United States Department of Labor
Employees' Compensation Appeals Board

R.O., Appellant	)	
and	)	**Docket No. 14-835**
	)	**Issued: November 10, 2014**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, Los Angeles, CA, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 5, 2014 appellant, through his counsel, filed a timely appeal from a January 14, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP) regarding a schedule award and a January 23, 2014 decision denying his claim for a consequential injury. 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.[2]

ISSUES

The issues are: (1) whether appellant established that he sustained more than an eight percent permanent impairment to the left upper extremity, for which he received a schedule

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the issuance of the January 23, 2014 OWCP decision, appellant submitted new evidence. The Board is precluded from reviewing evidence which was not before OWCP at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c)(1).

award; and (2) whether he met his burden of proof to establish that he sustained a right shoulder injury as a consequence of his accepted left elbow injuries.

On appeal, counsel contends that OWCP's decisions were contrary to fact and law.

FACTUAL HISTORY

OWCP accepted that appellant, then a 37-year-old correctional officer, sustained a left elbow sprain, loose body, left ulnar nerve lesion and left cubital tunnel syndrome on November 1, 2004 as a result of pulling and pushing food carts. Appellant underwent left elbow surgery on July 16, 2008 and filed a claim for a recurrence. By decision dated February 1, 2010, OWCP accepted his recurrence claim and retroactively authorized the surgery.[3] It further authorized a February 17, 2009 left elbow resection and a June 8, 2010 cubital tunnel release.

In a November 29, 2011 report, Dr. Chi K. Cheung, a general surgeon, diagnosed arthralgia of elbow and right shoulder strain. He stated that appellant "injured his right shoulder while doing exercise at home."

On December 15, 2011 Dr. Kevin J. Rossi, a Board-certified family practitioner, diagnosed right rotator cuff shoulder sprain and indicated that appellant "noticed the right hand swollen and painful on November 29, [2011] the day after exercising hard" and was still having pain with what felt like popping out of socket in the right shoulder area. He stated that appellant's "[c]ondition occurred because of rehab[ilitation] exercises for [the] left shoulder."

In a February 14, 2012 report, Dr. Madhav Boddula, a sports medicine specialist, diagnosed "right shoulder subscapularis strain versus tear versus subcoracoid impingement" and "right shoulder biceps tendinitis versus partial tear." He stated that appellant "was doing therapy at home on his left shoulder and that shoulder gave out and as a result his right shoulder started hurting after giving out also." Appellant reported that he had initial pain and that for the past two months he had consistent pain in the right shoulder and difficulty with activities of daily living and even sleeping on that side. His biceps area was also hurting along with the neck and he had difficulty with hygiene and driving.

In a March 5, 2012 letter, OWCP notified appellant of the deficiencies of his claim that his right shoulder condition was a consequential injury of his accepted left upper extremity conditions and afforded him 30 days to submit additional evidence and respond to its inquiries.

Appellant submitted a March 22, 2012 narrative statement indicating that on November 25, 2011 at approximately 6:00 p.m. he fell while at home in the kitchen "performing the physical therapy prescribed counter top push-ups exercise" on a stationary table. He attached

[3] Appellant participated in vocational rehabilitation. By decision dated September 7, 2012, OWCP found that the constructed position of user support analyst at the rate of $360.00 per week reasonably represented his wage-earning capacity, which resulted in a loss of wage-earning capacity. By decision dated December 13, 2012, it finalized its proposal to reduce appellant's compensation effective December 16, 2012. Appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative, which was held on February 25, 2013. By decision dated April 3, 2013, the hearing representative affirmed the December 13, 2012 loss of wage-earning capacity decision.

an illustration of a "PUSH UP PLUS" exercise routine and stated that the "immediate effects following the fall while doing the counter top push-ups exercise included left elbow pain, excruciating right shoulder pain, soreness in [his] right bicep and left elbow." Appellant also submitted a witness statement from his wife, who indicated that she observed her husband doing his home exercise on November 25, 2011 and "[w]hile pushing himself on the kitchen counter he fell, screamed and as a result hurt his left elbow and his right shoulder."

In a March 19, 2012 report, Dr. Hannah H. Kim, an occupational medicine specialist, diagnosed right bicipital tendinitis and right rotator cuff shoulder syndrome. She indicated that the injury occurred at home while appellant was doing shoulder exercises and opined that it was "not an industrial injury."

On March 22, 2012 Dr. Boddula stated that appellant's "injury mechanism was while doing push-ups against a counter and his left arm gave out and then he tried to catch himself and he had sudden right anterior shoulder pain." He reviewed a magnetic resonance imaging (MRI) scan of the right shoulder and found a subluxed biceps tendon, increased signal within the subscapularis tendon concerning for a tear and increased signal within the superior aspect of the myotendinous junction of the supraspinatus concerning for a partial tear, tendinitis.

The record contains physical therapy notes dated July 31, 2008 through February 15, 2012, indicating that appellant participated in therapeutic exercises that "consisted of joint mobilization followed by passive stretching to the left elbow" and was "instructed on stretching exercises." Appellant's treatment plan consisted of "electrical stimulation, home exercise program, joint mobilization, manual therapy, soft tissue mobilization, therapeutic exercises and ultrasound." On December 30, 2011 Dr. Rossi referred appellant to physical therapy for biceps strain and possible tear. The plan of care included a home exercise program and appellant was instructed in "independent exercises, precautions and given written handouts as appropriate," including "lying down; arms overhead," ... "neck glide backwards or posture correction exercises" and "rotate neck" to left and then right.

By decision dated April 30, 2012, OWCP denied appellant's claim on the basis that the evidence submitted was insufficient to establish that his right shoulder condition was a consequential injury of his accepted left elbow injuries. It found that his home physical therapy program did not include push-ups of the left upper extremity as treatment of his accepted conditions, thus, performing push-ups was intentional and not an independent intervening cause of his injury.

On May 7, 2012 appellant, through counsel, requested an oral hearing before an OWCP hearing representative, which was held *via* telephone on August 7, 2012.

In an August 10, 2012 report, Dr. Boddula reiterated that appellant "injured his right shoulder while doing therapy with his left shoulder." He stated that appellant was on disability for his left upper extremity due to multiple surgeries he had as a result of a complex elbow problem. Dr. Boddula indicated that appellant underwent right shoulder surgery on May 14, 2012 at which time his subscapularis tendon was repaired and his biceps tendon was tenodesed.

Appellant submitted a July 16, 2010 physical therapy note indicating that his treatment diagnosis was left cubital tunnel release. Under the long-term goals, it stated that he would "be able to do a push-up" by October 8, 2010.

In an October 8, 2012 report, Dr. Kim diagnosed left elbow and shoulder pain. She indicated that appellant hurt his left elbow and shoulder "from home exercises."

By decision dated October 19, 2012, the hearing representative affirmed the April 30, 2012 decision.[4]

On November 15, 2012 appellant, through counsel, requested reconsideration and submitted an October 1, 2012 report from Dr. Boddula, who opined that there was "a possibility that the right shoulder problem for which [he] operated was the result of an injury sustained during [appellant's] therapy on [the] left arm/elbow."

In reports dated November 29, 2010 through August 13, 2013, Dr. Kim diagnosed chronic left elbow joint pain and left cubital tunnel syndrome status post surgery. She opined that appellant's employment injury was permanent and restricted him from heavy lifting with the left upper extremity, no more than 15 pounds.

On September 10, 2013 appellant, through counsel, filed a claim for a schedule award.

In an October 2, 2013 letter, OWCP notified appellant of the deficiencies of his schedule award claim and requested additional evidence, including a recommended percentage of impairment of the affected member(s) of his body from his attending physician.

Appellant underwent a functional capacity evaluation (FCE) on October 28, 2013, which revealed that his left elbow flexion was 115 degrees, extension was 20 degrees, supination was 80 degrees and pronation was 80 degrees.

In an October 28, 2013 report, Dr. Jacob E. Tauber, a Board-certified orthopedic surgeon, found pain on appellant's left elbow motion with tenderness medially and laterally. Appellant lacked terminal extension of 20 degrees, his flexion was limited to 115 degrees and he had a loss of grip strength. Dr. Tauber opined that appellant had reached maximum medical improvement and concluded that he had a 10 percent permanent impairment of the left upper extremity under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Utilizing Table 15-4,[5] page 399, he found that appellant qualified for a five percent permanent impairment of the left upper extremity for the presence of loose bodies as some calcifications were present, consistent with additional loose debris. Dr. Tauber indicated that appellant also had a cubital tunnel syndrome for which he underwent surgery and

[4] On June 24, 2013 OWCP issued a preliminary determination that an overpayment of compensation in the amount of $102.86 arose because appellant received disability compensation and retirement benefits concurrently effective June 29, 2013. In a July 18, 2013 letter, it advised him that the overpayment of compensation in the amount of $102.86 had been repaid in full and, thus, his overpayment account had been fully liquidated and closed.

[5] Table 15-4, page 398-400, of the sixth edition of the A.M.A., *Guides* is entitled *Elbow Regional Grid: Upper Extremity Impairments*.

had significant intermittent residual symptoms with decreased sensation to the ulnar distribution, which qualified him for an additional five percent permanent impairment under Table 15-23,[6] on page 449.

On December 18, 2013 Dr. Ellen Pichey, an OWCP medical adviser Board-certified in family practice and occupational medicine, reviewed the medical evidence of record and determined that appellant had an eight percent permanent impairment of the left upper extremity according to the sixth edition of the A.M.A., *Guides*. She found that the diagnosis-based estimate for left elbow loose bodies or osteochondral lesions, under Table 15-4, page 399, was a class 1, default position C, which equated to five percent permanent impairment. Dr. Pichey assigned a grade modifier 1 for Physical Examination (GMPE), according to Table 15-8,[7] page 408 and a grade modifier 1 for Functional History (GMFH), under Table 15-7,[8] page 406. She found that Clinical Studies (GMCS) were not applicable. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Pichey found that (1-1) + (1-1) + (n/a) resulted in a net grade modifier 0, equaling a five percent permanent impairment of the left upper extremity. Regarding appellant's impairment due to cubital tunnel syndrome, she utilized Table 15-23,[9] page 449. Dr. Pichey assigned a grade modifier 2 for functional history and physical examination and found that clinical studies were not applicable. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), she found that (2-1) + (2-1) + (n/a) resulted in a net grade modifier 2, equaling a three percent permanent impairment of the left upper extremity. Dr. Pichey determined that the date of maximum medical improvement was November 29, 2010, as given by Dr. Kim. She noted that, while one best diagnosis was generally chosen under the A.M.A., *Guides*, appellant fell under the rare case discussed in section 15.2a,[10] page 390, when there were multiple diagnosis-based impairments and the values were combined. Dr. Pichey further explained that, utilizing Table 15-23, page 449 and Dr. Tauber's findings, the ulnar entrapment fell into grade modifier 1, not 2 as found by him, which accounted for the discrepancy in their impairment ratings.

By decision dated January 14, 2014, OWCP granted appellant a schedule award for eight percent permanent impairment of the left upper extremity for 24.96 weeks for the period June 30 through December 21, 2013, relying on Dr. Pichey's December 18, 2013 report.

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[6] Table 15-23, page 449, of the sixth edition of the A.M.A., *Guides* is entitled *Entrapment/Compression Neuropathy Impairment.*

[7] Table 15-8, page 408, of the sixth edition of the A.M.A., *Guides* is entitled *Physical Examination Adjustment: Upper Extremities*.

[8] Table 15-7, page 406, of the sixth edition of the A.M.A., *Guides* is entitled *Functional History Adjustment: Upper Extremities*.

[9] *See supra* note 6.

[10] Section 15.2a, page 389-90, of the sixth edition of the A.M.A., *Guides* is entitled *Diagnosis-Based Impairment Class Assignment: Regional Grids*. "All impairments in the wrist, elbow and shoulder regional grids are expressed as upper extremity impairment. In the rare case when there are multiple [diagnosis-based impairments] DBIs, the values are combined." *Id.* at 390.

By decision dated January 23, 2014, OWCP denied modification of its October 19, 2012 decision.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[11] provide for compensation to employees sustaining impairment from loss or loss of use of specified members 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 sound 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. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[12] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[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, the evaluator identifies the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[15] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[16]

ANALYSIS -- ISSUE 1

The record shows that OWCP paid appellant a schedule award for an eight percent permanent impairment of the left upper extremity due to his accepted left elbow conditions. Appellant has the burden to establish more than an eight percent permanent impairment of the left upper extremity due to his employment-related conditions. It is his burden to submit sufficient evidence to establish the extent of permanent impairment.[17]

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[11] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[12] *See Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000). *See also* 5 U.S.C. § 8107.

[13] *See D.T.*, Docket No. 12-503 (issued August 21, 2012); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[14] A.M.A., *Guides* (6th ed., 2009), page 3, section 1.3, *International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.*

[15] *Id.* at 494-531.

[16] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[17] *See Annette M. Dent*, 44 ECAB 403 (1993).

On October 28, 2013 Dr. Tauber, a Board-certified orthopedic surgeon, found pain on appellant's left elbow motion with tenderness medially and laterally. Appellant lacked terminal extension of 20 degrees, his flexion was limited to 115 degrees and he had a loss of grip strength. Utilizing Table 15-4, page 399, Dr. Tauber found that appellant qualified for a five percent permanent impairment of the left upper extremity for the presence of loose bodies as some calcifications were present, consistent with additional loose debris. He indicated that appellant also had a cubital tunnel syndrome for which he underwent surgery and had significant intermittent residual symptoms with decreased sensation to the ulnar distribution, which qualified him for an additional five percent permanent impairment under Table 15-23, on page 449. Dr. Tauber concluded that appellant had a 10 percent permanent impairment of the left upper extremity under the sixth edition of the A.M.A., *Guides*.

In accordance with its procedures, OWCP properly referred the evidence of record to the medical adviser, Dr. Pichey, who reviewed the clinical findings of record on December 18, 2013 and determined that appellant had an eight percent permanent impairment of the left upper extremity under the sixth edition of the A.M.A., *Guides*. Dr. Pichey found that the diagnosis-based estimate for left elbow loose bodies or osteochondral lesions, under Table 15-4, page 399, was a class 1, default position C, which equated to five percent permanent impairment. She assigned a grade modifier 1 for physical examination, according to Table 15-8, page 408 and a grade modifier 1 for functional history, under Table 15-7, page 406. Dr. Pichey found that clinical studies were not applicable. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), she found that (1-1) + (1-1) + (n/a) resulted in a net grade modifier 0, equaling a five percent permanent impairment of the left upper extremity. Regarding appellant's impairment due to cubital tunnel syndrome, Dr. Pichey utilized Table 15-23, page 449. She assigned a grade modifier 2 for functional history and physical examination and found that clinical studies were not applicable. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Pichey found that (2-1) + (2-1) + (n/a) resulted in a net grade modifier 1, equaling a three percent permanent impairment of the left upper extremity. She noted that, while one best diagnosis was generally chosen under the A.M.A., *Guides*, appellant fell under the rare case discussed in section 15.2a,[18] page 390, when there were multiple diagnosis-based impairments and the values were combined, which explained the discrepancy between the resulting impairment ratings of grade modifier 1 which she found *versus* grade modifier 2 found by Dr. Tauber. Dr. Pichey determined that the date of maximum medical improvement was November 29, 2010, as given by Dr. Kim.

The Board finds that the medical adviser applied the appropriate tables and grading schemes of the sixth edition of the A.M.A., *Guides* to Dr. Tauber's clinical findings. Dr. Pichey's calculations were mathematically accurate. There is no medical evidence of record utilizing the appropriate tables of the sixth edition of the A.M.A., *Guides* demonstrating a greater percentage of permanent impairment. Dr. Pichey explained that utilizing Table 15-23, page 449 and Dr. Tauber's findings, the ulnar entrapment fell into grade modifier 1, not 2 as found by Dr. Tabuer, which accounted for the discrepancy in their impairment ratings. Therefore, OWCP

[18] Section 15.2a, page 389-90, of the sixth edition of the A.M.A., *Guides* is entitled *Diagnosis-Based Impairment Class Assignment: Regional Grids*. "All impairments in the wrist, elbow and shoulder regional grids are expressed as upper extremity impairment. In the rare case when there are multiple [diagnosis-based impairments] DBIs, the values are combined." *Id.* at 390.

properly relied on the medical adviser's assessment of an eight percent permanent impairment of the left upper extremity.[19]

Drs. Cheung, Rossi, Boddula and Kim did not provide an impairment rating based on the sixth edition of the A.M.A., *Guides* in their reports, therefore, the Board finds that they lack probative value and are insufficient to establish appellant's claim.[20]

The October 28, 2013 FCE provides an impairment rating according to the fifth edition of the A.M.A., *Guides*. Thus, this report is of no probative value regarding appellant's permanent impairment under the appropriate sixth edition of the A.M.A., *Guides*.

There is no probative medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has more than an eight percent permanent impairment of the left upper extremity. Accordingly, appellant has not established that he is entitled to a schedule award greater than that previously received.[21]

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.

On appeal, counsel contends that OWCP's decision was contrary to fact and law. Based on the findings and reasons stated above, the Board finds counsel's argument is not substantiated.

LEGAL PRECEDENT -- ISSUE 2

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 employees own intentional conduct.[22] Aclaimant bears the burden of proof to establish a claim for a consequential injury. As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relationship.[23] Rationalized medical evidence is evidence which relates a work incident or factors of employment to a claimant's condition,

[19] *See M.T.*, Docket No. 11-1244 (issued January 3, 2012).

[20] *See Richard A. Neidert*, 57 ECAB 474 (2006) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

[21] FECA provides for reduction of compensation for subsequent injury to the same body member. It provides that schedule award compensation is reduced by the compensation paid for an earlier injury where the compensation in both cases are for impairment of the same member or function and where it is determined that the compensation for the later disability in whole or part would duplicate the compensation payable for the preexisting disability. 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

[22] *See S.S.*, 59 ECAB 315 (2008).

[23] *See Charles W. Downey*, 54 ECAB 421 (2003).

with stated reasons of a physician. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.[24]

ANALYSIS -- ISSUE 2

OWCP accepted that on November 1, 2004 appellant sustained a left elbow sprain, loose body, left ulnar nerve lesion and left cubital tunnel syndrome as a result of pulling and pushing food carts. Appellant claimed that on November 25, 2011 at approximately 6:00 p.m. he fell while at home in the kitchen "performing the physical therapy prescribed counter top push-ups exercise" on a stationary table. He stated that "immediate effects following the fall while doing the counter top push-ups exercise included left elbow pain, excruciating right shoulder pain, soreness in [his] right bicep and left elbow." Appellant also submitted a witness statement from his wife, who indicated that she observed her husband doing his home exercises on November 25, 2011 and "[w]hile pushing himself on the kitchen counter he fell, screamed and as a result hurt his left elbow and his right shoulder."

The Board finds that the evidence of record establishes that appellant participated in a physical therapy program authorized by OWCP for treatment of his November 1, 2004 employment injury. The record contains physical therapy notes dated July 31, 2008 through February 15, 2012 indicating that he participated in therapeutic exercises and that his treatment plan consisted of a "home exercise program." The record also contains an illustration of a "PUSH UP PLUS" exercise routine and a physical therapy note dated July 16, 2010 indicating that appellant's treatment diagnosis was left cubital tunnel release and that he would "be able to do a push-up" by October 8, 2010.

While none of the reports from appellant's attending physicians are completely rationalized, they are generally consistent in indicating that he sustained a right shoulder injury during at home physical therapy. The Board finds that the evidence is sufficient to require OWCP to further develop the medical evidence.[25] In this regard, on November 29, 2011 Dr. Cheung diagnosed arthralgia of elbow and right shoulder strain, indicating that appellant "injured his right shoulder while doing exercise at home." In his reports, Dr. Boddula stated that appellant "was doing therapy at home" and the "injury mechanism was while doing push-ups against a counter and his left arm gave out and then he tried to catch himself and he had sudden right anterior shoulder pain."

[24] *Id.*

[25] *See C.O.*, Docket No. 10-189 (issued July 15, 2010) (where OWCP accepted that claimant sustained lumbar conditions due to lifting bags in the performance of duty and participated in a physical therapy program authorized by OWCP for treatment of his employment-related conditions, which included reverse butterflies with weights in both arms, the Board remanded the case to OWCP for further evidentiary development on the issue of whether he sustained a consequential left shoulder injury during approved physical therapy sessions). *Cf.*, *K.C.*, Docket No. 12-1970 (issued March 13, 2013) (where the Board found that, as the physician did not provide an accurate factual history on knowledge of any authorized physical therapy and did not address the issue of causal relationship between specific physical therapy activity and a consequential injury, appellant did not meet his burden of proof).

It is well established that proceedings under FECA are not adversarial in nature and, while the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[26] Thus, the case will be remanded to OWCP for further evidentiary development regarding the issue of whether appellant sustained an employment-related right shoulder injury during approved at home physical therapy sessions, which included the performance of counter top push-up exercises. After such development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that appellant has not established that he sustained more than an eight percent permanent impairment to the left upper extremity, for which he received a schedule award. The Board further finds that the case is not in posture for decision regarding whether he sustained a right shoulder injury as a consequence of physical therapy for his accepted left elbow injuries.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated January 14, 2014 is affirmed and the January 23, 2014 decision is set aside. The case is remanded to OWCP for further development consistent with this decision of the Board.

Issued: November 10, 2014
Washington, DC

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

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

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

[26] *See Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).