

FACTUAL HISTORY

On February 23, 1991 appellant, then a 47-year-old flat sorter, filed a traumatic injury (Form CA-1) alleging on that date a coworker struck her on the left side of her body with a mail transporter. She alleged left elbow pain. Appellant returned to work on March 7, 1991 as a manual distribution clerk. The claim was assigned OWCP File No. xxxxxx449. OWCP accepted the claim for contusion of the left arm on March 15, 1991. Appellant underwent a magnetic resonance imaging (MRI) scan of the cervical spine on May 13, 1991 which was normal. On September 19, 1991 her electromyography (EMG) and motor and sensory conduction studies of the left shoulder girdle and the paraspinal muscles of the cervical region were normal.

Appellant filed a notice of recurrence of disability (Form CA-2a) on November 2, 1991 alleging that she sustained a recurrence of disability in July 1991 due to her February 23, 1991 employment injury. She stated that she was unable to perform her regular duties and that she developed pain and swelling in her neck and left shoulder.

Appellant filed a second Form CA-1 on May 19, 1992 alleging that, on that date, a shelf fell from her machine hitting her head, nose, neck, and right forearm. The claim was assigned OWCP File No. xxxxxx774. Appellant underwent a right shoulder MRI scan on June 15, 1992 which demonstrated a complete tear of the distal supraspinatus tendon as well as a sloping distal acromion impinging the supraspinatus tendon. Her cervical MRI scan of the same date demonstrated early degenerative changes at C4-5 and C5-6 with reversal of the curvature. OWCP accepted cervical strain and laceration of the nose as well as right shoulder contusion on July 13, 1992. It later approved right shoulder rotator cuff tear surgical repair on August 26, 1992. Appellant underwent right shoulder rotator cuff repair, with acromioplasty, and release of the coracoacromial ligament on September 22, 1992. She returned to duty on March 22, 1993.

On December 13, 1993 appellant underwent a left shoulder MRI scan which demonstrated mild acromioclavicular (AC) joint arthropathy without significant impingement of the rotator cuff with a partial tear along the under surface of the supraspinatus tendon. Her cervical MRI scan of the same date demonstrated mild spondylosis unchanged as compared to prior studies.

In a letter dated June, 17, 1994, OWCP informed appellant that her claim in OWCP File No. xxxxxx449 had not been accepted for a right arm condition. Appellant underwent left shoulder arthroscopy and debridement of the rotator cuff on June 30, 1994 with arthroscopic acromioplasty and release of the coracoacromial ligament. OWCP accepted her claim for additional conditions of left shoulder impingement and arthroscopy on June 30, 1994. Appellant returned to limited-duty work on February 21, 1996.

In a decision dated January 9, 1997, OWCP determined that appellant had sustained a loss of wage-earning capacity when she returned to modified work on July 13, 1996.

Appellant underwent left rotator cuff repair on January 5, 2006 with superior labral tear, anterior inferior instability with ligament tear, and shoulder impingement.

On January 21, 2008 appellant underwent a right shoulder MRI scan which demonstrated supraspinatus tendon tear and retraction. OWCP authorized right shoulder arthroscopy and rotator cuff repair on October 16, 2008.

Appellant underwent a second right shoulder rotator cuff repair, with right shoulder superior labral tear, anterior labral repair, and subacromial decompression of the bursa on November 11, 2008.

Appellant underwent a left shoulder MRI scan on September 15, 2009 which demonstrated return supraspinatus tendon and a chronic complete tear of the infraspinatus tendon with muscle and tendon edge atrophy. She also exhibited chronic intracapsular rupture of the long biceps tendon.

Appellant retired from the employing establishment on October 31, 2009 and elected retirement benefits effective that date. She requested a schedule award (Form CA-7) on February 10, 2011. By letter dated February 15, 2011, OWCP requested that appellant provide a medical report in support of her claim for a schedule award.

In a March 7, 2011 report, Dr. David L. Higgins, an orthopedic surgeon, found a 35 percent permanent impairment of the left shoulder.

Appellant underwent a right shoulder MRI scan on March 14, 2011 which demonstrated atrophy of the supraspinatus tendon with partial thickness tear at the insertion. Her left shoulder MRI scan of the same date demonstrated attenuation of the distal supraspinatus tendon and chronic intrasubstance tear of the biceps tendon.

In a report dated March 30, 2011, Dr. Higgins found that appellant had reached maximum medical improvement in regard to both shoulders. He found decreased range of motion in the right shoulder including loss of forward flexion at 90 degrees, abduction of 40 degrees, and loss of external rotation at 15 degrees. Dr. Higgins reported weakness of the internal rotators, external rotators, and supraspinatus. He noted that appellant had atrophy of the rotator cuff, the anterior third deltoid muscle, mid-third deltoid muscle, posterior third deltoid muscle, biceps, pectoralis major, and scapular stabilizers. Appellant's left shoulder had 20 degrees of external rotation, and 95 degrees of forward flexion. Dr. Higgins found crepitus at the glenohumeral joint, tendinitis of the biceps, as well as weakness of the internal rotators, external rotators, and supraspinatus muscles. He noted atrophy of the rotator cuff, anterior third deltoid muscle, mid-third deltoid muscle, and posterior third deltoid as well as atrophy of the biceps, pectoralis major, and scapular stabilizers. Appellant reported aching, atrophy, a burning sensation, clicking, and catching. Dr. Higgins concluded that she had reached maximum medical improvement and that she had 35 percent permanent impairment of each shoulder, but that the left shoulder was more symptomatic.

Dr. Higgins completed a report on August 25, 2010 and opined that appellant had 35 percent permanent impairment of both shoulders and neck due to pain, weakness, rotator cuff tears, and degenerative joint disease.

Appellant underwent a left shoulder MRI scan on January 7, 2013 which demonstrated biceps tendinitis, degenerative joint disease of the glenohumeral joint, full thickness tear of the

rotator cuff, and rotator cuff arthropathy. An MRI scan of her cervical spine on the same date demonstrated herniated disc, spinal stenosis, and spondylosis.

Dr. Higgins examined appellant on May 20, 2015 and found in the left shoulder weakness of the external rotators, and supraspinatus. He listed her range of motion as 60 degrees of active abduction and 115 degrees of forward flexion. Dr. Higgins also found rotator cuff atrophy, deltoid atrophy, bicep atrophy, pectoralis major atrophy, and atrophy of the scapular stabilizers. In regard to appellant's right shoulder, he found tenderness in the rotator cuff, weakness of the external rotators and supraspinatus muscles, and abduction of 70 degrees, with forward flexion of 125 degrees. Dr. Higgins also noted atrophy of the rotator cuff, deltoid muscle, biceps, pectoralis major, and scapular stabilizers.

OWCP referred the medical evidence to its medical adviser on August 3, 2015. It included a statement of accepted facts, which noted that appellant had a separate right shoulder claim accepted for contusion of the face, scalp, and neck, open wound of the face, sprain of the neck, and right rotator cuff sprain. OWCP described her left shoulder condition as adhesive capsulitis of the left shoulder, AC joint sprain, and surgery on January 5, 2006.

In a report dated August 3, 2015, Dr. Arnold T. Berman, OWCP's medical adviser reviewed Dr. Higgins' March 7, 2011 and May 20, 2015 reports and found that he failed to correctly utilize the American Medical Association, *Guides of the Evaluation of Permanent Impairment* (A.M.A., *Guides*) in determining appellant's impairment rating. He applied the A.M.A., *Guides* to Dr. Higgins' findings for the left arm and noted that, while the diagnosis-based estimate would equate to seven percent impairment due to a full thickness rotation cuff tear,² a schedule award based on appellant's loss of range of motion would result in a total of nine percent impairment. OWCP's medical adviser combined the finding of forward flexion of 115 degrees, three percent impairment,³ with abduction of 60 degrees, six percent impairment,⁴ to reach his rating under the A.M.A., *Guides*. He determined that a schedule award was appropriate for only the left shoulder not both shoulders.

By decision dated October 6, 2015, OWCP granted appellant a schedule award for nine percent permanent impairment of the left upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA⁵ and its implementing regulations⁶ set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of use of scheduled members or functions of the body. FECA, however, does not specify

² A.M.A., *Guides*, 403, Table 15-5.

³ *Id.* at 475, Table 15-34.

⁴ *Id.*

⁵ 5 U.S.C. § 8107.

⁶ 20 C.F.R. § 10.404.

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

The protocol and formula of the sixth edition of the A.M.A., *Guides* requires that the physician determine the Class of Diagnosis (CDX) for the lower extremity and apply the appropriate grade modifiers for functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS) and apply the following formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) to reach the appropriate grade within the class of diagnosis.⁸

It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment and OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings of the attending physician.⁹

ANALYSIS

The Board finds that this case is not in posture for a decision.

It is unclear from the record whether an OWCP medical adviser reviewed all of the surgical and narrative reports supporting appellant's diagnosed upper extremity conditions. The statement of accepted facts presented to him by OWCP did not include appellant's accepted right shoulder rotator cuff repair, with acromioplasty and release of the coracoacromial ligament on September 22, 1992 or the right shoulder rotator cuff repair, with right shoulder superior labral tear, anterior labral repair, and subacromial decompression of the bursa on November 11, 2008. The statement of accepted facts also listed only appellant's January 5, 2006 left shoulder surgery and failed to include appellant's left shoulder arthroscopy and debridement of the rotator cuff on June 30, 1994 with arthroscopic acromioplasty and release of the coracoacromial ligament. Neither, the statement of accepted facts nor the OWCP medical adviser mentioned the March 14, 2011 MRI scans, which demonstrated atrophy of the supraspinatus tendon with partial thickness tear at the insertion in the right shoulder and attenuation of the distal supraspinatus tendon and chronic intrasubstance tear of the biceps tendon in the left shoulder. OWCP also failed to mention January 7, 2013 left shoulder MRI scan which demonstrated biceps tendinitis, degenerative joint disease of the glenohumeral joint, full thickness tear of the rotator cuff, and rotator cuff arthropathy. Appellant has accepted claims for both right and left shoulder conditions, which have been consolidated under OWCP File xxxxxx449, serving as the master

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 2.808.5a (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

⁸ A.M.A., *Guides*, 521.

⁹ *Linda Beale*, 57 ECAB 429 (2006).

file number. She has received extensive electrodiagnostic and surgical treatment for both shoulders. The medical adviser limited his impairment rating to just the left upper extremity without explanation. He further limited his application of the A.M.A., *Guides* to the diagnosis of full thickness tear of the rotator cuff, without discussion of appellant's documented injuries AC joint capsule and coracoclavicular ligaments can result in impairment ratings from 8 to 24 percent of the arms.¹⁰

OWCP may undertake to develop either factual or medical evidence for determination of the claim. It is well established that proceedings under FECA are not adversarial in nature and that while the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. OWCP has an obligation to see that justice is done.¹¹ The Board finds that OWCP undertook development of the medical aspect of appellant's schedule award claim, but failed to provide a complete statement of accepted facts¹² or review of the record to the medical adviser. On remand OWCP should fully development a statement of accepted facts and refer her appellant for a second opinion examination to determine the extent of the permanent impairment of both her right and left upper extremities for schedule award purposes. After such further development, it should issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for a decision regarding the extent of appellant's bilateral upper extremity impairment. On remand OWCP should prepare a comprehensive statement of accepted facts and refer appellant for a second opinion evaluation.

¹⁰ A.M.A., *Guides*, 403, Table 15-5.

¹¹ *John J. Carlone*, 41 ECAB 354, 358-60 (1989).

¹² As the Board has had, a medical opinion based on an incomplete statement of accepted facts is of reduced probative value. *See E.O.*, Docket No. 12-517 (issued July 6, 2012). Moreover, OWCP procedures specify that the statement of accepted facts must include all accepted conditions. *Id.* Federal (FECA) Procedures Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600(a)(4) (October 1990).

ORDER

IT IS HEREBY ORDERED THAT the October 6, 2015 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this decision of the Board.

Issued: July 14, 2016
Washington, DC

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

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

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