United States Department of Labor
Employees' Compensation Appeals Board

R.M., Appellant	)	
and	)	**Docket No. 13-931**
	)	**Issued: September 11, 2013**
DEPARTMENT OF HOMELAND SECURITY, WILLIAM P. HOBBY AIRPORT, Houston, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On March 11, 2013 appellant filed a timely appeal of a February 1, 2013 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 to consider the merits of the case.

ISSUE

The issue is whether appellant has more than 11 percent impairment of her right upper extremity for which she received a schedule award.

FACTUAL HISTORY

On April 4, 2007 appellant, then a 55-year-old transportation security officer supervisor, filed a traumatic injury claim alleging that on February 25, 2007 she strained her right shoulder

[1] 5 U.S.C. § 8101 *et seq.*

and shoulder blade while lifting a 50-pound bag. OWCP accepted her claim for sprain of shoulder and upper arm.

Appellant underwent a right shoulder magnetic resonance imaging (MRI) scan on June 25, 2006 which demonstrated moderate supraspinatus tendinitis with a small tear in the anterior fibers of the supraspinatus tendon, small joint effusion and fluid in the subdeltoid-subacromial bursa as well as mild impingement by lateral down sloping edge of the acromion and deformed anteroinferior labrum and glenoid bone likely to be the result of remote trauma. On August 22, 2007 she underwent right shoulder glenohumeral arthroscopy with debridement and anterior labral repair.

Appellant underwent an arthrogram of the right shoulder on May 8, 2008 which demonstrated a high-grade partial undersurface tear of the supraspinatus tendon, tendinopathy of the infraspinatus tendon, osteoarthritic changes with grade 3 chondromalacia of the bony glenoid and tearing of the anterior and inferior labrum. She underwent additional shoulder surgery on October 21, 2008 consisting of primary arthroscopy right shoulder bankart repair with rotator cuff repair and subacromial decompression.

In a decision dated July 29, 2009, OWCP noted that appellant was employed as a supervisor transportation security officer beginning December 7, 2008 and that this position fairly and reasonably represented her wage-earning capacity.

Appellant underwent an MRI scan of her right upper extremity on September 23, 2009 which demonstrated a complete tear of the supraspinatus tendon. Her attending physician, Dr. Marcos V. Masson, a Board-certified surgeon, performed a revision of the right shoulder arthroscopic rotator cuff tear on December 17, 2009.

On May 15, 2009 appellant underwent an MRI scan of the cervical spine, which demonstrated disc protrusions at C2-3 and C4-5 as well as reverse spondylolisthesis of C5 over C6 and disc extrusion at C6-7. She underwent a right shoulder MRI scan on September 20, 2010 which demonstrated a large recurrent full thickness tear of the distal anterior supraspinatus tendon. Appellant also underwent another cervical MRI scan on September 20, 2010 which demonstrated posterior subluxation of C5 on C6 with posterior disc protrusion, minimal anterior subluxation of C4 on C5 with a posterior disc protrusion and C6-7 posterior disc extrusion as well as mild multiple level bilateral cervical facet arthrosis.

On April 20, 2011 OWCP accepted appellant's claim for cervical degenerative disc disease with disc herniation of radiculopathy. It authorized cervical spine surgery on June 15, 2011. On October 24, 2011 appellant underwent anterior cervical discectomy at C5-6 and C6-7, decompression of the right C7 nerve root and anterior interbody fusion at C5-6 and C6-7.

Dr. Masson completed a report on March 7, 2012 and stated that appellant had reached maximum medical improvement in regard to her shoulder and neck. He provided an impairment rating on April 12, 2012 and noted that her right shoulder range of motion was extension and flexion from 50 to 80 degrees, adduction 30 degrees, abduction 70 degrees, external rotation 50 degrees and internal rotation 50 degrees. Dr. Masson found that clinical studies, including the

September 20, 2012 MRI scan, demonstrated a large recurrent full-thickness tear of the supraspinatus tendon. On physical examination he noted loss of active shoulder range of motion, atrophy of the right forearm and weakness of the right upper extremity significant and related to pain and existing tear of the rotator cuff. Dr. Masson stated that appellant's shoulder region impairment rating was based on the diagnosis of a full thickness rotator cuff tear following a clavicle resection and release with recurrence tear with residual loss. He assigned a class 1 impairment with a default rating of 10 percent of the upper extremity.[2] Dr. Masson stated that a *Quick*DASH score of 63.8 was a grade modifier 3 and that the physical examination grade modifier was 2 due to 20 percent loss of range of motion.[3] He found that appellant had a clinical studies modifier 2 due to the full thickness rotator cuff tear.[4] Dr. Masson concluded that she had a net adjustment of positive 1 to grade D impairment or 11 percent impairment of the right upper extremity.

Dr. Masson noted that flexion of 80 degrees was nine percent impairment, extension of 50 was not a ratable impairment, abduction of 70 degrees was six percent impairment, adduction of 30 degrees was one percent impairment, external rotation of 50 degrees was two percent impairment and internal rotation of 50 degrees was two percent impairment. He further noted that applying the range of motion evaluation alone resulted in 20 percent impairment of the upper extremity.[5] Dr. Masson also provided an impairment rating for appellant's cervical spine based on the diagnosis-based estimate for intervertebral disc herniation of seven percent.

Appellant requested a schedule award on April 20, 2012. An OWCP medical adviser reviewed the medical evidence on May 11, 2012 and found that her diagnosis-based estimate due to her right shoulder condition resulted in an impairment rating of 12 percent. He noted that appellant's acromial joint disease with resection had a default value of 10 percent. The medical adviser noted function history modifier 3, physical examination modifier 2, clinical studies modifier 2 and diagnosis class 1 with the net adjustment formula resulted in a positive 4 or grade E, 12 percent impairment.[6]

In regard to appellant's impairment rating based on loss of range of motion of the shoulder, the medical adviser agreed that the total loss of range of motion was 20 percent. He then referred Table 15-35 and noted that the grade modifier for loss of range of motion was 2 and that her functional history adjustment based on the *Quick*Dash of 63.8 resulted in a grade modifier 3 with a total difference of 1 which results in five percent increase.[7] The medical adviser found that this resulted in 21 percent impairment, but that Dr. Masson had not included the functional modifier. He noted that the spine and whole person were not scheduled members and that he was not able to recommend impairment based on these conditions. The medical

[2] A.M.A., *Guides* 403.

[3] *Id*. at 408.

[4] *Id*. at 410.

[5] *Id*. at 463, 475.

[6] *Id*. at 403, Table 15-5.

[7] *Id*. at 477, Table 15-36.

adviser requested an additional impairment evaluation which would include any impairment based on radiculopathy.

On July 12, 2012 OWCP referred appellant for a second opinion evaluation with Dr. Zvi Kalisky, a physician Board-certified in physical medicine and rehabilitation. In his August 3, 2012 report, Dr. Kalisky calculated her cervical radiculopathy impairment based on *The Guides Newsletter* July-August 2009 utilizing Table 1 (Spinal Nerve Impairment: Upper Extremity Impairment. He noted that appellant demonstrated nonspecific dermatomal distribution of pain or paresthesias in the upper extremities and that there were no objective physical findings of radiculopathy. Dr. Kalisky concluded that she belonged in a class 0 for roots C5, C6, C7 and T1, which resulted in no impairment for the upper extremities bilaterally.

In regard to appellant's right shoulder, Dr. Kalisky noted that range of motion impairment[8] was appropriate and applied Table 15-34[9] finding right shoulder flexion of 105 degrees gives three percent upper extremity impairment, right shoulder abduction of 90 degrees gives three percent upper extremity impairment, internal rotation of 70 degrees gives two percent upper extremity impairment and external rotation of 50 degrees gives two percent upper extremity impairment. He stated that the other motions were normal and that appellant's total motion impairment is therefore 10 percent upper extremity impairment. Dr. Kalisky stated:

> "Referencing Table 15-35 on page 477, 10 percent upper extremity impairment is consistent with grade modifier 1. Referencing Table 15-7 on page 406 (Functional History Adjustment: Upper Extremities), her condition is consistent with grade modifier 2 (able to perform self-care activities with modification but unassisted). Since her functional history grade modifier is one unit higher than the range of motion grade modifier, the range of motion impairment is to be increased by a factor of 5 percent *i.e.*, to 10.5 upper extremity impairment (based on Table 15-36 on page 477). 10.5 percent is rounded to 11 percent upper extremity impairment. Combining the right shoulder impairment with impairment due to radiculopathy gives a total of 11 percent upper extremity impairment."

The medical adviser reviewed Dr. Kalisky's report on August 24, 2012 and agreed with his application of the A.M.A., *Guides*. He applied the appropriate formula and reached the same impairment rating for loss of range of motion. The medical adviser noted that Dr. Kalisky examined appellant for signs of spinal nerve impairment but found a nonspecific dermatomal distribution of pain and no objective physical findings of radiculopathy and consequentially properly denied a ratable impairment.

By decision dated February 1, 2013, OWCP granted appellant a schedule award for 11 percent impairment of her right upper extremity.

[8] *Id*. at 459-78.

[9] *Id*. at 475, Table 15-34.

LEGAL PRECEDENT

The schedule award provision of FECA[10] and its implementing regulations[11] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss, or loss of use, of scheduled members or functions 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 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[12] In addressing upper extremity impairments, the sixth edition requires identification of 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). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13]

FECA does not authorize the payment of schedule awards for the permanent impairment of the whole person.[14] Payment is authorized only for the permanent impairment of specified members, organs or functions of the body.

No schedule award is payable for a member, function or organ of the body not specified in FECA or in the regulations.[15] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back or spine,[16] no claimant is entitled to such an award.[17]

Amendments to FECA, however, modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. As the schedule award provisions of FECA include the extremities, a claimant may be entitled to a

[10] 5 U.S.C. §§ 8101-8193, 8107.

[11] 20 C.F.R. § 10.404.

[12] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[13] A.M.A., *Guides* 411.

[14] *W.D.*, Docket No. 10-274 (issued September 3, 2010); *Ernest P. Govednick*, 27 ECAB 77 (1975).

[15] *W.D., id., William Edwin Muir*, 27 ECAB 579 (1976).

[16] FECA itself specifically excludes the back from the definition of organ. 5 U.S.C. § 8101(19).

[17] *W.D., supra* note 14. *Timothy J. McGuire*, 34 ECAB 189 (1982).

schedule award for permanent impairment to a limb even though the cause of the impairment originated in the spine.[18]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. Recognizing that certain jurisdictions, such as federal claims under FECA, mandate ratings for extremities and preclude ratings for the spine, the A.M.A., *Guides* has offered an approach to rating spinal nerve impairments consistent with sixth edition methodology.[19] OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures.[20] Specifically, it will address lower extremity impairments originating in the spine through Table 16-11[21] and upper extremity impairment originating in the spine through Table 15-14.[22]

ANALYSIS

OWCP accepted appellant's claim for right shoulder strain and multiple surgeries as well as cervical degenerative disc disease with disc herniation of radiculopathy. Appellant's attending physician, Dr. Masson found that she had reached maximum medical improvement and recommended a schedule award based on 20 percent loss of range of motion of her right shoulder as well as 7 percent impairment of the cervical spine based on the cervical spine regional grid.[23] Dr. Masson did not properly apply the A.M.A., *Guides* to appellant's physical findings in accordance with FECA. As noted above, there is no schedule award available for impairment to the cervical spine. Thus, OWCP properly referred appellant for a second opinion evaluation on the advice of the medical adviser. It is well established that, 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 of the attending physician.[24] In this case, the medical adviser found that Dr. Masson had not provided the necessary findings to determine if appellant had upper extremity impairment due to her accepted cervical condition and requested additional development of the medical evidence.

In his August 3, 2012 report, Dr. Kalisky properly calculated appellant's cervical radiculopathy impairment finding that appellant demonstrated nonspecific dermatomal distribution of pain or paresthesias in the upper extremities and that there were no objective

[18] *W.D., supra* note 14. *Rozella L. Skinner*, 37 ECAB 398 (1986).

[19] FECA Transmittal No. 10-04 (issued January 9, 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter Exhibit 4 (January 2010).

[20] *Id.* at (Exhibits 1, 4) (January 2010).

[21] A.M.A., *Guides* 533, Table 16-11.

[22] *Id*. at 425, Table 15-14.

[23] *Id*. at 564, Table 17-2.

[24] *Linda Beale*, 57 ECAB 429 (2006).

physical findings of radiculopathy. He determined that she had no impairment for the upper extremities bilaterally due to her accepted cervical condition. The medical adviser reviewed this report and agreed with Dr. Kalisky's findings and the application of the A.M.A., *Guides*. The Board finds that the weight of the medical evidence does not establish a ratable impairment of the cervical spine as there is no medical evidence establishing impairment of the upper extremities, scheduled members, as a result of appellant's accepted cervical spine conditions.

In regard to appellant's right shoulder, Dr. Kalisky found right shoulder flexion of 105 degrees gives three percent upper extremity impairment, right shoulder abduction of 90 degrees gives three percent upper extremity impairment, internal rotation of 70 degrees gives two percent upper extremity impairment and external rotation of 50 degrees gives two percent upper extremity impairment. He stated that the other motions were normal and that appellant's total motion impairment is therefore 10 percent upper extremity impairment. Dr. Kalisky found that range of motion grade modifiers of less than 12 percent was a grade modifier 1.[25] He further found that appellant's functional history adjustment was grade modifier 2 resulting in a functional history grade adjustment for range of motion. The A.M.A., *Guides* require that with a net modifier 1 or higher the total range of motion impairment is multiplied by five percent.[26] Applying this increase to total range of motion impairment Dr. Kalisky found that appellant had 11 percent impairment of the right upper extremity. The medical adviser reviewed Dr. Kalisky's report and reached the same impairment rating for loss of range of motion.

The Board finds that the weight of the medical evidence establishes that appellant has no more than 11 percent of her right upper extremity for which she 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.

CONCLUSION

The Board finds appellant has no more than 11 percent of her right upper extremity for which she has received a schedule award.

[25] A.M.A., *Guides* 477, Table 15-35.

[26] *Id*. at 477, Table 15-36.

ORDER

IT IS HEREBY ORDERED THAT February 1, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 11, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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