United States Department of Labor
Employees' Compensation Appeals Board

W.A., Appellant	)	
and	)	**Docket No. 15-1014**
	)	**Issued: September 10, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Solon, Ohio, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On April 1, 2015 appellant, through counsel, filed a timely appeal from a March 10, 2015 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 established that he sustained more than six percent permanent impairment to the right upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On January 6, 2009 appellant, then a 52-year-old distribution clerk, filed a traumatic injury claim alleging that he injured his right shoulder when he slipped and fell on black ice that day. Under claim number xxxxxx944 OWCP accepted right shoulder sprain, contusion, and

[1] 5 U.S.C. § 8101 *et seq.*

aggravation of right rotator cuff tear. Appellant underwent an authorized right shoulder arthroscopic rotator cuff repair for a full-thickness tear on October 26, 2009. On November 18, 2010 he filed an occupational disease claim alleging that he sustained a right rotator cuff tear and bicep tendon tear in the performance of duty. Appellant attributed his conditions to processing mail and the repetitive use of his shoulder at work. OWCP accepted the claim for recurrent right rotator cuff tear under claim number xxxxxx921.[2] It authorized a March 18, 2011 arthroscopic debridement with biceps tenotomy and open rotator cuff repair. This surgery was performed by Dr. Matthew Levy, a Board-certified orthopedic surgeon. Appellant worked intermittently before retiring from the employing establishment on January 31, 2013.

Initial reports advised that appellant was first injured in a nonwork-related motor vehicle accident in December 2007 that resulted in a small tear in one of the rotator cuff muscles. Dr. Kent Soderstrum, Board-certified in internal and occupational medicine, and Dr. Levy advised that the work-related slip and fall aggravated the right rotator cuff tear. Following the October 26, 2009 right shoulder arthroscopy appellant underwent physical therapy. In a June 29, 2010 report, Dr. Levy advised that appellant related that he was ready to return to full-duty work although he still had shoulder pain with certain movements. Progress reports from Dr. Levy advised that appellant continued to experience pain after returning. In an October 19, 2010 report, Dr. Levy advised that appellant related that full-duty work was contributing to his significant shoulder pain. He noted that he would seek a magnetic resonance imaging (MRI) scan. On December 14, 2010 Dr. Levy opined that repetitive mail racking, lifting boxes, reaching, and pulling substantially aggravated his shoulder. He proposed another arthroscopic evaluation of the rotator cuff with possible rotator cuff repair and a bicep tenodesis versus bicep tenotomy.

In a December 16, 2010 MRI scan report for the right shoulder, Dr. James Zelch, a Board-certified diagnostic radiologist, advised that testing showed a recurrent full-thickness tear of the rotator cuff with marked retraction and mild atrophy of the supraspinatus muscle.

Dr. Levy, in a March 18, 2011 operative report, noted performing an arthroscopic debridement with biceps tenotomy and open rotator cuff repair. He continued to submit status reports. In a June 29, 2011 report, Dr. Levy advised that appellant's pain was improving and that he was gaining better tone in his upper arm. He also noted that appellant had excellent motion, trace weakness on external rotation, and a slight grind within the shoulder. In a February 1, 2012 report, Dr. Levy advised that appellant returned to work for four hours per day with limitations. On examination he noted that appellant had no pain with palpation, wounds were healed, motion was good, and he had weakness of resisted internal and external rotation. In a February 11, 2013 report, Dr. Levy advised that appellant continued to complain of shoulder pain. He noted that appellant retired but still attempted to keep up with his home therapy protocol. Dr. Levy assessed rotator cuff sprain and strain and advised that appellant was at maximum medical improvement. On August 13, 2013 he again opined that appellant had reached maximum medical improvement.

On September 30, 2013 appellant claimed a schedule award.

[2] OWCP doubled claim numbers xxxxxx921 and xxxxxx944.

In an October 14, 2013 report, Dr. Catherine Watkins-Campbell, Board-certified in family and occupational medicine, noted appellant's history and reviewed his medical record. She noted that appellant was initially injured when he slipped on black ice causing him to fall landing on his right shoulder. Dr. Watkins-Campbell noted that he was diagnosed with torn rotator cuff and biceps tendon tears for which he underwent an arthroscopic procedure in October 2009. She further noted that he returned to work six months later, but later needed a second procedure which was performed in March 2011. Dr. Watkins-Campbell advised that appellant worked intermittently before retiring in 2013. On examination she noted 95 degrees of flexion, 50 degrees of extension, 127 degrees of adduction, 90 degrees of internal rotation, and 80 degrees of external rotation. Dr. Watkins-Campbell advised that there was mild-to-moderate trigger point tenderness in the right supraspinatus, upper trapezius and biceps muscles, minimal variable acromioclavicular (AC) and sub-AC tenderness, no signs of impingement, and normal muscle strength except for grade 4/5 muscle strength for flexion and abduction. She advised that appellant related that he was unable to lift heavy weight, had moderate difficulty reaching above the shoulders, pushing, pulling, opening doors, opening jars, sweeping, and vacuuming. Dr. Watkins-Campbell noted that appellant related that he was able to perform the majority of activities of daily living without assistance, but other more advanced activities such as golfing, bowling, and lifting a full bucket were significantly limited. She assessed a *Quick*DASH score of 90. Dr. Watkins-Campbell advised that using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[3] appellant had 34 percent right arm impairment. She identified shoulder arthroplasty as the impairment class, under Table 15-5 (shoulder-region grid), page 405. Dr. Watkins-Campbell advised that appellant's impairment was a class 3, default position C, which equated to 30 percent impairment. She stated that appellant had two surgical procedures with the second one being an open procedure presumed to include an arthroplasty procedure. Dr. Watkins-Campbell further advised that she chose grade modifier 3 for functional history as the *Quick*DASH score of 90 seemed excessively high compared to the other data collected. She assessed grade modifier 1 for physical examination as there was only mildly limited range of motion, strength, and tenderness with no significant instability, alignment deformity, or muscle atrophy. Dr. Watkins-Campbell did not assess a grade modifier for clinical study. She calculated a net adjustment of +2 which moved the impairment to grade E for 34 percent impairment. Dr. Watkins-Campbell advised that the date of maximum medical improvement was August 13, 2013, a date assessed by Dr. Levy.

On February 10, 2014 Dr. Morley Slutsky, an OWCP medical adviser, reviewed Dr. Watkins-Campbell's report and disagreed with the 34 percent upper extremity impairment rating. He explained that under Table 15-5 using the criteria for full rotator cuff tear with residual dysfunction, appellant was in class 1 with a default five percent impairment rating. Dr. Slutsky explained that Dr. Watkins-Campbell rated appellant using an incorrect diagnosis of right shoulder arthroplasty. He assessed a grade 1 modifier for Physical Examination (GMPE) as appellant had tenderness to palpation. Dr. Slutsky assessed a grade 2 modifier for Clinical Studies (GMCS) as a December 16, 2010 MRI scan demonstrated a recurrent full-thickness rotator cuff tear with mild atrophy of the supraspinatus muscles. He then explained that Dr. Watkins-Campbell's grade 3 modifier for Functional History (GMFH) was unreliable because the A.M.A., *Guides* provide that, if the grade for functional history differs by two or

[3] A.M.A., *Guides* (6th ed. 2009).

more grades from that described by physical examination or clinical studies, the functional history should be deemed unreliable and excluded from the grading process.[4] Using the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), the medical adviser calculated a net adjustment of +1, moving to grade D for a six percent upper extremity impairment.

By decision dated July 1, 2014, OWCP granted appellant a schedule award for six percent right upper extremity impairment.

By letter dated July 9, 2014, appellant, through counsel, requested an oral telephone hearing. The hearing took place on January 26, 2015. Counsel argued that Dr. Watkins-Campbell correctly determined the impairment rating as she used the criteria for arthroplasty and the type of surgery that appellant underwent best fit within the criteria for arthroplasty. Counsel also argued that OWCP medical adviser ignored appellant's bicep failure which was obviously related to the work injury, and therefore the claims examiner should have sent the claim back for an updated statement of accepted facts.

By decision dated March 10, 2015, an OWCP hearing representative affirmed the July 1, 2014 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA provide for compensation to employees sustaining impairment from loss or loss of use of specified members 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 sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized 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 OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[5]

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).[6] Under the sixth edition, the evaluator identifies the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[7] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

[4] *Id*. at 406.

[5] *See Bernard A. Babcock, Jr*., 52 ECAB 143 (2000). *See also* 5 U.S.C. § 8107.

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

[7] *Id.* at 494-531.

Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[8]

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 in accordance with the A.M.A., *Guides* with the medical adviser providing rationale for the percentage of impairment specified.[9]

ANALYSIS

The Board finds that OWCP properly determined appellant's permanent impairment of his right shoulder. OWCP accepted the claim for right shoulder sprain, contusion, and rotator cuff tear. It authorized an October 26, 2009 rotator cuff repair and a March 18, 2011 debridement with biceps tenotomy and open rotator cuff repair. Appellant claimed a schedule award and submitted an impairment rating from Dr. Watkins-Campbell.

In her October 14, 2013 report, Dr. Watkins-Campbell found 34 percent right arm impairment. She rated appellant's right shoulder under Table 15-5 as a class 3 shoulder arthroplasty, page 405, which had a default, grade C, impairment of 30 percent. Dr. Watkins-Campbell found a grade 3 modifier for functional history, grade 1 for physical examination, and found that the clinical studies grade modifier was not applicable. She calculated a net adjustment of +2 which moved the impairment to grade E for 34 percent impairment. The Board finds that this rating is not in conformance with the A.M.A., *Guides*. Rating appellant for an arthroplasty is incorrect because the medical evidence does not support that appellant underwent an arthroplasty. Rather, the March 18, 2011 operative report shows appellant underwent an arthroscopic debridement, biceps tenotomy, and open rotator cuff repair. Although Dr. Watkins-Campbell indicated that she presumed that this procedure included an arthroplasty she did not further explain the basis of her opinion and the operative report does not support this assertion. She also improperly assessed grade modifiers. Dr. Watkins-Campbell selected a grade 3 modifier for functional history even though she acknowledged that appellant's *Quick*DASH score of 90 seemed excessively high compared to the other data collected. Given the fact that the modifier for functional history was two grades higher than that for physical examination, she should have found it unreliable and excluded it when calculating the net adjustment.[10] As the

[8] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

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

[10] *See* A.M.A., *Guides* at 406-07 (if the grade for functional history differs by two or more grades from that described by physical examination or clinical studies, the functional history should be assumed to be unreliable and is excluded from the grading process).

impairment rating was not properly based on the sixth edition of the A.M.A., *Guides*, it is of limited probative value.[11]

Consistent with its procedures,[12] OWCP properly referred the matter to an OWCP medical adviser for an opinion regarding appellant's permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*. The Board finds that OWCP medical adviser applied the appropriate tables and grading schemes of the A.M.A., *Guides*, in determining that appellant has six percent permanent impairment of the right shoulder. The medical adviser found the most appropriate diagnosis-based estimate was for full-thickness rotator cuff tear with residual loss, under Table 15-5 (shoulder-region grid), page 403. A class 1, default grade C equated to five percent permanent impairment of the arm. This selection was appropriate because the medical evidence of record specifies that appellant had a full-thickness rotator cuff tear with residual dysfunction. The medical adviser then explained that the grade modifier for functional history was unreliable, and that appellant had a grade modifier 1 for physical examination, according to Table 15-8, page 408. The medical adviser assessed a grade modifier 2 for clinical studies, according to Table 15-9, page 410 because clinical studies confirmed a rotator cuff tear. Using the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), he found that (n/a) + (1-1) + (2-1) resulted in a net grade modifier +1. This moves the default grade C impairment to grade D which results in six percent permanent impairment of the right upper extremity. There is no other current probative medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has more than a six percent permanent impairment of the right arm.

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 has not established that he had greater than six percent impairment of his right upper extremity, for which he received a schedule award.

[11] *See Linda Beale*, 57 ECAB 429 (2006) (when the attending 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 reported by the attending physician); *C.J.*, Docket No. 13-1959 (issued February 6, 2014).

[12] *See supra* note 9.

ORDER

IT IS HEREBY ORDERED THAT the March 10, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 10, 2015
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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