United States Department of Labor
Employees' Compensation Appeals Board

C.C., Appellant	)	
	)	**Docket No. 15-1459**
and	)	**Issued: October 22, 2015**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, Employer	)	
	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JAMES A. HAYNES, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 24, 2015 appellant, through counsel, filed a timely appeal from a March 4, 2015 merit 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 established greater than five percent impairment of the right upper extremity, for which he received a schedule award.

FACTUAL HISTORY

OWCP accepted that on September 9, 2010 appellant, then a 49-year-old letter carrier, sustained a right shoulder and rotator cuff sprain when he attempted to lift a tub of mail. Appellant stopped work on the date of injury and sought treatment in a hospital emergency room.

[1] 5 U.S.C. § 8101 *et seq.*

In a September 9, 2010 emergency room report, Dr. Steve L. Andrews, an attending Board-certified family practitioner, provided a history of the accepted incident and diagnosed cervical radiculopathy due to the lifting incident.

Appellant received compensation for temporary total disability through June 10, 2011. OWCP later expanded the claim to accept right-sided brachial neuritis/radiculitis.

While off work, appellant was followed by Dr. Gregory Daly, an attending osteopath Board-certified in family practice, who initially diagnosed a right-sided cervical paraspinal sprain on September 13, 2010. Dr. Daly later found a partial supraspinatus tendon tear based on a November 1, 2010 magnetic resonance imaging (MRI) scan study.[2] He provided progress notes through May 9, 2011.

On June 11, 2011 appellant returned to light-duty work for six hours a day, and received compensation for the remaining two hours a day through March 2012 and continuing. He remained under medical care.[3]

In a March 22, 2012 report, Dr. Seymour noted that a subacromial injection relieved appellant's symptoms for two to three weeks, but that his pain had returned. He referred appellant to his partner, Dr. Erling Ho, a Board-certified orthopedic surgeon, who specialized in shoulder procedures.

On May 3, 2012 Dr. Ho performed an arthroscopic right rotator cuff repair, glenohumeral debridement, and subacromial decompression. OWCP authorized the procedure. Following surgery, appellant participated in physical therapy. He remained off work, receiving compensation for total disability through December 13, 2012, when he returned to full-time modified duty.

In a March 11, 2013 report, Dr. Ho noted that appellant could perform all activities of daily living with minimal pain. On examination he observed full active abduction of the right shoulder and full forward flexion of the right shoulder, 4+/5 strength with resisted abduction, and a very minimally positive impingement sign. In a May 13, 2013 report, Dr. Ho released appellant to full, unrestricted duty. He opined that appellant had attained maximum medical improvement (MMI). Appellant returned to full duty effective June 6, 2013.

On June 14, 2013 appellant claimed a schedule award. In a June 18, 2013 letter, OWCP advised him of the additional evidence needed to establish his claim, including an impairment rating from his attending physician utilizing the tables and grading schemes of the sixth edition

[2] A November 1, 2010 MRI scan of the right shoulder showed a small partial insertional tear of the anterior supraspinatus. Dr. Daly referred appellant to Dr. Scott A. Seymour, an attending Board-certified orthopedic surgeon, who provided a November 29, 2010 report diagnosing right shoulder impingement and tendinitis with a partial rotator cuff tear. A March 23, 2011 MRI scan of the cervical spine showed mild degenerative changes, with a trace diffuse disc bulge at C4-5, and a mild diffuse disc bulge at C6-7 causing trace right-sided foraminal narrowing.

[3] On February 16, 2012 Dr. Seymour diagnosed a partial supraspinatus tear with recurrent impingement. He administered a subacromial corticosteroid injection, noting that appellant might require surgery.

of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).

In support of his claim, appellant submitted an August 13, 2013 report from Dr. Neil Allen, an attending Board-certified neurologist and internist, noting findings on July 2, 2013 examination. Dr. Allen provided a history of injury and treatment. He related appellant's symptoms of neck and right shoulder pain, weakness and restricted motion, improved but not to preinjury baseline following surgery. Dr. Allen noted that the impairment caused mild interference with activities of daily living, a *Quick*DASH score of 43, and a pain disability questionnaire (PDQ) score of 91. On physical examination he noted 3 centimeters atrophy of the right brachium, increased tone throughout the right upper trapezius, reflexes at 1/5 in the C5-6 dermatome, reduced cutaneous sensation in the right C5 dermatome with two-point discrimination intact, tenderness in the long head of the biceps tendon, and 4/5 weakness of abduction and external rotation in the right shoulder. Dr. Allen observed the following ranges of right shoulder motion: 170 degrees flexion; 61 degrees extension; 152 degrees abduction; 55 degrees adduction; 34 degrees internal rotation; and 77 degrees external rotation. Regarding right shoulder impairment, he referred to Table 15-5[4] to assess a class 1 Class of Diagnosis (CDX) impairment for a rotator cuff injury, with a default value of three percent. Dr. Allen noted a grade modifier for Functional History (GMFH) of 2 for a *Quick*DASH score of 43, pain with normal activity, a grade modifier for findings on Physical Examination (GMPE) of 3 for consistently documented palpatory findings, moderate motion deficit according to Table 15-34,[5] and muscle atrophy in the brachium, and a grade modifier for Clinical Studies (GMCS) of 2 for the preoperative MRI scan showing the supraspinatus tear. Applying the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), he calculated five percent permanent impairment of the right upper extremity. Referring to proposed Table 1 of the July/August 2009 *The Guides Newsletter* of the A.M.A., *Guides*, and Table 15-14,[6] Dr. Allen found a class 1 diagnosis-based impairment for a mild motor deficit at C5, with a default value of four percent. He noted a grade modifier for functional history of 1 for a PDQ of 91 and pain with strenuous activity. Dr. Allen calculated a total 13 percent permanent impairment of the right upper extremity, 5 percent for the right shoulder, 4 percent for motor impairment, and 4 percent for sensory impairment.

In a March 31, 2014 report, an OWCP medical adviser opined that Dr. Allen's rating did not conform to the A.M.A., *Guides*. He noted that for impairments, due to cervical spine abnormalities under Table 17-2,[7] there must be a documented intervertebral disc herniation or alteration in motion segment integrity affecting the upper extremity. "However, neither of these objective criteria have been met. Consequently, there is no basis for any permanent partial impairment (PPI) as it related to the cervical spine." The medical adviser agreed with Dr. Allen that appellant had five percent permanent impairment of the right upper extremity according to

[4] Table 15-5, page 401 of the sixth edition of the A.M.A., *Guides* is entitled "Shoulder Regional Grid: Upper Extremity Impairments."

[5] Table 15-34, page 475 of the sixth edition of the A.M.A., *Guides* is entitled "Shoulder Range of Motion."

[6] Table 15-14, page 425 of the sixth edition of the A.M.A., *Guides* is entitled "Sensory and Motor Sensitivity."

[7] Table 17-2, page 564 of the sixth edition of the A.M.A., *Guides* is entitled "Cervical Spine Regional Grid."

Table 15-5 for shoulder impairment. He opined that appellant attained MMI as of May 11, 2013, as found by Dr. Ho.

By decision dated April 9, 2014 and reissued April 17, 2014, OWCP granted appellant a schedule award for five percent permanent impairment of the right upper extremity. The period of the award ran from May 11 to June 28, 2013 for a total of 15.6 weeks.

Appellant disagreed and, in a May 6, 2014 letter, through counsel, requested a telephonic hearing before an OWCP hearing representative, held December 16, 2014. At the hearing, counsel argued that OWCP medical adviser misinterpreted Dr. Allen's report. He contended that Dr. Allen properly utilized the diagnosis-based impairment rating method for brachial neuritis. Counsel asserted that the medical adviser failed to consider the accepted brachial neuritis in calculating the percentage of impairment.

By decision dated March 4, 2015, an OWCP hearing representative affirmed the April 17, 2014 schedule award, finding that the additional argument did not establish a greater percentage of impairment. She found that OWCP's medical adviser "thoroughly considered Dr. Allen's findings and basis of impairment." The hearing representative explained that as Dr. Allen's calculations did not conform to the A.M.A., *Guides*, there was no conflict of opinion, and a new evaluation was not necessary.

LEGAL PRECEDENT

The schedule award provisions of FECA[8] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. It, 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.[9] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[10]

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).[11] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on functional history,

[8] 5 U.S.C. § 8107.

[9] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

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

physical examination, and clinical studies.[12] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

In addressing upper extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on functional history, physical examination, and clinical studies.[13] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[14]

No schedule award is payable for a member, function, or organ of the body not specified in FECA or in the regulations.[15] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back,[16] no claimant is entitled to such an award.[17] However, in 1966, amendments to FECA modified the schedule award provision 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 provision of FECA includes the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[18]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.[19]

ANALYSIS

OWCP accepted that appellant sustained a right rotator cuff tear, right shoulder sprain, and right brachial neuritis/radiculitis. Appellant underwent an authorized arthroscopic right rotator cuff repair with subacromial decompression, performed by Dr. Ho, a Board-certified orthopedic surgeon. Dr. Ho found that appellant achieved MMI on or before May 11, 2013.

Appellant claimed a schedule award on June 14, 2013. OWCP advised him on June 18, 2013 to submit an impairment rating from his attending physician, utilizing the sixth edition of the A.M.A., *Guides*. In response, appellant submitted an August 13, 2013 impairment rating from Dr. Allen, an attending Board-certified neurologist and internist, derived from using the

[12] *Id.* at 494-531 (6th ed. 2008).

[13] *Id.* at 385-419; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[14] *Id.* at 411.

[15] *Henry B. Floyd, III*, 52 ECAB 220 (2001).

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

[17] *Thomas Martinez*, 54 ECAB 623 (2003).

[18] *See Thomas J. Engelhart*, 50 ECAB 319 (1999).

[19] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

A.M.A., *Guides* for both accepted conditions. Dr. Allen calculated five percent permanent impairment of the right upper extremity for the rotator cuff tear using the diagnosis-based impairment rating scheme under Table 15-5. He also used the diagnosis-based method in assessing four percent permanent impairment of the right arm due to a brachial plexus sensory deficit, and four percent for a brachial plexus motor deficit due to the accepted brachial neuritis/radiculitis.

An OWCP medical adviser reviewed Dr. Allen's report and agreed that appellant had a five percent permanent impairment from the rotator cuff tear. However, he found that, because appellant did not have a ratable impairment involving the cervical spine, Dr. Allen's assessment of an additional eight percent permanent impairment due to brachial plexus neurologic deficits was not reached in accordance with the A.M.A., *Guides*. OWCP issued a schedule award on April 9, 2014, reissued April 17, 2014, for five percent permanent impairment of the right upper extremity, based on OWCP medical adviser's review of Dr. Allen's report.

The Board finds, however, that OWCP medical adviser misunderstood Dr. Allen's report. Appellant did not claim and OWCP never accepted a cervical spine condition. However, OWCP did accept right-sided brachial neuritis/radiculitis. Dr. Andrews, an attending Board-certified family practitioner, diagnosed cervical radiculopathy due to the lifting incident, and Dr. Daly, an attending osteopath Board-certified in family practice, diagnosed a cervical sprain. Dr. Allen, in rating impairment, found objective evidence of brachial plexus impairment, motor and sensory deficits in the arm. OWCP medical adviser found that appellant had no ratable impairment originating in the cervical spine, but did not consider the brachial plexus deficits documented by Dr. Allen. Therefore, the case will be remanded for additional development.

On return of the case, OWCP shall obtain a supplemental report from OWCP medical adviser regarding the appropriate percentage of permanent impairment attributable to the accepted brachial neuritis/radiculitis. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision in the case.

On appeal, counsel contends that OWCP's March 4, 2015 decision is "contrary to law and fact." As stated above, the case will be remanded for additional development regarding the appropriate percentage of permanent impairment.

CONCLUSION

The Board finds that the case is not in posture for a decision. The case will be remanded to OWCP for additional development regarding the appropriate percentage of permanent impairment.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 4, 2015 is set aide, and the case remanded to OWCP for additional development in accordance with this decision and order.

Issued: October 22, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board