

**United States Department of Labor
Employees' Compensation Appeals Board**

R.T., Appellant)	
)	
and)	Docket No. 15-1242
)	Issued: September 18, 2015
U.S. POSTAL SERVICE, MAIN POST OFFICE,)	
Indianapolis, IN, Employer)	
)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 12, 2015 appellant filed a timely appeal from an April 28, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (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 established greater than a four percent impairment of the right upper extremity, for which he received a schedule award.

FACTUAL HISTORY

OWCP accepted that on or before April 17, 2002 appellant, then a 28-year-old mail handler, sustained right rotator cuff tendinopathy due to repetitive upper extremity motion and repetitive heavy lifting at work.² Dr. Peter I. Sallay an attending Board-certified orthopedic

¹ 5 U.S.C. § 8101 *et seq.*

² OWCP denied appellant's previous claim for a September 25, 2000 traumatic right shoulder injury.

surgeon, performed a right shoulder acromioplasty on April 16, 2002. Appellant returned to modified-duty work on May 1, 2002. Dr. Sallay followed appellant for recurrent right shoulder pain and impingement.

On December 5, 2002 OWCP obtained a second opinion from Dr. Richard A. Hutson, a Board-certified orthopedic surgeon, who opined that appellant could perform full-time modified work. Dr. Hutson submitted a July 30, 2003 addendum reiterating that appellant required permanent restrictions due to right shoulder impingement and crepitus.

In a March 14, 2003 report, Dr. Sallay opined that appellant required permanent restrictions against lifting more than 10 pounds above shoulder level with the right arm, minimizing repetitive work above shoulder level, and no use of a flat sorter machine. He released appellant from care.

On November 7, 2003 appellant claimed a schedule award. He submitted a November 19, 2003 report from Dr. Sallay, noting possible acromioclavicular joint dysfunction. In a March 15, 2004 report, Dr. Sallay opined that appellant had attained maximum medical improvement, with normal range of motion and strength in the right shoulder. He released appellant to modified duty.

In an April 14, 2004 report, an OWCP medical adviser reviewed the medical record, and opined that appellant had no ratable impairment of the right upper extremity, as Dr. Sallay observed full range of motion with normal strength.

By decision dated April 28, 2004, OWCP denied appellant's schedule award claim as the medical evidence did not support a ratable impairment of the right upper extremity.³

Dr. Brian S. Jacobs, an attending Board-certified internist, diagnosed right shoulder pain. He provided work restrictions in reports from April 2006 through March 9, 2010.⁴

Appellant submitted reports dated from March 1 to May 10, 2011 from Dr. Elizabeth T. Nolan, an attending Board-certified orthopedic surgeon. Dr. Nolan opined that his laboratory and imaging studies were unremarkable, and did not explain his persistent symptoms. She opined that appellant could perform full-time modified-duty work.⁵

³ By decision dated May 20, 2004, OWCP denied appellant's April 2, 2004 claim for a left shoulder condition. It denied reconsideration by decision dated May 12, 2005.

⁴ Appellant was off work from March 12, 2009 to June 6, 2010 as the employing establishment had no work available within his restrictions.

⁵ OWCP conducted development regarding appellant's work restrictions and wage-earning capacity. In an April 5, 2011 report, Dr. Louis J. Angelicchio, a Board-certified orthopedic surgeon and second opinion physician, opined that appellant could perform full-time sedentary work as a policy holder information clerk. By notice dated April 18, 2011 and finalized June 1, 2011, OWCP reduced appellant's compensation effective June 5, 2011, based on his ability to earn \$447.00 a week in the selected position of policy holder information clerk. In a July 9, 2012 report, Dr. Paul K. Ho, an attending Board-certified orthopedic surgeon, found full motion of the right shoulder with no muscular atrophy or bony abnormalities. He diagnosed "[r]ight shoulder pain, cause uncertain." On July 19, 2012 OWCP obtained a second opinion from Dr. Norman Mindrebo, a Board-certified orthopedic surgeon, who decreased appellant's work limitations.

On January 11, 2013 appellant accepted a full-time position as a modified clerk at the employing establishment. By decision dated April 10, 2013, OWCP reduced his wage-loss compensation to zero effective January 9, 2013, as he returned to work with no loss of wage-earning capacity.

On May 10, 2013 OWCP obtained an impairment rating from Dr. Ralph M. Bushbacher, a Board-certified physiatrist and second opinion physician. Dr. Bushbacher reviewed the medical record and a statement of accepted facts. On examination of the right upper extremity, he found full range of motion, no muscular atrophy, full strength, tenderness to palpation of the acromion and biceps tendon, mild discomfort with internal rotation, and moderate symptom aggravation with horizontal adduction. Dr. Bushbacher opined that appellant had reached maximum medical improvement. He diagnosed right shoulder pain. Referring to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*), Dr. Bushbacher found a class 1 diagnosis-based impairment Class of Diagnosis (CDX) according to Table 15-5.⁶ He assessed a grade modifier for Functional History (GMFH) of 2, and a grade modifier for findings on Physical Examination (GMPE) of 3, and a grade modifier for Clinical Studies (GMCS) of 3. Dr. Bushbacher stated that this resulted in a “[g]rade E rating, which corresponds to 12 percent upper extremity rating.”

In a June 1, 2013 addendum, Dr. Bushbacher explained that according to Table 15-5, appellant had a class 1 CDX for acromioclavicular joint injury or disease. He noted that he erred in his prior report regarding the GMPE, which was properly “1 instead of 3.” Dr. Bushbacher noted that according to Table 15-7,⁷ appellant had a GMFH of 2 for pain with normal activities, a GMPE of 1 according to Table 15-8⁸ for a mildly abnormal examination, and a GMCS of 2 according to Table 15-9,⁹ as clinical studies, although not provided for review, confirmed “the lack of part of the bone of the distal acromion.” Applying the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (2-1) + (1-1) + (2-1), he found a net adjustment of 2, moving the default CDX from grade C to grade E which, “for a distal clavicular resection, corresponds to a 12 percent upper extremity rating.”

On September 30, 2013 an OWCP medical adviser reviewed the medical record and statement of accepted facts. He noted that there was no operative report of record regarding appellant’s 2002 acromioplasty, and no mention of a distal clavicle resection. The medical adviser opined that appellant attained maximum medical improvement as of June 1, 2013, the date of Dr. Bushbacher’s impairment rating. He explained that the diagnosis-based rating method was the preferred means of assessing upper extremity impairment, as appellant’s most impairing diagnosis was acromioclavicular joint disease and not restricted motion. The medical

⁶ Table 15-5, page 403 of the sixth edition of the A.M.A., *Guides* is entitled “Shoulder Regional Grid: Upper Extremity Impairments.”

⁷ Table 15-7, page 406 of the sixth edition of the A.M.A., *Guides* is entitled “Functional History Adjustment: Upper Extremities.”

⁸ Table 15-8, page 408 of the sixth edition of the A.M.A., *Guides* is entitled “Physical Examination Adjustment: Upper Extremities.”

⁹ Table 15-9, page 410 of the sixth edition of the A.M.A., *Guides* is entitled “Clinical Studies Adjustment: Upper Extremities.”

adviser noted a CDX of 1, GMFH of 2, GMPE of 1, and GMCS of zero. Applying the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (2-1) + (1-1) + (0-1), he found a net adjustment of zero, leaving the default CDX at grade C, equaling three percent impairment of the right upper extremity according to Table 15-5.

By decision dated December 19, 2013, OWCP issued a schedule award for three percent impairment of the right upper extremity. The period of the award ran from May 10 to July 14, 2013.

In a December 3, 2014 letter, appellant requested reconsideration. He contended that he was entitled to a 12 percent impairment rating as found by Dr. Bushbacher, under the facts described in the Board's decision and order in *A.G.*,¹⁰ where an OWCP medical adviser concurred with an attending physician that the claimant's "right shoulder open acromioplasty and repair was equally as impairing as a distal clavicle arthroplasty."

Appellant provided a copy of Dr. Sallay's April 16, 2002 operative note. Dr. Sallay described his arthroscopic evaluation of the glenohumeral joint, labrum, biceps tendon, and undersurface of the rotator cuff, arthroscopic debridement of the subacromial space, arthroscopic shaving of four to five millimeters of the anteroinferior bone at the acromion. He did not indicate that he removed bone from the distal clavicle.

Appellant also submitted a December 1, 2014 report from Dr. Brian W. Case, an attending physician Board-certified in occupational medicine. He noted that according to *A.G.*,¹¹ "an acromioplasty is equally impairing to a distal clavicle resection." On examination, Dr. Case noted surgical scars consistent with previous arthroscopic surgery. He related appellant's complaints of chronic right shoulder pain, with a *QuickDASH* score of 59. On examination of the right shoulder, Dr. Case found mild tenderness to palpation, full range of motion, and normal muscle strength. He opined that, according to Table 15-5, appellant had a default 10 percent impairment of the right upper extremity. Dr. Case noted a GMFH of 2, GMPE of 1, and GMCS of 2, resulting in a net adjustment of +2, raising the default 10 percent CDX to 12 percent. He therefore found 12 percent impairment of the right arm.

On March 10, 2015 an OWCP medical adviser reviewed Dr. Sallay's operative note, Dr. Case's December 1, 2014 report, and an updated statement of accepted facts. He opined that the new evidence indicated that appellant had GMCS of 1 as opposed to his prior finding of zero. Reapplying the net adjustment formula, or (2-1) + (1-1) + (1-1), the net adjustment of 1 raised the default CDX of C to D, equaling four percent impairment of the right upper extremity, greater than the three percent previously awarded.

By decision dated April 28, 2015, OWCP issued appellant a schedule award for an additional one percent impairment of the right upper extremity, for a total of four percent.

¹⁰ Docket No. 07-0677 (issued June 21, 2007).

¹¹ *Id.*

LEGAL PRECEDENT

The schedule award provisions of FECA¹² 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.¹³ For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.¹⁴

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).¹⁵ In addressing upper extremity impairments under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, GMCS.¹⁶ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹⁷

While section 15.2 of the sixth edition of the A.M.A., *Guides* provides that “[d]iagnosis-based impairment is the primary method of evaluation for the upper limb,” Table 15-5 also provides that, if motion loss is present for a claimant who has a rotator cuff injury, 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-based impairment.¹⁸

Section 15.7 of the sixth edition of the A.M.A., *Guides* provides:

“Range of motion should be measured after a ‘warm up,’ in which the individual moves the joint through its maximum range of motion at least [three] times. The range of motion examination is then performed by recording the active measurements from [three] separate range of motion efforts. Measurements should be rounded up or down to the nearest number ending in 0.... All measurements should fall within 10 [degrees] of the mean of these three

¹² 5 U.S.C. § 8107.

¹³ *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

¹⁴ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

¹⁵ A.M.A., *Guides* (6th ed., 2008), page 3, section 1.3, “ICF: A Contemporary Model of Disablement.”

¹⁶ *Id.* at (6th ed., 2008), pp. 494-531.

¹⁷ *Id.* at 411.

¹⁸ *Id.* at 387, 405, 475-78.

measurements. The maximum observed measurement is used to determine the range of motion impairment....”¹⁹

It is well established that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.²⁰ There is no basis for including subsequently acquired conditions. OWCP procedures provide: “Impairment ratings for schedule awards include those conditions accepted by OWCP as job-related and any preexisting permanent impairment of the same member or function.”²¹ OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.²²

ANALYSIS

OWCP accepted that appellant sustained right rotator cuff tendinopathy, necessitating arthroscopic acromioplasty on April 16, 2002. On November 7, 2003 appellant claimed a schedule award. OWCP denied the schedule award claim on April 28, 2004, finding that Dr. Sallay, an attending Board-certified orthopedic surgeon, indicated that appellant did not have a permanent impairment of the right upper extremity.

OWCP obtained an impairment rating from Dr. Bushbacher, a Board-certified physiatrist and second opinion physician. In May 10 and June 1, 2013 reports, Dr. Bushbacher found that appellant attained maximum medical improvement, and calculated a 12 percent impairment rating under the diagnosis-based method of Table 15-5, based on a distal clavicle resection. However, an OWCP medical adviser found that Dr. Bushbacher erred as the 2002 arthroscopy did not include a distal clavicle resection. The medical adviser noted a class 1 diagnosis-based impairment CDX for acromioclavicular joint disease, a grade 2 modifier for GMFH, a grade 1 modifier for findings on GMPE, and no applicable modifier for GMCS. He calculated a net adjustment of zero, leaving the default CDX at grade C, equaling three percent impairment of the right upper extremity according to Table 15-5. Based on the medical adviser’s review, OWCP issued a schedule award on December 19, 2003 for three percent impairment of the right upper extremity.

Appellant requested reconsideration. He provided Dr. Sallay’s April 16, 2002 operative note, which did not indicate that he performed any procedure involving the distal clavicle. Appellant also submitted a December 1, 2014 report from Dr. Case, an attending physician Board-certified in occupational medicine, who opined that appellant had 12 percent impairment of the right arm. He cited to the Board’s decision in *A.G.*,²³ where physicians found that an acromioplasty was “equally impairing to a distal clavicle resection.” However, Dr. Case did not

¹⁹ *Id.* at 464.

²⁰ *R.G.*, Docket No. 13-220 (issued May 9, 2013); *Peter C. Belkind*, 56 ECAB 580 (2005); *Raymond E Gwynn*, 35 ECAB 247 (1983).

²¹ *Supra* note 14 at Chapter 2.806.5(d) (February 2013).

²² *Id.* at, Chapter 2.808.6(f); *see also L.R.*, Docket No. 14-674 (issued August 13, 2014); *D.H.*, Docket No. 12-1857 (issued February 26, 2013).

²³ *Supra* note 10.

explain which aspects of appellant's clinical presentation supported such impairment, considering his findings of full strength and motion of the right shoulder. An OWCP medical adviser reviewed the new evidence, and opined that it supported a GMCS of 1, an increase from the prior rating of zero. Applying the net adjustment formula resulted in a net modifier of +1, raising the default CDX from three to four percent. OWCP therefore issued the April 28, 2015 decision, granting appellant a schedule award for an additional one percent impairment of the right upper extremity.

The Board finds that an OWCP medical adviser applied the appropriate tables and grading schemes to the clinical findings observed by Dr. Bushbacher. The medical adviser provided a detailed explanation and supporting calculations for his finding of four percent impairment of the right upper extremity. There is no probative medical evidence of record indicating a greater percentage of impairment. Accordingly, OWCP's April 28, 2015 decision finding that appellant had four percent impairment of the right upper extremity is appropriate under the law and facts of the case.

On appeal, appellant reiterated his argument that he sustained 12 percent impairment of the right arm under the Board's holding in *A.G.*²⁴ As his arthroscopic surgery was equally disabling to an open distal clavicle resection, appellant contends that OWCP should not have reduced his rating based on the diagnosis-based method applicable to acromioclavicular joint disease. The medical opinions found in *A.G.*, were offered under the standards of the fifth edition of the A.M.A., *Guides*, not the sixth edition currently in use.²⁵ Furthermore, as stated above, there is no probative medical opinion of record indicating that the 2002 arthroscopic surgery caused upper extremity impairment equivalent to an open distal clavicle resection. Dr. Case found normal strength and range of motion of the right shoulder.

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 sustained more than a four percent impairment of the right upper extremity, for which he received schedule awards.

²⁴ Docket No. 07-0677 (issued June 21, 2007).

²⁵ *Supra* note 14.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 28, 2015 is affirmed.

Issued: September 18, 2015
Washington, DC

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

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

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