United States Department of Labor
Employees' Compensation Appeals Board

D.G., Appellant	)	
and	)	**Docket No. 11-1074**
	)	**Issued: March 22, 2012**
DEPARTMENT OF DEFENSE, DEFENSE DEPOT OGDEN, Ogden, UT, 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
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 25, 2011 appellant filed a timely appeal from a November 16, 2010 schedule award decision of the Office of Workers' Compensation Programs (OWCP). 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 the schedule award decision.

ISSUE

The issue is whether appellant has more than 49 percent impairment of the right upper extremity for which he received schedule awards.

On appeal appellant generally asserts that OWCP delayed in processing his current schedule award claim such that it was processed under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[2] rather than the fifth edition of the A.M.A., *Guides*,[3] under which he would have received a

[1] 5 U.S.C. §§ 8101-8193.

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

[3] *Id*. (5th ed. 1999).

greater impairment rating. He also alleges that his shoulder was injured by an OWCP referral physician, Dr. Aubrey Swartz.

FACTUAL HISTORY

This case has previously been before the Board. In an April 23, 2001 decision, the Board adopted a December 10, 1999 OWCP decision in which a hearing representative affirmed a January 19, 1999 finding that appellant was not entitled to a schedule award greater than that previously received.[4] Appellant retired on September 30, 2000. On June 25, 2002 he underwent a third surgery on his right shoulder.[5] In a December 4, 2003 decision, the Board affirmed a May 27, 2003 decision in which OWCP granted appellant a schedule award for an additional five percent right upper extremity impairment.[6] The facts of the previous Board decisions are incorporated herein by reference.

On February 14, 2007 appellant filed a claim for an additional schedule award. In a March 29, 2007 report, Dr. Corey D. Anden, a Board-certified physiatrist, provided findings for right arm range of motion that included 58 degrees of flexion, 20 degrees of extension, 40 degrees of abduction, 0 degrees of adduction, 5 degrees of external rotation and 60 degrees of internal rotation. He diagnosed right shoulder pain and restricted mobility and weakness consistent with a rotator cuff tear at work on December 11, 1985 and three shoulder operations. Dr. Anden advised that appellant was at maximum medical improvement and that, under the fifth edition of the A.M.A., *Guides*, he had 22 percent impairment due to reduced mobility. He stated that, in accordance with Table 16-22, moderate subluxation yielded 40 percent joint impairment and under Table 16-18, the glenohumeral joint yielded 60 percent impairment. Dr. Anden multiplied 40 percent by 60 percent and concluded that appellant had 24 percent right arm impairment. He combined 24 percent with 20 percent, to total 39 percent right arm impairment. In an April 10, 2008 report, Dr. Anden provided examination findings including right upper extremity range of motion measurements of 85 degrees of flexion, 45 degrees of extension, 85 degrees of abduction and 30 degrees of internal rotation. He diagnosed right shoulder rotator cuff injury, supraspinatus sprain/strain and stiffness of shoulder joint. Dr. Anden reiterated his March 29, 2007 impairment rating.

[4] Docket No. 00-1557 (issued April 23, 2001). Appellant sustained a right shoulder strain and rotator cuff tear when he slipped and fell on ice. After rotator cuff repair, on January 23, 1990 he was granted a schedule award for a 16 percent permanent impairment of the right arm. Appellant had a second surgery on May 10, 1991. On April 7, 1992 he was granted a schedule award for a 28 percent impairment of the right arm. OWCP determined that appellant should have been granted a schedule award for an additional 12 percent only, for a total 28 percent entitlement. On March 24, 1994 it issued a preliminary overpayment finding. On October 26, 1994 an OWCP hearing representative waived the overpayment. In a September 12, 1996 decision, OWCP found that appellant was not entitled to an increased schedule award. On May 6, 1997 a hearing representative remanded the case and on September 22, 1997 OWCP again found that appellant was not entitled to an increased award. On September 17, 1998 a hearing representative again remanded the case and by decision dated January 19, 1999, OWCP found that appellant was not entitled to an increased schedule award. This was affirmed by a hearing representative on December 10, 1999 and adopted by the Board on April 23, 2001.

[5] The procedure included extensive debridement of the glenohumeral joint and subacromial space, chondroplasty, removal of loose bodies, partial synovectomy and debridement of labrum.

[6] Docket No. 03-1723 (issued December 4, 2003). While appellant was only entitled to an impairment rating totaling 33 percent, he actually received schedule awards totaling 49 percent. *See supra* note 4.

In a July 23, 2008 report, Dr. Morley Slutsky, an OWCP medical adviser found that maximum medical improvement was reached on April 10, 2008. Dr. Slutsky disagreed with Dr. Anden's range of motion rating, noting that the physician did not document how he achieved his rating. He advised that the range of motion measurements on April 10, 2008 showed improvement over those on March 29, 2007. Dr. Slutsky could not confirm that shoulder subluxation was a persistent finding, as he had been provided Dr. Anden's reports only and not the entire medical record. He stated that, based on available records, appellant had a right arm impairment due to loss of right shoulder motion of 21 percent and a moderate right shoulder subluxation impairment of 24 percent, for a combined right arm impairment of 40 percent.

In September 2008, OWCP referred appellant for a second opinion evaluation to Dr. Michael Giovanniello, a Board-certified physiatrist, who noted the history of injury and reviewed the medical record. He advised that appellant had residual chronic deltoid tear, persistent full thickness rotator cuff tear, post-traumatic glenohumeral arthritis, glenohumeral subluxation and chronic shoulder pain with significantly restricted range of motion and significantly impaired function, all of which were the consequence of the December 11, 1985 employment injury and subsequent surgical procedures. Dr. Giovanniello provided examination findings, noting significant guarding of the right arm and provided range of motion findings of 80 degrees of flexion, 15 degrees of extension, 80 degrees of abduction, 5 degrees of adduction, 25 degrees of internal rotation and 50 degrees of external rotation. He advised that, under Figures 16-40, 16-43 and 16-46 of the fifth edition of the A.M.A., *Guides*, appellant's range of motion deficits yielded a 21 percent impairment, and that under Table 16-22 in conjunction with Table 16-18,[7] he had an additional 24 percent impairment due to persistent glenohumeral subluxation on the right. When combined with the 21 percent impairment due to loss of shoulder motion, appellant had a total of 40 percent right arm impairment due to the December 1985 work injury.

On October 30, 2008 OWCP accepted additional work-related conditions of recurrent dislocation, shoulder region, right/right shoulder subluxation; complete rotator cuff rupture, right/persistent full-thickness right rotator cuff tear; localized unspecific osteoarthritis, shoulder region, right/post-traumatic right glenohumeral arthritis.

In a November 13, 2008 report, Dr. Ronald J. Swarsen, a medical adviser, reviewed the medical record, including the report of Dr. Giovanniello. Dr. Swarsen advised that the shoulder instability should be assessed in accordance with pages 501-03 of the fifth edition, rather than under the tables referenced by Dr. Giovanniello. He also disagreed with Dr. Giovanniello's assessment of the right shoulder range of motion impairment, advising that it was 20 percent rather than 21 percent. Dr. Swarsen recommended that Dr. Giovanniello be contacted to address these issues. In a supplementary report dated April 8, 2009, Dr. Giovanniello advised that 20 percent was the correct impairment rating for right shoulder decreased motion. He further advised that right shoulder subluxation should have been evaluated under Table 16-26, which provided for a 12 percent impairment due to the subluxing humeral head. Dr. Giovanniello concluded that appellant had a 30 percent right upper extremity impairment, secondary to the December 11, 1985 employment injury. On May 8, 2009 Dr. Swarsen reviewed

[7] This report contains a typographical error. Dr. Giovanniello stated that he utilized Table 16-8 and referred to page 499. A review of the fifth edition of the A.M.A., *Guides* indicates that Table 16-18 is on page 499, not Table 16-8. A.M.A., *Guides*, fifth edition, *supra* note 3 at 499.

Dr. Giovanniello's April 8, 2009 report and agreed with his conclusion that appellant had a 30 percent right upper extremity impairment, with a date of maximum medical improvement of June 14, 2003.

On May 29, 2009 OWCP informed appellant that all further impairment ratings had to comply with the sixth edition of the A.M.A., *Guides*. It referred him to Dr. Aubrey Swartz, a Board-certified orthopedic surgeon, for an impairment evaluation. In a September 19, 2009 report, Dr. Swartz noted his review of the statement of accepted facts and medical record. He stated that appellant drove a manual shift vehicle and described his complaints of persistent radiating right shoulder pain and pain in his neck from a cervical spine strain. Since appellant's retirement in September 2000, he had worked in private jobs including child care, massage therapy, and with a construction company as an equipment operator in 2005 and 2006. He advised that appellant markedly guarded his right shoulder and did not like to move it because it was painful. Dr. Swartz provided right shoulder examination findings, noting that appellant was very tender to light fingertip touch. Range of motion examination demonstrated flexion of 10 degrees, abduction of 30 degrees, adduction of 20 degrees, extension of 20 degrees, internal rotation of 5 degrees and external rotation of 5 degrees. There were no neurologic findings. Dr. Swartz stated that, under the sixth edition, none of the diagnoses found in Table 15-5, Shoulder Regional Grid, addressed limited motion but found that appellant would best be placed into the diagnostic classification for rotator cuff injury, full-thickness tear with a residual loss. He found that, for a rotator cuff tear, the default value was grade C or a five percent upper extremity impairment. Dr. Swartz then applied the grade modifiers, finding that, under functional history appellant had a severe problem for a grade modifier of 3; that under physical examination he also had a severe problem, for a grade modifier of 4; and that under clinical studies he also had severe pathology, for a grade modifier of 3. He then applied the net adjustment formula, finding that an adjustment of plus six resulted in grade E for a seven percent upper extremity impairment. Dr. Swartz also advised that appellant had a diagnosis of adhesive capsulitis which was not addressed in the Shoulder Regional Grid. Based on this, the range of motion method would be the proper way to address appellant's right upper extremity impairment. He found that, under Table 15-34,[8] flexion of 10 degrees or less resulted in a 16 percent upper extremity impairment; extension of 20 degrees yielded a 2 percent impairment; abduction of 30 degrees yielded a 6 percent impairment; adduction of 20 degrees yielded a 1 percent impairment; internal rotation of 5 degrees yielded a 9 percent impairment; and external rotation of 5 degrees yielded an 8 percent impairment, or a total 42 percent impairment of the right upper extremity due to loss of shoulder motion. Dr. Swartz determined that the date of maximum medical improvement was two years past the date of appellant's most recent shoulder surgery of June 25, 2004.

On November 13, 2009 Dr. Swarsen, OWCP's medical adviser, reviewed Dr. Swartz's report. He disagreed with Dr. Swartz's conclusion that appellant had a 42 percent arm impairment, noting that this was based solely on range of motion, not a diagnosis-based impairment. Dr. Swarsen stated that he had noted a discrepancy between the range of motion findings and Dr. Swartz's report that on physical examination appellant exhibited marked guarding of motion and was very tender to light fingertip touch. Dr. Swartz also reported that

[8] Dr. Swartz's report contains a typographical error. He identified Table 15-4, on page 475 of the sixth edition of the A.M.A., *Guides*. A review of the sixth edition indicates that Table 15-34, Shoulder Range of Motion, is found on page 475, not Table 15-4. A.M.A., *Guides*, sixth edition, *supra* note 2 at 475.

appellant drove a manual transmission vehicle. Dr. Swarsen advised that the A.M.A., *Guides* provides that, when such discrepancies exist, range of motion cannot be relied on to determine an impairment rating and should be disregarded. He concluded that appellant had seven percent right upper extremity impairment and thus was not entitled to an increased award.

On January 5, 2010 OWCP forwarded Dr. Swarsen's report to Dr. Swartz for review. In a January 13, 2010 report, Dr. Swartz advised that, with respect to signs of marked guarding, there was marked restriction of motion during the September 19, 2009 examination. He advised that some may well have been voluntary, and the tenderness to very light touch would also indicate some degree of embellishment. Dr. Swartz noted that the substantial pathology of multiple operations, which produced additional scar tissue, adhesions, fibrosis and arthritis, could contribute to further limitation of motion. He reviewed the diagnosis-based impairments in Table 15-5, but found that range of motion method was a more appropriate method, "although admittedly his markedly restricted motion was of concern." Dr. Swartz stated a rotator cuff tear diagnosis but assessing appellant's impairment under range of motion was more equitable. Appellant's impairment could be assessed under Table 15-5 for a diagnosis of post-traumatic degenerative joint disease based on the arthritis in the glenohumeral joint. Dr. Swartz determined that, under Table 15-5, appellant would be in class 1 for a default value of five percent. He applied the modifiers, finding a functional history modifier of 2, a physical examination modifier of 2 and a clinical studies modifier of 2. Dr. Swartz then applied the net adjustment formula, concluding that appellant would have an adjustment of zero, with a total right upper extremity impairment of 5 percent for a diagnosis-based impairment, versus a 42 percent impairment based on range of motion. Dr. Swartz concluded that appellant should be reexamined for a very careful look at his range of motion, both actively and passively on a gentle basis.

On January 21, 2010 OWCP referred appellant back to Dr. Swartz. In a February 9, 2010 report, Dr. Swartz noted appellant's report that he last drove a manual shift vehicle over 10 years prior and continued to provide massage therapy for patients with disabilities for about two hours per week. Appellant had continued complaints of right shoulder and neck pain, similar to those of his prior examination. Dr. Swartz reviewed the record and provided examination findings, including both active and passive range of motion findings of the right shoulder. Right shoulder active flexion was 10 degrees and passive flexion 75 degrees; active abduction was 55 degrees and passive abduction was 110 degrees; active adduction was 20 degrees and passive adduction was 40 degrees; active extension was 40 degrees and passive extension was 45 degrees; active internal rotation was 5 degrees and passive internal rotation was 10 degrees; active external rotation was 0 degrees and passive was 20 degrees. Dr. Swartz stated that the A.M.A., *Guides* provide that, if full active excursion is incomplete, assisted active and/or passive measurements are necessary. He opined that there appeared to be substantial voluntary restriction by appellant. Dr. Swartz stated that appellant was probably a reasonably functional individual, and there appeared to be some level of embellishment during both examinations. He found it appropriate to utilize the passive range of motion instead of the active range of motion in assessing appellant's right upper extremity impairment, due to the discrepancy between the active and passive range of motion measurements and because appellant had no atrophy of the right arm. Dr. Swartz found that, under Table 15-34 of the A.M.A., *Guides*, flexion of 75 degrees yielded a three percent upper extremity impairment; abduction of 110 degrees yielded a three percent impairment; adduction of 20 degrees yielded a one percent impairment; extension of 95 degrees yielded no impairment; internal rotation of 10 degrees yielded a four percent impairment; and

external rotation of 20 degrees yielded a four percent impairment. He added the impairments, finding a total 15 percent upper extremity impairment due to loss of shoulder motion. Dr. Swartz then referred to Table 15-35 and advised that a 15 percent upper extremity impairment would qualify for a grade 1 modifier. He referenced Table 15-7, stating that appellant's symptoms with normal activities and use of medication to control his symptoms would place him in a grade modifier of 2. Dr. Swartz then referred to Table 15-36 and found that appellant's range of motion impairment of 15 percent would by multiplied by 0.5 percent, which yielded an additional 0.75, rounded up to 1.0, for a total right upper extremity impairment of 16 percent.

On April 2, 2010 Dr. Swarsen, the medical adviser, accepted the rating of Dr. Swartz and found that appellant did not have greater impairment than that previously awarded.

In an April 22, 2010 decision, OWCP found no increased impairment.

Appellant requested a hearing that was held on August 10, 2010. At the hearing, he contended that Dr. Swartz hurt him during the second examination and asserted that the 16 percent impairment rating was not fair.

In a November 16, 2010 decision, an OWCP hearing representative affirmed the April 22, 2010 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,[9] and its implementing federal regulations,[10] 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.[11] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* was used to calculate schedule awards.[12] For decisions issued after May 1, 2009, the sixth edition is used.[13]

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).[14] 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

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] *Id.* at § 10.404(a).

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

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

[14] A.M.A., *Guides*, *supra* note 2 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

Clinical Studies (GMCS).[15] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[16]

Although the diagnosis-based approach is the preferred method of evaluating permanent impairment under the sixth edition of the A.M.A., *Guides*,[17] Table 15-5, Shoulder Regional Grid, provides that, if loss of motion is present, the impairment may alternatively be assessed under section 17-7, range of motion impairment.[18] A range of motion impairment stands alone and is not combined with a diagnosis-based impairment.[19]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[20]

ANALYSIS

The Board finds that appellant has no greater right arm impairment than that previously awarded. Appellant received schedule awards for impairment totaling 49 percent. A schedule award for a 16 percent right upper extremity was granted on January 23, 1990, a schedule award for a 28 percent impairment on April 7, 1992,[21] and a schedule award for an additional 5 percent on May 27, 2003.

Appellant filed a claim for an additional schedule award on February 14, 2007. The Board finds that the weight of the medical evidence rests with the February 9, 2010 report of Dr. Swartz, a Board-certified orthopedic surgeon and OWCP referral physician, who found that appellant had a total 16 percent impairment of the right arm.

Dr. Anden's March 29, 2007 and April 10, 2008 reports are insufficient to establish entitlement to an increased schedule award. On March 29, 2007 Dr. Anden advised that in accordance with the fifth edition of the A.M.A., *Guides*, appellant's decrease in right shoulder range of motion yielded a 22 percent impairment, and that he had an additional 24 percent impairment, found under Table 16-22 and Table 16-18, due to right shoulder subluxation, for a combined right upper extremity impairment of 39 percent. He also provided right shoulder range of motion findings in an April 10, 2008 report, which showed that appellant's shoulder motion had improved. Dr. Anden, however, referred to the March 29, 2007 impairment evaluation without further explanation or addressing the improved right shoulder range of motion. The fifth

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

[16] *Id*. at 411.

[17] *Id*. at 461, section 15.7.

[18] *Id*. at 401-05.

[19] *Supra* note 14.

[20] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[21] *Id*. at 461, section 15.7.

edition of the A.M.A., *Guides* provides that shoulder instability is to be assessed under Table 16-26, Upper Extremity Impairment Due to Symptomatic Shoulder Instability Patterns, rather than Table 16-22 and Table 16-18.[22] For these reasons, Dr. Anden's reports are insufficient to establish greater impairment.

In an October 13, 2008 report, Dr. Giovanniello, an OWCP referral physician, advised that appellant's range of motion measurements yielded a 21 right upper extremity impairment, and that glenohumeral subluxation on the right yielded an additional 24 percent impairment, for a total right upper extremity impairment of 40 percent. As noted by Dr. Swarsen, OWCP's medical adviser, Dr. Giovanniello's range of motion measurements yielded a 20 percent right upper extremity impairment, rather than the 21 percent as rated. Dr. Swarsen also properly explained that a subluxing humeral head should be rated under Table 16-26.[23] Dr. Giovanniello's October 13, 2008 report does not establish entitlement to an increased schedule award. In a supplementary report dated April 8, 2009, he properly advised that appellant's right shoulder range of motion measurements yielded a 20 percent impairment. Dr. Giovanniello further found that, under Table 16-26, a subluxing humeral head yielded a 12 percent impairment. While these calculations were correct under the fifth edition of the A.M.A., *Guides*, as noted by Dr. Giovanniello, a 20 percent impairment combined with a 12 percent impairment yielded a 30 percent right upper extremity impairment, which is less than the 49 percent right upper extremity impairment previously rated. Dr. Giovanniello's April 8, 2009 report is insufficient to establish greater impairment.

As noted, effective May 1, 2009, the sixth edition of the A.M.A., *Guides* is to be used in noting permanent impairment. The method used in rating impairment for purposes of a schedule award is a matter which rests in the sound discretion of the Director. In the case *Harry D. Butler*,[24] the Board addressed OWCP's use of the A.M.A., *Guides* to evaluate impairment since the first edition single volume published in 1971. The Director has adopted the subsequent editions of the A.M.A., *Guides* and stated the specific date when use of each edition should be made applicable to claims under FECA. Appellant has not established that the Director abused his discretion delegated under section 8107 or the implementing federal regulations to make the sixth edition of the A.M.A., *Guides* applicable to all claimants as of May 1, 2009. The fact that the sixth edition revised the evaluation methods used in previous editions does not establish error or abuse of discretion. As noted in FECA Bulletin No. 09-03,[25] the American Medical Association periodically revises the A.M.A., *Guides* to incorporate current scientific clinical knowledge and judgment and to establish standardized methodologies for calculating permanent impairment.[26]

The only medical reports of record that were completed in accordance with the sixth edition are those of Dr. Swartz dated September 19, 2009, January 13 and February 9, 2010.

[22] A.M.A., *Guides* 503-05 (5th ed.).

[23] *Id.* at 505.

[24] 43 ECAB 859 (1992).

[25] FECA Bulletin No. 09-03, *supra* note 13.

[26] *See R.W.*, Docket No. 11-456 (issued September 28, 2011).

Dr. Swarsen, the medical adviser, reviewed these reports. As Dr. Swartz's September 19, 2009 report contained inconsistencies, he was asked to provide an updated examination and impairment rating.

Dr. Swartz explained in his January 5, 2010 report that appellant exhibited marked restriction of motion at his September 19, 2009 examination. He advised that some may well have been voluntary, and the tenderness to very light touch would also indicate some degree of embellishment. Dr. Swartz concluded that appellant should be reexamined for a very careful look at his range of motion, both actively and passively on a gentle basis. Upon reexamination on February 9, 2010 he opined that there appeared to be substantial voluntary restriction by appellant, and that there appeared to be some level of embellishment at both office visits. Dr. Swartz provided both active and passive range of motion measurements and recommended that passive range of motion be utilized in assessing appellant's right upper extremity impairment, due to the discrepancy between the measurements for active and passive range of motion and because appellant had no atrophy of the right upper extremity.[27] He found that, under Table 15-34 of the A.M.A., *Guides*, appellant had a total 15 percent upper extremity impairment due to loss of shoulder motion. Dr. Swartz then properly referred to the modifiers found in Table 15-35 and Table 15-36, and assigned appellant a total right upper extremity impairment of 16 percent. Dr. Swarsen reviewed this report and properly found that appellant was not entitled to an additional schedule award.

The Board finds that the weight of the medical evidence establishes only a 16 percent right upper extremity impairment. Appellant is not entitled to an increased schedule award. There is no other probative medical evidence of record addressing the extent of his permanent impairment under the appropriate edition of the A.M.A., *Guides*, which supports any greater impairment.

As to appellant's argument that he was injured durning examination, the general rule respecting consequential injuries is that, when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause, which is attributable to the employee's own intentional conduct. The subsequent injury is compensable if it is the direct and natural result of a compensable primary injury.[28] Any medical condition resulting from authorized examination or treatment may form the basis of a compensation claim for impairment or disability, regardless of the compensability of the original injury.[29] Nonetheless, in this case appellant has not filed a claim for a consequential injury, and OWCP has not issued a decision on this issue. The Board's jurisdiction extends only to the review of final decisions issued by OWCP.[30]

[27] Dr. Swartz found that right shoulder active flexion was 10 degrees and passive flexion 75 degrees; active abduction was 55 degrees and passive abduction was 110 degrees; active adduction was 20 degrees and passive adduction was 40 degrees; active extension was 40 degrees and passive extension was 45 degrees; active internal rotation was 5 degrees and passive internal rotation was 10 degrees; active external rotation was 0 degrees and passive was 20 degrees.

[28] *J.J.*, Docket No. 09-27 (issued February 10, 2009).

[29] *D.B.*, 58 ECAB 354 (2007).

[30] 20 C.F.R. § 501.2(c); *E.L.*, 59 ECAB 405 (2008).

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 entitlement to an additional schedule award for his right upper extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the November 16, 2010 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: March 22, 2012
Washington, DC

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

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

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