United States Department of Labor
Employees' Compensation Appeals Board

B.W., Appellant	)	
and	)	**Docket No. 14-379**
	)	**Issued: December 19, 2014**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Richmond, VA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On December 6, 2013 appellant, through counsel, filed a timely appeal from the August 16, 2013 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 this case.

ISSUE

The issue is whether appellant has more than seven percent impairment to his right upper extremity, for which he received a schedule award.

On appeal appellant's counsel contends that OWCP's schedule award determination is contrary to fact and law.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On February 17, 2011 appellant, then a 58-year-old internal revenue agent, sustained injury to his right shoulder, while picking up a box.[2] OWCP accepted his claim for sprain of the right shoulder and upper arm, recurrent tear of the right rotator cuff, and disorder of the right bursae and tendon.

On June 11, 2011 Dr. Thomas J. Chambers, a Board-certified orthopedic surgeon, performed a right shoulder arthroscopy with a revision rotator cuff repair and subacromial decompression.

In a March 16, 2012 report, Dr. Chambers assessed appellant as status post right shoulder cuff repair with partial undersurface tearing with probable small perforation. On examination, he noted good strength in the shoulder with a half-grade weakness in abduction and flexion, 140 degrees of flexion and 15 degrees of extension. Dr. Chambers observed 85 degrees of external rotation but only 9 degrees of internal rotation with 150 degrees of abduction and 30 degrees of adduction. He noted that appellant was still tender over the cuff with some mild acromioclavicular joint tenderness. In an April 19, 2012 addendum, Dr. Chambers deemed appellant to be at maximum medical improvement. He stated that appellant had 10 percent impairment to his right upper extremity impairment for his Mumford procedure. Dr. Chambers also noted that appellant merited an additional 12 percent impairment for full range of motion deficits and 6 percent for strength deficits. He noted that this combined to total 25 percent right upper extremity impairment.

On May 25, 2012 appellant, through counsel, filed a claim for a schedule award.

In a memorandum dated May 29, 2012, OWCP asked its medical adviser to review the record and determine the permanent functional loss of use of the right upper extremity. Dr. James W. Dyer, the medical adviser, noted that appellant had a revision of cuff repair on June 1, 2011 and that a November 2, 2011 magnetic resonance imaging (MRI) scan revealed acromioclavicular arthrosis with impingement. He stated that the record required clarification because he could not find a surgical report. OWCP obtained additional medical records. On August 10, 2012 Dr. Dyer reviewed the surgical reports. He found that no Mumford procedure was performed at the June 1, 2011 surgery yet Dr. Chambers had assigned 10 percent impairment for such procedure. Dr. Dyer also noted that no measurements were provided describing the loss of motion in the right shoulder and that the report of March 30, 2012 was not reliable for purposes of a schedule award. He recommended a second opinion from a Board-certified orthopedic surgeon.

On August 24, 2012 OWCP referred appellant for a second opinion evaluation. In a September 10, 2012 report, Dr. Robert M. Moore, a Board-certified orthopedic surgeon, diagnosed appellant with rotator cuff tendinopathy and recurrent tear of the right shoulder. He noted that objective findings include limitation in range of motion of the right shoulder and weakness of abduction, forward flexion, and rotation on strength testing. Dr. Moore noted that

[2] The record reflects that appellant previously underwent surgery on November 3, 2010 for a right shoulder rotator cuff repair.

the only objective finding on x-ray was mild sclerosis in the great tuberosity region consistent with previous anchor placement. He noted that the MRI scan of the right shoulder on October 17, 2011 showed objective evidence of partial thickness tear of the rotator cuff and subacromial bursitis. Dr. Moore found that appellant reached maximum medical improvement in June 2012. He applied the Shoulder Regional Grid of Table 15-5 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A. *Guides*), for a rotator cuff injury, full thickness tear with residual loss, with a class 1 default impairment value of five percent.[3] Dr. Moore found a functional history grade modifier of 2 for pain/symptoms with normal activity, a physical examination grade modifier of 2 for mild-to-moderate decrease in range of motion and weakness of rotator cuff function on resistance testing, and a clinical grade modifier of 2 for an MRI scan confirming the diagnosis of rotator cuff tear. He found that the net adjustment was +3, which moved the rating from a default value level C to level E, which corresponded to an upper extremity impairment of seven percent.

On October 23, 2012 OWCP referred Dr. Moore's report to the medical adviser. On October 24, 2012 Dr. H.P. Hogshead, the medical adviser, stated that the second opinion evaluation and impairment rating by Dr. Moore was thorough and objective and correctly determined that appellant had seven percent impairment of the right upper extremity.

By decision dated January 14, 2013, OWCP granted appellant a schedule award for seven percent permanent impairment of the right arm. The period of the award ran from March 30 to August 29, 2012.

By letter dated January 22, 2013, appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative. At the hearing held on May 8, 2013, counsel noted that he had submitted a medical report that was not mentioned in the prior decision. The hearing representative advised that the report was not in the record, and counsel was provided 30 additional days to submit the report.

Following the hearing, appellant submitted a July 2, 2012 medical report by Dr. William C. Daniels, a Board-certified orthopedic surgeon, who diagnosed appellant with sprain of the right shoulder and upper arm, rotator cuff and disorder of bursae and tendons in the right shoulder region. Dr. Daniels applied Table 15-5 of the A.M.A., *Guides*,[4] but used the impairment class for acromioclavicular joint injury or disease, class 1, which he opined most closely represented the etiology of appellant's complex shoulder problems. He noted that Dr. Chambers performed a Mumford procedure, also known as a distal clavicle resection, which would place appellant with a default impairment of 10 percent. Dr. Daniels indicated that, with the functional history adjustment category, appellant would fit grade 3. With regard to the physical examination adjustment, he noted that appellant would fit the grade 2 category based on range of motion loss. With regard to the clinical studies adjustment, based on Dr. Daniels' report, appellant would be grade 2. As the net adjustment was +4, this slid appellant's rating to the right in class 1, and would equal a 12 percent impairment of the right upper extremity.

[3] A.M.A., *Guides* 403, Table 15-5.

[4] *Id.*

In a decision dated July 26, 2013, the hearing representative set aside the January 14, 2013 decision, and remanded the case for an OWCP medical adviser to review Dr. Daniel's July 2, 2012 report.

On July 29, 2013 Dr. Hogshead noted that the report of Dr. Daniels used the Mumford procedure (or distal clavicle excision) as the central diagnosis in rating the impairment of the right upper extremity, which was clearly erroneous. He noted the prior report of Dr. Dyer on August 10, 2012 noted that the June 2011 surgery did not include a Mumford procedure. Dr. Hogshead stated that Dr. Moore had properly applied the A.M.A., *Guides*, and concluded that appellant had seven percent impairment of the right upper extremity. In an August 9, 2013 memorandum, OWCP asked Dr. Hogshead to further explain whether Dr. Daniels' report was erroneous and to apply the A.M.A., *Guides.* Dr. Hogshead replied that a rating for a Mumford procedure was provided and that this was untrue. He further opined that a rating for range of motion that could be a stand-alone rating but not combined with a diagnosis-based impairment method. Dr. Hogshead also noted that loss of strength was included but that loss of strength was seldom used in the sixth edition of the A.M.A., *Guides.*

By decision dated August 16, 2013, OWCP determined that appellant had no more than seven percent impairment of the right arm.[5]

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing regulations[7] 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 all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[8] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[9] For impairment ratings

[5] OWCP failed to send a copy of its August 16, 2013 decision to appellant's attorney. Its regulations and Board precedent require OWCP to send a copy of its decision to the claimant's representative. *See* 20 C.F.R. § 10.127. The Board has held that a decision under FECA is not properly issued unless both appellant and the authorized representative have been sent copies of the decision. *See Travis L. Chambers*, 55 ECAB 138 (2003). However, OWCP's failure to properly serve appellant's counsel with the August 16, 2013 decision was harmless error as appellant's counsel filed a timely appeal of the August 16, 2013 decision to the Board.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* For impairment ratings calculated on and after May 1, 2009, OWCP should advise any physician evaluating permanent impairment to use the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

[9] *See id.; Jacqueline S. Harris*, 54 ECAB 139 (2002).

calculated on or after May 1, 2009, OWCP should advise any physician evaluating per impairment to use the sixth edition.[10]

The sixth edition requires identifying the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[11] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[12] The sixth edition of the A.M.A., *Guides* also provides that range of motion may be selected as an alternative approach in rating impairment under certain circumstances. A rating that is calculated using range of motion may not be combined with a diagnosis-based impairment and stands alone as a rating.[13]

Section 8123(a) provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[14] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[15]

ANALYSIS

OWCP accepted appellant's claim for sprain of the right shoulder and upper arm, recurrent tear of the right rotator cuff and disorder of the right bursae and tendon. On January 14, 2013 it issued a decision awarding a schedule award for seven percent impairment of the right upper extremity. Appellant contends that he is entitled to a greater award.

Dr. Chambers performed a right shoulder arthroscopy with minimal debridement of superior labrum, subacromial decompression with release of coracoacromial ligament, and arthroscopic cuff repair on November 3, 2010. On June 1, 2011 he performed a right shoulder arthroscopy with revision repair and subacromial decompression. In a March 16, 2012 report, Dr. Chambers listed range of motion measurements and noted tenderness over the cuff with mild acromioclavicular joint tenderness. In an April 19, 2012 addendum, he stated that appellant had 10 percent impairment to his upper right extremity for his "Mumford," 12 percent impairment for range of motion deficits and 6 percent impairment for strength deficits. Dr. Chambers combined these ratings to find a total 25 percent right upper extremity impairment. The Board

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

[11] A.M.A., *Guides* 494-531.

[12] *Id.* at 521.

[13] *L.B.*, Docket No. 12-910 (issued October 5, 2012).

[14] 5 U.S.C. § 8123(a).

[15] 20 C.F.R. § 10.321.

finds, however, that he did not adequately explain his conclusions. Dr. Chambers did not state that he applied the sixth edition of the A.M.A., *Guides*, or refer to any applicable charts or tables to explain how he arrived at his figures. It is well established that it is the responsibility of the evaluating physician to explain in writing why a particular method was used to assign an impairment rating.[16] Further, Dr. Chambers combined impairment ratings for loss of range of motion with diagnosis-based impairment, which is not allowed under the sixth edition. It is well established that a rating that does not address how the extent of impairment was determined under the applicable edition of the A.M.A., *Guides* is of reduced probative value.[17] Accordingly, the opinion of Dr. Chambers is of diminished probative value.

OWCP referred appellant to Dr. Moore for a second opinion. Dr. Moore utilized Table 15-5 of the A.M.A., *Guides* for the impairment class represented by the diagnosis rotator cuff injury, full-thickness tear. He found that appellant had a class 1 impairment, characterized by residual loss, functional with normal motion, which would indicate a five percent default value. Dr. Moore determined that, based on grade modifiers of +2 for functional history, +2 for physical examination, and +2 for clinical studies, the net adjustment was +3, which moved the rating from a default value C to E which corresponded to an upper extremity impairment of seven percent.[18] Dr. Hogshead determined in an October 24, 2012 report that Dr. Moore's impairment rating was thorough and objective and that he correctly applied the A.M.A., *Guides* to find a seven percent impairment of the right upper extremity. OWCP issued a schedule award for a seven percent impairment of the right arm on January 14, 2013.

In a July 2, 2012 report, Dr. Daniels utilized the same table of the A.M.A., *Guides*, as Dr. Moore, Table 15-5, but stated that appellant's impairment class was represented by the diagnosis of acromioclavicular joint injury or disease. He then found a class 1 impairment based on distal clavicle resection. Dr. Daniels stated that Dr. Chambers performed a Mumford procedure, also known as a distal clavicle resection, which would give appellant a default impairment of 10. He noted grade modifiers of 3 for functional history adjustment, 2 for physical examination adjustment, and 2 for clinical studies. Dr. Daniels then noted that this amounted to a net adjustment of +4, which would move appellant's impairment rating to E, which corresponds to a 12 percent impairment of the right upper extremity.[19] Dr. Hogshead reviewed Dr. Daniels' rating but concluded that the physician erred by basing the diagnosis on a Mumford procedure. He also noted that range of motion was included but it could not be combined with the diagnosis-based impairment method. Dr. Hogshead also noted that loss of strength was included but that loss of use is seldom used under the sixth edition of the A.M.A., *Guides*.

The Board finds that there is an unresolved conflict in the medical evidence. Dr. Moore and the medical advisers determined appellant's impairment rating by applying Table 15-5 of the

[16] *See Peter C. Belkind*, 56 ECAB 580, 584-85 (2005); *see also Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

[17] *See Derrick C. Miller*, 54 ECAB 266 (2002); *James Kennedy, Jr.*, 40 ECAB 620 (1989); *see also M.M.*, Docket No. 13-1136 (issued June 10, 2014).

[18] A.M.A., *Guides* 403, Table 15-5.

[19] *Id.*

sixth edition of the A.M.A., *Guides.* They determined that appellant's impairment class was represented by the diagnosis of rotator cuff injury, full-thickness tear. Dr. Daniels, who conducted an examination on behalf of appellant, utilized the same table of the A.M.A., *Guides,* but determined that appellant's impairment class was based on the diagnosis of an acromioclavicular joint injury or disease, with the class 1 rating characterized by status post distal clavicle resection. The medical opinion is in conflict as to the proper impairment class. Dr. Hogshead contended that the use of the Mumford procedure was erroneous, as appellant did not undergo this procedure. Dr. Daniels, however, stated that Dr. Chambers performed a Mumford procedure. Dr. Chambers did not clearly state in his operative reports of November 3, 2010 or June 1, 2011 that he performed a Mumford procedure. In his April 19, 2012 addendum, he indicated that appellant had 10 percent impairment for his "Mumford." There is a conflict with regard to whether appellant underwent a Mumford procedure and the proper impairment class under Table 15-5 to be utilized in rating impairment.

The case will be remanded to OWCP for referral of appellant and a statement of accepted facts to an impartial medical specialist for a determination regarding the extent of his right upper extremity impairment in accordance with the relevant standards of the A.M.A., *Guides*.[20] After such further development as OWCP deems necessary, a *de novo* decision should be issued regarding the extent of appellant's right upper extremity impairment.

CONCLUSION

The Board finds that this case is not in posture for decision due to an unresolved conflict in the medical opinion evidence regarding the percentage of impairment of the right lower extremity.

[20] *See* Docket No. 14-27 (issued July 3, 2014).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 16, 2013 is set aside and the case remanded for further proceedings consistent with this opinion.

Issued: December 19, 2014
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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