

May 20, 1968 appellant fell on his left side and experienced left hip and arm pain. OWCP accepted calcific tendinitis of the left shoulder with surgery resulting on May 19, 1976. Appellant filed a claim for compensation on account of injury or occupational disease on June 3, 1971 due to a May 20, 1968 employment injury. OWCP accepted his claim for calcific tendinitis of the left shoulder.

On June 21, 1977 OWCP granted appellant an additional schedule award for 11 percent impairment of his left upper extremity. OWCP noted that appellant had previously received a schedule award for 36 percent impairment of his left upper extremity. On March 7, 1978 OWCP's medical adviser reviewed the claim and noted that appellant underwent left shoulder surgery on May 19, 1976 including rerouting of the long head of the biceps tendon. The Branch of Hearings and Review granted appellant a schedule award for an additional five percent impairment of his left upper extremity on March 20, 1978. In a decision dated August 3, 1978, OWCP granted appellant a schedule award for an additional five percent impairment of the left arm. It noted that appellant had previously received a schedule award for 41 percent impairment of his left arm.

By decision dated December 18, 2007, OWCP denied appellant's claim for an additional schedule award for his left upper extremity (shoulder), finding that he had not established impairment above the 62 percent already received. Appellant requested reconsideration on January 7, 2008. OWCP denied modification of the December 18, 2007 decision on February 11, 2008.

On July 31, 2008 appellant underwent a nerve conduction study (NCS) which demonstrated a generalized polyneuropathy which was most likely diabetic in nature.

Appellant requested reconsideration on August 7, 2008. OWCP denied modification on November 4, 2008.

In a note dated October 10, 2008, Dr. Kirk L Jensen, a Board-certified orthopedic surgeon, diagnosed left shoulder posttraumatic arthritis based on x-rays. Appellant underwent a computerized tomography (CT) scan of his left shoulder on December 3, 2009 which demonstrated advanced changes of osteoarthritis with the glen humeral joint markedly narrowed as well as multiple intra-articular loose bodies, calcification of the long head of the biceps tendon and advanced degenerative changes of the acromioclavicular joint including the inferior border of the acromion which is hooked caudally. The CT scan also demonstrated that inferiorly projecting spurs narrow the subacromial space and osteoarthritis of the left sternoclavicular joint. On June 18, 2010 Dr. Jensen requested authorization for a left shoulder arthroplasty. In a note dated May 4, 2012, Dr. Jensen stated that appellant was a poor surgical candidate and recommended that appellant utilize pain medication when necessary.

In a letter dated April 3, 2012, OWCP requested that Dr. Jensen provide appellant's permanent impairment due to his accepted left shoulder conditions of left shoulder calcific tendinitis and left shoulder osteoarthritis for schedule award purposes. Dr. Jensen completed a report on March 22, 2012 and stated that appellant's left shoulder was permanent and stationary. He reported range of motion including forward elevation of 30 degrees, external rotation of 10 degrees and internal rotation to L5. Dr. Jensen noted that appellant demonstrated abduction

strength of 4/5 and had crepitus and pain with any shoulder motion. He diagnosed left shoulder post-traumatic arthritis.

On November 21, 2012 OWCP referred appellant for a second opinion evaluation with Dr. Varsha Sikka, a physician Board-certified in physical medicine and rehabilitation. In a report dated January 16, 2013, Dr. Sikka noted that appellant was currently 80 years old and in addition to left shoulder pain experienced type 2 diabetes mellitus, hypertension, bowel trouble, chronic cough, chronic fatigue syndrome, cancer arthritis, drug abuse and anxiety. He stated that appellant had left shoulder surgery in the past. Dr. Sikka stated that appellant's daughter brought him to the appointment in a wheelchair. He diagnosed advanced osteoarthritis of the left shoulder with multiple intraarticular loose bodies, degenerative changes of the acromioclavicular joint with type three acromion and compromise of the subacromial space. Dr. Sikka relied on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*² and found that the range of motion method of calculating impairment was more appropriate than the diagnosis-based estimates.³ He found that 50 degrees of flexion was 9 percent impairment,⁴ that 20 degrees of extension was 2 percent impairment,⁵ that 50 degrees of abduction was 6 percent impairment,⁶ that 40 degrees of adduction was 0 percent impairment⁷ and that internal rotation of 20 degrees was 6 percent impairment⁸ while 20 degrees of external rotation was 8 percent impairment.⁹ Dr. Sikka added these impairments to reach 31 percent impairment of the left shoulder due to loss of range of motion. He utilized Table 15-35 and found that 31 percent impairment was grade modifier 2¹⁰ and that functional history grade adjustment was 3,¹¹ a severe problem based on appellant's symptoms. Dr. Sikka concluded, "Per Table 15-36, since functional history grade adjustment (grade 3) is one grade higher than ROM [range of motion] grade modifier (grade 2), we would need to multiply 31 percent by 5 percent equaling 1.55 percent, which rounds to 2 percent. We then add 2 percent from 31 percent and we have a final rating of 33 percent." Dr. Sikka stated that the date of maximum medical improvement was January 16, 2013.

² 20 C.F.R. § 10.404. For impairment ratings calculated on and after May 1, 2009, OWCP should advise any physician evaluating permanent impairment to use the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

³ A.M.A., *Guides* 461.

⁴ *Id.* at 475, Table 15-34.

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.* at 477, Table 15-35

¹¹ *Id.* at 477, Table 15-36.

In a separate report dated January 16, 2013, Dr. Sikka applied the diagnosis-based estimates and found that under Table 15-5, tendinitis is class 1 impairment and that acromioclavicular joint medial disease is also class 1 equal to 13 percent impairment of the upper extremity.¹² He applied the functional upper extremity Table 15-7¹³ grade modifier 4 and Physical Examination, Table 15-8, to find the range of motion grade modifier 4.¹⁴ Dr. Sikka reached adjustment grade modifier 4.¹⁵ He stated that clinical studies adjustment was based on imaging studies and x-ray results and resulted in grade modifier 4.¹⁶ Dr. Sikka utilized appellant's range of motion finding internal rotation of 20 degrees an 8 percent upper extremity impairment¹⁷ and external rotation is 20 degrees, 9 percent of upper extremity which added to the other figures described above equal to 34 percent of the upper extremity. He used the additional impairments found for internal rotation and external rotation and followed the steps outlined above to reach 36 percent impairment of the left upper extremity.

OWCP's medical adviser reviewed the medical evidence on April 30, 2013 and stated that on the disputed range of motions, in accordance with the A.M.A., *Guides* appellant had 4 percent impairment for 20 degrees of internal rotation and 2 percent impairment for 20 degrees of external rotation.¹⁸ He concluded that appellant had 23 percent impairment of his left upper extremity due to loss of range of motion.

By decision dated May 14, 2013, OWCP denied appellant's claim for an additional schedule award finding that the medical evidence did not establish that appellant had more than 62 percent impairment of his left upper extremity for which he had already received schedule awards.

LEGAL PRECEDENT

The schedule award provision of FECA¹⁹ and its implementing regulations²⁰ set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of

¹² *Id.* at 402-03, Table 15-5.

¹³ *Id.* at 406, Table 15-7.

¹⁴ *Id.* at 408, Table 15-8.

¹⁵ *Id.* at 406, Table 15-6.

¹⁶ *Id.* at 410, Table 15-9.

¹⁷ *Id.* at 475, Table 15-34.

¹⁸ *Id.*

¹⁹ 5 U.S.C. §§ 8101-8193, 8107.

²⁰ 20 C.F.R. § 10.404.

tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.²¹

ANALYSIS

Appellant has previously received schedule awards totaling 62 percent impairment of his left shoulder. He requested an additional schedule award, but failed to submit medical evidence in support of increased permanent impairment. OWCP referred appellant for a second opinion evaluation with Dr. Sikka who determined that appellant's impairment should be determined based on his loss of range of motion due to his accepted left shoulder conditions. Dr. Sikka determined that appellant's loss of range of motion resulted in impairment ratings of 33 and 34 percent impairment. He provided detailed findings and correlated these findings with the A.M.A., *Guides*, finding two different impairment values for internal and external rotation of the left shoulder initially six and eight percent impairment respectively and in another report eight and nine percent respectively. These figures resulted in two impairment ratings, one for 33 and the other for 34 percent impairment of the left upper extremity.

OWCP's medical adviser reviewed these reports and determined that appellant's permanent impairment due to loss of range of motion was 23 percent. He based his findings on values of four percent for 20 degrees of internal rotation and two percent for 20 degrees of external rotation while agreeing with Dr. Sikka on the remainder of the evaluations as described in detail above. It is well established that, when a 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 and OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings of the attending physician.²²

The Board notes that both physicians applied the appropriate table of the A.M.A., *Guides* and in reaching the various impairment ratings. While the impairment ratings differ by 10 percent based on varying provisions in Table 15-34 regarding internal and external rotation, the Board finds that this variance is harmless. Appellant has not submitted any medical evidence supporting his contention that he has more than 62 percent impairment of his left upper extremity. Even considering the most generous impairment rating, appellant is not entitled to an additional schedule award. The Board finds that the medical evidence does not establish that appellant has any greater impairment than that for which he has already received schedule awards.²³

²¹ For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

²² *Linda Beale*, 57 ECAB 429 (2006).

²³ *S.C.*, Docket No. 11-1679 (issued September 12, 2012).

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 there is no medical evidence in the record supporting that appellant has more than 62 percent impairment of his left upper extremity for which he has received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the May 14, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 19, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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