United States Department of Labor
Employees' Compensation Appeals Board

B.C., Appellant	)	
and	)	**Docket No. 13-869**
	)	**Issued: August 14, 2013**
DEPARTMENT OF THE NAVY, NAVAL AVIATION DEPOT, Cherry Point, NC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On February 21, 2013[1] appellant filed a timely appeal from an August 28, 2012 decision of the Office of Workers' Compensation Programs (OWCP) denying his claim for an additional schedule award. Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

[1] Under the Board's *Rules of Procedure,* the 180-day time period for determining jurisdiction is computed beginning on the day following the date of OWCP's decision. *See* 20 C.F.R. § 501.3(f)(2). As OWCP's merit decision was issued on August 28, 2012, the 180-day computation begins August 29, 2012. One hundred and eighty days from August 29, 2012 was February 25, 2013. Since using March 1, 2013, the date the appeal was received by the Clerk of the Board, would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is February 21, 2013, which renders the appeal timely filed. *See* 20 C.F.R. § 501.3(f)(1).

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has more than a six percent impairment of the right arm for which he received a schedule award.

On appeal appellant asserts that he has greater impairment because he was not at maximum medical improvement following his first surgery.

FACTUAL HISTORY

On May 21, 2003 appellant, then a 55-year-old aircraft mechanical parts worker, injured his right arm lifting a heavy brake off a pallet. OWCP accepted that he sustained a right rotator cuff tear, right lateral epicondylitis, right bicipital tenosynovitis and a superior glenoid labrum (SLAP) tear of the right shoulder.[3] On November 6, 2006 Dr. T.E. Bates, a Board-certified orthopedic surgeon, performed right shoulder arthroscopy with open rotator cuff tear repair, subacromial decompression and distal clavicle resection. Appellant received compensation following surgery and returned to full-time modified duty on December 26, 2006.

On August 3, 2009 appellant filed a schedule award claim. In an October 15, 2009 report, Dr. Bates stated that appellant was at maximum medical improvement. He provided physical examination findings including right upper extremity range of motion measurements of 50 degrees of extension, 60 degrees of external rotation, 100 degrees of abduction and 50 degrees of adduction. In a November 9, 2009 report, Dr. James W. Dyer, an OWCP medical adviser Board-certified in orthopedic surgery, found that maximum medical improvement was reached on October 15, 2009. He noted that the range of motion method was the most accurate and objective method by which to assess appellant's impairment. Under Table 15-34 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[4] appellant had a six percent right upper extremity impairment, based on the range of motion measurements reported by Dr. Bates.

On November 25, 2009 appellant was granted a schedule award for six percent impairment of the right upper extremity.

On November 15, 2010 appellant requested reconsideration, indicating that he could do very little with his right hand and arm. In a November 4, 2010 report, Dr. Edward C. Brown, III, Board-certified in orthopedic surgery, noted the history of injury and appellant's medical treatment, including right shoulder surgery. After physical examination, he diagnosed right shoulder pain of several sources including a detached anterior deltoid and a suspected recurrent supraspinatus rotator cuff tear. Dr. Brown recommended a computerized tomography (CT) arthrogram scan study. A November 17, 2010 CT scan arthrogram of the right shoulder demonstrated a full thickness supraspinatus tendon retear, mild-to-moderate glenohumeral

[3] The instant claim was adjudicated by OWCP under file number xxxxxx362. Appellant has an additional claim, adjudicated under file number xxxxxx938, accepted for chondromalacia patella, right knee; knee contusion, right; and hip piriformis syndrome, right hip.

[4] A.M.A., *Guides* (6th ed. 2008).

osteoarthritis and a complete tear of the intra-articular long head biceps tendon. On December 7, 2010 Dr. Brown reviewed the CT arthrogram and recommended revision of the rotator cuff repair.

In a merit decision dated January 21, 2011, OWCP denied appellant's claim for an additional schedule award on the grounds that the medical evidence submitted did not provide an impairment evaluation.

On April 21, 2011 appellant again requested reconsideration, asserting that he continued to have problems with his right arm. On February 11, 2011 Dr. Brown noted that appellant wanted to proceed with shoulder surgery. On May 10, 2011 OWCP authorized the procedure.

By decision dated May 20, 2011, OWCP denied modification of the prior decisions. It found that, as additional right shoulder surgery was needed, appellant had not reached maximum medical improvement and was therefore not eligible for an increased schedule award. On July 21, 2011 Dr. Brown performed right shoulder diagnostic arthroscopy with right shoulder arthroscopic subacromial decompression. In a July 22, 2011 report, he stated that appellant had not reached maximum medical improvement regarding his right shoulder. Appellant returned to full-time modified duty on September 6, 2011.

On May 14, 2012 appellant requested reconsideration, stating that his condition had improved following the second surgery but that he was still impaired. He submitted reports from Dr. Brown dated August 2 to December 21, 2011. Dr. Brown described appellant's postoperative care and improving condition. On December 21, 2011 he noted that appellant reported that he had less pain and improved shoulder motion but had occasional radiating symptoms of some hand numbness. Dr. Brown indicated that the right shoulder demonstrated overall good range of motion actively of 140/40 which was symmetric, with mild limitations of elevation and internal rotation and some mild occasional pain and radicular symptoms that could be cervical but that a Spurling's test was negative. He concluded that appellant had an overall good result at five months after the right shoulder arthroscopic decompression. Dr. Brown stated that appellant had now reached maximum medical improvement. He also advised that appellant could return to work on December 21, 2011 without restrictions. In an undated report, Dr. Brown indicated that appellant reached maximum medical improvement on December 21, 2011 and that, under Table 15-34 of the sixth edition of the A.M.A., *Guides*, appellant had five percent impairment of the right arm.

Appellant retired from federal service effective December 31, 2011.

On July 19, 2012 Dr. Dyer noted that appellant had a second surgical repair of the right shoulder. After review of the medical record, there was no evidence to support an impairment rating greater than the six percent previously awarded. In a supplementary report dated August 2, 2012, Dr. Dyer noted that, under Table 15-34, forward elevation of 140 degrees yielded a three percent impairment, backward elevation of 40 degrees a one percent impairment, and internal rotation of 50 degrees a two percent impairment, for a total six percent right upper extremity impairment, the same as that granted in the 2009 schedule award.

In a merit decision dated August 28, 2012, OWCP found that appellant did not have additional impairment to his right arm.

LEGAL PRECEDENT

The schedule award provision of FECA,[5] and its implementing federal regulations,[6] 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.[7] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8] For decisions issued after May 1, 2009, the sixth edition will be used.[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 and Health (ICF).[10] Under the sixth edition, for upper extremity impairments the evaluator identifies 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).[11] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[12] The sixth edition of the A.M.A., *Guides* also provides that, under certain circumstances, range of motion may be selected as an alternative approach in rating impairment. An impairment rating that is calculated using range of motion may not be combined with a diagnosis-based impairment and stands alone as a rating.[13]

ANALYSIS

The Board finds this case is not in posture for decision. Neither Dr. Brown nor Dr. Dyer provided adequate rationale for their impairment ratings.

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[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*. at § 10.404(a).

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

[9] FECA Bulletin No. 09-03 (issued March 15, 2009).

[10] A.M.A., *Guides, supra* note 3 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[11] *Id*. at 385-419.

[12] *Id*. at 411.

[13] *Id*. at 390. The A.M.A., *Guides* explains that diagnoses in the grid that may be rated using range of motion are followed by an asterisk.

OWCP accepted that appellant sustained a right rotator cuff tear, right lateral epicondylitis, right bicipital tenosynovitis and a superior glenoid labrum (SLAP) tear of the right shoulder. On November 6, 2006 Dr. Bates performed right shoulder arthroscopy with open rotator cuff tear repair, subacromial decompression and distal clavicle resection. On November 25, 2009 appellant was granted a schedule award for a six percent impairment of the right upper extremity. In merit decisions dated January 21 and May 20, 2011, OWCP denied modification of the November 25, 2009 schedule award decision.

Regarding appellant's argument on appeal that he had not reached maximum medical improvement following the 2006 surgery, it is well established that a schedule award cannot be paid until a claimant has reached maximum medical improvement.[14] The determination of whether maximum medical improvement has been reached is based on the medical evidence of record.[15] In this case, on November 6, 2006 Dr. Bates performed right shoulder surgery and on October 15, 2009 reported that appellant had reached maximum medical improvement. OWCP therefore did not err in granting appellant a schedule award on November 25, 2009. A finding by OWCP of maximum medical improvement does not preclude a deterioration of the condition, as occurred here, after the November 6, 2006 surgery.[16] OWCP developed the claim with regard to appellant's claim for an increased schedule award.

On July 21, 2011 Dr. Brown performed right shoulder diagnostic arthroscopy with right shoulder arthroscopic subacromial decompression. Appellant requested reconsideration on May 14, 2012. In a December 11, 2011 treatment note, Dr. Brown noted that appellant had reached maximum medical improvement. He indicated that the right shoulder demonstrated overall good range of motion actively of 140/40 which was symmetric, with mild limitations of elevation and internal rotation and some mild occasional pain and radicular symptoms that could be cervical. Dr. Brown concluded that appellant had an overall good result at five months after the right shoulder arthroscopic subacromial decompression. In an undated report, he indicated that appellant reached maximum medical improvement on December 21, 2011 and that, under Table 15-34 of the sixth edition of the A.M.A., *Guides*, appellant had five percent impairment of the right arm.

On July 19, 2012 Dr. Dyer, an OWCP medical adviser, noted that appellant had a second surgical repair of the right shoulder; but there was no medical evidence to support an impairment rating greater than the six percent previously awarded. In a supplementary report dated August 2, 2012, OWCP's medical adviser indicated that, under Table 15-34, forward elevation of 140 degrees yielded a three percent impairment, backward elevation of 40 degrees a one percent impairment, and internal rotation of 50 degrees a two percent impairment, for a total six percent right upper extremity impairment, the same as that granted in the 2009 schedule award.

As noted above, under the sixth edition, for upper extremity impairments the evaluator identifies the impairment class for the diagnosed condition, which is then adjusted by grade

[14] *D.S.*, Docket No. 08-885 (issued March 17, 2009).

[15] *C.J.*, Docket No. 08-2429 (issued August 3, 2009).

[16] *E.P.*, 58 ECAB 719 (2007).

modifiers. Dr. Brown merely provided a conclusory impairment rating of five percent under the sixth edition and did not address how he rated impairment based on the appropriate formula and grade modifiers described above. Schedule awards under FECA are to be based on the A.M.A., *Guides*. An estimate of permanent impairment is irrelevant and not probative where it is not based on the A.M.A., *Guides*.[17] Accordingly, Dr. Brown's opinion is insufficient to establish that appellant is entitled to an additional right upper extremity schedule award.

Table 15-5, Shoulder Regional Grid, however, marks a number of diagnoses with an asterisk.[18] These include the accepted conditions of rotator cuff and labral lesions.[19] The asterisk indicates that, if motion loss is present, the shoulder impairment may alternatively be assessed using loss of range of motion.[20] In his last treatment note dated December 21, 2011, Dr. Brown merely stated that the right shoulder demonstrated overall good range of motion actively of 140/40 which was symmetric. Dr. Dyer, OWCP's medical adviser, provided an August 2, 2012 report that included right shoulder range of motion measurements for forward and backward elevation and internal and concluded that appellant had a six percent right upper extremity impairment. It is unclear where Dr. Dyer found the range of motion measurements provided in his August 2, 2012 report. Furthermore, he did not explain why he chose the range of motion method. If more than one rating method can be used, the method that provides the higher rating should be adopted.[21]

Section 15.2e of the A.M.A., *Guides* provides that it is not uncommon for several diagnoses such as a SLAP lesion and biceps tendon pathology to be present simultaneously. In that circumstance, the evaluator is expected to choose the most significant diagnosis and rate only that diagnosis using the diagnosis-based impairment method, which can be modified utilizing the clinical studies adjustment table.[22] Section 15.7 of the A.M.A., *Guides* advises that the method of choice for calculating impairment is the diagnosis-based method.[23] Section 15.7a provides specific requirements to be used in assessing motion.[24] In addition to a right rotator cuff tear and SLAP lesion, appellant has additional accepted right upper extremity conditions of right lateral epicondylitis and right bicipital tenosynovitis. The record does not indicate that these conditions were evaluated regarding entitlement to a schedule award.

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, OWCP

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[17] *Shalanya Ellison*, 56 ECAB 150 (2004).

[18] *Supra* note 3 at 401-05.

[19] *Id*. at 402-04.

[20] *Id*.

[21] *See C.J., supra* note 14.

[22] *Supra* note 3 at 390.

[23] *Id*. at 460-61.

[24] *Id*. at 464.

shares responsibility in the development of the evidence. Once it has begun an investigation of a claim, it must pursue the evidence as far as reasonably possible. OWCP has an obligation to see that justice is done.[25] Without a detailed report comporting with the standards of the sixth edition of the A.M.A., *Guides*, the Board is unable to determine whether appellant has an increased impairment due to the accepted right upper extremity conditions that would entitle her to an additional schedule award. Accordingly, as there is no medical evidence of record that fully comports with the A.M.A., *Guides* or provides a complete analysis or explanation regarding appellant's right upper extremity impairment, the Board finds that the case is not in posture for decision. The case is remanded to OWCP for further development on the extent of impairment of appellant's right upper extremity in accordance with the sixth edition of the A.M.A., *Guides*. After such development as deemed necessary, OWCP should issue an appropriate decision on the issue of appellant's entitlement to an additional schedule award.

CONCLUSION

The Board finds this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the August 28, 2012 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: August 14, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[25] *A.A.*, 59 ECAB 726 (2008).