United States Department of Labor
Employees' Compensation Appeals Board

T.S., Appellant	)	
and	)	**Docket No. 11-740**
	)	**Issued: November 3, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Waterloo, IA, 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
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On February 2, 2011 appellant filed a timely appeal from the August 27, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP) granting him a schedule award and the October 18, 2010 nonmerit decision of OWCP denying his request for merit review. Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] 20 C.F.R. § 8101 *et seq.*

ISSUES

The issues are: (1) whether appellant met his burden of proof to establish that he has more than a three percent permanent impairment of his right arm or three percent permanent impairment of his left arm, for which he received schedule awards; and (2) whether OWCP properly denied appellant's request for further review of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On February 22, 2009 appellant, then a 45-year-old mail handler, filed an occupational disease claim alleging that he sustained bilateral shoulder conditions due to the repetitive duties of his job. OWCP accepted that he sustained right shoulder, upper arm and rotator cuff sprains, unspecified disorder of bursae and tendons in the bilateral shoulder region and adhesive capsulitis of both shoulders. Appellant received wage-loss compensation for periods of disability.

In May 2009 appellant came under the care of Dr. James E. Crouse, an attending Board-certified orthopedic surgeon. On May 29, 2009 he was released to return to work without restrictions.

On October 29, 2009 Dr. Crouse performed right shoulder arthroscopy with arthroscopic synovectomy of the glenohumeral joint and arthroscopic acromioplasty. The procedures were authorized by OWCP. Following surgery, Dr. Crouse excused appellant from work until he released him to return to work without restrictions on November 20, 2009.

On February 26, 2010 Dr. Crouse performed left shoulder arthroscopy with trimming of torn glenoid labrum, arthroscopic acromioplasty and excision of subacromial bursa. The procedures were authorized by OWCP and Dr. Crouse excused appellant from work until he released him to return to work without restrictions on March 23, 2010.

In an August 11, 2010 report, Dr. Crouse stated that appellant reached maximum medical improvement and was discharged from his care on June 15, 2010. He described the left shoulder surgery he performed on February 26, 2010 and noted that, at the time of discharge on June 15, 2010, appellant continued to have mild stiffness and aching of the left shoulder with occasional sharper pain. Appellant was given a release for full activities as tolerated, but it was anticipated that he would have some residual stiffness and soreness in the shoulder which would be aggravated by activities. Dr. Crouse stated that, using Table 15-5 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009), appellant would have a 10 percent permanent impairment of his left arm. He noted, "This is a result of the discomfort, residual tendinitis/tendinopathy, and glenoid labrum tear." Dr. Crouse did not address the right arm impairment.

On August 24, 2010 Dr. Daniel D. Zimmerman, a Board-certified internist serving as an OWCP medical adviser, reviewed the medical evidence of record. Based on the reports of Dr. Crouse, he determined that appellant a three percent permanent impairment of his right arm and a three percent permanent impairment of his left arm under the sixth edition of the A.M.A.,

Guides. The A.M.A., *Guides* provide on page 387 that when a patient has two significant diagnoses the examiner should use the diagnosis with the highest causally-related impairment for the impairment calculation. Dr. Zimmerman indicated that, under Table 15-5 (Shoulder Regional Grid), appellant's ratable diagnosis for the right shoulder was tendinitis, which fell under class 1 with a default value of three percent. Under the same table, he chose the glenoid labrum tear as the ratable diagnosis for the left shoulder, which fell under class 1 with a default value of three percent (due to appellant's residual symptoms and consistent objective findings).

With respect to the modifiers of the diagnosis values, Dr. Zimmerman stated that, under Table 15-7 on page 406, both of appellant's shoulders fell under grade modifier one for functional history due to his pain/symptoms with strenuous/vigorous activity and a *Quick*DASH score which fell between 21 and 40. Under Table 15-8 on page 408, both shoulders fell under grade modifier one for physical examination because appellant had a mild decrease of range of motion from normal. Dr. Zimmerman found that a grade modifier for clinical studies was not applicable in the present case. He applied the Net Adjustment Formula to find that there was no movement from the default values for each arm and, therefore, appellant had a three percent permanent impairment of his right arm and a three percent permanent impairment of his left arm.[2]

In an August 27, 2010 decision, OWCP granted appellant a schedule award for a three percent permanent impairment of his right arm and a three percent permanent impairment of his left arm. The award ran for 18.72 weeks from August 11 to December 20, 2010 and was based on the calculation of Dr. Zimmerman.

In a September 30, 2010 letter, appellant requested reconsideration of his claim. He argued that he had more than a three percent permanent impairment in each arm and asserted that he should have undergone an in-person examination by an impartial physician. Appellant submitted numerous documents from his surgery and hospitalization on February 26, 2010.

In an October 18, 2010 decision, OWCP denied appellant's request for further review of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA[3] and its implementing regulations[4] 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to

[2] For the left shoulder, use of a tendinitis or subacromial impingement diagnosis would also yield a three percent impairment rating and, as only one diagnosis may be used, these diagnosis-based ratings would provide no rating higher than that obtained using the glenoid labrum tear diagnosis. *See* A.M.A., *Guides* 402, Table 15-5.

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[5] For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.[6]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401. After the Class of Diagnosis (CDX) is determined from the Shoulder Regional Grid (including identification of a default grade value), the Net Adjustment Formula is applied using the grade modifier for Functional History (GMFH), grade modifier for Physical Examination (GMPE) and grade modifier for Clinical Studies (GMCS). The Net Adjustment Formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[7] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[8]

In some instances, an OWCP medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides*. In this instance, a detailed opinion by an OWCP medical adviser which gives a percentage based on reported findings and the A.M.A., *Guides* may constitute the weight of the medical evidence.[9]

ANALYSIS -- ISSUE 1

Appellant sustained right shoulder, upper arm and rotator cuff sprains, unspecified disorder of bursae and tendons in the bilateral shoulder region and adhesive capsulitis of both shoulders. On May 29, 2009 Dr. Crouse, an attending Board-certified orthopedic surgeon, performed right shoulder arthroscopy with arthroscopic synovectomy of the glenohumeral joint and arthroscopic acromioplasty. On February 26, 2010 he performed left shoulder arthroscopy with trimming of torn glenoid labrum, arthroscopic acromioplasty and excision of subacromial bursa. The procedures were authorized by OWCP. On August 27, 2010 OWCP granted appellant a schedule award for a three percent permanent impairment of his right arm and a three percent permanent impairment of his left arm. The award was based on an August 24, 2010

[5] *Id*.

[6] *See* FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5th ed. 2001) is used.

[7] *See* A.M.A., *Guides* (6th ed. 2009) 401-11.

[8] *Id.* at 23-28.

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(h) (April 1993).

calculation of Dr. Zimmerman, a Board-certified internist serving as an OWCP medical adviser, who based his evaluation on the medical findings of record, including those of Dr. Crouse.

The Board finds that Dr. Zimmerman properly determined that, under the standards of the sixth edition of the A.M.A., *Guides*, appellant has a three percent permanent impairment of each arm. Under Table 15-5 (Shoulder Regional Grid), appellant's ratable diagnosis for the right shoulder was tendinitis, which fell under class 1 with a default value of three percent. Under the same table, he chose the glenoid labrum tear as the ratable diagnosis for the left shoulder, which fell under class 1 with a default value of three percent.[10] With respect to the modifiers of the diagnosis values, Dr. Zimmerman found that, under Table 15-7 on page 406, both of appellant's shoulders fell under grade modifier one for functional history and that, under Table 15-8 on page 408, both shoulders fell under grade modifier one for physical examination.[11] Dr. Zimmerman provided reasons for his various rating choices. He applied the Net Adjustment Formula to find that there was no movement from the default values for each arm and, therefore, appellant had a three percent permanent impairment of his right arm and a three percent permanent impairment of his left arm.[12]

In an August 11, 2010 report, Dr. Crouse stated that, using Table 15-5 of the A.M.A., *Guides*, appellant would have a 10 percent permanent impairment of his left arm. He noted, "This is a result of the discomfort, residual tendinitis/tendinopathy, and glenoid labrum tear. However, this impairment rating is of little probative value because Dr. Crouse did not provide a detailed description of how his rating was made in accordance with the relevant standards of the A.M.A., *Guides*.[13]

On appeal, appellant suggested that it was inappropriate for Dr. Zimmerman to provide an impairment rating because he did not examine him. However, in schedule award cases where the percentage estimate by an examining physician is not based on the A.M.A., *Guides*, a detailed opinion by an OWCP medical adviser which gives a percentage based on reported findings and the A.M.A., *Guides* may constitute the weight of the medical evidence.[14]

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.

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[10] *See* A.M.A., *Guides* 401-05, Table 15-5.

[11] In appellant's case, it was not appropriate to choose a grade modifier for clinical studies.

[12] *See supra* note 7. The Board note that, for the left shoulder, use of a tendinitis or subacromial impingement diagnosis would also yield a three percent impairment rating and, as only one diagnosis may be used, these diagnosis-based ratings would provide no rating higher than that obtained using the glenoid labrum tear diagnosis. *See* A.M.A., *Guides* 402, Table 15-5.

[13] *See James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).

[14] Appellant also suggested that Dr. Zimmerman did not provide a fair evaluation, but he did not articulate the basis for this belief.

LEGAL PRECEDENT -- ISSUE 2

To require OWCP to reopen a case for merit review under section 8128(a) of FECA,[15] OWCP's regulations provide that the evidence or argument submitted by a claimant must: (1) show that OWCP erroneously applied or interpreted a specific point of law; (2) advance a relevant legal argument not previously considered by OWCP; or (3) constitute relevant and pertinent new evidence not previously considered by OWCP.[16] To be entitled to a merit review of an OWCP decision denying or terminating a benefit, a claimant also must file his or his application for review within one year of the date of that decision.[17] When a claimant fails to meet one of the above standards, OWCP will deny the application for reconsideration without reopening the case for review on the merits.[18] The Board has held that the submission of evidence or argument which repeats or duplicates evidence or argument already in the case record[19] and the submission of evidence or argument which does not address the particular issue involved does not constitute a basis for reopening a case.[20] While a reopening of a case may be predicated solely on a legal premise not previously considered, such reopening is not required where the legal contention does not have a reasonable color of validity.[21]

ANALYSIS -- ISSUE 2

OWCP issued a decision on August 27, 2010 and appellant requested reconsideration of this decision on September 30, 2010. The question is whether he met any of the requirements of 20 C.F.R. § 10.606(b)(2), requiring OWCP to reopen the case for review of the merits of the claim. In his application for reconsideration, appellant did not show that OWCP erroneously applied or interpreted a specific point of law. He did not identify a specific point of law or show that it was erroneously applied or interpreted. Appellant did not advance a new and relevant legal argument. He argued that he believed that he had more than a three percent permanent impairment in each arm. The underlying issue in this case was whether the medical evidence shows that appellant has more than a three percent permanent impairment of his right arm and a three percent permanent impairment of his left arm. That is a medical issue which must be addressed by relevant medical evidence.[22] Appellant asserted that he should have undergone an in-person examination by a "neutral" physician. This argument is not relevant as appellant was

[15] Under section 8128 of FECA, "[t]he Secretary of Labor may review an award for or against payment of compensation at any time on his own motion or on application." 5 U.S.C. § 8128(a).

[16] 20 C.F.R. § 10.606(b)(2).

[17] *Id.* at § 10.607(a).

[18] *Id.* at § 10.608(b).

[19] *Eugene F. Butler*, 36 ECAB 393, 398 (1984); *Jerome Ginsberg*, 32 ECAB 31, 33 (1980).

[20] *Edward Matthew Diekemper*, 31 ECAB 224, 225 (1979).

[21] *John F. Critz*, 44 ECAB 788, 794 (1993).

[22] *See Bobbie F. Cowart*, 55 ECAB 746 (2004).

in fact examined by Dr. Crouse and it was appropriate for Dr. Zimmerman, OWCP's medical adviser, to provide a calculation based on Dr. Crouse's findings and other medical evidence of record.[23]

Appellant may be entitled to a merit review by submitting new and relevant evidence, but he did not submit any new and relevant medical evidence in this case. He submitted numerous documents from his surgery and hospitalization on February 26, 2010, but these documents are not relevant to the main issue of the present case because they do not contain a medical opinion on his arm impairment.[24]

The Board accordingly finds that appellant did not meet any of the requirements of 20 C.F.R. § 10.606(b)(2). Appellant did not show that OWCP erroneously applied or interpreted a specific point of law, advance a relevant legal argument not previously considered by OWCP, or submit relevant and pertinent evidence not previously considered. Pursuant to 20 C.F.R. § 10.608, OWCP properly denied merit review.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he has more than a three percent permanent impairment of his right arm and a three percent permanent impairment of his left arm, for which he received a schedule award. The Board further finds that OWCP properly denied his request for further review of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

[23] *See supra* note 9.

[24] Moreover, most of these documents had previously been submitted and considered by OWCP.

ORDER

IT IS HEREBY ORDERED THAT the October 18 and August 27, 2010 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: November 3, 2011
Washington, DC

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

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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