

ISSUE

The issue is whether appellant has more than 12 percent permanent impairment of the right upper extremity for which he received a schedule award.

FACTUAL HISTORY

On January 22, 2006 appellant, then a 50-year-old letter carrier, injured his right shoulder when he slipped and fell on ice while delivering mail. OWCP accepted the claim for right shoulder contusion, closed fracture of the right sternal end clavicle, and right calcifying tendinitis of the shoulder. It expanded the claim to include arthritis of the right acromioclavicular (AC) joint and partial thickness insertional tear of the right infraspinatus tendon. Appellant stopped work on January 25, 2006, returned to part-time limited-duty work on February 7, 2006, and thereafter full-time work.

A magnetic resonance imaging (MRI) scan of the right shoulder dated January 25, 2006 revealed findings consistent with nondisplaced fracture involving the distal clavicle and partial thickness insertional tear of the infraspinatus tendon. Appellant came under the treatment of Dr. David McCarty, a Board-certified orthopedist, who, on April 2, 2007, performed an authorized arthrotomy of the right shoulder with distal clavicle resection and acromioplasty for decompression, exploration of the rotator cuff for incomplete tear of the supraspinatus, and debridement and repair of site of incomplete tear of the rotator cuff.

Appellant filed a claim for a schedule award (Form CA-7) and submitted a January 27, 2009 report from Dr. Jeffrey Coe, a Board-certified orthopedist. Dr. Coe diagnosed right shoulder internal derangement with aggravation of degenerative arthritis of the right AC joint, and partial rotator cuff tear with rotator cuff impingement. He opined that under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,⁴ (A.M.A., *Guides*) appellant had eight percent permanent impairment of the right arm based on loss of range of motion.

In an April 15, 2009 report, an OWCP medical adviser reviewed the medical records provided and opined that in accordance with the sixth edition of the A.M.A., *Guides*,⁵ appellant sustained 12 percent impairment of the right arm due to loss of shoulder range of motion (ROM). The medical adviser diagnosed right AC joint arthritis and partial rotator cuff tear.

In a decision dated May 15, 2009, OWCP granted appellant a schedule award for 12 percent permanent impairment of the right upper extremity. The period of the award was from February 27 to November 16, 2009.

On July 21, 2010 appellant filed a traumatic injury claim, Form CA-1, alleging that on that same date he reached to grab a falling parcel and felt a rip and pain in his right biceps region. OWCP accepted his claim for right shoulder/rotator cuff sprains and right biceps tendon rupture,

⁴ A.M.A., *Guides* (5th ed. 2001).

⁵ A.M.A., *Guides* (6th ed. 2009).

claim number xxxxxx373. This claim was consolidated with the current case before the Board, which serves as the master file number.

Appellant came under the treatment of Dr. Joshua Alpert, a Board-certified orthopedist. On October 18, 2010 Dr. Alpert performed an authorized right shoulder arthroscopy with debridement of rotator cuff, arthroscopic partial synovectomy, subacromial decompression, and open biceps tenodesis. He diagnosed right shoulder proximal biceps tear, extensive synovitis, subacromial bursitis with impingement, and partial thickness rotator cuff tear, less than 20 percent.

On April 22, 2011 appellant filed a claim for an additional schedule award. On April 29, 2011 OWCP requested that Dr. Alpert evaluate the extent of appellant's permanent impairment under the A.M.A., *Guides*. In a May 4, 2011 report, Dr. Alpert noted that appellant had done well postsurgery following his October 2010 right shoulder arthroscopy and biceps tenodesis, advising that appellant had returned to his employing establishment position, and his second job. He diagnosed right shoulder proximal biceps tendon tear. Dr. Alpert noted maximum medical improvement occurred on April 4, 2011. He noted that appellant had no permanent impairment after surgery and his biceps tendon had healed. Dr. Alpert indicated that appellant returned to work full duty without restriction and showed no evidence of permanent impairment.

In a May 18, 2011 report, an OWCP medical adviser reviewed and concurred with Dr. Alpert's opinion that appellant had no additional impairment for the right arm. He noted that examination revealed excellent strength and full range of motion of the shoulder.

Appellant submitted a May 24, 2011 report from Dr. Coe who noted that appellant sustained an injury to his proximal right biceps and biceps tendon at work on July 21, 2010. Dr. Coe noted that the injury caused a rupture of the proximal right biceps tendon and internal derangement of the right shoulder with synovitis, bursitis, and rotator cuff fraying. He noted that appellant underwent surgery on October 18, 2010. Dr. Coe noted that examination revealed postoperative scarring of the right shoulder from the surgery of October 18, 2010, deformity of the right biceps, decreased range of motion of the right shoulder in abduction, forward elevation and internal rotation, residual right shoulder joint tenderness and crepitus, and associated weakness of the right shoulder and elbow in association with his biceps tendon tear and repair. He noted with regard to the right shoulder, pursuant to the A.M.A., *Guides*, Table 15-5, Shoulder Regional Grid, biceps tendon (page 404), appellant was a class 1, grade D, with a modifier of 3 for a total nine percent right upper extremity impairment.

In a decision dated January 5, 2012, OWCP denied appellant's claim for an additional schedule award.

Appellant requested reconsideration and resubmitted Dr. Coe's report dated May 24, 2011. He also submitted a January 5, 2012 report from Dr. Alfred Rosche, a Board-certified anesthesiologist, who administered a right shoulder injection.

In a May 28, 2012 report, an OWCP medical adviser reviewed the medical records provided and disagreed with Dr. Coe's impairment rating. The medical adviser noted Dr. Coe found nine percent impairment based on residual biceps tendon lesion pursuant to Table 15-5, page 404 of the A.M.A., *Guides*. However, under the A.M.A., *Guides*, the highest award for

biceps tendon condition was five percent impairment. Additionally, Dr. Coe's May 24, 2011 report noted findings of persistent pain in the shoulder and loss of strength which was different from appellant's surgeon, Dr. Alpert, who reported that appellant was doing excellent and shoulder range of motion and strength were normal. The medical adviser found no objective evidence for any additional right upper extremity impairment.

In a decision dated July 23, 2012, OWCP denied appellant's claim for an additional schedule award. It also indicated that further medical treatment was not authorized and prior authorization was terminated. Appellant requested a hearing before an OWCP hearing representative.

On December 10, 2012 the OWCP hearing representative vacated the July 23, 2012 decision. She found that OWCP did not meet its burden of proof to terminate medical benefits. The hearing representative also found that, while the medical adviser found that Dr. Coe did not properly use the A.M.A., *Guides* by providing nine percent impairment for a biceps tendon condition, he improperly disregarded the remainder of Dr. Coe's report. She instructed OWCP to refer appellant to a second opinion examination to obtain a complete assessment of impairment of the right upper extremity pursuant to the A.M.A., *Guides*.

On April 23, 2013 OWCP referred appellant for a second opinion to Dr. Allan M. Brecher, a Board-certified orthopedist, for an impairment rating for appellant's right shoulder in accordance with the sixth edition of the A.M.A., *Guides*. In a June 20, 2013 report, Dr. Brecher noted a history of appellant's work injury and surgery. Findings included full active range of motion of the right shoulder and no tenderness other than along the medial proximal humeral scar where the biceps tenodesis was present. Dr. Brecher noted that appellant brought the arthroscopic picture showing the degenerative biceps tendon. He opined that appellant had no residuals of the right rotator cuff repair. Dr. Brecher noted that appellant did well after the surgery, but reported tenderness and pain after the open biceps tenodesis. He noted that, under the A.M.A., *Guides*, page 404, biceps tendon pathology, appellant had five percent permanent impairment. Dr. Brecher noted a functional score of 2, physical examination was 1, and clinical studies 2. Appellant had a *QuickDASH* score of 63. Maximum medical improvement was reached six months after the second surgery. Dr. Brecher noted that appellant had scarring with some discomfort and tenderness along the biceps tenodesis, but there was no change in strength or atrophy of muscles. He had subjective complaints of pain, fatigue, discomfort, and weakness, but normal range of motion in all planes. Dr. Brecher opined that appellant had five percent permanent impairment using the shoulder regional grid for biceps tendon pathology.

In an August 25, 2013 report, an OWCP medical adviser reviewed the medical records provided and concurred in the impairment determination of Dr. Brecher who found that appellant sustained five percent impairment for biceps tenodesis pursuant to the A.M.A., *Guides*.

In a decision dated October 9, 2013, OWCP denied appellant's claim for an additional schedule award. Appellant requested an oral hearing which was held on March 19, 2014. He submitted a January 20, 2014 procedure note from Dr. Rosche who had administered a right shoulder supraspinatus injection.

In a decision dated June 4, 2014, the OWCP hearing representative set aside the October 9, 2013 decision and remanded the matter for further medical development. The hearing

representative instructed OWCP to correct the statement of accepted facts to reflect the original schedule award was paid under claim number xxxxxx819, refer the file to the medical adviser for further clarification of right arm impairment and advise whether the 12 percent impairment rating previously provided reflects the impairment due to biceps rupture and surgery.

In an August 4, 2014 report, an OWCP medical adviser reviewed the medical records. He noted that the A.M.A., *Guides* provide that whenever possible impairment ratings should be based on diagnosis-based estimates and that the most clinically relevant diagnosis should be rated. The medical adviser noted that page 387 of the A.M.A., *Guides* provides that “If a patient has 2 significant diagnoses, for instance, rotator cuff tear and biceps tendinitis, the examiner should use the diagnoses with the highest impairment rating for the impairment calculation.” He noted that pursuant to Table 15-5, pages 403 and 404 of the A.M.A., *Guides* the rotator cuff tear diagnosis-based estimate was seven percent impairment and the right biceps tendon condition provided five percent impairment. The medical adviser noted that the rotator cuff condition would be used for impairment. He noted that if appellant received the most allowable for a rotator cuff tear of seven percent, this amount was still less than what was already awarded for the same condition in 2010. The medical adviser found that no additional permanent impairment was warranted.

In a decision dated September 9, 2014, OWCP denied appellant’s claim for an additional schedule award. It noted that there were no objective findings to support any additional permanent impairment to the right arm beyond the 12 percent already paid.

On April 1, 2015 appellant requested reconsideration. In a statement dated April 24, 2015, appellant through his counsel asserted that OWCP disregarded the clear finding of the hearing officer of the distinction between an accidental injury of January 23, 2006 involving a rotator cuff injury and the injury of July 21, 2010 involving a distal clavicle resection and a rupture of the bicep tendon which required surgery. Counsel asserted that OWCP created confusion when consolidating two unrelated cases and noted the July 21, 2010 employment injury was an entirely new injury. Appellant contended that the July 21, 2010 employment injury resulted in permanent impairment which was distinct and established a basis for an impairment award.

In a May 11, 2015 report, OWCP’s medical adviser reviewed the medical record and found that appellant did not have additional impairment of the right arm. He noted that Dr. Brecher’s report dated June 20, 2013 recommended five percent right arm impairment based on a biceps tendon tear. The medical adviser noted that this rating is less than the 12 percent arm impairment already awarded for a similar condition. Regarding Dr. Coe’s May 24, 2011 report, which proposed an impairment rating of nine percent based on the “biceps tendon” as noted in Table 15-5, page 404 of the A.M.A., *Guides*, he noted that the most that can be awarded for biceps tendon pathology was five percent based on the tables on page 404. The medical adviser further noted that in his January 27, 2009 report, Dr. Coe recommended eight percent upper extremity impairment for loss of range of motion. However, page 387 of the A.M.A., *Guides* provides that “ROM is used primarily as a physical examination adjustment factor and only to determine actual impairment values in the rare case when it is not possible to otherwise define impairment: this is a significant change from other editions.” The medical adviser opined that the right arm impairment remained at 12 percent.

By decision dated July 16, 2015, OWCP denied appellant's claim for an additional schedule award. It found that he was previously awarded 12 percent permanent impairment of the right upper extremity and was not entitled to an additional award.

LEGAL PRECEDENT

The schedule award provision of FECA⁶ and its implementing federal regulations,⁷ 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.⁸ For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁹ For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.¹⁰

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).¹¹ Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment Class of diagnosis (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 The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.¹⁴

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical consultant for an opinion concerning the nature and

⁶ 5 U.S.C. § 8107.

⁷ 20 C.F.R. § 10.404.

⁸ *Id.* at § 10.404(a).

⁹ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

¹⁰ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a, (February 2013) and Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

¹¹ A.M.A., *Guides*, 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

¹² *Id.* at 385-419.

¹³ *Id.* at 411.

¹⁴ *Id.* at 411-12.

percentage of impairment in accordance with the A.M.A., *Guides* with OWCP's medical consultant providing rationale for the percentage of impairment specified.¹⁵

ANALYSIS

In claim number xxxxxx819, OWCP accepted right shoulder contusion, closed fracture of the right sternal end clavicle, and right calcifying tendinitis of the shoulder, arthritis of the right AC joint, and partial thickness insertional tear of the right infraspinatus tendon. It authorized an arthrotomy of the right shoulder, which was performed on April 2, 2007. In claim number xxxxxx373, OWCP accepted appellant's claim for right shoulder/rotator cuff sprains and right biceps tendon rupture. It authorized a right shoulder arthroscopy with debridement of rotator cuff and open biceps tenodesis performed on October 18, 2010. On May 15, 2009 appellant was granted 12 percent impairment of the right arm based on loss of range of motion in the shoulder. He claimed an additional award.

In support of his request, appellant submitted a May 24, 2011 report from Dr. Coe, who noted appellant's history and found nine percent right arm impairment under the A.M.A., *Guides*, Table 15-5, Shoulder Regional Grid,¹⁶ for a residual biceps tendon lesion. He indicated that appellant was a class 1, grade D, with a grade modifier of 3 for a total nine percent right arm impairment. However, the shoulder regional grid contains no class 1 diagnoses with a grade D impairment of nine percent. Rather, Table 15-5, Shoulder Regional Grid, class 1, grade D provides that the highest award for biceps tendon condition is five percent impairment. As Dr. Coe's impairment rating of nine percent impairment of the right arm is not properly based on the A.M.A., *Guides*, it is of limited probative value.¹⁷ Furthermore, this rating is less than the 12 percent permanent impairment previously found for which a schedule award was paid.

OWCP referred appellant for a second opinion evaluation to Dr. Brecher. In a June 20, 2013 report, Dr. Brecher noted examination findings of full active range of motion of the right shoulder and tenderness over the medial proximal humeral scar where the biceps tendinitis was present. He opined that appellant had no residuals of the right rotator cuff repair. Dr. Brecher noted that pursuant to the A.M.A., *Guides*, Table 15-5, Shoulder Regional Grid, biceps tendon pathology, appellant was a class 1 with a functional grade modifier of 2, a physical examination grade modifier of 1 and clinical studies grade modifier of 2 and a *QuickDASH* score of 63. He opined that appellant sustained five percent permanent impairment.

The medical adviser reviewed Dr. Brecher's report dated June 20, 2013 and concurred in his finding that appellant had five percent right upper extremity impairment based on a biceps tendon tear. He noted that the A.M.A., *Guides* provide that the most clinically relevant diagnosis should be rated. The medical adviser noted that page 387 of the A.M.A., *Guides* provides that "If a patient has 2 significant diagnoses, for instance, rotator cuff tear and biceps tendinitis, the examiner should use the diagnoses with the highest causally-related impairment rating for the impairment calculation." He noted that pursuant to Table 15-5, pages 403 and 404 of the

¹⁵ See *Federal (FECA) Procedure Manual, Part 2 -- Claims, Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

¹⁶ See A.M.A., *Guides*, Table 15-5, at 401-05.

¹⁷ See *Linda Beale*, 57 ECAB 429 (2006).

A.M.A., *Guides* the rotator cuff tear diagnosis-based estimate allowed up to seven percent impairment and the right biceps tendon condition provided up to five percent impairment as noted by Dr. Brecher. The medical adviser noted that the rotator cuff condition would be used for impairment as it was the highest causally-related impairment for the impairment calculation. He noted that the seven percent impairment for the rotator cuff tear was still less than what was already awarded for the same condition in 2010 such that there was no additional permanent impairment.

The Board finds that there is no current medical evidence in accordance with the A.M.A., *Guides* which supports that appellant sustained more than 12 percent impairment for the right upper extremity for which he has already received a schedule award.

On appeal, counsel asserts that Dr. Coe's report substantiated his claim for a schedule award. However, as noted above, Dr. Coe's report failed to clearly explain how he arrived at a nine percent upper extremity impairment rating under the A.M.A., *Guides*. Additionally, even if his rating were in full conformance with the A.M.A., *Guides* it would be a lesser amount than that for which appellant already received a schedule award. To the extent that counsel asserts that appellant should receive an award for both the right shoulder biceps tendon injury and the right shoulder rotator cuff injury, the Board has noted that FECA and its regulations provide for the reduction of compensation for subsequent injury to the same scheduled member.¹⁸ Furthermore, the A.M.A., *Guides*, provides that if a claimant has two significant diagnoses in the same region, OWCP should use the diagnosis with the greatest impairment.¹⁹

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 no more than 12 percent permanent impairment of the right upper extremity for which he received a schedule award.

¹⁸ 5 U.S.C. § 8108; 20 C.F.R. § 10.404(d); *see G.J.*, Docket No. 15-1103 (issued October 14, 2015).

¹⁹ *See* A.M.A., *Guides* 419.

ORDER

IT IS HEREBY ORDERED that the July 16, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 15, 2016
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board