United States Department of Labor
Employees' Compensation Appeals Board

M.P., Appellant	)	
and	)	**Docket No. 13-2087**
	)	**Issued: April 8, 2014**
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:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On September 13, 2013 appellant filed a timely appeal of an August 14, 2013 merit award 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 this case.

ISSUE

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

FACTUAL HISTORY

On October 7, 2011 appellant, then a 52-year-old city carrier, injured his left shoulder while twisting and reaching at work. On December 2, 2011 OWCP accepted the claim for sprain

[1] 5 U.S.C. § 8101 *et seq.*

of the left shoulder and upper arm acromioclavicular (AC), other affections of the shoulder region, not otherwise specified. It expanded the claim to include impingement syndrome, with partial rotator cuff tear, arthroscopic subacromial decompression and chondral debridement. Appellant received compensation benefits.

On April 23, 2012 Dr. Charles Herring, a Board-certified orthopedic surgeon, performed an authorized left shoulder arthroscopy with subacromial decompression, with bursectomy and coracoacromial ligament resection, as well as extensive rotator cuff debridement. In an April 27, 2012 report, he noted that appellant had normal postoperative pain. Dr. Herring diagnosed high-grade partial shoulder rotator cuff tear, left shoulder glenoid osteochondral defect, cervical sprain/strain, status post left shoulder arthroscopy with subacromial decompression and chondral debridement on April 23, 2012. In a December 4, 2012 report, he noted that appellant had full range of motion of the left shoulder and negative impingement sign with Hawkins and Neer test. Dr. Herring advised that there was a well-healed incision status postsurgical intervention and that appellant had reached maximum medical improvement. In a January 9, 2013 report, Dr. Vikram Hatti, a Board-certified diagnostic radiologist, advised that a left shoulder magnetic resonance imaging (MRI) scan showed no full thickness tear of the rotator cuff. He also noted supraspinatus tendinopathy, a small amount of fluid in the subacromial/subdeltoid bursa, which indicated possible bursitis and AC joint arthropathy.

On April 25, 2013 appellant filed a claim for a schedule award. He submitted a January 14, 2013 report from Dr. Charles Xeller, a Board-certified orthopedic surgeon, who 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*). Dr. Xeller noted that the January 9, 2013 MRI scan revealed no full thickness tear and some remnant of a partial tear. His narrative report listed range of motion findings for the left shoulder that included flexion of 150 degrees, abduction of 150 degrees, internal rotation of 40 degrees and external rotation of 40 degrees. Dr. Xeller noted that appellant had a painful impingement test; however, he found no evidence of radiculopathy. He opined that appellant reached maximum medical improvement. Dr. Xeller diagnosed status post left shoulder arthroscopy with subacromial decompression and extensive chondral debridement as well as left shoulder residual tendinopathy. He advised that impairment should be rated utilizing range of motion. Dr. Xeller referred to Table 15-34[2] and noted: flexion of 30 degrees corresponded to three percent upper extremity impairment and abduction of 150 degrees also corresponded to three percent upper extremity impairment, external rotation of 40 degrees corresponded to four percent upper extremity impairment and external rotation of 40 degrees corresponded to four percent upper extremity impairment. He totaled these ratings and opined that appellant had 14 percent impairment of the left arm.

In an attached January 14, 2013 range of motion study, he listed left shoulder findings of flexion of 170 degrees, abduction of 170 degrees, internal rotation of 69 degrees and external rotation of 60 degrees. The study noted that the active range of motion was objectively evaluated using the dual inclinometry protocols outlined in the A.M.A., *Guides*, to include three consecutive range of motion measurements with the mean or average calculated.

[2] *Id*. at 475.

In an August 1, 2013 report, OWCP's medical adviser noted appellant's history of injury and treatment and utilized the A.M.A., *Guides.* She noted that the accepted conditions included left shoulder sprain and impingement syndrome, with partial rotator cuff tear, arthroscopic subacromial decompression and chondral debridement. The medical adviser determined that impairment due to left shoulder post-traumatic degenerative joint disease would be rated according to Table 15-5.[3] She explained that appellant was in the class 1 default position C, five percent arm impairment. For grade modifiers, the medical adviser noted that clinical studies was inapplicable as it was used for placement. The medical adviser referred to a modifier for physical examination and determined that appellant had a grade modifier 2, pursuant to Table 15-8.[4] Regarding the functional history modifier, she determined that appellant had a grade modifier 2, pursuant to Table 15-7.[5] The medical adviser utilized the net adjustment formula.[6] She explained that the default position was modified by +2, moving to position E, and an impairment of nine percent. The medical adviser noted that, while Dr. Xeller used range of motion for the impairment rating, range of motion could vary based on effort and pain. She explained that 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 indicated that this was why she used a diagnosis-based rating. She opined that the total impairment for the left upper extremity was nine percent and that appellant reached maximum medical improvement on November 22, 2010.

On August 14, 2013 OWCP granted appellant a schedule award for nine percent permanent impairment of the left upper extremity. The award covered a period of 28.08 weeks from July 27, 2013 to February 8, 2014.[7]

LEGAL PRECEDENT

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.[8] 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.[9] The A.M.A., *Guides* has been adopted by the implementing regulations as the

[3] *Id*. at 405.

[4] *Id*. at 408.

[5] *Id*. at 406.

[6] *Id*. at 411.

[7] The record reflects that appellant received a schedule award of five percent to the right upper extremity in a prior claim that is not presently before the Board. File No. xxxxxx704.

[8] 5 U.S.C. § 8107.

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

appropriate standard for evaluating schedule losses.[10] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides.*[11]

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).[12] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[13]

ANALYSIS

OWCP accepted appellant's claim for conditions that included left shoulder sprain and impingement syndrome, with partial rotator cuff tear. It authorized arthroscopic subacromial decompression and chondral debridement. On August 14, 2013 OWCP granted appellant a schedule award for nine percent impairment of the left arm based on the August 1, 2013 opinion of OWCP's medical adviser.

In a January 14, 2013 report, Dr. Xeller utilized the A.M.A., *Guides* and the range of motion method to provide an impairment rating for the shoulder. He noted some remnant of a partial tear referred to Table 15-34 and determined that appellant had an impairment of 14 percent of the left arm due to lost range of motion.[14] However, Dr. Xeller did not sufficiently explain how he arrived at this rating utilizing range of motion. The A.M.A., *Guides* provides that, under specific circumstances, range of motion may be selected as an alternative approach in rating upper extremity impairment and cautions that an impairment rating that is calculated using range of motion stands alone and may not be combined with a diagnosis-based impairment.[15] Additionally, section 15.7a indicates that range of motion should be measured after a warm up, that the maximum range of motion should be measured at least three times and that the maximum measurement is used to determine range of motion measurement.[16] While Dr. Xeller indicated that he had complied with these requirements, he did not show the three individual measurements and appears to have listed the average of the measurements. Without these measurements, the Board is not able to verify how he determined his impairment findings. The Board also notes that the measurements contained in the range of motion study that Dr. Xeller attached to his narrative report are not the same as the measurements listed in Dr. Xeller's

[10] 20 C.F.R. § 10.404.

[11] 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).

[12] A.M.A., *Guides* 385-419; *see J.B.*, Docket No. 09-2191 (issued May 14, 2010).

[13] *Id*. at 411.

[14] *Id*. at 475.

[15] *Id*. at 390.

[16] *Id*. at 464.

narrative report that he used to rate impairment.[17] He did not explain the discrepancies. Additionally, the Board notes that Dr. Xeller did not indicate if or how he made any adjustments utilizing functional history or range of motion grade modifiers.[18] As it does not appear that Dr. Xeller correctly complied with the procedures outlined in the A.M.A., *Guides*, his calculations are not valid for impairment rating purposes.[19] As his report did not comport with the A.M.A., *Guides*, it is of diminished probative value and insufficient to establish appellant's left arm impairment.

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 percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[20]

The Board notes that, in an August 1, 2013 report, OWCP's medical adviser properly chose the diagnosis-based method for determining the degree of impairment as opposed to the methodology for loss of range of motion in the left shoulder, the method used by Dr. Xeller and based her rating on post-traumatic degenerative joint disease diagnosis in Table 15-5 on page 405 of the A.M.A., *Guides*. She explained that appellant qualified for the default position, class 1, grade C, or five percent impairment for post-traumatic degenerative joint disease. The medical adviser then utilized the grade modifier tables. She explained that clinical studies was inapplicable as it was used for placement.[21] The medical adviser referred to Table 15-7 for functional history adjustment and found a grade modifier of two.[22] She also referred to Table 15-8 for physical examination and found a grade modifier of 2.[23] The medical adviser utilized the net adjustment formula: (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX)[24] and determined that the default position was modified by +2, moving the grade from position C to position E, for an impairment rating of nine percent of the left upper extremity. The Board finds that OWCP properly relied on this impairment rating and finds the record does not support a greater permanent impairment.

[17] In his narrative report, Dr. Xeller listed left shoulder flexion of 150 degrees, abduction 150, internal rotation 40, and external rotation 40. The corresponding numbers from the range of motion study are 170, 170, 69 and 60.

[18] A.M.A., *Guides* 406, Table 15-7 and 477, Table 15-36.

[19] An opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment. *I.F.*, Docket No. 08-2321 (issued May 21, 2009).

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

[21] *See* A.M.A., *Guides* 407 (if a finding is used for placement of diagnosis within a specific class in a diagnosis-based impairment grid, that same finding cannot also be used as a grade modifier).

[22] *Id*. at 406.

[23] *Id*. at 408.

[24] *Id*. at 411.

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

Appellant may submit evidence or argument with a written request for reconsideration within one year of this merit decision pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he sustained more than a nine percent permanent impairment of his left upper extremity.

ORDER

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

Issued: April 8, 2014
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board