United States Department of Labor
Employees' Compensation Appeals Board

S.G., Appellant	)	
and	)	**Docket No. 14-1464**
	)	**Issued: November 14, 2014**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, St. Cloud, MN, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 16, 2014 appellant filed a timely appeal from the May 14, 2014 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 this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has more than a 40 percent permanent impairment of his left arm, for which he received schedule awards.

FACTUAL HISTORY

OWCP accepted that on March 24, 1988 appellant, then a 31-year-old licensed practical nurse, sustained dislocation, adhesive capsulitis and localized primary osteoarthritis of his left

[1] 5 U.S.C. §§ 8101-8193.

shoulder due to lifting a patient up into bed with the aid of a coworker.[2] He underwent left shoulder arthroscopy on July 20, 1988, anterior left shoulder stabilization; a cruciate capsular repair on May 1, 1990; and a left shoulder open revision surgery with decompression on November 8, 1999. The procedures were authorized by OWCP.

In a decision dated September 12, 2002, OWCP granted appellant a schedule award for a 15 percent permanent impairment of his left arm. The award ran for 46.8 weeks from November 1, 2001 to September 24, 2002. The award was based on a July 29, 2002 impairment rating under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001) by Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as an OWCP medical adviser. Dr. Garelick based his impairment rating on physical examination findings obtained in May 2002 by Dr. Daniel D. Bus, an attending Board-certified orthopedic surgeon.

On November 12, 2008 Dr. Michael Q. Freehill, an attending Board-certified orthopedic surgeon, performed an authorized total left shoulder replacement surgery, which included left pectoralis major tendon transfer for subscapularis deficiency with graft jacket and biceps tenodesis.

In a November 19, 2009 report, Dr. Freehill stated that appellant reported feeling significantly better after his November 12, 2008 left shoulder surgery despite experiencing some pain and locking sensation in his left shoulder. The physician provided findings for range of motion testing of appellant's left shoulder and noted that his pectoralis major tendon appeared to be intact and firing. There was no crepitus in appellant's left shoulder and strength was 5/5. Dr. Freehill observed that appellant's surgical incision appeared dry and clean with no drainage and that he was intact with regard to sensory and motor function.

On March 3, 2010 Dr. Freehill determined that, under Table 15-5 on page 405 of the sixth edition of the A.M.A., *Guides* (6th ed. 2009), appellant had a class 3 diagnosis-based impairment of his left arm due to his total left shoulder arthroplasty. Appellant had a grade modifier 1 for functional history and modifier 1 for physical examination and application of the net adjustment formula caused movement two places to the left from the default value on Table 15-5. Dr. Freehill rated a 26 percent impairment of appellant's left arm, noting that maximum medical improvement (MMI) was November 19, 2009.

On April 26, 2010 Dr. Garelick, serving as an OWCP medical adviser, discussed Dr. Freehill's findings regarding appellant's left shoulder condition after his November 12, 2008 total left shoulder replacement surgery. He noted that Dr. Freehill stated that appellant had done relatively well since the surgery despite complaining of pain with activity. Physical examination by Dr. Freehill revealed healed surgical incisions without infection, normal 5/5 strength and active range of motion slightly diminished with 150 degrees of forward elevation and 100 degrees of abduction. The remainder of the examination was unremarkable and x-rays showed that the arthroplasty was in a good position without evidence of loosening. Dr. Garelick stated

[2] OWCP had previously accepted that on September 4, 1987 appellant sustained a left shoulder contusion and permanent aggravation of preexisting left shoulder instability with post-traumatic early glenohumeral arthritis due to being punched in his left shoulder by a patient.

that, under Table 15-5 on page 405 of the sixth edition of the A.M.A., *Guides*, appellant had a class 3 diagnosis-based left arm impairment with a default value of 40 percent due to a complicated total shoulder arthroplasty necessitating a pectoralis major transfer. He noted that the award included consideration of range of motion, weakness and pain and that there was no change from the default value of 40 percent upon application of the net adjustment formula. The date of MMI occurred on November 19, 2009 as found by Dr. Freehill.

In a decision dated May 10, 2010, OWCP granted appellant a schedule award for an additional 25 percent permanent impairment of his left arm, compensating him for a total impairment of 40 percent. The award ran for 78 weeks from November 19, 2009 to May 18, 2011 and was based on the examination findings of Dr. Freehill and the April 26, 2010 report of Dr. Garelick.

On March 13, 2013 Dr. Freehill performed authorized revision surgery to reverse total left shoulder arthroplasty. In June 2013, appellant returned to limited-duty work for the employing establishment.

On March 27, 2014 appellant filed a claim for an additional schedule award.

In a March 7, 2014 report, Dr. Freehill detailed the findings of his physical examination on that date, noting that appellant reported that he currently had minimal pain and good function in his left shoulder. He stated that appellant had well-healed surgical incisions and that there was no shoulder atrophy. Dr. Freehill reported range of motion findings for appellant's left shoulder, including active flexion to 150 degrees and active abduction to 145 degrees. Strength of appellant's left shoulder was 4+ and he was able to fire his deltoid muscle without difficulty.

In a form report dated March 7, 2014, Dr. Freehill determined that, under Table 15-5 on page 405 of the sixth edition of the A.M.A., *Guides*, appellant had a class 3 diagnosis-based impairment of his left arm due to his reverse total left shoulder arthroplasty. He stated that appellant had a grade modifier 1 for functional history and modifier 1 for physical examination[3] and determined that appellant had a 43 percent permanent impairment of his left arm based on the diagnosis-based impairment. Dr. Freehill found that appellant had one percent permanent impairment of his left arm due to loss of left shoulder motion. He then added the 43 percent rating for diagnosis-based impairment and the 1 percent rating for range of motion impairment to conclude that appellant had total left arm impairment of 44 percent.

On April 28, 2014 Dr. Garelick, the medical adviser, reviewed the reports from Dr. Freehill, who indicated that appellant had done relatively well following his left shoulder surgery and experienced minimal pain with good function. Examination of appellant's left shoulder demonstrated that all surgical incisions had healed and that range of left shoulder motion was near normal. Strength in his left shoulder was 4+ without tenderness signs and x-rays revealed that the glenoid and humeral components were in good position without evidence of loosening or scapular notching. Dr. Garelick noted that Dr. Freehill had recommended a

[3] Dr. Freehill did not provide a grade modifier for clinical studies.

44 percent impairment rating of appellant's left arm based on diagnosis-based impairment and range of motion impairment and stated:

> "However, this is not allowed based on the rules set forth in the [sixth edition of the A.M.A., *Guides*]. Thus, I would suggest [appellant] award be disregarded. By all accounts, [appellant] has done well and there is no objective basis for any change to his award. However, given the revision surgery, the date of MMI needs to be updated and occurred on March 7, 2014, approximately 1 year postoperatively. TOTAL left upper extremity [permanent partial impairment] = 40 percent Date of MMI = March 7, 2014."

By decision dated May 14, 2014, OWCP found that appellant did not establish that he has more than a 40 percent permanent impairment of his left arm, for which he received schedule awards. It found that the medical evidence did not establish greater permanent impairment of his left arm. OWCP explained that Dr. Garelick determined that Dr. Freehill impermissibly added impairment ratings for diagnosis-based impairment with range of motion impairment.

LEGAL PRECEDENT

The schedule award provision of FECA[4] and its implementing regulations[5] 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[6] For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used for evaluating permanent impairment.[7]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401.[8] After the Class of Diagnosis (CDX) is determined from the Shoulder Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for Functional History (GMFH), grade modifier for Physical Examination (GMPE) and

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999).

[6] *Id*.

[7] *See* FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5th ed. 2001) is used.

[8] A.M.A., *Guides* 401-05.

grade modifier for Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9] Table 15-5 also provides that, if motion loss is present for a claimant who has undergone a shoulder arthroplasty, impairment may alternatively be assessed using Section 15.7 (range of motion impairment). Such a range of motion impairment stands alone and is not combined with a diagnosis impairment.[10]

ANALYSIS

OWCP accepted that on March 24, 1988 appellant sustained dislocation, adhesive capsulitis and localized primary osteoarthritis of his left shoulder and it authorized multiple surgeries of his left shoulder. On November 12, 2008 Dr. Freehill, an attending Board-certified orthopedic surgeon, performed total left shoulder replacement surgery, which included left pectoralis major tendon transfer for subscapularis deficiency with graft jacket and biceps tenodesis. On March 13, 2013 he performed OWCP-authorized revision surgery to reverse total left shoulder arthroplasty. OWCP granted appellant schedule awards for a 40 percent permanent impairment of his left arm. The determination that appellant had this degree of left arm impairment was based on the opinion of Dr. Garelick, a Board-certified orthopedic surgeon serving as an OWCP medical adviser. Dr. Garelick calculated his impairment rating based on the findings of Dr. Freehill.

The Board finds that appellant has not submitted sufficient medical evidence to establish that he has more than a 40 percent permanent impairment of his left arm.

The Board notes that Dr. Garelick properly calculated that appellant had 40 percent permanent impairment of his left arm based on findings provided by Dr. Freehill. On April 26, 2010 Dr. Garelick stated that, under Table 15-5 on page 405 of the sixth edition of the A.M.A., *Guides*, appellant had class 3 diagnosis-based left arm impairment with a default value of 40 percent due to his complicated total shoulder arthroplasty necessitating a pectoralis major transfer.[11] He considered appellant's range of motion, weakness and pain and found that the grade modifiers did not cause any change from the default value of 40 percent impairment upon application of the net adjustment formula.[12] Therefore, Dr. Garelick found that appellant had 40 percent permanent impairment of his left arm.

In a March 7, 2014 report, Dr. Freehill provided an opinion that appellant had 44 percent permanent impairment of his left arm. However, his opinion is of limited probative value in that

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

[10] *Id.* at 405, 475-78.

[11] *Id*. at 405.

[12] *See id* at 405-11.

he failed to provide adequate explanation of how this rating of permanent impairment was derived in accordance with the standards of the sixth edition of the A.M.A., *Guides*.[13]

Dr. Freehill indicated that appellant had 43 percent left arm impairment due to his class 3 left shoulder arthroplasty. Under Table 15-5 of the sixth edition of the A.M.A., *Guides*, the highest default value for a grade 3 shoulder arthroplasty is 40 percent. Dr. Freehill stated that appellant had a grade modifier 1 for functional history and modifier 1 for physical examination.[14] However, under Table 15-5, application of the net adjustment formula to these grade modifiers would cause movement two places to the left of the default value of 40 percent and would render a diagnosis-based impairment value of 34 percent, not an impairment rating of 43 percent. Dr. Freehill also added 1 percent impairment based on loss of range of motion findings, to his diagnosis-based rating of 43 percent. While Table 15-5 allows for consideration of range of shoulder motion in arthroscopy cases as an alternative rating method, it explicitly provides that the range of motion rating stands alone and may not be combined with a rating derived under the diagnosis-based method.[15]

On appeal, appellant indicated that the pain in his left shoulder had worsened and that he had less range of motion; however, the medical evidence of record does not establish more than a 40 percent permanent impairment of his left arm, for which he received schedule awards.

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 did not meet his burden of proof to establish that he has more than 40 percent permanent impairment of his left arm, for which he received schedule awards.

[13] *See James Kennedy, Jr.*, 40 ECAB 620 (1989) (finding that 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).

[14] Dr. Freehill did not provide a grade modifier for clinical studies.

[15] A.M.A., *Guides* 405, 475-78.

ORDER

IT IS HEREBY ORDERED THAT the May 14, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 14, 2014
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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