

FACTUAL HISTORY

Appellant, a 70-year-old retired letter carrier, has an accepted claim for right shoulder traumatic impingement, which occurred on October 1, 1991.¹ On May 28, 2008 he filed a claim for a schedule award (Form CA-7). By letter dated August 15, 2008, the Office advised appellant that it needed to recreate his case file. It explained that the original case record had been destroyed because it was identified as a “no time lost injury” without any expected permanent residuals. Appellant was advised to contact his former employer and request copies of any relevant documentation. The Office also instructed him to submit any documents he may have retained relative to his employment injury.

Appellant reportedly was unable to obtain copies of his prior treatment records other than a November 12, 1991 report from Dr. David L. Galt, a Board-certified orthopedic surgeon, who noted that appellant was injured on October 1, 1991 when he stepped on a freshly painted curb that was quite slick. He slipped and fell, striking his right elbow and jamming his arm up into his shoulder and over the six-week period since his injury, he had been experiencing anterior and lateral pain in the right shoulder. Dr. Galt also reported complaints of intermittent popping in the shoulder, but no loss of motion. He further noted that appellant had been undergoing therapy, which based on appellant’s description, fairly resembled a right rotator cuff rehabilitation program. Appellant, however, reported increasing pain with the therapy. Dr. Galt’s diagnostic impression was right shoulder traumatic impingement. He also provided a differential diagnosis of right glenoid chip fracture. Dr. Galt recommended rotator cuff rehabilitation therapy and possible further evaluation to rule out a loose body.

Appellant advised the Office that he had been told that all other medical documents had been destroyed. He further indicated that he eventually resumed full duty following his 1991 employment injury and had not undergone any type of surgical intervention. Appellant stated that he received therapy for his injury until December 9, 2001, but did not recall exactly when he returned to full duty. He further indicated that from the time of his injury until the present he had recurring problems with his right shoulder, which he related to his October 1, 1991 employment injury. Since his retirement in April 1995, appellant reportedly had not seen any doctors or received any therapy for his injury. He stated that he had played it safe and curtailed many activities so as not to cause further discomfort. Appellant also stated that he took over-the-counter pain medication at times and tried various light exercises to attempt to keep his shoulder in good condition. He also claimed not to have sustained any subsequent injuries.

Appellant submitted a May 12, 2008 report and impairment rating from Dr. Thomas J. Purtzer, a Board-certified neurosurgeon, who examined him on May 5, 2008 and diagnosed mild chronic pain syndrome due to chronic right shoulder impingement syndrome with secondary osteoarthritis. Dr. Purtzer noted a history of injury on October 1, 1991, when appellant slipped and fell, landing onto his right elbow. He reported that appellant subsequently developed pain in the right elbow, right shoulder, right biceps, mid-back and neck. Dr. Purtzer further noted that the pain eventually settled into appellant’s right shoulder where it had continued since the time

¹ Appellant reported that he had slipped on a freshly painted curb and fell on his right elbow. He retired effective April 2, 1995.

of injury. He also noted that appellant had been treated by Dr. Galt in the past, but had not had any diagnostic testing in the past 10 years. Additionally, appellant had a short course of physical therapy, but had not had any treatment for his shoulder for many years. His current complaints included right shoulder pain and limitation in range of motion, but no definite focal weakness in either the arm or shoulder. Dr. Purtzer recommended further evaluation including right shoulder x-rays and a magnetic resonance imaging (MRI) scan.

As to the extent of any permanent impairment, Dr. Purtzer noted that appellant was adamantly opposed to any type of surgical intervention and had reached maximum medical improvement. Based on his May 5, 2008 examination findings, he calculated five percent impairment of the right upper extremity due to loss of shoulder abduction (one percent) and internal rotation (four percent). Dr. Purtzer attributed appellant's loss of motion to his right shoulder impingement syndrome, which in turn was caused by his employment injury.

Appellant also submitted right shoulder x-rays and an MRI scan dated August 21, 2008. The studies revealed mild to moderate degenerative changes of the acromioclavicular joint and glenohumeral joint. The MRI scan also showed significant thinning of the supraspinatus adjacent to the rotator cuff suggesting partial thickness tearing.

In an addendum dated October 30, 2008, Dr. Purtzer reviewed the recent right shoulder x-ray and MRI scan findings and explained that the results had not changed his five percent impairment rating. However, he noted that the studies suggested the possibility that appellant might benefit from surgery to relieve him from the impingement of his rotator cuff area.

In a decision dated December 16, 2008, the Office denied appellant's claim for a schedule award. It found that Dr. Purtzer had not provided an explanation of how appellant's five percent impairment was related to the October 1, 1991 employment injury.

On April 6, 2009 appellant requested reconsideration. He submitted much of what had already been made part of the record, but no new information regarding the cause and extent of his right upper extremity impairment.

By decision dated April 17, 2009, the Office denied appellant's April 6, 2009 request for reconsideration.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.² The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate

² For a total loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1) (2006).

standard for evaluating schedule losses.³ Effective February 1, 2001, schedule awards are determined in accordance with the A.M.A., *Guides* (5th ed. 2001).⁴

ANALYSIS

Before applying the A.M.A., *Guides*, the Office must determine whether the claimed impairment of a scheduled member is causally related to the accepted work injury.⁵ It did not question Dr. Purtzer's method of calculating appellant's reported five percent right upper extremity impairment, but instead rejected his impairment rating because he did not explain how the current right shoulder impairment was related to the October 1, 1991 employment injury. Dr. Purtzer was unequivocal in his opinion that the "impairment from [appellant's] shoulder impingement syndrome ... was caused by his injury." However, as the Office correctly noted, he did not provide much by way of explanation regarding causal relationship. The Office further noted that, between November 1991 and May 2008, there was no medical evidence in the record to document the history of appellant's condition. While this latter assessment is accurate, appellant is not entirely to blame for the lack of medical documentation given the fact that the Office destroyed his original case file.

Proceedings under the Act are not adversarial in nature and the Office is not a disinterested arbiter. While the claimant has the burden to establish his entitlement, the Office shares responsibility in the development of the evidence to see that justice is done.⁶ Although Dr. Purtzer's opinion is insufficient to discharge appellant's burden of proving that the current right shoulder impairment is causally related to appellant's federal employment, this evidence is sufficient to require further development of the case record by the Office.⁷ On remand, the Office should refer appellant, the case record, and a statement of accepted facts to an orthopedic specialist for an evaluation and a rationalized medical opinion regarding the cause and extent of any right upper extremity impairment. After it has developed the case record to the extent it deems necessary, a *de novo* decision shall be issued.

CONCLUSION

The Board finds that the issue of appellant's entitlement to a schedule award is not in posture for decision.⁸

³ 20 C.F.R. § 10.404 (2009).

⁴ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

⁵ *Michael S. Mina*, 57 ECAB 379, 385 (2006).

⁶ *Horace L. Fuller*, 53 ECAB 775, 777 (2002); *James P. Bailey*, 53 ECAB 484, 496 (2002); *William J. Cantrell*, 34 ECAB 1223 (1983).

⁷ *See John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 820 (1978).

⁸ Given the Board's disposition on the merits of the schedule award claim, the issue of whether the Office properly denied appellant's April 6, 2009 request for reconsideration is moot.

ORDER

IT IS HEREBY ORDERED THAT the April 17, 2009 and December 16, 2008 decisions of the Office of Workers' Compensation Programs are set aside, and the case remanded for further action consistent with this decision.

Issued: January 21, 2010
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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