United States Department of Labor
Employees' Compensation Appeals Board

M.P., Appellant	)	
and	)	**Docket No. 13-622**
	)	**Issued: October 21, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Long Beach, CA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case submitted on the record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On January 24, 2013 appellant filed a timely appeal of a December 6, 2012 merit decision 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 merits of his claim.

ISSUE

The issue is whether appellant met his burden of proof to establish more than five percent permanent impairment of his right upper extremity.

FACTUAL HISTORY

On July 22, 2009 appellant, then a 50-year-old city carrier, filed an occupational disease claim alleging that he sustained pain in the neck and right shoulder while carrying his satchel at work. He indicated that he had internal derangement of the right shoulder with a tear of the acromioclavicular joint and degenerative changes. Appellant also indicated that he had cervical

[1] 5 U.S.C. § 8101 *et seq.*

disc syndrome and cervical osteoarthritis. In response to an initial development letter, he submitted a June 19, 2009 report from Dr. Harry Mittleman, a Board-certified cosmetic surgeon. OWCP accepted the claim for sprain of neck and closed dislocation right shoulder. On December 14, 2009 it authorized right shoulder arthroscopic surgery, which was performed on January 25, 2010. Appellant received compensation benefits.

On January 25, 2010 Dr. Charles Herring, a Board-certified orthopedic surgeon, noted that appellant had right shoulder impingement syndrome and performed a right shoulder arthroscopy and subacromial decompression, resection of the inferior acromioclavicular ligament and debridement, coracoacromial ligament resection and postoperative Depo Medrol injection.

In an October 22, 2010 report, Dr. Herring noted appellant's history of injury and treatment. He examined appellant and found that for the right shoulder, appellant had full range of motion with minimal weakness with forward elevation and abduction. Dr. Herring determined that appellant was status post right shoulder arthroscopy and subacromial decompression. He advised that appellant had arthroscopic scars and slight pain with forward elevation and abduction of the shoulder. Dr. Herring indicated that appellant was permanent and stationary.

In a December 6, 2010 report, Dr. Charles Xeller, a Board-certified orthopedic surgeon, noted appellant's history of injury and treatment and utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (6th ed. 2008) (A.M.A., *Guides*). He advised that regarding the upper extremities appellant had well-healed arthroscopic portals and crepitation in the right shoulder more than on the left. Regarding motion, Dr. Xeller determined that appellant had restricted motion comprised of 150 degrees of abduction, 150 degrees of flexion and 40 degrees of external rotation. He indicated that appellant had full flexion, extension, pronation and supination of the elbow and wrist. Dr. Xeller also determined that appellant had full digital flexion and extension. He determined that x-rays of the right shoulder revealed an "[acromioclavicular] (AC) arthroplasty procedure over the left shoulder, fairly benign."[2] Dr. Xeller referred to the A.M.A., *Guides* and explained that appellant would be rated utilizing his range of motion. He referred to Table 15-34 for shoulder range of motion.[3] Dr. Xeller determined that appellant had: abduction of 150 degrees which corresponded to three percent upper extremity impairment; flexion of 160 degrees, which corresponded to three percent arm impairment; external rotation of 40 degrees, which corresponded to two percent impairment. He added these impairment values and opined that appellant had a total right upper extremity impairment of eight percent.

On February 3, 2011 appellant filed a claim for a schedule award.

In an August 1, 2011 report, OWCP's medical adviser noted appellant's history of injury and treatment. He referred to Table 15-5 for impairment due to AC joint injury or disease and explained that appellant fell into the class 1 default position C, which corresponded to three

[2] It appears that physician meant right shoulder, as the x-ray was of the right shoulder.

[3] A.M.A., *Guides* 475.

percent impairment.[4] The medical adviser referred to Table 15-9 and noted that the impairment for Clinical Studies (GMCS) corresponded to a grade modifier 2.[5] Regarding adjustment for Physical Examination (GMPE), he referred to Table-15-8 and determined that appellant qualified for a grade modifier of 1.[6] The medical adviser referred to Table 15-7 for Functional History (GMFH) and determined that appellant was eligible for a grade modifier of 2.[7] He applied the net adjustment formula and explained that the default position was modified by +2, which moved appellant to position E, which corresponded with an impairment of five percent.[8] The medical adviser noted that Dr. Xeller had utilized the range of motion method in rating impairment. However, he explained that Dr. Herring determined that appellant had normal range of motion in his October 22, 2010 report.[9] The medical adviser explained that range of motion could vary based upon effort and pain. He explained why the A.M.A., *Guides* had moved away from range of motion as a sole method of rating and moved to diagnosis-based impairment classes. The medical adviser opined that appellant had a five percent impairment of the right arm. He noted that appellant reached maximum medical improvement on November 22, 2010.

On December 6, 2012 OWCP granted appellant a schedule award for a five percent permanent impairment of the right upper extremity. The award covered a period of 15.6 weeks from February 13 to June 2, 2011.

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.[10]

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.[11] 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.[12] The A.M.A., *Guides* has been adopted by the implementing regulations as the

[4] *Id.* at 403.

[5] *Id.* at 410-11.

[6] *Id.* at 408.

[7] *Id.* at 406.

[8] *Id.* at 411.

[9] OWCP's medical adviser actually indicated November 22, 2010; however, this appears to be a typographical error, as the report is dated October 22, 2010.

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

[11] 5 U.S.C. § 8107.

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

appropriate standard for evaluating schedule losses.[13] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides.*[14]

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 GMFH, GMPE and GMCS.[15] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[16]

The A.M.A., *Guides* explains that diagnosis-based impairment is the method of choice for calculating impairment, while range of motion is used principally as an adjustment factor. When other grids refer the evaluator to the range of motion section or when no other diagnosis-based system is applicable, range of motion impairment serves as a stand-alone rating, one that cannot be combined with a diagnosis-based estimate.[17]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP 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.[18]

ANALYSIS

OWCP accepted the claim for sprain of neck and closed dislocation of the right shoulder. On February 3, 2011 appellant requested a schedule award and submitted a report from Dr. Xeller.

In his report, Dr. Xeller noted appellant's history of injury and treatment and utilized the A.M.A., *Guides.* The Board notes that he utilized the range of motion method of calculating impairment. As noted above, diagnosis-based impairment is the method of choice for calculating impairment, while range of motion is used principally as an adjustment factor.[19] However, when other grids refer the evaluator to the range of motion section or when no other diagnosis-based system is applicable, range of motion impairment serves as a stand-alone rating, one that cannot

[13] 20 C.F.R. § 10.404.

[14] 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).

[15] A.M.A., *Guides* 494-531; *see J.B.*, *id*.

[16] *Id*. at 521.

[17] *Id*. at 461.

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

[19] *See id.*

be combined with a diagnosis-based estimate.[20] While Dr. Xeller chose to rate appellant on range of motion he did not adequately explain why this was proper and why his range of motion findings were valid in view of the October 22, 2010 report from another treating physician, Dr. Herring, who found that appellant had full range of motion with minimal weakness.

> The Board further notes that Dr. Xeller did not document valid range of motion measurements as required by section 15.7 of the A.M.A., *Guides*. This section requires the rating physician to perform three measurements per joint motion, that the measurements be averaged and that each of the three measurements is within 10 degrees of the calculated average. The measurements for the affected extremity must also be compared with that of the opposite extremity to determine the percentage of relative deficit of the affected extremity.[21] As Dr. Xeller did not document performing valid range of motion measurements as required by section 15.7, his calculation is not valid for impairment rating purposes.

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 is correct to follow the advice of its medical adviser or consultant where he or she has properly applied the A.M.A., *Guides*.[22]

OWCP's medical adviser referred to the Shoulder Regional Grid for upper extremity impairments in Table 15-5.[23] He explained that appellant qualified for the default position, class 1 or three percent impairment for a rotator cuff injury, full thickness rotator tear. The medical adviser then utilized the grade modifier Tables. The Board notes that he referred to Table 15-7 for functional history adjustment and found a grade modifier of two.[24] The medical adviser also referred to Table 15-8 for physical examination and found a grade modifier of 1.[25] Furthermore, he referred to Table 15-9 for clinical studies and explained that appellant qualified for a grade modifier of two. The medical adviser utilized the net adjustment formula: (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[26] He applied the grade modifiers of two for functional history, one for physical examination and two for clinical studies under Table 15-7, Table 15-8 and Table 15-9. The medical adviser applied the net adjustment formula and determined that the default position was modified by +2, moving to position E, and an impairment of five percent of the right upper extremity. The Board finds that the medical evidence does not support that appellant has a greater permanent impairment.

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[20] *Supra* note 17. Here, the Shoulder Regional Grid, Table 15-5, allows for alternatively assessing impairment by the range of motion method. *See id*. at 403, 405.

[21] *Id.* at 461-64.

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

[23] *Id.* at 403.

[24] *Id.* at 406.

[25] *Id.* at 408.

[26] *Id.* at 405-12.

The Board finds that appellant did not meet his burden of proof to establish more than a five percent permanent impairment of his right upper extremity.

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 did not meet his burden of proof to establish that he sustained more than a four percent permanent impairment of his right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the December 6, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 21, 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