United States Department of Labor
Employees' Compensation Appeals Board

C.A., Appellant	)	
and	)	**Docket No. 13-1877**
	)	**Issued: April 8, 2014**
DEPARTMENT OF HOMELAND SECURITY, IMMIGRATION & CUSTOMS ENFORCEMENT, Washington, DC, Employer	)	

Appearances:
Appellant, pro se
No appearance, for the Director

Oral Argument March 6, 2014

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 13, 2013 appellant filed a timely appeal from an April 11, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) regarding a schedule award and a June 10, 2013 nonmerit decision denying his request for reconsideration. 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 has established that he sustained more than a six percent permanent impairment of the right upper extremity, for which he received a schedule award; and (2) whether OWCP properly refused to reopen appellant's case for further reconsideration of the merits pursuant to 5 U.S.C. § 8128(a).

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the issuance of the June 10, 2013 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).

At oral argument, appellant contended that Dr. Robert A. Smith, a Board-certified orthopedic surgeon and OWCP referral physician, did not conduct the required strength tests or measurements of the right shoulder area with an inclinometer as reported in his February 15, 2013 report. As a result, Dr. Arnold T. Berman, an OWCP medical adviser and a Board-certified orthopedic surgeon, relied upon an inaccurate second opinion evaluation to determine his right upper extremity impairment. Appellant further contends that the medical record established an 11 percent impairment of the right arm.

FACTUAL HISTORY

OWCP accepted that on June 30, 2005 appellant, then a 42-year-old federal criminal investigator, sustained rotator cuff tendinitis in the right shoulder while participating in a mandatory fitness program in the performance of duty.

On April 23, 2012 appellant filed a claim for a schedule award.

Appellant submitted reports from Dr. Stephen D. Brown, a Board-certified orthopedic surgeon, who listed a history that appellant injured his right shoulder at work on June 30, 2005. On May 25, 2012 Dr. Brown advised that appellant continued to have symptoms over the shoulder and neck, including problems over the acromioclavicular (AC) joint and some mild pain with cross-chest adduction as well as with rolling on the shoulder and reaching back. Upon examination, he found a positive impingement and Hawkins' test, positive cross-chest adduction and some crepitus in the shoulder. Dr. Brown found that appellant had reached maximum medical improvement as of that date.

In a May 14, 2012 letter, OWCP notified appellant of the deficiencies of his claim. It requested additional evidence, including a physician's report recommending a percentage of permanent impairment of the right upper extremity based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

Appellant submitted a June 7, 2012 report from Dr. Edwin C. Fulton, a Board-certified orthopedic surgeon, who diagnosed right rotator cuff tendinitis with impingement syndrome. Upon physical examination, Dr. Fulton found the right shoulder revealed AC joint tenderness with some persistent fullness, a mildly positive cross-chest adduction test and limitation of motion and internal rotation of approximately 25 degrees compared to the left side. Appellant had pain on abduction though he had full passive range of motion. Neurovascular findings in both upper extremities were within normal limits. Dr. Fulton opined that appellant had an 11 percent permanent impairment of the right upper extremity according to Table 15-5 on page 402 of the fifth edition of the A.M.A., *Guides* where both tendinitis and impingement syndrome fell into the same category of class 1 with a grade D modifier. He indicated that this took into account appellant's residual motion loss as well as his residual pain complaints and functional limitations with over the shoulder activities. Dr. Fulton determined that maximum medical improvement was achieved on March 7, 2012.

On November 8, 2012 Dr. William Stewart, an OWCP medical adviser, reviewed the medical evidence of record. He found that Dr. Fulton's impairment rating was based on the fifth edition of the A.M.A., *Guides* and the data provided by Dr. Fulton was not easily applied to the

sixth edition as a complete range of motion assessment was not addressed. Dr. Stewart recommended that a second opinion evaluation to properly determine the impairment to appellant's right arm under the sixth edition of the A.M.A., *Guides*.

In a November 20, 2012 letter to Dr. Fulton, appellant requested a supplemental report with an updated impairment rating based on the sixth edition of the A.M.A., *Guides*.

In a June 7, 2012 report, Dr. Fulton reiterated his findings and opined that appellant had an 11 percent permanent impairment of the right upper extremity according to Table 15-5, page 402,[3] of the sixth edition of the A.M.A., *Guides*.

On February 15, 2013 Dr. Smith conducted a second opinion examination and reviewed appellant's medical records and a statement of accepted facts. He noted that appellant complained of pain in his shoulder, particularly when he lies down on it. Upon physical examination, Dr. Smith found no deformity or atrophy of the shoulder. Active range of motion was measured with an inclinometer and revealed flexion 170 degrees, abduction 160 degrees, internal and external rotation 80 degrees each, adduction 40 degrees and extension 50 degrees. Dr. Smith indicated that during the maneuvers there were very mild impingement findings, but no evidence of any crepitation or instability. Motor strength was satisfactory and the neurological examination was normal. Dr. Smith diagnosed history of a work incident provoking symptoms of tendinitis and impingement of the right shoulder and determined that the date of maximum medical improvement was six months following the June 30, 2005 injury or December 30, 2005. He indicated that appellant had a class 1 condition and assigned a grade modifier of 1 for Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS), which resulted in a net modifier of 0. Utilizing Table 15-34, page 475,[4] of the sixth edition of the A.M.A., *Guides*, he concluded that appellant had a six percent permanent impairment of the right upper extremity due to his flexion of 170 degrees and abduction of 160 degrees. Dr. Smith noted that appellant's rotation and adduction and extension were within normal ranges and therefore did not warrant any impairment rating.

On March 16, 2013 Dr. Berman, an OWCP medical adviser, reviewed the medical evidence of record and concurred with Dr. Smith's impairment rating. He explained that Dr. Smith's use of range of motion to determine the impairment rating was an accepted method of calculation from the A.M.A., *Guides* for the diagnosis in this case. Dr. Berman stated that the other method available for the accepted condition of rotator cuff tendinitis was Table 15-5. However, appellant did not have normal motion and, therefore, it was appropriate to utilize page 405, footnote asterisk, "If motion loss is present, this impairment may alternatively be assessed using Section 15.7, *Range of Motion Impairment*."[5] Dr. Berman concluded that it was appropriate to use Table 15-34 for the impairment rating based upon Dr. Smith's examination of 170 degrees of flexion, which equated to three percent permanent impairment and abduction of

[3] Table 15-5, page 401-05, of the sixth edition of the A.M.A., *Guides* is entitled *Shoulder Regional Grid: Upper Extremity Impairments*.

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

[5] *See supra* note 3.

160 degrees, which equated to three percent permanent impairment, for a total of six percent permanent impairment of the right upper extremity. He noted that Dr. Fulton did not properly utilize the sixth edition of the A.M.A., *Guides* in his calculation. Thus, Dr. Berman's recommendation of an 11 percent permanent impairment was not accepted. He determined that the date of maximum medical improvement was the date of Dr. Smith's examination on February 15, 2013.

By decision dated April 11, 2013, OWCP granted appellant a schedule award for six percent permanent impairment of the right upper extremity for 6.24 weeks for the period February 15 through March 30, 2013.[6]

On May 8, 2013 appellant requested reconsideration. He resubmitted his November 20, 2012 letter to Dr. Fulton. Appellant also submitted a May 8, 2013 narrative statement, indicating that Dr. Smith's second opinion examination included a visual observation, questions regarding his comfort/discomfort level during the approximately 10-minute evaluation and only entailed a measurement of his right arm bicep muscle, not his right shoulder.

By decision dated June 10, 2013, OWCP denied appellant's request for reconsideration of the merits finding that he did not submit pertinent new and relevant evidence and did not show that OWCP erroneously applied or interpreted a point of law not previously considered by OWCP.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[7] 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.[8] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[9]

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

[6] In its April 11, 2013 decision, OWCP indicated that appellant was previously awarded a schedule award for four percent permanent impairment of the right upper extremity on October 10, 2012 under OWCP File No. xxxxxx506 and, therefore, he was entitled to an additional two percent permanent impairment of the right upper extremity.

[7] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

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

[9] *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 2.808.6.6a (January 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

and Health (ICF).[10] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[11] 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.[12]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed through the medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[13]

ANALYSIS -- ISSUE 1

OWCP accepted that on June 30, 2005 appellant sustained rotator cuff tendinitis in the right shoulder. In an April 11, 2013 award of compensation, it granted him a schedule award for six percent permanent impairment of the right upper extremity. On May 8, 2013 appellant requested reconsideration of the schedule award determination, claiming an 11 percent permanent impairment of the right upper extremity. It is his burden to submit sufficient evidence to establish the extent of permanent impairment.[14]

OWCP properly referred appellant to Dr. Smith for a second opinion examination. In his February 15, 2013 report, Dr. Smith conducted a physical examination and reviewed appellant's medical records and a statement of accepted facts. He indicated that appellant complained of pain in his shoulder, particularly when he lies down on it. Upon physical examination, Dr. Smith found no deformity or atrophy of the shoulder. Active range of motion was measured and revealed flexion 170 degrees, abduction 160 degrees, internal and external rotation 80 degrees each, adduction 40 degrees and extension 50 degrees. Dr. Smith indicated that during the maneuvers there were very mild impingement findings, but no evidence of any crepitation or instability. Motor strength was satisfactory and the neurological examination was normal. Dr. Smith diagnosed history of a work incident provoking symptoms of tendinitis and impingement of the right shoulder and determined that the date of maximum medical improvement was six months following the June 30, 2005 injury or December 30, 2005. He indicated that appellant had a class 1 condition and assigned a grade modifier of 1 for GMFH, GMPE and GMCS, which resulted in a net modifier of 0. Utilizing Table 15-34, page 475,[15] of

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

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

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

[13] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (January 2010); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

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

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

the sixth edition of the A.M.A., *Guides*, he concluded that appellant had a six percent permanent impairment of the right upper extremity due to his flexion of 170 degrees and abduction of 160 degrees. Dr. Smith noted that appellant's rotation and adduction and extension were within normal ranges and therefore did not warrant any impairment rating.

In accordance with its procedures, OWCP properly referred the evidence of record to Dr. Berman, a medical adviser, who reviewed the clinical findings of Dr. Smith on March 16, 2013 and concurred with his impairment rating. Dr. Berman also concurred with the usage of range of motion as the method of calculation from the A.M.A., *Guides* for the diagnosis in this case. He indicated that the other method available for the accepted condition of rotator cuff tendinitis was Table 15-5, but explained that appellant did not have normal motion and, therefore, it was appropriate to utilize page 405, footnote asterisk, "If motion loss is present, this impairment may alternatively be assessed using Section 15.7, *Range of Motion Impairment*."[16] Dr. Berman concluded that it was appropriate to use Table 15-34 for the calculation based upon Dr. Smith's examination of 170 degrees of flexion, which equated to three percent permanent impairment and abduction of 160 degrees, which equated to three percent permanent impairment, for a total of six percent permanent impairment of the right upper extremity.

The Board finds that OWCP medical adviser's applied the appropriate tables and grading schemes of the sixth edition of the A.M.A., *Guides* to Dr. Smith's clinical findings. The medical adviser'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. OWCP's medical adviser explained that Dr. Fulton's 11 percent permanent impairment rating for the right upper extremity was erroneous as the range of motion was the appropriate method of assessing appellant's impairment under the A.M.A., *Guides*. Therefore, OWCP properly relied on the medical adviser's assessment of a six percent permanent impairment of the right upper extremity.[17]

The reports from Dr. Brown do not provide an impairment rating. Thus, these reports are of no probative value regarding appellant's permanent impairment under the sixth edition of the A.M.A., *Guides*.[18]

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 six percent permanent

[16] *See supra* note 3.

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

[18] *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).

impairment of the right upper extremity. Accordingly, appellant has not established that he is entitled to a schedule award greater than that previously received.[19]

On appeal and at oral argument, appellant contends that Dr. Smith did not conduct the required strength tests or measurements of the right shoulder area with an inclinometer as reported in his February 15, 2013 report and, as a result, OWCP's medical adviser relied upon an inaccurate second opinion evaluation to determine his right upper extremity impairment. He further contends that the medical record established an 11 percent permanent impairment of the right upper extremity. The record reflects that Dr. Smith's February 15, 2013 second opinion report was based on a review of appellant's medical records, including diagnostic testing, medical history and a physical examination. The Board finds that Dr. Smith performed a comprehensive physical examination and provided an extensive evaluation of appellant's impairment under the relevant standards.[20] Moreover, in his May 8, 2013 narrative statement, appellant indicated that Dr. Smith's examination included a visual observation and a measurement of his right arm bicep muscle. Although it is not clear whether Dr. Smith used an inclinometer to take his measurements, the record establishes that he did conduct measurements to support his impairment rating as corroborated by appellant's own statement. The Board finds that appellant's arguments are not substantiated.

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.

LEGAL PRECEDENT -- ISSUE 2

Section 8128(a) of FECA does not entitle a claimant to a review of an OWCP decision as a matter of right; it vests OWCP with discretionary authority to determine whether it will review an award for or against compensation.[21] OWCP, through regulations, has imposed limitations on the exercise of its discretionary authority under section 8128(a).[22]

To require OWCP to reopen a case for merit review under section 8128(a) of FECA, OWCP regulations provide that the evidence or argument submitted by a claimant must: (1) show that OWCP erroneously applied or interpreted a specific point of law; (2) advance a relevant legal argument not previously considered by OWCP; or (3) constitute relevant and pertinent new evidence not previously considered by OWCP.[23] To be entitled to a merit review

[19] 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).

[20] *See C.D.*, Docket No. 12-249 (issued June 12, 2012).

[21] 5 U.S.C. § 8101 *et seq.* Under section 8128 of FECA, the Secretary of Labor may review an award for or against payment of compensation at any time on her own motion or on application. 5 U.S.C. § 8128(a).

[22] *See Annette Louise*, 54 ECAB 783, 789-90 (2003).

[23] 20 C.F.R. § 10.606(b)(3). *See A.L.*, Docket No. 08-1730 (issued March 16, 2009).

of an OWCP decision denying or terminating a benefit, a claimant also must file his or her application for review within one year of the date of that decision.[24] When a claimant fails to meet one of the above standards, OWCP will deny the application for reconsideration without reopening the case for review on the merits.[25]

ANALYSIS -- ISSUE 2

In support of his May 8, 2013 reconsideration request, appellant submitted a May 8, 2013 narrative statement and resubmitted a November 20, 2012 letter to Dr. Fulton. The Board finds that submission of the narrative statement did not require reopening appellant's case for merit review as it was focused on the history of his claim and did not provide a medical opinion regarding his impairment rating, which was the issue before OWCP. Therefore, it does not constitute relevant and pertinent new evidence and is not sufficient to require OWCP to reopen the claim for consideration of the merits.

The Board further finds that the submission of the November 20, 2012 letter to Dr. Fulton did not require reopening appellant's case for merit review because appellant had submitted the same letter, which was previously reviewed by OWCP in a decision dated April 11, 2013. As the report repeats evidence already in the case record, it is duplicative and does not constitute relevant and pertinent new evidence. Therefore, appellant has not established a basis for reopening his case.[26]

Appellant did not submit any evidence to show that OWCP erroneously applied or interpreted a specific point of law or advanced a relevant legal argument not previously considered by OWCP, nor did he submit any pertinent new and relevant evidence not previously considered. The Board finds that appellant did not meet any of the necessary requirements and, thus, he is not entitled to further merit review.[27]

CONCLUSION

The Board finds that appellant has not established that he sustained more than a six percent permanent impairment of the right upper extremity, for which he received a schedule award. The Board further finds that OWCP properly refused to reopen his case for further reconsideration of the merits pursuant to 5 U.S.C. § 8128(a).

[24] *Id.* at § 10.607(a).

[25] *Id.* at § 10.608(b).

[26] *See D.K.*, 59 ECAB 141 (2007).

[27] *See L.H.*, 59 ECAB 253 (2007).

ORDER

IT IS HEREBY ORDERED THAT the June 10 and April 11, 2013 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: April 8, 2014
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board