United States Department of Labor
Employees' Compensation Appeals Board

J.H., Appellant	)	
and	)	**Docket No. 13-2063**
	)	**Issued: January 30, 2014**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, Chantilly, VA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 9, 2013 appellant filed a timely appeal from a May 21, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) regarding a schedule award. 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 a 15 percent permanent impairment to his left arm, for which he received a schedule award.

On appeal, appellant requests a referee examination and contends that in his December 17, 2012 second opinion report Dr. Robert A. Smith, a Board-certified orthopedic surgeon, never looked at any x-rays or magnetic resonance imaging (MRI) scan reports and did not perform any tests to determine his ability to move his arm.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that appellant, then a 45-year-old supervisory federal air marshal, sustained a left shoulder rotator cuff tear as a result of slipping and falling on ice on December 7, 2009. On July 21, 2011 appellant filed a claim for a schedule award.

Appellant submitted a February 2, 2010 MRI scan report of the upper extremity. The report showed "mild generalized thinning of the supraspinatus, however, no evidence of rotator cuff tear" and extensive large area of cartilage wear involving the superior aspect of humeral head. There were findings of superior labral tear, with tear of the posterior labrum at the labral cartilaginous junction and probably also the anterior labrum.

In reports dated December 14, 2009 through February 22, 2010, Dr. Jeffrey H. Berg, a Board-certified orthopedic surgeon, diagnosed a complete left rotator cuff tear, shoulder pain, osteoarthritis, shoulder strain, injury to the ulnar nerve and a possible left cubital tunnel syndrome. On January 4, 2010 he indicated that x-rays of appellant's left elbow revealed no evidence of fracture, dislocation or destructive lesions. On February 22, 2010 Dr. Berg diagnosed left glenohumeral (GH) joint osteoarthritis with acute exacerbation and asymptomatic acromioclavicular (AC) joint osteoarthritis.

By letter dated August 8, 2011, OWCP notified appellant of the deficiencies of his schedule award claim and afforded him 30 days to submit additional evidence.

Appellant submitted an August 25, 2011 report from Dr. Berg who reiterated the diagnosis of left shoulder GH joint osteoarthritis as confirmed by an August 25, 2011 x-ray. Dr. Berg found that appellant had reached maximum medical improvement and rated a one percent permanent impairment of the left upper extremity under the sixth edition of the A.M.A., *Guides*.

On October 25, 2011 Dr. Christopher R. Brigham, an OWCP medical adviser Board-certified in occupational medicine, reviewed the medical evidence of record. He determined that appellant had a 15 percent permanent impairment of the left arm according to Table 15-35, page 477, of the A.M.A., *Guides*.[2] Dr. Brigham found that appellant had reached maximum medical improvement effective August 25, 2011. According to Table 15-35, 14 percent upper extremity impairment was classified as a grade modifier 2 for moderate impairment. Dr. Brigham assigned appellant a functional history grade modifier of 3 which under Table 15-36,[3] resulted in further impairment of five percent. The motion loss percentage of 14 percent was multiplied by 5 percent, resulting in a 15 percent permanent impairment of the left upper extremity.

Appellant submitted a December 21, 2011 MRI scan report of the brain which showed a small arachnoid cyst at the upper lateral edge of the left sylvian fissure.

[2] Table 15-35, page 477, of the sixth edition of the A.M.A., *Guides* is entitled *Range of Motion Grade Modifiers.*

[3] Table 15-36, page 477, of the sixth edition of the A.M.A., *Guides* is entitled *Functional History Grade Adjustment -- Range of Motion.*

By decision dated March 14, 2012, OWCP granted appellant a schedule award for 15 percent permanent impairment to the left upper extremity running for 46 weeks for the period August 25, 2011 to July 17, 2012.

Subsequently, appellant submitted an August 11, 2012 narrative statement and a September 4, 2012 report from Dr. Berg who opined that appellant had a 36 percent permanent impairment of the left upper extremity, according to Table 15-36 of the A.M.A., *Guides*.[4] Dr. Berg stated that appellant had significant motion deficits and therefore the most appropriate rating was based on his range of motion, as follows: nine percent flexion; two percent extension; six percent abduction; one percent adduction; eight percent external rotation; nine percent internal rotation. He indicated that because appellant was unable to position in these motions, the highest impairment rating of 33 percent was given. Dr. Berg assigned appellant's diagnosis to class 1 and his functional history grade modifier was 3, severe, which resulted in a 36 percent impairment rating.

On November 8, 2012 Dr. Lawrence A. Manning, an orthopedic surgeon and OWCP medical adviser, reviewed the record and indicated that it was not clear how appellant could not perform various planes of motion passively unless he had true ankylosis of the shoulder. The medical adviser recommended a second opinion evaluation with a specific request for range of motion measurement in degrees in all planes to determine if appellant's impairment had increased from the 15 percent previously awarded.

OWCP referred appellant to Dr. Smith for a second opinion examination. On December 17, 2012 Dr. Smith conducted a physical examination and reviewed appellant's medical records and a statement of accepted facts. He indicated there was no evidence of ankylosis or adhesions upon physical examination or MRI scan report. Dr. Smith opined that appellant's accepted condition of left rotator cuff tear was a mistake and the correct diagnosis was osteoarthritis of the left shoulder region, exacerbated by the December 7, 2009 employment incident. He found that appellant's examination results suggested embellishment and nonphysiological behavior and therefore it would be appropriate to rate his condition solely on a diagnosis basis, rather than using range of motion, which allowed manipulation by voluntary and subjective factors. Dr. Smith stated that as Dr. Brigham was supplied with incorrect information his impairment rating could not be used and determined that appellant had a nine percent permanent impairment of the left upper extremity, according to Table 15-5, on page 405, of the A.M.A., *Guides*,[5] where the condition of degenerative joint disease of the shoulder was a class 1 injury with a default rating of five percent to the upper extremity. He assigned a Functional History grade modifier (GMFH) of 2, a Physical Examination grade modifier (GMPE) of 2 and a Clinical Studies grade modifier (GMCS) of 2, resulting in a net grade modifier of 3. Dr. Smith assigned appellant to class 1, grade E and concluded that he had a nine percent permanent impairment of the left upper extremity.

[4] *See id.*

[5] Table 15-5, pages 401-05, of the sixth edition of the A.M.A., *Guides* is entitled *Shoulder Regional Grid -- Upper Extremity Impairments*.

On January 10, 2013 Dr. Manning, OWCP's medical adviser, reviewed the medical evidence of record and concurred with Dr. Smith that appellant had a nine percent permanent impairment of the left upper extremity under the A.M.A., *Guides*. He opined that, according to Table 15-5,[6] appellant's degenerative joint disease placed him in class 1, default value five percent impairment. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Manning found that (2-1) + (2-1) + (2-1) resulted in a net grade modifier of 3, resulting in an impairment class 1, grade E, equaling a nine percent permanent impairment of the left upper extremity. He also concurred with deleting the inappropriate diagnosis of compete rotator cuff tear and instead using the appropriate diagnosis of exacerbation of osteoarthritis of the left shoulder. Dr. Manning noted that the 9 percent impairment rating was not in addition to the 15 percent previously awarded, but rather should be encompassed in the prior award and as such no additional impairment was warranted.

By decision dated March 13, 2013, OWCP denied an additional schedule award for the left upper extremity, finding that the medical evidence did not support an increase in the impairment already compensated.

On April 18, 2013 appellant requested reconsideration and submitted an April 5, 2013 report from Dr. Berg who reiterated his diagnoses and medical opinions.

By decision dated May 21, 2013, OWCP denied modification of its March 13, 2013 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] 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.[8] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[9]

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

[6] *See id.*

[7] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

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

[9] *See D.T.*, Docket No. 12-503 (issued August 21, 2012); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

and Health (ICF).[10] 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 and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[12]

ANALYSIS

The record shows that OWCP paid appellant a schedule award in 2012 for a 15 percent permanent impairment of the left upper extremity due to the accepted left shoulder condition. As appellant filed a claim for an additional schedule award in 2013, he has the burden to establish more than a 15 percent permanent impairment of his left upper extremity due to his employment-related condition. It is his burden to submit sufficient evidence to establish the extent of permanent impairment.[13]

In his December 17, 2012 report, Dr. Smith, a referral physician, conducted a physical examination and reviewed appellant's medical records and a statement of accepted facts. He indicated there was no evidence of ankylosis or adhesions upon physical examination or MRI scan report. Dr. Smith opined that appellant's accepted condition of left rotator cuff tear was a mistake and the correct diagnosis was osteoarthritis of the left shoulder region, exacerbated by the December 7, 2009 employment incident. He found that appellant's examination results suggested embellishment and nonphysiological behavior and therefore it would be appropriate to rate his condition solely on a diagnosis basis, rather than using range of motion, which allowed manipulation by voluntary and subjective factors. Dr. Smith determined that appellant had a nine percent permanent impairment of the left upper extremity, according to Table 15-5, on page 405, of the A.M.A., *Guides*,[14] where the condition of degenerative joint disease of the shoulder was a class 1 injury with a default rating of five percent to the upper extremity. He assigned a functional history grade modifier of 2, a physical examination grade modifier of 2 and a clinical studies grade modifier of 2, resulting in a net grade modifier of 3. Dr. Smith assigned appellant to class 1, grade E and concluded that he had a nine percent permanent impairment of the left upper extremity.

In accordance with its procedures, OWCP properly referred the evidence of record to its OWCP medical adviser, Dr. Manning, who reviewed the clinical findings of Dr. Smith on January 10, 2013 and concurred with his impairment rating. Dr. Manning also concurred with deleting the inappropriate diagnosis of compete rotator cuff tear and instead using the

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

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

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

[13] *See Annette M. Dent*, 44 ECAB 403 (1993).

[14] Table 15-5, pages 401-05, of the sixth edition of the A.M.A., *Guides* is entitled *Shoulder Regional Grid -- Upper Extremity Impairments*.

appropriate diagnosis of exacerbation of osteoarthritis of the left shoulder. He opined that, according to Table 15-5,[15] appellant's degenerative joint disease placed him in class 1, default value five percent impairment. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Manning found that (2-1) + (2-1) + (2-1) resulted in a net grade modifier of 3, resulting in an impairment class 1, grade E, equaling a nine percent permanent impairment of the left upper extremity. He noted that the 9 percent impairment rating was not in addition to the 15 percent previously awarded, but rather should be encompassed in the prior award, and as such no additional impairment was warranted.

The Board finds that the medical adviser applied the appropriate tables and grading schemes of the sixth edition of the A.M.A., *Guides* to Dr. Smith's clinical findings. The medical adviser's calculations were mathematically accurate. There is no medical evidence of record utilizing the appropriate tables of the sixth edition of the A.M.A., *Guides* demonstrating a greater percentage of permanent impairment. OWCP's medical adviser explained that Dr. Berg's 36 percent impairment rating for the left upper extremity was erroneous as the range of motion was not the appropriate method of assessing appellant's impairment under the A.M.A., *Guides*. Therefore, OWCP properly relied on the medical adviser's assessment of a nine percent permanent impairment of the left upper extremity.[16]

The February 2, 2010 and December 21, 2011 MRI scan reports are diagnostic in nature do not provide an impairment rating. Thus, these reports are of no probative value regarding appellant's permanent impairment under the sixth edition of the A.M.A., *Guides*.[17]

There is no probative medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has more than a 15 percent permanent impairment to the left upper extremity. Accordingly, appellant has not established that he is entitled to a schedule award greater than that previously received.[18]

On appeal, appellant requests a referee examination and contends that in his December 17, 2012 second opinion report Dr. Smith never looked at any x-rays or MRI scan reports and did not perform any tests to determine his ability to move his arm. The record reflects that Dr. Smith's December 17, 2012 second opinion report was based on a review of appellant's medical records, including diagnostic testing, medical history and a physical examination. As noted above, Dr. Smith properly provided an evaluation of appellant's permanent impairment under the sixth edition of the A.M.A., *Guides*. Thus, the Board finds that appellant's request and arguments are not substantiated.

[15] *See id.*

[16] *See M.T.*, Docket No. 11-1244 (issued January 3, 2012).

[17] *See Richard A. Neidert*, 57 ECAB 474 (2006) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

[18] FECA provides for reduction of compensation for subsequent injury to the same body member. It provides that schedule award compensation is reduced by the compensation paid for an earlier injury where the compensation in both cases are for impairment of the same member or function and where it is determined that the compensation for the later disability in whole or part would duplicate the compensation payable for the preexisting disability. 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

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 15 percent permanent impairment to the left upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the May 21, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 30, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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