United States Department of Labor
Employees' Compensation Appeals Board

L.B., Appellant	)	
and	)	**Docket No. 16-1054**
	)	**Issued: October 12, 2016**
DEPARTMENT OF THE NAVY, NAVAL AMPHIBIOUS BASE LITTLE CREEK, Norfolk, VA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 22, 2016 appellant filed a timely appeal from an April 5, 2016 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.[2]

ISSUE

The issue is whether appellant has more than 5 percent permanent impairment of the right upper extremity and 21 percent permanent impairment of the right lower extremity, for which he received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

[2] Appellant submitted new evidence with his appeal. The Board's jurisdiction is limited to the review of evidence which was before OWCP at the time it issued its final decision. Thus, the Board has no jurisdiction to review new evidence on appeal; *see* 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

On December 1, 1994 appellant, then a 51-year-old firefighter, filed a traumatic injury claim (Form CA-1) alleging that on November 3, 1994 he experienced lung problems after exposure to heavy smoke in the performance of duty. OWCP accepted the claim for bronchitis and pneumonitis due to fumes and vapors, osteomyelitis of the pelvis and bilateral thigh, a right shoulder and upper arm sprain, aseptic necrosis of the head and neck of the bilateral femur, post inflammatory pulmonary fibrosis, and a complete right rotator cuff rupture. Appellant retired from employment on August 1, 1997.[3]

By decision dated November 17, 2004, OWCP granted appellant a schedule award for 50 percent permanent impairment of the left lower extremity. In a decision dated February 2, 2011, it granted him a schedule award for 26 percent permanent impairment of the lungs.[4]

On March 6, 2012 Dr. Michael M. Romash, a Board-certified orthopedic surgeon, performed a right total hip arthroplasty. On December 7, 2012 an OWCP medical adviser found that the surgery was warranted based on appellant's osteonecrosis of the bilateral hips due to his work injury.

On March 5, 2013 appellant filed a claim for a schedule award (Form CA-7). By letter dated March 19, 2013, OWCP requested that he submit an impairment evaluation from his attending physician in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

Dr. Romash, in a report dated March 20, 3013, diagnosed right lateral hip pain. On examination he found a normal gait and equal leg length. Dr. Romash diagnosed bilateral hip pain, greater trochanteric bursitis, gluteal tendinitis and traumatic myositis ossificans.

In an impairment evaluation dated April 9, 2013, Dr. Samuel Brown, a Board-certified orthopedic surgeon, discussed appellant's history of a 1994 injury in his work as a firefighter. He diagnosed mild-to-moderate primary localized osteoarthritis of the right shoulder with right shoulder pain, shoulder impingement syndrome, and joint arthrosis of the acromioclavicular joint. Referencing the A.M.A., *Guides*, Dr. Brown opined that appellant had 10 percent right upper extremity impairment.

On April 10, 2013 Dr. Romash provided an impairment evaluation for appellant's right hip. He discussed his complaints of marked pain and noted that he walked with a moderate limp. On examination Dr. Romash found no fixed adduction, internal or external rotation, or flexion

[3] By decision dated March 6, 2003, OWCP denied appellant's claim for a schedule award for chest impairment. On June 18, 2009 it denied his request for reconsideration of its March 6, 2003 decision as it was untimely filed and did not demonstrate clear evidence of error.

[4] In a decision dated April 14, 2011, OWCP denied appellant's request for an oral hearing on the February 2, 2011 decision under 5 U.S.C. § 8124 as it was untimely. On June 27, 2011 the Board issued an order dismissing appeal of the April 14, 2011 decision at his request. *Order Dismissing Appeal*, Docket No. 11-1487 (issued June 27, 2011). By decision dated April 14, 2011, OWCP again denied appellant's request for an oral hearing on the February 2, 2011 decision as untimely under 5 U.S.C. § 8124.

contracture. He further found a leg discrepancy on x-ray of five millimeters. Dr. Romash measured right hip range of motion of 90 degrees flexion, 30 degrees abduction, 20 degrees adduction, more than 30 degrees external rotation, and more than 15 degrees internal rotation. He advised that based on the examination findings appellant had a poor result from surgery, which constituted 75 percent leg impairment. Dr. Romash diagnosed bilateral hip pain, a total hip replacement, gluteal tendinitis, and greater trochanteric bursitis.

A magnetic resonance imaging (MRI) scan of appellant's right shoulder, obtained July 19, 2013, revealed moderate-to-severe tendinosis without a definite tear.

On August 1, 2013 Dr. Arthur W. Wardell, a Board-certified orthopedic surgeon, diagnosed a partial thickness rotator cuff tear as the result of appellant use of crutches due to his work injury. He interpreted the MRI scan as showing a partial thickness tear of the supraspinatus tendon.

OWCP expanded acceptance of appellant's claim on January 13, 2014 to include a complete rupture of the right rotator cuff.

On June 10, 2014 Dr. Wardell performed an open rotator cuff repair of the right shoulder. He noted that appellant had "an underlying split in the rotator cuff" that was "debrided and repaired." Dr. Wardell, in a January 30, 2015 progress report, found a positive right shoulder impingement test and right shoulder stiffness and pain. He indicated that appellant underwent surgery on May 20, 2014 for a full-thickness rotator cuff tear. Dr. Wardell measured range of motion of the right shoulder as 150 degrees flexion and 140 degrees passive abduction.

An OWCP medical adviser reviewed the evidence on March 19, 2016. He found that the MRI scan and operative report showed a partial rotator cuff tear. The medical adviser identified the right shoulder diagnosis as a class 1 partial thickness tear with some loss of function but normal motion, which yielded a default value of three percent under Table 15-5 on page 402 of the A.M.A., *Guides*. He applied a grade modifier of two for physical examination based on appellant's loss of shoulder motion, a grade modifier of 2 for functional history due to symptoms with normal activity, and a grade modifier of 2 for clinical studies, which moved the default value two places and yielded five percent permanent impairment of the right arm. The medical adviser found that he reached maximum medical improvement for the right shoulder on April 9, 2013, the date of the impairment evaluation.

For the right hip, OWCP's medical adviser reviewed Dr. Romash's finding of 75 percent leg impairment rating for the hip and noted that it did not conform with the A.M.A., *Guides*. He found that Dr. Romash, in his March 20, 2013 examination, found a normal gait with free hip movement and no loosening of the prosthesis. The medical adviser identified the diagnosis as a class 2 total hip replacement that was stable and functional, which yielded a default value of 25 percent pursuant to Table 16-4 on page 515 of the A.M.A., *Guides*. He applied a grade modifier of 1 for functional history and physical examination due to appellant's good range of motion and a grade of 2 for clinical studies, which after applying the net adjustment formula moved the default value two places to the left for 21 percent right lower extremity impairment.

By decision dated April 5, 2016, OWCP granted appellant a schedule award for 5 percent permanent impairment of the right upper extremity and 21 percent permanent impairment of the right lower extremity. The period of the awards ran for 76.08 weeks from April 9, 2013 to September 23, 2014.

On appeal appellant argues that OWCP misdiagnosed his shoulder as he had a right rotator cuff tear and acromial spur. He also contends that due to his need for a right hip replacement he lost half of each kidney, which should be considered in the award. Appellant questions why his award for a left hip replacement was greater than for the right hip replacement.

LEGAL PRECEDENT

The schedule award provision of FECA,[5] and its implementing federal regulations,[6] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

The sixth edition requires identifying the impairment Class of Diagnosis condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[9] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

OWCP 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*.[10]

ANALYSIS

OWCP accepted appellant's claim for bronchitis, pneumonitis, osteomyelitis of the pelvis and both thighs, a sprain of the right shoulder and upper arm, aseptic necrosis of the head and neck of the femurs, postinflammatory pulmonary fibrosis, and a complete right rotator cuff

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

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

[9] A.M.A., *Guides* at 494-531.

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013); *see also L.R.*, Docket No. 14-0674 (issued August 13, 2014).

rupture. It paid him a schedule award for 50 percent permanent impairment of the left lower extremity and 26 percent permanent impairment of the lungs.

On March 5, 2013 appellant filed a schedule award claim. He submitted an April 9, 2013 impairment evaluation of the right shoulder by Dr. Brown. Dr. Brown diagnosed right shoulder osteoarthritis, impingement syndrome, and arthrosis of the acromioclavicular joint and opined that appellant had 10 percent right upper extremity impairment. He, however, did not reference the tables and pages of the A.M.A., *Guides* used in evaluating the extent of permanent impairment and thus his opinion is of diminished probative value.[11]

Dr. Wardell, on August 1, 2013, found that an MRI scan of appellant's right shoulder revealed a partial thickness rotator cuff tear. He performed an open rotator cuff repair on July 10, 2014, repairing a split in the rotator cuff. In a progress report dated January 30, 2015, Dr. Wardell noted that appellant had surgery in May 2014 for a full-thickness rotator cuff tear.

Regarding the right shoulder, on March 19, 2016 an OWCP medical adviser identified the diagnosis as a class 1 partial thickness tear of the right rotator cuff with some functional loss but normal motion using Table 15-5 on page 402, which yielded a default impairment value of three percent. It is unclear, however, whether appellant had a partial thickness or full-thickness rotator cuff tear. Dr. Wardell reviewed an August 2013 MRI scan and found a partial thickness rotator cuff tear but referred to a full-thickness rotator cuff tear after the surgery. OWCP further expanded acceptance of the claim to include a complete rupture of the right rotator cuff. Additionally, OWCP's medical adviser identified the diagnosis as a partial thickness tear of the right rotator cuff with normal motion, but then found a grade modifier of 2 for physical examination due to abnormal shoulder motion. He also found that appellant reached maximum medical improvement on April 9, 2013, prior to his rotator cuff repair. The Board finds, consequently, that OWCP should obtain clarification regarding the appropriate shoulder diagnosis prior to determining the extent of appellant's right upper extremity impairment.

In support of his claim for a schedule award for the right hip, appellant submitted an April 10, 2013 impairment evaluation from Dr. Romash. Dr. Romash noted that appellant walked with a moderate limp and had significant pain. On examination he found a leg discrepancy by x-ray of five millimeters and measured range of motion. Dr. Romash concluded that appellant had 75 percent right lower extremity impairment due to his poor result from his hip replacement. He did not reference the A.M.A., *Guides* in reaching his impairment evaluation and thus his report is insufficient to establish the extent of the right lower extremity impairment.[12]

An OWCP medical adviser noted that Dr. Romash, in a March 20, 2013 report, found that appellant had a normal gait and no loosening of the prosthesis. He identified the diagnosis as a class 2 total hip replacement that was stable and functional, which yielded 25 percent

[11] *See Carl J. Cleary*, 57 ECAB 563 (2006) (an opinion which is not based upon the standards adopted by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of permanent impairment).

[12] *Id.*

permanent impairment under Table 16-4 on page 515 of the A.M.A., *Guides*. The medical adviser did not, however, explain why he used Dr. Romash's findings from his March 20, 2013 report rather than the April 10, 2013 impairment evaluation. As noted, on April 10, 2013 Dr. Romash found a moderate limp, a discrepancy in leg length based on x-rays, and that appellant had a poor result from his total hip replacement. On remand, the medical adviser should explain his finding of a good result following a total hip replacement in view of the more recent findings by Dr. Romash of a moderate limp and objective evidence of a leg length discrepancy. Following such further development as deemed necessary, OWCP shall issue a *de novo* decision regarding the extent of appellant's right upper and lower extremity impairment.[13]

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the April 5, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: October 12, 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

[13] Regarding appellant's argument that OWCP should consider his kidney impairment in his schedule award, he has the burden of proof to submit medical evidence supporting impairment to a scheduled member or function. *See D.H.*, 58 ECAB 358 (2007); *Annette M. Dent*, 44 ECAB 403 (1993).