United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 14-661**
	)	**Issued: December 19, 2014**
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:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 31, 2014 appellant filed a timely appeal of a December 10, 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 to consider the merits of the case.

ISSUE

The issue is whether appellant has more than 3 percent impairment of his left arm or more than 14 percent impairment of his right arm, for which he received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board. On June 3, 1999 appellant, then a 46-year-old marine machinery mechanic, injured his right shoulder while unloading his tools in the performance of duty. OWCP accepted his claim for right shoulder strain and temporary

[1] 5 U.S.C. § 8101 *et seq.*

aggravation of cervical degenerative disc disease and a cervical subluxation. On April 4, 2000 appellant underwent a C3-4, C5-6 and C6-7 microforaminotomy with 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. It 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. Appellant 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 surgery for a C3-7 cervical fusion on February 19, 2002. Dr. Bernard Robinson, a neurosurgeon, performed the 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 joint degenerative joint disease on April 21, 2008. An x-ray dated April 21, 2008 demonstrated a mild glenohumeral and AC joint degenerative changes.

By decision dated May 28, 2010, OWCP granted appellant a schedule award for four percent impairment of the right arm and three percent impairment of the left arm. In a September 13, 2011 decision, the Board found that the medical evidence was not sufficient to establish the degree of permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] The case was remanded for further development of the medical evidence in regard to appellant's impairment due to his cervical and right shoulder conditions.

OWCP referred appellant for a second opinion evaluation to Dr. Stephen Scheper, an osteopath Board-certified in physical medicine and rehabilitation. In an October 28, 2011 report, Dr. Scheper reviewed appellant's diagnostic test results and x-rays. He examined appellant's shoulders and found range of motion on the right 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 test 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

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

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*[3] to find that appellant had impingement syndrome in accordance with Table 15-5, page 402 of the A.M.A., *Guides*, class 1 impairment. He determined that appellant's functional history grade modifier was 1 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 2 due to positive finding with provocative testing and a 14 percent decrease in range of motion from normal based on Table 15-34, page 475. He found that appellant's clinical studies grade modifier was 1 due to mild pathology and reached a net adjustment of plus 1, grade D, four percent impairment of the upper extremity.

Dr. Scheper also determined that appellant had a motor deficit of mild severity 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 2 due to axon loss with abnormal spontaneous activity on electromyogram (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 function history grade modifier was 1 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 right upper extremity. He concluded that appellant had an upper extremity impairment of seven percent.

On December 24, 2011 Dr. Arthur S. Harris, a Board-certified orthopedic surgeon and an OWCP medical adviser, noted that appellant's accepted conditions were status post left cervical decompression/foramintomy C3-4, C4-5, C5-6 and C6-7, on April 4, 2000; status post anterior cervical fusion C3-7 on February 19, 2002, chronic cervical radiculopathy and right rotator cuff tendinitis and impingement syndrome. He found four percent upper extremity impairment due to residual right shoulder tendinitis and impingement in accordance with Table 15-5, page 402 of the A.M.A., *Guides*. Dr. Harris 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. Dr. Harris also found that appellant had three percent left upper extremity impairment due to cervical radiculopathy resulting in mild pain/impaired sensation at C5, C6 and C7 of one percent each.

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.

In a June 5, 2013 decision,[4] the Board found that the case was not in posture for a decision as to the degree of permanent impairment under the sixth edition of the A.M.A., *Guides*.

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

[4] Docket No. 13-152 (issued June 5, 2013).

The Board requested a detailed report, which comported with the sixth edition of the A.M.A., *Guides* for both upper extremities due to appellant's cervical and right shoulder conditions. The Board stated that this report should address whether he has any diagnosis-based impairments, peripheral nerve impairments, and impairments of the upper extremity due to cervical radiculopathy in either upper extremity. The facts and the circumstances of the case as set forth in the Board's prior decisions are adopted herein by reference.

On July 8, 2013 OWCP asked Dr. Scheper to clarify his opinion on appellant's permanent impairment. In a report dated July 26, 2013, Dr. Scheper addressed the question of whether the diagnosis-based impairment based on subacromial impingement and rotator cuff pathology encompassed the suprascapular neuropathy. He stated:

> "A suprascapular neuropathy, although relatively uncommon, is a significant cause of functional impairment resulting from bony or ligamentous constrain at the suprascapular or spinal glenoid notches, extrinsic compression from a glenohumeral ganglion or other soft tissue mass, direct trauma, for a traction neuropathy following excessive nerve excursion during overhead activities. A suprascapular neuropathy is rarely seen with concomitant rotator cuff injury, typically through massive retracted rotator cuff tears in older patients. MRI [scan] evaluation of the shoulder in this case failed to reveal extrinsic or ligamentous compression and he is not involved in recreational repetitive overhead activities typically seen resulting in a suprascapular neuropathy, which leaves the potential from a traction injury INDIRECTLY related to the supraspinatus rotator cuff injury and subacromial compression pertinent in this case." (Emphasis in the original.)

Dr. Scheper concluded that appellant experienced a rotator cuff injury with an indirectly-related suprascapular neuropathy and an aggravation of cervical spondylosis. He reiterated that appellant had a right upper extremity impairment of seven percent. Dr. Scheper noted that OWCP did not include spine ratings and that he completed the assessment based on shoulder and nerve pathology.

In a report dated November 23, 2013, Dr. Harris stated that the following diagnoses had been established right C3-4, C5, C6 and C7 right-sided foraminotomies, anterior cervical fusion C3-7, chronic right cervical radiculopathy, and right rotator cuff tendinitis, and impingement syndrome. He found that appellant had five percent upper extremity impairment for residual problems with right rotator cuff tendinitis, impingement, and partial thickness tearing in accordance with Table 15-5.[5]

Dr. Harris noted that cervical radiculopathy must be calculated in accordance with *The Guides Newsletter* July/August 2009 and found that appellant had four percent impairment of the right upper extremity for residual problems with mild motor weakness from right C5 cervical radiculopathy and five percent impairment of the right upper extremity for residual mild motor weakness or nine percent impairment for cervical radiculopathy. He combined 5 percent for the

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

right shoulder and 9 percent for cervical radiculopathy to rate 14 percent right upper extremity impairment. Dr. Harris stated that appellant had no impairment of his left upper extremity.

Dr. Harris found that appellant's residual weakness appeared to be secondary to cervical radiculopathy as well as rotator cuff tendinitis and impingement resulting in 14 percent impairment of his right upper extremity. He stated, "I would agree with Dr. Scheper that [appellant] does not clinically have evidence of suprascapular neuropathy."

By decision dated December 10, 2013, OWCP found that appellant had an additional 7 percent impairment of his right upper extremity for a total impairment rating of 14 percent. It denied any additional impairment of his left upper extremity. OWCP noted that appellant had previously received a schedule award for three percent impairment of his left upper extremity in error.

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 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*.[8]

The schedule award provision of FECA[9] and its implementing regulations[10] 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*.

[6] 5 U.S.C. §§ 8101-8193, 8107.

[7] 20 C.F.R. § 10.404.

[8] 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 Award*, Chapter 3.700, Exhibit 1 (January 2010).

[9] 5 U.S.C. §§ 8101-8193, 8107.

[10] 20 C.F.R. § 10.404.

In addressing upper extremity impairments, the sixth edition requires identification of 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). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

No schedule award is payable for a member, function or organ of the body not specified in FECA or in the regulations.[12] 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,[13] no claimant is entitled to such an award.[14]

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 schedule award for permanent impairment to a limb even though the cause of the impairment originated in the spine.[15]

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 the sixth edition methodology.[16] 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.[17] Specifically, it will address lower extremity impairments originating in the spine through Table 16-11[18] and upper extremity impairment originating in the spine through Table 15-14.[19]

ANALYSIS

OWCP accepted appellant's cervical and right shoulder conditions including left cervical decompression/foramintomy C3-4, C4-5, C5-6 and C6-7, on April 4, 2000; anterior cervical

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

[12] *William Edwin Muir*, 27 ECAB 579 (1976).

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

[14] *Timothy J. McGuire*, 34 ECAB 189 (1982).

[15] *Rozella L. Skinner*, 37 ECAB 398 (1986).

[16] FECA Transmittal No. 10-04 (issued January 9, 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Award*, Chapter 3.700, Exhibit 4 (January 2010).

[17] Federal (FECA) Procedure Manual, *supra* note 8, Chapter 3.700 (Exhibits 1, 4) (January 2010).

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

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

fusion C3-7 on February 19, 2002, chronic cervical radiculopathy and right rotator cuff tendinitis and impingement syndrome. Appellant requested a schedule award due to permanent impairments resulting from these accepted conditions.

Dr. Harris, the medical adviser, found that appellant had five percent upper extremity impairment for residual problems with right rotator cuff tendinitis, impingement and partial thickness tearing in accordance with Table 15-5.[20] The Board is unable to determine how he reached this impairment rating. The A.M.A., *Guides* provide that, if more than one diagnosis can be used, the highest causally related impairment should be used. Dr. Harris did not specify which diagnosis he was using or address the grade modifiers to explain how he reached the highest class 1 impairment rating for tendinitis, impingement syndrome, or rotator cuff partial thickness tear.

Dr. Harris noted that cervical radiculopathy should be calculated in accordance with *The Guides Newsletter* July/August 2009. He determined that appellant had four percent impairment of the right upper extremity for residual problems with mild motor weakness from right C5 cervical radiculopathy. *The Guides Newsletter* provides that mild motor weakness of C5 ranges from zero to eight percent impairment with a grade C impairment of four percent. Dr. Harris also stated that appellant had five percent impairment of the right upper extremity for residual mild motor weakness at C6. *The Guides Newsletter* provides a range between zero and nine percent impairment mild motor weakness at C6. Grade C impairment of C6 is five percent impairment. The ratings are insufficient as Dr. Harris did not clearly address how he rated impairment under *The Guides Newsletter*. He did not explain how he determined the grade modifiers for functional history or clinical studies to the diagnosed conditions or provide any application of the appropriate formula.[21] The Board further notes that Dr. Harris did not provide adequate reasoning for eliminating the three percent impairment of appellant's left upper extremity, which he previously found, on December 24, 2011. Dr. Harris' reports are of diminished probative value.[22]

The Board finds that the application of the A.M.A., *Guides* by Dr. Harris does not comport with the standards of the A.M.A., *Guides*. Dr. Harris did not address these grade modifiers or explain and did not provide his application of the upper extremity formula of the A.M.A., *Guides.* On remand, he should fully explain his impairment ratings for both upper extremities in accordance with the standards of the A.M.A., *Guides*. After this and such other development as OWCP deems necessary, it should issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision as there is no adequate correlation of the medical findings with the standards of the A.M.A., *Guides*.

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

[21] *See I.F.*, Docket No. 08-2321 (issued May 21, 2009) (an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of diminished probative value in determining the extent of permanent impairment).

[22] *P.H.*, Docket No. 13-1760 (issued May 7, 2014).

ORDER

IT IS HEREBY ORDERED THAT the December 10, 2013 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this decision of the Board.

Issued: December 19, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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