United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 13-152**
	)	**Issued: June 5, 2013**
DEPARTMENT OF THE NAVY, PACIFIC FLEET SHIPYARD, Pearl Harbor, HI, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 16, 2012[1] appellant filed a timely appeal of an April 27, 2012 Office of Workers' Compensation Programs' (OWCP) merit decision addressing his permanent impairment for schedule award purposes. Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

[1] Under the Board's *Rules of Procedure*, the 180-day time period for determining jurisdiction is computed beginning on the day following the date of OWCP's decision. *See* 20 C.F.R. § 501.3(f)(2). As OWCP's merit decision was issued on April 27, 2012, the 180-day computation begins April 28, 2012. One hundred and eighty days from April 28, 2012 was October 24, 2012. Since using October 25, 2012, the date the appeal was received by the Clerk of the Board, would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is October 16, 2012, which renders the appeal timely filed. *See* 20 C.F.R. § 501.3(f)(1).

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has more than seven percent impairment of his right upper extremity and three percent impairment of his left upper extremity for which he has received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board on appeal. On June 3, 1999 appellant, then a 46-year-old marine machinery mechanic, filed a traumatic injury claim alleging that he injured his right shoulder while unloading his tools in the performance of duty. OWCP accepted his claim for right shoulder strain and temporary aggravation of cervical degenerative disc disease and cervical subluxation. 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 neurosurgeon, performed this surgery. Appellant returned to light-duty work on March 17, 2003.

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, a Board-certified orthopedic surgeon, diagnosed shoulder impingement and AC degenerative joint disease on April 21, 2008. An x-ray dated April 21, 2008 demonstrated a mild glenohumeral and AC degenerative changes.

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. In its September 13, 2011 decision, the Board found that the medical evidence did not include 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* and remanded 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.[3]

Following the Board's September 13, 2011 decision, OWCP referred appellant for a second opinion evaluation with Dr. Stephen Scheper, an osteopath Board-certified in physical

[3] Docket No. 11-55 (issued September 13, 2011).

medicine and rehabilitation. In his October 28, 2011 report, Dr. Scheper reviewed appellant's diagnostic test results and x-rays. He examined appellant's shoulders and found on the range of motion on the right including flexion, 130 degrees, extension 40 degrees, abduction 130 degrees, adduction 30 degrees, external rotation of 70 degrees and internal rotation of 50 degrees. On the left appellant demonstrated 140 degrees of flexion, 40 degrees of extension, 100 degrees of abduction, 30 degrees of adduction, 40 degrees of external rotation and 20 degrees of internal rotation. Dr. Scheper found Empty Can, Neers and Yergasons tests positive on the right and Hawkins and Speeds tests positive on the left. He reported diffuse tenderness in the right of the supraspinatus, infraspinatus, subscapularis and biceps brachial at the proximal humerus. Dr. Scheper diagnosed chronic right shoulder pain and functional impairment secondary to subacromial impingement and partial rotator cuff tear, chronic degenerative joint disease of the glenohumeral and AC joints as well as right suprascapular neuropathy with resultant motor deficit right infraspinatus, supraspinatus and degenerative cervical spine disease. He opined that appellant reached maximum medical improvement on or before February 19, 2003.

Dr. Scheper applied the A.M.A., *Guides*,[4] and found that appellant had impingement syndrome in accordance with Table 15-5 of the A.M.A., *Guides*, a class 1 impairment. He determined that appellant's functional history grade modifier was one due to pain with strenuous or vigorous activity and the ability to perform self-care activities independently and a *Quick*DASH score of 34. Dr. Scheper reached a physical examination grade modifier of two due to positive finding with provocative testing and a 14 percent decrease in range of motion from normal based on Table 15-34. He found that appellant's clinical studies grade modifier was one due to mild pathology and reached a net adjustment of plus one, grade D, four percent impairment of the upper extremity.

Dr. Scheper also determined that appellant had a motor deficit of mild severity or grade 1, Table 15-14, peripheral nerve impairment of the suprascapular in accordance with Table 15-21 a class 1 impairment. He found a clinical studies grade modifier of two due to axon loss with abnormal spontaneous activity on EMG. Dr. Scheper stated, "EMG report did not distinguish between 1+ or 2+ abnormal spontaneous activity, although significant atrophy is noted on physical examination, so the more severe grade modifier was adopted." He determined that functional history grade modifier was one due to significant intermittent symptoms and that the *Quick*DASH score was 34. Applying the formula, Dr. Scheper reached a net adjustment of positive one grade D or three percent impairment of the upper extremity. He concluded that appellant had an upper extremity impairment of seven percent.

OWCP's medical adviser reviewed this report on December 24, 2011. He found four percent upper extremity impairment due to residual right shoulder tendinitis and impingement in accordance with Table 15-5 of the A.M.A., *Guides*. OWCP's medical adviser further found one percent right upper extremity impairment due to pain and impaired sensation due to right C5 radiculopathy, one percent impairment due to right C6 radiculopathy and one percent impairment due to right C7 radiculopathy. He combined appellant's right upper extremity impairments to reach seven percent. OWCP also found that appellant had three percent left upper extremity impairments due to cervical radiculopathy at C5, C6 and C7.

[4] A.M.A., *Guides*, 6th ed. (2009).

By decision dated April 27, 2012, OWCP granted appellant an additional three percent impairment of the right upper extremity for a total of seven percent impairment of this scheduled member. It found that he had no additional impairment of his left upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing regulations[6] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or 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*.[7]

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).[8]

No schedule award is payable for a member, function or organ of the body not specified in FECA or in the regulations.[9] 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,[10] no claimant is entitled to such an award.[11]

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

[5] 5 U.S.C. §§ 8101-8193, 8107.

[6] 20 C.F.R. § 10.404.

[7] 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).

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

[9] *W.D.*, Docket No. 10-274 (issued September 3, 2010); *William Edwin Muir*, 27 ECAB 579 (1976).

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

[11] *W.D., supra* note 9. *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.[12]

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

ANALYSIS

OWCP accepted appellant's claim for right shoulder strain and temporary aggravation of cervical degenerative disc disease and cervical subluxation as well as C3-4, C5-6 and C6-7 microforaminotomy with some decompression of the lateral spinal cord. The Board previously found that the medical evidence did not establish appellant's permanent impairment for schedule award purposes and remanded the case for additional development. OWCP referred appellant for a second opinion evaluation with Dr. Scheper, who examined appellant on October 28, 2011 concluding that he had seven percent impairment of his right upper extremity due to impingement syndrome and peripheral suprascapular nerve involvement.

Dr. Scheper found that appellant had right impingement syndrome, class 1 impairment.[17] He determined that appellant's functional history grade modifier was one due to pain with strenuous or vigorous activity and the ability to perform self-care activities independently and a *Quick*DASH score of 34. Dr. Scheper reached a physical examination grade modifier of two due to positive finding with provocative testing and a 14 percent decrease in range of motion from normal based on Table 15-34.[18] He found that appellant's clinical studies grade modifier was one due to mild pathology and reached a net adjustment of plus 1, grade D, four percent impairment of the right upper extremity. OWCP's medical adviser agreed that appellant had

[12] *W.D., supra* note 9. *Rozella L. Skinner*, 37 ECAB 398 (1986).

[13] FECA Transmittal No. 10-04 (issued January 9, 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Exhibit 4 (January 2010).

[14] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 (January 2010) (Exhibits 1, 4).

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

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

[17] *Id*. at 402, Table 15-5

[18] *Id*. at 475, Table 15-34.

four percent upper extremity impairment due to residual right shoulder tendinitis and impingement in accordance with Table 15-5 of the A.M.A., *Guides*.

Dr. Scheper also determined that appellant had a motor deficit of mild severity or class 1, Table 15-14[19] peripheral nerve impairment of the suprascapular of the right upper extremity in accordance with Table 15-21, class 1 impairment.[20] He found a clinical studies grade modifier of two due to axon loss with abnormal spontaneous activity on EMG. Dr. Scheper stated, "EMG report did not distinguish between 1+ or 2+ abnormal spontaneous activity, although significant atrophy is noted on physical examination, so the more severe grade modifier was adopted." He determined that functional history grade modifier was one due to significant intermittent symptoms and that the *Quick*DASH score was 34. Applying the formula, Dr. Scheper reached a net adjustment of positive one grade D or three percent impairment of the upper extremity. OWCP's medical adviser did not review this aspect of Dr. Scheper's report.

Dr. Scheper has provided a detailed and comprehensive basis for his impairment rating of three percent due to motor impairment of the peripheral suprascapular nerve. The A.M.A., *Guides* provide that peripheral nerve impairment may be combined with diagnosis-based estimates at the upper extremity level as long as the diagnosis-based estimate does not encompass the nerve impairment.[21] However, without comment from either Dr. Scheper or the medical adviser, the Board is unable to determine whether the diagnosis-based estimate encompasses the nerve impairment.

OWCP's medical adviser further found one percent right upper extremity impairment due to pain and impaired sensation due to right C5 radiculopathy, one percent impairment due to right C6 radiculopathy and one percent impairment due to right C7 radiculopathy. He combined appellant's right upper extremity impairments to reach seven percent. OWCP also found that appellant had three percent left upper extremity impairments due to cervical radiculopathy at C5, C6 and C7.

The Board finds that the case is not in posture for decision regarding appellant's right upper extremity impairments due to cervical radiculopathy and peripheral nerve impairment. While Dr. Scheper properly provided his impairment rating for a peripheral nerve impairment, OWCP's medical adviser did not offer any opinion on the validity of this impairment rating. Instead, the medical adviser repeated his previous finding regarding cervical radiculopathy which the Board found inadequate. He again did not offer any citations to the A.M.A., *Guides* and again 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 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.,

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

[20] *Id*. at 442, Table 15-21.

[21] *Id*. at 419, Section 15.4.

Guides in regard to both appellant's upper extremity impairments due to his cervical and right shoulder conditions. This report should address whether appellant has any diagnosis-based impairments, peripheral nerve impairments and impairments of the upper extremity due to cervical radiculopathy in either upper extremity. After this and such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that the case requires further development of the medical evidence to determine the extent of appellant's permanent impairment for schedule award purposes.

ORDER

IT IS HEREBY ORDERED THAT the April 27, 2012 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this decision of the Board.

Issued: June 5, 2013
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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