United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, FEDERAL AIR MARSHAL SERVICE, El Segundo, CA, Employer	)	**Docket No. 14-1306** **Issued: October 16, 2014**

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 20, 2014 appellant filed a timely appeal from a May 12, 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 has more than a five percent impairment of his right upper extremity, for which he received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On January 30, 2012 appellant, then a 59-year-old supervisory federal air marshal, filed a traumatic injury claim (Form CA-1) alleging that on January 26, 2012 he injured his right arm while stowing a bag of equipment in an overhead bin. He stated that he felt an extremely sharp pain in his right arm muscle. OWCP accepted his claim for an unspecified sprain of the shoulder and arm on March 28, 2012. On March 7, 2013 it expanded his claim to accept a right rotator cuff tear.

A Form CA-16, authorization for examination and/or treatment, was issued by the employing establishment on January 30, 2012.[2]

In a report dated April 24, 2012, Dr. Bradley Greenbaum, a Board-certified orthopedic surgeon, assessed appellant with right rotator cuff syndrome, a partial articular cuff tear and right shoulder pain. On examination of appellant's right shoulder, he found tenderness to palpation over the anterior shoulder and rotator cuff area. Dr. Greenbaum noted that appellant had lateral deltoid pain and weakness resisting external rotation, with positive impingement testing. The right shoulder had full passive range of motion, but too much pain to demonstrate a full active range of motion. Dr. Greenbaum recommended a surgical procedure of arthroscopic rotator cuff repair with subacromial decompression.

Appellant underwent a magnetic resonance imaging (MRI) scan on June 28, 2012, which demonstrated findings consistent with a subtle anterior superior labral tear.

Appellant underwent surgery on his right shoulder on July 2, 2012. In an operative report from that date, Dr. Greenbaum provided postoperative diagnoses of a type IV superior labral tear from anterior to posterior, right rotator cuff syndrome, a partial articular tear of less than 50 percent and right shoulder pain. He performed procedures of an arthroscopic biceps tenotomy, an extensive arthroscopic glenohumeral joint debridement and arthroscopic subacromial decompression.

In a postoperative report dated July 9, 2012, Dr. Greenbaum noted that appellant had already begun to discontinue use of his sling and participated in a formal postoperative physical therapy program.

On August 6, 2012 Dr. Greenbaum noted that appellant still had diffuse shoulder pain, loss of motion and weakness around his right shoulder and arm. On examination of appellant's right shoulder, he noted that appellant had improved passive range of motion, but that he still had pain throughout testing, no instability, residual diffuse tenderness and lateral deltoid pain with provocative cuff testing and improving strength.

[2] When the employing establishment properly executes a Form CA-16 which authorizes medical treatment as a result of an employee's claim for an employment-related injury, the Form CA-16 creates a contractual obligation, which does not involve the employee directly, to pay for the cost of the examination or treatment regardless of the action taken on the claim. The period for which treatment is authorized by a Form CA-16 is limited to 60 days from the date of issuance, unless terminated earlier by OWCP. *See* 20 C.F.R. § 10.300(c); *Tracy P. Spillane*, 54 ECAB 608, 610 (2003).

In a report dated October 29, 2012, Dr. Greenbaum stated that appellant's passive range of motion of the right shoulder had improved tremendously, but that his active range of motion was lacking secondary to some pain and weakness. On examination of the right shoulder, he found near full passive range of motion, except for internal rotation, extension and adduction, which was L-3/4 on the right versus T10/11 on the left. Rotator cuff testing demonstrated 4+/5 abduction, 4-4+/5 external rotation and 5/5 internal rotation. Dr. Greenbaum recommended work restrictions of driving no more than 5 to 10 miles to and from work; no heavy lifting, pushing, pulling, or carrying of over 10 pounds; and no repetitive activities at or above the shoulder level. Additionally, he stated that appellant would never be able to return to his preinjury duties as an air marshal because he would not "regain the ability to be placed into a combative situation or altercation with someone in flight posing a risk to the lives of those on board or the country in general."

On March 12, 2013 OWCP requested a second opinion physician to provide additional evidence on the nature of appellant's condition, the extent of his disability, appropriate treatment and an impairment rating with a detailed description of objective findings and application of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (hereinafter, A.M.A., *Guides*).

In a report dated July 17, 2013, Dr. Thomas G. Grace, a Board-certified orthopedic surgeon, stated that appellant had reached maximum medical improvement on January 2, 2013. He stated that he applied the A.M.A., *Guides* and explained that because appellant had discrepancies of active and passive range of motion greater than 10 degrees, it was inappropriate to utilize the A.M.A., *Guides*' range of motion methodology. Therefore, Dr. Grace stated that the appropriate manner in which to calculate appellant's impairment rating was found in Table 15-5 on page 404 under "labral lesions including SLAP tears." He noted that this was an impairment rating ranging between one percent and five percent of the upper extremity with a default impairment rating of three. Dr. Grace applied a grade 1 modifier for appellant's physical examination and a grade 2 modifier for clinical studies. He calculated the net modifier at +1, giving appellant a final impairment rating of four percent of the right upper extremity. Dr. Grace noted that, because appellant's CDX was one and the grade modifier for functional history was two levels higher, it should not be utilized to modify appellant's diagnosis-based impairment. He also provided medical restrictions for appellant of no more than 4.5 hours of intermittent operation of a motor vehicle both to and from and at work per day; no more than 1 hour of pushing, pulling, or lifting intermittently per workday and no more than 15 pounds of weight or force; no overhead lifting or activities involving the right shoulder; and no climbing. Dr. Grace stated that appellant was capable of working an eight-hour workday with these restrictions.

On July 30, 2013 appellant requested a schedule award.

A district medical adviser (DMA) reviewed Dr. Grace's impairment rating on August 9, 2013. He found that appellant's final impairment rating for the right upper extremity was five percent. The DMA disagreed with Dr. Grace's grade modifiers for functional history, physical examination and clinical studies, finding that the final net adjustment was two and the final grade was E. He found that the most impairing diagnosis was the labral tear of the right shoulder rather than a labral lesion. The DMA noted that appellant's shoulder range of motion was equal to a 15 percent upper extremity impairment, which according to Table 15-35 on page

477 of the A.M.A., *Guides* was equal to a grade modifier of two. He explained that, based on appellant's significant loss of shoulder motion, he would likely need to perform modification to achieve self-care, such that his functional history modifier was two. The DMA noted that Dr. Grace had not documented the need to use assistance to perform self-care by use of the *Quick*DASH form. He found that appellant's physical examination grade modifier was two. Based on appellant's MRI scan and findings on surgery, appellant's clinical studies modifier was four. Applying these modifiers to appellant's diagnosis class, he arrived at a final right upper extremity impairment of five percent. The DMA noted that the date of maximum medical improvement was July 17, 2013, the date of the examination by Dr. Grace.

By letter dated October 2, 2013, OWCP informed appellant that a schedule award was payable consecutively but not concurrently with an award for wage loss for the same injury. It asked him to respond within 30 days to clarify whether he desired completion of the processing of his schedule award or continued wage-loss compensation.

By letter dated October 8, 2013, appellant informed OWCP that he would like to suspend his claim for a schedule award and continue his compensation for wage loss on the periodic rolls.

In a record of a telephone conversation dated April 16, 2014, appellant informed OWCP that he had been notified that he was medically retired. He elected benefits from the Office of Personnel Management over FECA benefits on April 21, 2014.

Appellant again requested a schedule award on April 25, 2014.

By decision dated May 12, 2014, OWCP granted appellant a schedule award for five percent impairment of his right upper extremity. It noted that it had afforded the weight of the medical evidence regarding appellant's percentage of impairment to the DMA rather than Dr. Grace, as the DMA correctly applied the A.M.A., *Guides* to the examination findings.

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, functions and organs of the body. 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.[5] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[6] For decisions issued after

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

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

[6] *Id.*

May 1, 2009, the sixth edition is used to calculate schedule awards.[7] It is well established that, in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[8]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[9] Under the sixth edition, the evaluator identifies 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).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

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.[12]

ANALYSIS

OWCP accepted that appellant sustained a sprain of the right shoulder and arm and a right rotator cuff tear as a result of his January 26, 2012 employment injury. Appellant's attending physician, Dr. Greenbaum, did not provide an impairment rating. OWCP referred the medical evidence to Dr. Grace, a second opinion physician, for determination of appellant's percentage of impairment.

In a report dated July 17, 2013, Dr. Grace stated that he had applied the A.M.A., *Guides* and explained that, because appellant had discrepancies of active and passive range of motion greater than 10 degrees, it was inappropriate to utilize the A.M.A., *Guides*' range of motion methodology. Therefore, he stated that the appropriate manner in which to calculate appellant's impairment rating was found in Table 15-5 on page 404 under "labral lesions including SLAP tears." Dr. Grace noted that this was an impairment rating ranging between one percent and five percent of the upper extremity with a default impairment rating of three. He applied a grade 1

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

[8] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a.3 (January 2010). This portion of OWCP's procedure provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

[9] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[10] *Id*. at 383-419.

[11] *Id*. at 411.

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

modifier for appellant's physical examination (GMPE) and a grade 2 modifier for clinical studies (GMCS). Dr. Grace calculated the net modifier at +1, giving appellant a final impairment rating of four percent of the right upper extremity. He noted that, because appellant's CDX was 1 and the grade modifier for functional history was two levels higher, it should not be utilized to modify appellant's diagnosis-based impairment.

A DMA reviewed Dr. Grace's impairment rating on August 9, 2013. He found that appellant's final impairment rating for the right upper extremity was five percent. The DMA disagreed with Dr. Grace's grade modifiers for functional history, physical examination and clinical studies, finding that the final net adjustment was two and the final grade was E. He found that the most impairing diagnosis was the labral tear of the right shoulder rather than a labral lesion. The DMA noted that appellant's shoulder range of motion was equal to a 15 percent upper extremity impairment, which according to Table 15-35 on page 477 of the A.M.A., *Guides* was equal to a grade modifier of two. He explained that, based on appellant's significant loss of shoulder motion, he would likely need to perform modification to achieve self-care, such that his functional history modifier was two. The DMA noted that Dr. Grace had not documented the need to use assistance to perform self-care by use of the *Quick*DASH form. He found that appellant's physical examination grade modifier was two. Based on appellant's MRI scan and findings on surgery, appellant's clinical studies modifier was four. Applying these modifiers to appellant's diagnosis class, he arrived at a final right upper extremity impairment of five percent.

The Board finds that the DMA's rating properly utilized the A.M.A., *Guides* and represents the weight of medical opinion. The DMA explained the differences between his impairment rating calculations with citations to the A.M.A., *Guides* for his diagnosis-based estimate and adjustments based on the functional history, clinical studies and physical examination adjustments, and noted the areas in which Dr. Grace's report did not comport with the A.M.A., *Guides*. When an attending physician's report does not comport with the A.M.A., *Guides*, OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings of the attending physician.[13] Hence, OWCP properly relied on the DMA's final upper right extremity impairment rating of five percent over Dr. Grace's impairment rating of four percent. There was no other medical evidence of record to support a greater impairment rating than five percent.

Therefore, the Board finds that appellant has no more than a five percent impairment of his right upper extremity, for which he has received a schedule award.

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.

[13] *Linda Beale*, 57 ECAB 429 (2006). Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810(8) (September 2010)

CONCLUSION

The Board finds that appellant has no more than a five percent impairment of his right upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the May 12, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 16, 2014
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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