United States Department of Labor
Employees' Compensation Appeals Board

J.W., Appellant	)	
and	)	**Docket No. 12-1567**
	)	**Issued: November 8, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Chambers, GA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On July 16, 2012 appellant filed a timely appeal from a March 5, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) which granted him a schedule award. He also appealed an April 24, 2012 decision finding that he abandoned his request for a hearing. 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 case.

ISSUES

The issues are: (1) whether appellant has more than 10 percent impairment of his right arm for which he received a schedule award; and (2) whether OWCP properly determined that appellant abandoned his request for a hearing.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On September 30, 2008 appellant, then a 51-year-old letter carrier, filed a Form CA-1, notice of traumatic injury, alleging that he sustained a right shoulder injury while delivering a heavy parcel. He did not stop work but returned to a limited-duty position and full duty on January 28, 2010. OWCP accepted appellant's claim for sprain of the right shoulder, trapezius and osteoarthritis of the right shoulder.

Appellant came under the treatment of Dr. Thomas Branch, a Board-certified orthopedist, from January 13, 2009 to December 10, 2010, for a right shoulder injury sustained on September 28, 2008 while lifting a parcel of mail at work. He noted tenderness over the acromioclavicular joint with a positive impingement sign. Dr. Branch diagnosed tendinitis of the right rotator cuff, disorders of the bursae and displacement of the cervical intervertebral disc. On September 17, 2010 he noted appellant's continued complaints of right shoulder pain in the acromioclavicular region and recommended surgery. On December 10, 2010 appellant underwent an authorized right shoulder diagnostic arthroscopy, distal clavicle resection and subacromial decompression. Dr. Branch diagnosed arthritis of the shoulder, subacromial bursitis, rotator cuff tendinitis and shoulder pain. On January 26, 2010 appellant underwent a magnetic resonance imaging (MRI) scan of the right shoulder which revealed marginal anatomic setting for impingement. An MRI scan of the cervical spine dated January 26, 2010 revealed generalized degenerative disc changes at all levels of the cervical spine from C4-5 and C7-T1.

Appellant continued to be treated by Dr. Branch, who noted in reports dated December 23, 2010 to August 23, 2011, that appellant was progressing well postoperatively and returned to work limited duty on June 12, 2011 and full duty on August 23, 2011. Dr. Branch diagnosed adhesive capsulitis of the shoulder, osteoarthrosis of the primary shoulder region, bicipital tenosynovitis and disorders of the bursae and tendons of the shoulder.

On December 9, 2011 appellant filed a claim for a schedule award. He submitted an October 4, 2011 report from Dr. Branch who noted appellant's symptoms remained stable for 10 months. Dr. Branch noted tenderness of the anterior acromion and biceps tendon, abduction was 165 degrees, external rotation was 85 degrees, negative impingement sign, cross body abduction revealed residual pain at the acromioclavicular joint and the biceps stress test was positive. He opined that appellant was at maximum medical improvement. Dr. Branch provided an impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[2] of 12 percent permanent impairment of the right upper extremity. He noted that, pursuant to Table 15-5, Shoulder Regional Grid, Ligament/Bone/Joint, for the distal clavicle resection, appellant had a 12 percent impairment of the right upper extremity.

In a December 20, 2011 report, OWCP's medical adviser reviewed the medical evidence and opined that appellant reached maximum medical improvement on October 4, 2011. He noted that there were two methodologies to be considered in rating a case under the A.M.A., *Guides,* the Diagnosis-Based Impairment or range of motion method. The medical adviser noted

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

that the greater of the two methods was the most appropriate. He noted that, pursuant to section 15.2, Diagnosis-Based Impairment, Table 15-5, Shoulder Regional Grid, Ligament/Bone/Joint, for the diagnosed acromioclavicular disease, status post distal clavicle resection, appellant was a class 1 rating for status post distal clavicle resection, grade C, with a default rating of 10 percent upper extremity impairment. The medical adviser noted that, pursuant to the adjustment grid: functional history, Table 15-7, appellant was assigned a grade modifier 1 for pain symptoms. For physical examination adjustment, appellant was assigned a grade modifier of 1 as the physical examination reported motion loss. For clinical studies adjustment, there was no grade modifier. The medical adviser noted that the adjustments were for functional history grade modifier 1, physical examination grade modifier of 1. Application of the net adjustment formula resulted in a grade C and 10 percent upper extremity impairment. The medical adviser noted that, with regard to the range of motion method for impairment evaluation, Table 15-34, Shoulder Range of Motion, provides that 165 degrees of abduction and 85 degrees of external rotation yields no impairment.[3] He noted that the diagnosis-based impairment provided the greatest impairment.

On January 30, 2012 OWCP requested Dr. Branch to review the impairment rating of the medical adviser and address whether he concurred with his impairment determination. In a February 16, 2012 report, Dr. Branch noted reviewing the report of the medical adviser and concurring in his finding that appellant sustained 10 percent impairment of the right upper extremity. He opined that his impairment rating of 12 percent was incorrect.

In a decision dated March 5, 2012, OWCP granted appellant a schedule award for 10 percent impairment of the right arm. The period of the award was from January 4 to August 9, 2012.

Appellant requested an oral hearing. On March 7, 2012 OWCP advised him that a telephone hearing would be held on April 13, 2012 at 9:45 p.m. Eastern Time. It instructed appellant to call the provided toll-free number a few minutes before the hearing time and enter the pass code to gain access to the conference call. OWCP mailed the April 13, 2012 letter to appellant's address of record.

Appellant submitted operative reports for the December 10, 2010 arthroscopic surgery, previously of record.

By decision dated April 24, 2012, OWCP found that appellant had abandoned his request for a hearing. It determined that he received a written notice of the hearing 30 days before the scheduled hearing but did not appear and did not explain his absence either before or after the scheduled hearing.

[3] *Id.* at 495, Table 15-34.

LEGAL PRECEDENT -- ISSUE 1

Section 8107 of FECA[4] and its implementing federal regulations,[5] 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.[6] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[8]

ANALYSIS -- ISSUE 1

Appellant's claim was accepted by OWCP for trapezius sprain of the right shoulder and osteoarthritis of the right shoulder for which he underwent surgery on December 15, 2010 for distal clavicle resection and subacromial decompression. On December 9, 2011 he filed a claim for a schedule award. The Board finds that the medical evidence of record establishes 10 percent impairment to appellant's right arm.

Under the sixth edition of the A.M.A., *Guides*, impairments of the upper extremities are covered by Chapter 15. Section 15-2, entitled diagnosis-based impairment, which indicates that diagnosis-based impairment is the primary method of evaluation of the upper limb.[9] The initial step in the evaluation process is to identify the impairment class by using the corresponding diagnosis-based regional grid. Appellant's treating physician, Dr. Branch, in reports dated October 4, 2011 and February 16, 2012, noted tenderness of the anterior acromion and biceps tendon, abduction was 165 degrees, external rotation was 85 degrees, negative impingement sign, cross body abduction revealed residual pain at the acromioclavicular joint and the biceps stress test was positive. He utilized the Shoulder Regional Grid, Table 15-5, A.M.A., *Guides*, page 402, and identified a class 1 impairment based on a distal clavicle resection. Dr. Branch noted that, pursuant to the shoulder regional grid, ligament/bone/joint, for the distal clavicle resection, appellant was entitled to a 10 percent impairment of the right upper extremity.[10]

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id.* at § 10.404(a).

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

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

[9] Section 15.2, A.M.A., *Guides* 387.

[10] In his October 4, 2011 report, Dr. Branch opined that appellant had 12 percent right arm impairment but he did not explain how he applied the A.M.A., *Guides* to reach this rating. It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his opinion is of diminished probative. *Linda Beale*, 57 ECAB 429 (2006). As noted, *infra*, Dr. Branch acknowledged in his February 16, 2012 report that his 12 percent rating was incorrect and concurred with OWCP's medical adviser's rating of 10 percent.

Based on Dr. Branch's physical examination, an OWCP medical adviser utilized the sixth edition of the A.M.A., *Guides* to rate 10 percent impairment of the right arm. The medical adviser noted that there were two methodologies to be considered in rating a case under the A.M.A., *Guides*, the diagnosis-based impairment or range of motion method. He noted that the greater of the two methods was the most appropriate. Under the range of motion method, the medical adviser found, as noted above, that there was no ratable impairment. He noted that pursuant to section 15.2, diagnosis-based impairment, Table 15-5, shoulder regional grid, ligament/bone/joint, for the diagnosed acromioclavicular disease, status post distal clavicle resection, appellant was a class 1 rating for status post distal clavicle resection with a default grade C, impairment rating of 10 percent upper extremity impairment. After determining the impairment class (CDX) and default grade, the medical adviser determined whether there were any applicable grade adjustments for so-called nonkey factors or modifiers. These include adjustments for Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). The grade modifiers are used in the net adjustment formula to calculate a net adjustment.[11] The final impairment grade is determined by adjusting the grade up or down from the default value C by the calculated net adjustment. The medical adviser identified two modifiers; one based on the functional history and the other based on physical examination. For the functional history, he assigned a grade modifier 1 based on pain symptoms. The medical adviser also assigned a grade modifier 1 based on appellant's right shoulder physical examination findings.[12] Applying the net adjustment formula resulted in a modifier of zero. The corresponding upper extremity impairment for a class 1, grade C, distal clavicle resection was 10 percent.[13] As noted, Dr. Branch, in his February 16, 2012 report, concurred with this rating.

The Board finds that the medical adviser properly applied the A.M.A., *Guides* (6th ed. 2008) to rate impairment to appellant's right arm. There is no medical evidence in conformance with the A.M.A., *Guides* that supports any greater impairment.

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.

LEGAL PRECEDENT -- ISSUE 2

OWCP regulations provide guidance as to how a claimant may postpone a hearing, and when a hearing will be considered to be abandoned. Section 10.622 of the regulations provide:

> "(c) Once the oral hearing is scheduled and OWCP has mailed appropriate written notice to the claimant and representative, OWCP will, upon submission of proper written documentation of unavoidable serious scheduling conflicts (such as court-ordered appearances/trials, jury duty or previously scheduled outpatient procedures), entertain requests from a claimant or his representative for

[11] Net Adjustment = (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX). Section 15.3d, A.M.A., *Guides* 411.

[12] Table 15-8, A.M.A., *Guides* 408.

[13] Table 15-5, A.M.A., *Guides* 402.

rescheduling as long as the hearing can be rescheduled on the same monthly docket, generally no more than seven days after the originally scheduled time. When a request to postpone a scheduled hearing under this subsection cannot be accommodated on the docket, no further opportunity for an oral hearing will be provided. Instead, the hearing will take the form of a review of the written record and a decision issued accordingly.

"(d) Where the claimant or representative is hospitalized for a nonelective reason or where the death of the claimant's or representative's parent, spouse, child or other immediate family prevents attendance at the hearing, OWCP will, upon submission of proper documentation, grant a postponement beyond one monthly docket.

"(e) Decisions regarding rescheduling under paragraphs (b) through (d) of this section are within the sole discretion of the hearing representative and are not reviewable.

"(f) A claimant who fails to appear at a scheduled hearing may request in writing within 10 days after the date set for the hearing that another hearing be scheduled. Where good cause for failure to appear is shown, another hearing will be scheduled and conducted by teleconference. The failure of the claimant to request another hearing within 10 days, or the failure of the claimant to appear at the second scheduled hearing without good cause shown, shall constitute abandonment of the request for a hearing. Where good cause is shown for failure to appear at the second scheduled hearing, review of the matter will proceed as a review of the written record."[14]

ANALYSIS -- ISSUE 2

By decision dated March 5, 2012, OWCP granted appellant a schedule award for 10 percent impairment of the right arm. Appellant timely requested an oral hearing. In a March 7, 2012 letter, OWCP notified him that a telephone hearing was scheduled for April 13, 2012 at 9:45 p.m., Eastern Time. It instructed appellant to telephone a toll-free number and enter a pass code to connect with the hearing representative. Appellant did not telephone at the appointed time. He did not request a postponement of the hearing or explain his failure to appear at the hearing within 10 days of the scheduled hearing date of April 13, 2012.[15] The Board therefore finds that appellant abandoned his request for a hearing.

[14] 20 C.F.R. § 10.622. With respect to abandonment of hearing requests, OWCP's procedures provide that the failure of the claimant to request another hearing within 10 days, or the failure of the claimant to appear at the second scheduled hearing without good cause shown, shall constitute abandonment of the request for a hearing. Under these circumstances, the Branch of Hearings and Review will issue a formal decision finding that the claimant has abandoned his or her oral request for a hearing. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Hearings and Review of the Written Record*, Chapter 2.1601.6(g) (October 2011).

[15] *Id*.

On appeal appellant asserted that he underwent surgery and was heavily medicated and could not remember daily events and did not abandon the hearing. As explained, he failed to request a postponement; failed to appear at a scheduled hearing; and failed to provide any notification for such failure within 10 days of the scheduled date and therefore abandoned his request for a hearing.

CONCLUSION

The Board finds that appellant has no more than 10 percent impairment of the right arm, for which he received a schedule award. The Board further finds that he abandoned his request for an oral hearing.

ORDER

IT IS HEREBY ORDERED THAT the April 24 and March 5, 2012 decisions of Office of Workers' Compensation Programs are affirmed.

Issued: November 8, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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