United States Department of Labor
Employees' Compensation Appeals Board

C.M., Appellant	)	
and	)	**Docket No. 17-1732**
	)	**Issued: August 3, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Evansville, WI, 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 August 7, 2017 appellant filed a timely appeal from a February 10, 2017 merit decision and a July 11, 2017 nonmerit 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 the claim.[2]

ISSUES

The issues are: (1) whether appellant has more than five percent permanent impairment of her left upper extremity, for which she previously received a schedule award; and (2) whether OWCP properly denied appellant's request for reconsideration of the merits of her claim pursuant to 5 U.S.C. § 8128(a).

[1] 5 U.S.C. § 8101 *et seq.*

[2] The record provided the Board includes evidence received after OWCP issued its July 11, 2017 decision. The Board's jurisdiction is limited to the evidence that was before OWCP at the time of its final decision. Therefore, the Board is precluded from reviewing this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

Appellant, then a 48-year-old rural letter carrier, filed an occupational disease claim (Form CA-2) on July 25, 2012 alleging that she felt sharp pain in her upper left arm while delivering mail and telephone books on May 22 and 23, 2012. She did not initially stop work. OWCP accepted the claim for left rotator cuff strain.

An October 14, 2013 left shoulder magnetic resonance imaging (MRI) scan revealed mild degenerative osteoarthritic changes of the acromioclavicular joint with inferior spurring, otherwise normal examination.

Appellant stopped work on February 3, 2015. She subsequently filed a recurrence claim (Form CA-2a) alleging disability commencing February 18, 2015 due to a worsening of the accepted condition. Appellant also claimed lost wages beginning February 18, 2015.

By decision dated April 20, 2015, OWCP accepted appellant's recurrence claim. It also expanded acceptance of appellant's claim to include other maladies of left shoulder region not elsewhere classified and calcifying tendinitis of left shoulder. OWCP paid appellant temporary total disability from February 18 through June 26, 2015. Appellant retired effective April 30, 2015.

On July 10 and November 17, 2015 appellant filed claims for compensation (Form CA-7) requesting a schedule award.

By development letter dated November 23, 2015, OWCP advised appellant that the evidence of record was insufficient to establish her schedule award claim. It requested that she submit a medical report from her treating physician which provided a date of maximum medical improvement (MMI) and rated permanent impairment pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (2009).[3]

On February 24, 2016 OWCP received its November 23, 2015 development letter with annotations that physical therapy records from July were submitted, that MMI had been achieved, and that there was 20 percent permanent impairment shoulder rating. Copies of July 2 and November 2, 2015 progress reports from Dr. Peter Szachnowski, a rheumatologist, were included with a July 21, 2015 physical work performance evaluation report. Dr. Szachnowski indicated that appellant had chronic left shoulder rotator cuff dysfunction with no tear and left-sided C4 through C7 left-sided disc bulges with various degrees of compression and radiculopathy.

In a March 22, 2016 report, a district medical adviser (DMA) noted his review of the statement of accepted facts (SOAF), reports from Dr. Szachnowski and appellant's October 14, 2013 left shoulder MRI scan. He noted that a February 24, 2016 impairment rating referenced in the questions posed by OWCP was not available, but stated that the 20 percent impairment rating could not be verified as the documented full range of motion (ROM) and intact rotator cuff with calcific tendinitis would not result in a schedule award of 20 percent. The DMA reported that the

[3] (6th ed. 2009).

date of MMI was the date of Dr. Szachnowski's February 24, 2016 report, as this was the date of the impairment calculation and represented a stable clinical picture. Citing to the pages and tables in the sixth edition of the A.M.A., *Guides,* the DMA selected tendinitis as the most accurate diagnosis and assigned class 1 for default value of three percent. He assigned 1 for functional history, physical examination and clinical studies grade modifiers, and, under the net adjustment formula calculated 0, for a final grade C three percent impairment of the left upper extremity.

By decision dated June 13, 2016, OWCP issued a schedule award for three percent permanent impairment of her left upper extremity. The period of the award was 9.36 weeks from February 24 to April 29, 2016. OWCP indicated that the impairment rating was based on the medical findings and report of Dr. Szachnowski dated February 24, 2016 and the report of the DMA dated March 22, 2016.

On July 5, 2016 appellant requested a review of the written record before an OWCP hearing representative. In a July 5, 2016 letter, she argued that she deserved additional compensation based on her condition, difficulties with daily activities and loss of income.

By decision dated November 2, 2016, OWCP's hearing representative set aside the June 13, 2016 decision, finding that the DMA failed to identify the date of Dr. Szachnowski's report or the examination findings he used to calculate the impairment and there were issues with the DMA's selection of the date of MMI as February 24, 2016. She remanded the case back to the DMA.

On November 18, 2016 OWCP referred the case, a SOAF, and a list of questions, back to its DMA for rereview. The DMA was asked to document the actual date of examination and physical findings used to determine the final impairment rating. He was also asked to readdress the date of MMI selected based on the medical record.

In an April 18, 2016 report, Dr. Szachnowski reported that appellant had increased symptoms of the left shoulder. Examination showed a grossly positive rotator cuff examination with painful external rotation, guarded abduction to about 60 degrees, and a painful arc. However, drop-arm test was negative. Dr. Szachnowski indicated that appellant had symptoms of chronic rotator cuff disease with partial tear.

In an October 18, 2016 report, Dr. Szachnowski indicated that appellant had bilateral rotator cuff impingement phenomena and injected both shoulders. He also stated that appellant had cervical multilevel degenerative disc disease involving C3 through C7 with bulges of various degrees, worse at C4-5 and C6-7 with left-sided predominance.

October 18 and 27, 2016 MRI scans of cervical spine indicated multilevel degenerative disease with stable or minimally increased neuroforaminal narrowing since 2012. Bilateral multilevel neural foraminal narrowing was also seen, particularly at C5-6 and C6-7.

In a December 21, 2016 report, the DMA indicated that, since the time of his original report of March 22, 2016, appellant was reexamined by Dr. Szachnowski on April 18, 2016, who diagnosed chronic rotator cuff disease with partial tear. He indicated that, based on that additional information, the accepted condition should be expanded to include rotator cuff partial tear. Utilizing the April 18, 2016 examination findings of Dr. Szachnowski, the DMA indicated that

appellant had had increasing symptoms of the left shoulder with limited abduction with guarding at 60 degrees. Under Table 15-5 of the A.M.A., *Guides*, he selected rotator cuff injury, partial-thickness tear, as the most accurate diagnosis and assigned class 1 for default value of three percent for residual loss of function with normal motion. Citing to and using the appropriate tables in the A.M.A., *Guides*, the DMA assigned grade modifier 2 for functional history and physical examination and clinical studies and, using the net adjustment formula, calculated +2. He found that the net adjustment of +2 calculated into final grade E or 5 percent impairment of the left upper extremity. The DMA indicated that this was an increase of two percent over his previous recommendation of three percent impairment. He indicated that the date of MMI was April 18, 2015 as that was when Dr. Szachnowski last examined appellant and because that date met the definition of MMI as described on page 612 of the A.M.A., *Guides.*

By decision dated February 10, 2017, OWCP granted a schedule award for an additional two percent permanent impairment, for a total of five percent left upper extremity permanent impairment. The award ran 6.24 weeks from April 30 to June 12, 2016.

On April 12, 2017 appellant requested reconsideration and explained why she felt that she deserved more money based on her condition, difficulties with daily activities, and loss of income. She also indicated that she has been to the rheumatologist five times since her claim was last reviewed and that her April 3, 2017 visit with Dr. Szachnowski indicated that she had repetitious rotator cuff disease.

Copies of Dr. Szachnowski's progress reports dated February 17 and April 3, 2017 were provided along with a compact disc (CD) and April 3, 2017 right shoulder x-ray report. In his reports, Dr. Szachnowski reported left and right rotator cuff syndrome/bilateral rotator cuff disease and performed injections. The February 17, 2017 examination showed appellant had painful arc at 60 degrees and that she was unable to fully internally and externally rotate the shoulder. In his April 3, 2017 report, Dr. Szachnowski examined both left and right shoulders and indicated that there was decreased ROM typical for rotator cuff disease and impingement phenomena positive. He stated that the x-rays showed no evidence of osteoarthritis and previous MRI scans failed to disclose any tears.

By decision dated July 11, 2017, OWCP denied appellant's request for reconsideration of the merits of the claim. It found that the evidence submitted was irrelevant or immaterial to the underlying issue of permanent impairment of the left upper extremity.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[4] 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

[4] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

has concurred in such adoption.[5] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*.[6]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based impairment (DBI) method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[7] Under the sixth edition, the evaluator identifies 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).[8] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX). Evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[9]

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] In some instances, an OWCP medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an attending physician indicates that the MMI has been reached and described the permanent impairment of the affected member, but does not offer an impairment rating. In this instance, a detailed opinion by an OWCP medical adviser, who gives a percentage based on reported findings and the A.M.A., *Guides*, may constitute the weight of the medical evidence.[11]

ANALYSIS -- ISSUE 1

The Board finds that OWCP properly determined on February 10, 2017 that appellant had not established that the five percent permanent impairment of the left upper extremity was previously awarded.

OWCP accepted that appellant sustained left rotator cuff strain, other maladies of left shoulder region not elsewhere classified, and calcifying tendinitis of the left shoulder. An April 18, 2016 medical report from Dr. Szachnowski was provided. However, Dr. Szachnowski did not provide an impairment rating or calculation referring to specific elements of the A.M.A.,

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

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

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

[8] A.M.A., *Guides* 383-492 (6th ed. 2009).

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

[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); *D.H.*, Docket No. 12-1857 (issued February 26, 2013).

[11] *See* Federal (FECA) Procedure Manual, *id.* at Chapter 2.810.8(i) (September 2010).

Guides. An estimate of permanent impairment is of diminished probative value where it is not based on the A.M.A., *Guides*.[12]

The DMA noted that Dr. Szachnowski indicated in his April 18, 2016 report that appellant had symptoms of chronic rotator cuff disease with partial tear. He stated that the acceptance of appellant's claim should be expanded to include chronic rotator cuff disease with partial tear. The DMA utilized this as rationale for his selection of rotator cuff injury, partial-thickness tear, in his impairment calculation.

The DMA reviewed Dr. Szachnowski's April 18, 2016 examination findings and opined that appellant had five percent left upper extremity impairment. He indicated that this represented a two percent increase over the three percent impairment previously awarded. Based on this, OWCP issued a February 10, 2017 decision, finding that appellant was entitled to an additional award of two percent impairment for her left upper extremity, for a total five percent permanent impairment of the left upper extremity.

Under Table 15-5 of the A.M.A., *Guides*, the DMA selected rotator cuff injury, partial-thickness tear, as the most accurate diagnosis and assigned class 1 for default value of three percent for residual loss of function with normal motion. Citing to and using the appropriate tables in the A.M.A., *Guides*, he assigned grade modifier 2 for functional history, physical examination and clinical studies. Calculation of the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) equates to (2-1) + (2-1) + (2-1) or +3 net adjustment, which moved the default three percent impairment value upward to an E or five percent final impairment.

The diagnosis of rotator cuff injury, partial thickness tear, by asterisk, allows the impairment to be alternatively assessed using ROM impairment.[13] The DMA noted in his March 22 and December 21, 2016 reports that the record indicated that appellant had normal ROM of the left shoulder. Therefore, a ROM assessment was not appropriate. As of February 10, 2017, the Board finds that the evidence of record did not establish that appellant had more than five percent permanent impairment of her left upper extremity, for which she received a schedule award.

LEGAL PRECEDENT -- ISSUE 2

To require OWCP to reopen a case for merit review under section 8128(a) of FECA,[14] OWCP's regulations provides that a claimant may obtain review of the merits of the claim by submitting a written application for reconsideration that sets forth arguments and contains evidence that either: "(i) shows that OWCP erroneously applied or interpreted a specific point of law; (ii) advances a relevant legal argument not previously considered by OWCP; or

[12] *See Shalanya Ellison*, 56 ECAB 150, 154 (2004) (an estimate of permanent impairment is irrelevant and of diminished probative value where it is not based on the A.M.A., *Guides*).

[13] *Supra* note 8 at page 402.

[14] 5 U.S.C. § 8128(a) (providing that the Secretary of Labor may review an award for or against payment of compensation at any time on his own motion or on application).

(iii) constitutes relevant and pertinent new evidence not previously considered by OWCP."[15] 20 C.F.R. § 10.608(b) states that any application for review that does not meet at least one of the requirements listed in 20 C.F.R. § 10.606(b)(3) will be denied by OWCP without review of the merits of the claim.[16]

ANALYSIS -- ISSUE 2

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

The underlying issue on reconsideration was whether appellant had more than five percent permanent impairment of the left lower extremity, for which she previously received a schedule award, thereby warranting an increased or additional schedule award.

The Board finds that appellant has not shown that OWCP erroneously applied or interpreted a specific point of law, nor has she advanced a relevant legal argument not previously considered by OWCP. Appellant alleged that she was entitled to additional compensation; however, she did not otherwise elaborate regarding the particular basis for requesting reconsideration. Thus, she was not entitled to a review of the merits of her claim based on the first and second above-noted requirements under section 10.606(b)(3).[17]

Appellant did however submit additional reports from Dr. Szachnowski dated February 17 and April 3, 2017 on reconsideration. In these reports Dr. Szachnowski related that appellant was unable to fully internally and externally rotate the shoulder and that she had decreased ROM typical for rotator cuff disease. These reports provided pertinent new and relevant evidence as the previous medical reports of record indicated that appellant had normal ROM of the left shoulder.

OWCP issued FECA Bulletin No. 17-06 to provide a uniform methodology for calculating permanent impairment of the upper extremities using the sixth edition of the A.M.A., *Guides*.[18] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating….
>
> "Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30

[15] 20 C.F.R. § 10.606(b)(3).

[16] *Id.* at § 10.608(b); *see also Norman W. Hanson*, 45 ECAB 430 (1994).

[17] 20 C.F.R. § 10.606(b)(3)(i) and (ii).

[18] FECA Bulletin No. 17-06 (issued May 8, 2017).

> days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physician's evaluation, the CE should route that report to the DMA for a final determination."[19]

This case will, therefore, be remanded for further proceedings consistent with this opinion, to be followed by a *de novo* decision.

ORDER

IT IS HEREBY ORDERED THAT the February 10, 2017 decision of the Office of Workers' Compensation Programs is affirmed. The July 11, 2017 decision is set aside and the case is remanded for further proceedings consistent with this opinion.

Issued: August 3, 2018
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

[19] *Id.*