United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 11-55**
	)	**Issued: September 13, 2011**
DEPARTMENT OF THE NAVY, PACIFIC FLEET SHIPYARD, Pearl Habor, HI, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 8, 2010 appellant filed a timely appeal of a May 28, 2010 Office of Workers' Compensation Programs' (OWCP) schedule award decision. Pursuant to the Federal Employees' Compensation Act (FECA)[1] 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 four percent impairment of his right upper extremity and three percent impairment of his left upper extremity for which he received schedule awards.

On appeal, appellant asked that the Board explain his impairment rating and requested a lump sum for his medical benefits.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On June 3, 1999 appellant, then a 46-year-old marine machinery mechanic, filed a traumatic injury alleging that he injured his right shoulder on June 1, 1999 unloading his tools in the performance of duty. OWCP accepted his claim for right shoulder strain and temporary aggravation of cervical degenerative disc disease. On April 4, 2000 appellant underwent C3-4, C5-6 and C6-7 microforaminotomy with some decompression of the lateral spinal cord as authorized by OWCP.

Appellant underwent a magnetic resonance imaging (MRI) scan of his right shoulder on May 1, 2001 which demonstrated degenerative arthritis involving the glenohumeral joint and acromioclavicular (AC) joint with erosions on the humeral head and impingement of the supraspinatus and degenerative changes of the AC joint. He underwent a cervical spine MRI scan on November 26, 2001 which demonstrated chronic moderate foraminal narrowing at C4 on the right and C7 on the right, with loss of cervical lordosis and mild disc bulge at C4-5, C5-6 and C6-7.

OWCP authorized C3-7 cervical fusion on February 19, 2002. Dr. Bernard Robinson, a Board-certified neurological surgeon, performed this surgery. Appellant returned to light-duty work on March 17, 2003.

Appellant requested a schedule award on March 23, 2005. By decision dated May 20, 2005, OWCP denied his request for a schedule award stating that FECA does not provide for a schedule award entitlement for neck or back injuries.

An MRI scan dated April 12, 2006 demonstrated moderate supraspinatus tendinitis with a possible small undersurface tear and significant impingement upon the tendon by AC joint hypertrophy, mild glenohumeral joint degenerative changes. Dr. Jerry Van Meter diagnosed shoulder impingement and AC degenerative joint disease on April 21, 2008. An x-ray dated April 21, 2008 demonstrated mild glenohumeral and AC degenerative changes.

Appellant requested a schedule award on October 1, 2008. OWCP requested that appellant's attending physician, Dr. Patricia Walcyk, an osteopath, provide an evaluation of appellant's permanent impairment. It referred appellant for a second opinion evaluation with Dr. Thomas B. Grollman, a Board-certified orthopedic surgeon, on August 10, 2009 to determine whether appellant had reached maximum medical improvement of the right shoulder and if so, the extent of permanent impairment.

In a report dated September 28, 2009, Dr. Grollman examined appellant and reviewed the medical history and statement of accepted facts. He reported appellant's statement of constant neck pain radiating to both shoulders and shoulder blades with intermittent headaches. Appellant reported an average pain of 6 to 7 out of 10. He retired from the employing establishment in November 2005. Dr. Grollman found that appellant had tenderness over the right anterior shoulder and over both trapezia. He provided range of motion for appellant's neck and shoulders. Appellant demonstrated 40 degrees of shoulder extension, 150 degrees of shoulder flexion, 130 degrees of abduction, 30 degrees of adduction, 80 degrees of external rotation and 90 degrees of internal rotation in the right shoulder. Dr. Grollman found no significant weakness

on manual muscle testing, but appellant demonstrated loss of grip strength 80/80/75 on the right compared to 100/100/90 on the left. He noted that deep tendon reflexes were plus two and symmetrical with sensory examination to light touch intact in both upper extremities. Dr. Grollman reported right infraspinatus shoulder girdle muscle atrophy, mild to moderate. Appellant also demonstrated mild positive impingement test as well as a mildly positive supraspinatus isolation test. Dr. Grollman diagnosed cervical spine degenerative disc disease C3-7 with no definitive evidence of cervical radiculopathy. He noted that it was unclear whether appellant's right shoulder infraspinatus atrophy was cervical in origin or the result of compression of the suprascapular nerve. Dr. Grollman also diagnosed right shoulder mild impingement with MRI scan evidence of intact rotator cuff and degenerative changes and chronic pain syndrome.

When asked by OWCP whether appellant's accepted temporary aggravation of his cervical condition had ceased, Dr. Grollman opined that appellant's accepted employment injury was a permanent aggravation of a preexisting cervical condition because it resulted in two subsequent neck surgeries. He stated that appellant had reached maximum medical improvement in 2004. Dr. Grollman further stated that appellant's accepted cervical condition had not resulted in any permanent impairment of the upper extremities, but did result in limited motion in the right shoulder.

OWCP's medical adviser reviewed this report on March 6, 2010 and diagnosed left cervical decompression C3-7, anterior cervical fusion C3-7, chronic cervical radiculopathy, right rotator cuff tendinitis and impingement syndrome. He found that appellant had one percent permanent impairment of the upper extremity due to rotator cuff tendinitis and partial rotator cuff tear.[2] The medical adviser also found that appellant had one percent permanent impairment of the right upper extremity due to residual problems with mild pain or impaired sensation from C5 and C6 cervical radiculopathy as well as one percent impairment due to mild pain and impaired sensation from C7 radiculopathy resulting in three percent impairment of the right upper extremity due to cervical radiculopathy. He concluded that appellant had four percent impairment of the right upper extremity. The medical adviser also found three percent impairment of the left upper extremity due to one percent impairment each due to mild pain from C5, C6 and C7 radiculopathy. He found that appellant reached maximum medical improvement on April 19, 2004.

By decision dated May 28, 2010, OWCP granted appellant a schedule award for four percent impairment of the right upper extremity and three percent impairment of the left upper extremity.

[2] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), 402, Table 15-5.

LEGAL PRECEDENT

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 for loss of 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*.[5]

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).[6]

FECA does not authorize the payment of schedule awards for the permanent impairment of the whole person.[7] 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.[8] 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,[9] no claimant is entitled to such an award.[10]

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

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[3] 5 U.S.C. §§ 8101-8193, 8107.

[4] 20 C.F.R. § 10.404.

[5] 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).

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

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

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

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

[10] *W.D., supra* note 7. *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.[11]

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.[12] 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.[13] Specifically, it will address lower extremity impairments originating in the spine through Table 16-11[14] and upper extremity impairment originating in the spine through Table 15-14.[15]

In addressing lower extremity impairments, the sixth edition requires identifying 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).[16]

ANALYSIS

OWCP accepted appellant's claim for right shoulder and cervical spine conditions. Appellant requested a schedule award and OWCP referred him for a second opinion evaluation with Dr. Grollman to determine the extent of his permanent impairment for schedule award purposes. Dr. Grollman completed a report on September 28, 2009 including findings of constant neck pain radiation to both shoulders. He listed appellant's shoulder range of motion and found loss of range of motion in the right shoulder. Dr. Grollman reported no significant weakness on manual muscle testing, but loss of grip strength as well as right infraspinatus shoulder girdle muscle atrophy. He diagnosed cervical spine degenerative disc disease C3-7 with no definitive evidence of cervical radiculopathy. Dr. Grollman stated that it was unclear whether appellant's right shoulder infraspinatus atrophy was cervical in origin or the result of compression of the suprascapular nerve. He also diagnosed right shoulder mild impingement with MRI scan evidence of intact rotator cuff and degenerative changes and chronic pain syndrome. Dr. Grollman opined that appellant had reached maximum medical improvement and stated that appellant's accepted cervical condition had not resulted in any permanent impairment of the upper extremities; but it did result in limitation of motion of the right shoulder. This report does not comport with the standards of the sixth edition of the A.M.A., *Guides*. Dr. Grollman did not provide an impairment rating and did not relate his findings to specific

[11] *W.D., id*. *Rozella L. Skinner*, 37 ECAB 398 (1986).

[12] FECA Transmittal No. 10-04 (issued January 9, 2010); *supra* note 3, Exhibit 4 (January 2010).

[13] *Id*. (Exhibits 1, 4).

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

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

[16] *Id*. at 521. *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

provisions of the A.M.A., *Guides*. When OWCP refers a claimant for a second opinion evaluation and the report does not adequately address the relevant issues, OWCP should secure an appropriate report on the relevant issues.[17]

On March 6, 2010 OWCP's medical adviser reviewed the medical evidence and diagnosed left cervical decompression C3-7, anterior cervical fusion C3-7, chronic cervical radiculopathy, right rotator cuff tendinitis and impingement syndrome as due to the accepted employment injury. He accorded appellant one percent impairment upper extremity impairment for residual problems with rotator cuff tendinitis and partial rotator cuff tear providing a single citation to the A.M.A., *Guides* referencing the Shoulder Regional Grid: Upper Extremity Impairments. The medical adviser did not apply the formula specified in the A.M.A., *Guides* and did not offer any explanation for how he reached his impairment rating of one percent. The Board is unable to determine how the medical adviser reached this aspect of appellant's shoulder impairment. The medical adviser did not mention appellant's grade modifiers for functional history, physical examination or clinical studies as required by the sixth edition of the A.M.A., *Guides*.

The medical adviser also found that appellant had three percent impairment of the bilateral upper extremities due to residual problems with mild pain or impaired sensation from C5, C6 and C7 cervical radiculopathy. He did not offer any citations to the A.M.A., *Guides* and did not explain the basis for his impairment ratings. The Board is unable to determine from the medical evidence in the record, the extent of appellant's impairment for schedule award purposes. The Board finds that the medical evidence does not contain a sufficiently reasoned medical opinion as to the degree of permanent impairment to a scheduled member or function of the body under the sixth edition of the A.M.A., *Guides* and must remand the case for further development of the medical evidence and a detailed report which comports with the sixth edition of the A.M.A., *Guides* in regard to appellant's upper extremity impairments due to his cervical and right shoulder conditions. After this and such further development as OWCP deems necessary, OWCP shall issue an appropriate decision.

In regard to appellant's specific questions on appeal, the Board agrees that the medical evidence does not establish the basis for determining how his schedule award was calculated and has remanded the case for clarification and additional development of this issue. In regard, to appellant's request for lump sum payment of his medical benefits, such a payment is not contemplated under FECA and is not payable to appellant. Neither OWCP nor the Board has the authority to enlarge the terms of FECA or to make an award of benefits under any terms other than those specified in the statute.[18]

[17] *See Robert Kirby*, 51 ECAB 474, 476 (2000); *Mae Z. Hackett*, 34 ECAB 1421 (1983); *Richard W. Kinder*, 32 ECAB 863 (1981).

[18] *W.C.*, 59 ECAB 372 (2008).

CONCLUSION

The Board finds that the case is not in posture for decision as the medical evidence is not sufficiently detailed and does not explain the extent of appellant's permanent impairment in terms of the sixth edition of the A.M.A., *Guides*.

ORDER

IT IS HEREBY ORDERED THAT May 28, 2010 decision of Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this decision of the Board.

Issued: September 13, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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