guides*.[13]

On February 20, 2013 Dr. Hogshead utilized the findings provided by Dr. Harrison to the A.M.A., *Guides*. He explained why Dr. Harrison's rating did not comport with the A.M.A., *Guides*. Under Table 15-5, Dr. Hogshead noted that each diagnosis provided by Dr. Harrison would yield only up to a five percent rating. He properly noted that only one condition per region could be included in the assessment. Dr. Hogshead concluded that the medical evidence from Dr. Harrison did not support more than 10 percent impartment of the left arm.

Appellant has not submitted any other medical evidence conforming with the A.M.A., *Guides* to establish greater impairment. The Board finds that the medical evidence does not establish that appellant has more than 10 percent permanent impairment of the left arm for which he previously received a schedule award. On appeal, appellant argued that his physician's report supported a greater impairment; but, as noted above, Dr. Harrison's report does not comport with the A.M.A., *Guides* and is of limited probative value.

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 not met his burden of proof to establish that he has greater than a 10 percent impairment of the left upper extremity, for which he received a schedule award.

[12] *See Linda Beale*, 57 ECAB 429 (2006) (it is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment).

[13] *J.Q.*, Docket No. 06-2152 (issued March 5, 2008); *Laura Heyen*, 57 ECAB 435 (2006).

ORDER

IT IS HEREBY ORDERED THAT the March 1, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 19, 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