United States Department of Labor
Employees' Compensation Appeals Board

T.H., Appellant	)	
and	)	**Docket No. 14-0943**
	)	**Issued: November 25, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Washington, IN, Employer	)	

Appearances:
Ron Watson, for the appellant[1]
No appearance, for the Director

Oral Argument May 19, 2015

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On March 14, 2014 appellant, through her representative, timely appealed the September 23, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.[3]

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id*. An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id*.; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq*.

[3] Appellant timely requested Oral Argument and the Board, exercising its discretion, granted appellant's request. *Order Granting Oral Argument*, Docket No. 14-0943 (issued April 17, 2015). The oral argument hearing was held on May 19, 2015. The Board subsequently requested a pleading on the application of Chapter 15 of the sixth edition American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*). Responses were received from both the Director of OWCP and appellant's representative.

ISSUE

The issue is whether appellant has established more than eight percent permanent impairment of the right upper extremity, for which she received a schedule award.

FACTUAL HISTORY

Appellant, a 57-year-old letter carrier, injured her right shoulder while delivering mail on June 18, 2007. She was walking up a flight of stairs when her mailbag got caught on a handrail and jerked her right shoulder.[4] OWCP accepted right shoulder sprain, rotator cuff tendinitis, and suprascapular neuropathy under File No. xxxxxx194.[5] Additionally, it approved a June 24, 2010 right shoulder arthroscopic procedure performed by Dr. Gary W. Misamore, a Board-certified orthopedic surgeon.[6]

On June 10, 2012 appellant filed a claim for a schedule award (Form CA-7). OWCP contacted Dr. Misamore on June 20, 2012 and requested that he provide an impairment rating in accordance with the A.M.A., *Guides* (6th ed. 2009). It instructed Dr. Misamore to include a discussion of the rationale for the calculation based on the applicable criteria and/or tables in the sixth edition of the A.M.A., *Guides*. Additionally, OWCP noted that, if there was more than one method of impairment evaluation in the A.M.A., *Guides*, the rating report should include "an explanation for the calculation method chosen."

In a report dated August 3, 2012, Dr. Misamore found 20 percent permanent impairment of the right upper extremity, which he attributed to loss of motion and strength due to glenohumeral osteoarthritis, rotator cuff tendinosis, and suprascapular neuropathy. Although he referenced various tables from Chapter 15 (The Upper Extremities) of the sixth edition of the A.M.A., *Guides*, it was not readily apparent how he arrived at his 20 percent permanent impairment rating.

OWCP referred appellant for a second opinion examination with Dr. Norman Mindrebo, a Board-certified orthopedic surgeon.[7] It prepared a statement of accepted facts (SOAF) which it forwarded to Dr. Mindrebo. OWCP also instructed him to examine appellant and provide a rating of the right upper extremity using the sixth edition of the A.M.A., *Guides*. The rating report was to include a "[d]escription of any restriction of movement in terms of degrees of retained active motion of the bilateral upper extremities." OWCP also provided Dr. Mindrebo an upper extremity impairment rating worksheet for the purpose of showing his calculations.

[4] Appellant had previously injured the same shoulder on September 19, 2005, and underwent surgery on January 6, 2006 (File No. xxxxxx259). OWCP accepted appellant's September 19, 2005 right shoulder injury for sprain/strain and impingement syndrome. The January 6, 2006 arthroscopic surgery included subacromial decompression/acromioplasty and right distal clavicle resection (Mumford procedure).

[5] OWCP doubled the two right shoulder injury claims and designated the June 18, 2007 injury as the master file (File No. xxxxxx194).

[6] The June 24, 2010 surgery included arthroscopic suprascapular nerve decompression, revision arthroscopic acromioplasty, and limited glenohumeral joint debridement.

[7] Dr. Mindrebo is also Board-certified in the subspecialty of orthopedic sports medicine.

Dr. Mindrebo examined appellant on July 18, 2013 and found 21 percent permanent impairment of the right upper extremity based on loss of shoulder ROM under Table 15-34, A.M.A., *Guides* 475 (6th ed.). His narrative report included the following information regarding appellant's bilateral upper extremity ROM:

> "[Appellant] definitely has limitations with regard to her shoulders and neck. For example, she has active forward flexion only to 85 degrees involving the right shoulder compared to 170 degrees with the left shoulder. [Appellant] has active abduction to 85 degrees with the right shoulder compared to active left shoulder abduction of 170 degrees. She has active extension of the right shoulder to 30 degrees compared to 50 degrees involving the unaffected left shoulder. [Appellant] has active internal rotation on the right to only 30 degrees compared to internal rotation actively to 90 degrees on the left. She has external rotation to 60 degrees on the right shoulder compared to 90 degrees on the left shoulder. [Appellant] has adduction to 30 degrees on the right shoulder compared to adduction of 60 degrees on the unaffected left shoulder."[8]

Dr. Mindrebo recorded the above-noted right shoulder ROM deficits on the ratings worksheet provided by OWCP and he identified the corresponding upper extremity impairment under Table 15-34, Shoulder Range of Motion, A.M.A., *Guides* 475 (6th ed. 2009). The impairments due to loss of flexion (9 percent), abduction (6 percent), adduction (1 percent), internal rotation (4 percent), and extension (1 percent) totaled 21 percent of the right upper extremity, which corresponded to a grade 2 ROM modifier under Table 15-35, A.M.A., *Guides* 477 (6th ed. 2009). Additionally, Dr. Mindrebo assigned a grade 2 modifier for Functional History (GMFH). Because the functional history and ROM grade modifiers were the same (2), no further adjustment was required pursuant to Table 15-36, A.M.A., *Guides* 477 (6th ed. 2009). Accordingly, Dr. Mindrebo calculated a final right upper extremity impairment rating of 21 percent.

On August 7, 2013 OWCP referred Dr. Mindrebo's July 18, 2013 impairment rating to a district medical adviser (DMA) for review. In a report dated August 8, 2013, Dr. Morley Slutsky, the designated DMA, disagreed with Dr. Mindrebo's right shoulder ROM impairment rating.[9] He noted that Dr. Mindrebo "used the less preferred ROM method with invalid measurements." Dr. Slutsky explained that diagnosis-based impairment (DBI) was the preferred methodology, rather than the ROM-based method the second opinion physician utilized. He quoted section 15.2, page 387 of the A.M.A., *Guides* (6th ed. 2008) noting that "*Range of motion is used primarily as a physical examination adjustment factor and only to determine actual impairment values in the rare case when it is not possible to otherwise define impairment*...." Dr. Slutsky also questioned the validity of Dr. Mindrebo's ROM measurements, noting he

[8] The narrative report also indicated that appellant exhibited some difficulty in performing activities of daily living (ADLs), such as caring for herself. Dr. Mindrebo noted for example, "when [appellant] tries to do her hair, she typically leans her head to the right and reaches out with her right hand keeping her shoulder forward flexed about 45 degrees and her elbow maximally flexed."

[9] Dr. Slutsky is Board-certified in occupational medicine.

documented only one measurement per joint, which was considered inconsistent with the criteria for assessing motion under section 15.7a, A.M.A., *Guides* 464-65 (6th ed. 2008).

Dr. Slutsky applied the DBI method and found seven percent permanent impairment of the right upper extremity for right shoulder glenohumeral post-traumatic degenerative joint disease under Table 15-5, A.M.A., *Guides* 405 (6th ed. 2008).[10] He also found an additional one percent for peripheral nerve impairment under Table 15-21, A.M.A., *Guides* 436, 442 (6th ed.).[11] Dr. Slutsky determined that appellant had a total of eight percent permanent impairment of the right upper extremity and was considered to be at maximum medical improvement (MMI) as of July 18, 2013, the date of Dr. Mindrebo's examination.

In a September 23, 2013 decision, OWCP granted a schedule award for eight percent permanent impairment of the right upper extremity. The award covered a period of 24.96 weeks beginning July 18, 2013. OWCP based the schedule award on Dr. Slutsky's August 8, 2013 impairment rating. The claims examiner noted that Dr. Slutsky, the DMA, disagreed with Dr. Mindrebo's impairment rating because he "used the less preferred [ROM] impairment method with invalid measurements." She further noted that Dr. Slutsky used the preferred DBI method and also quoted "[s]ection 15.2, page 387," noting that ROM was to be used for rating impairment "only ... in the rare case when it is not possible to otherwise define impairment...."[12] Accordingly, OWCP found that Dr. Slutsky's DBI rating represented the weight of the medical evidence because he "correctly applied the [A.M.A., *Guides*] to the examination findings."

Appellant's representative argues on appeal that OWCP should have based the September 23, 2013 schedule award on the 21 percent ROM-based rating provided by Dr. Mindrebo, OWCP's referral physician. He contends that Dr. Mindrebo found that appellant's primary impairing diagnosis was right shoulder glenohumeral arthritis and that he then appropriately rated appellant's arthritis/degenerative joint disease under the ROM methodology, finding loss of shoulder motion for 21 percent right upper extremity permanent impairment. Appellant's representative further contends that Dr. Slutsky, the DMA, improperly applied the A.M.A., *Guides* and rated appellant for a combination of impairments due to shoulder degenerative joint disease and a mild sensory loss (peripheral nerve impairment) under the DBI methodology on an improper application of the A.M.A., *Guides*. He asserts that Dr. Slutsky and the hearing representative erred in citation to section 15.2 of the A.M.A., *Guides* when quoting that ROM was to be used for rating impairment "*only … in the rare cases when it is not possible to otherwise define impairment*." Appellant's representative notes that the language of section 15.2 was amended in the second printing of the A.M.A., *Guides* and the updated language in section 15.2, page 387 now states that "*Range of motion is used primarily as*

[10] The DMA noted that appellant's right shoulder degenerative joint disease represented class 1, Class of Diagnosis (CDX) impairment, with a default upper extremity rating of five percent. Additionally, the DMA calculated a net adjustment of 1, which resulted in a final right upper extremity rating of seven percent. Net Adjustment (1) = (GMFH 1 - CDX 1) + (GMPE 1 - CDX 1) + (GMCS 2 - CDX 1). *See* section 15.3d, A.M.A., *Guides* 409-12 (6th ed.).

[11] The rating was based on a mild sensory deficit involving the suprascapular nerve.

[12] A.M.A., *Guides* 387 (6th ed. 2008).

a physical examination adjustment factor and only to determine actual impairment values when a grid permits its use as an option…."[13] Thus permitting the ROM calculation of Dr. Mindrebo.

LEGAL PRECEDENT

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to the Director of OWCP to implement the FECA program.[14] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[15] FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[16]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the American Medical Association issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment."* The document included various changes to the original text, intended to serve as an erratum/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[17] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[18]

ANALYSIS

The issue on appeal is whether appellant has more than eight percent permanent impairment of the right upper extremity, for which she had received a schedule award. The Board finds this case not in posture for decision.

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[13] A.M.A., *Guides* 387 (6th ed. 2009). The amended language -- "*when a grid permits it use as an option*" -- first appeared in the 2008 *Clarification and Corrections* document at page 15.

[14] *See* 20 C.F.R. §§ 1.1-1.4.

[15] For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

[16] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak,* 53 ECAB 130 (2001).

[17] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[18] *In the Matter of Isidoro Rivera*, 12 ECAB 348 (1961).

After appellant reached MMI she provided an impairment rating from her attending physician, Dr. Misamore, who found 20 percent permanent impairment of her right upper extremity using the ROM methodology. She was subsequently referred by OWCP for a second opinion examination. The second opinion physician, Dr. Mindrebo, also applied the ROM methodology under the sixth edition to find 21 percent permanent impairment of appellant's right upper extremity. The record was forwarded to Dr. Slutsky, the DMA, who disagreed with Dr. Mindrebo's second opinion impairment rating because he had "used the less preferred ROM method with invalid measurements." Dr. Slutsky quoted the A.M.A., *Guides*, noting that according to section 15.2, page 387, ROM was to be used for rating impairment "*only ... in the rare case when it is not possible to otherwise define impairment....*" Dr. Slutsky found that appellant had only eight percent permanent impairment of the right upper extremity using the DBI method. In its September 23, 2013 decision, OWCP granted appellant eight percent permanent impairment of the right upper extremity, finding that Dr. Slutsky's opinion represented the weight of the medical evidence regarding the extent of appellant's right upper extremity impairment. The claims examiner quoted the same language that Dr. Slutsky relied on from section 15.2, page 387 of the first printing of the sixth edition to find that ROM was to be used "*only ... in the rare case when it is not possible to otherwise define impairment....*"[19] However, the Board notes that with the 2009 second printing of the A.M.A., *Guides,* this quoted language was redacted and replaced. The second printing instructs that ROM "*is used primarily as a physical examination adjustment factor and only to determine actual impairment values when a grid permits its use as an option*."

OWCP adopted the "most recent version" of the sixth edition of the A.M.A., *Guides* on March 15, 2009, with an effective date of May 1, 2009. The most recent version of the sixth edition at that time was the second printing of the sixth edition.

The plain language of the A.M.A., *Guides* itself provides conflicting guidance as to how upper extremity impairments should be rated. In adopting the sixth edition, OWCP noted that this edition "substantially revises the evaluation methods used in previous editions, characterizing the new methodology's objectives as: to be consistent, to enhance relevancy, to promote precision and to standardize the rating process." OWCP, in FECA Bulletin No. 09-03, summarized key changes affecting the calculation of schedule awards for FECA claimants under the sixth edition. For musculoskeletal impairments of the upper extremities under Chapter 15, FECA Bulletin No. 09-03 noted that the upper extremity is divided into four separate zones including digits/hand, wrist, elbow, and shoulder and that diagnosis classes for the upper extremities are broken into the categories of soft tissue, muscle and tendon, ligament, and bone and joint. No further guidance was provided for use of the sixth edition for upper extremity impairment ratings, including no guidance for when to use the DBI methodology or when to use the ROM methodology.

The sixth edition "Principles of Assessment" for calculating impairment for upper extremity conditions notes that the user must initially become familiar with Chapters 1 and 2 and the Glossary. Chapters 1 and 2 discuss the A.M.A., *Guides'* purpose, applications, and methods of performing and reporting impairment evaluations while the glossary provides definitions of

[19] A.M.A., *Guides* 387 (6th ed. 2008).

common terms used in impairment evaluation. The procedures utilized for upper extremity impairment ratings are not specifically discussed in Chapters 1 and 2.

One of the fundamental principles under the sixth edition is that "If the [A.M.A.,] *Guides* provides more than one method to rate a particular impairment or condition, the method producing the higher rating must be used."[20] Impairment evaluations of the upper extremity must be performed within the context of the directives in Chapters 1 and 2 of the A.M.A., *Guides* and only performed when conditions have reached MMI.

Chapter 15, which provides the criteria for evaluating upper extremity impairment, notes that impairment ratings "must be performed within the context of the directives in Chapters 1 and 2 and only performed when conditions have reached MMI."[21] Under Chapter 15 of the sixth edition, DBI is noted as the primary method of evaluation of the upper limb and the A.M.A., *Guides* instruct that most impairment values for the upper extremity are calculated using the DBI method. Initially in Chapter 15, when defining DBI, ROM is noted to be used primarily as a physical examination adjustment factor and only to determine actual impairment values when a grid permits its use as an option. Diagnoses in the particular regional grids that may alternatively be rated using ROM are followed by an asterisk (*).

Chapter 15 divides the upper extremity into four regions: Digits/Hand; Wrist; Elbow; and Shoulder. In addition, Table 15-5, Shoulder Regional Grid, provides 20 specific diagnoses divided among three categories: Soft Tissue; Muscle/Tendon; and Ligament/Bone/Joint. Of those 20 diagnoses, 17 of them include an asterisk (*). At the bottom of Table 15-5, the asterisk (*) designation is explained as follows: "If motion loss is present, this impairment may alternatively be assessed using section 15.7, Range of Motion Impairment. A range of motion impairment stands alone and is not combined with diagnosis impairment."[22]

Section 15.7, Range of Motion Impairment, sets forth the process of rating upper extremity ROM deficits. The section begins by noting: "Range of motion determination is an essential component of upper extremity impairment rating with a strong historical precedent."[23] Section 15.7 also reiterates in section 15.2, that DBI is the method of choice for calculating impairment and ROM is used principally as an adjustment factor (physical examination). Section 15.7 further explains that "[s]ome of the DBI grids refer to the range of motion section when that is the most appropriate mechanism for grading the impairment."[24] The A.M.A., *Guides* explain that "[section 15.7] is to be used as a stand-alone rating when other grids refer [the evaluator/examiner] to this section or when no other diagnosis-based sections of [Chapter 15] are applicable for impairment rating of a condition." (Emphasis added.) Lastly, Figure 15-13, Upper Extremity Range of Motion Record, is used to record motion findings and to

[20] A.M.A., *Guides* 20 (6th ed. 2009).

[21] *Id.* at 384.

[22] *Id*. at Table 15-5, 405.

[23] *Id*. at 459-60.

[24] *Id*. at 461

document impairments.[25] The summary comment of Chapter 15, in apparent contradiction, notes that "only if no other approach is available to rating, calculate impairment based on range of motion, as explained in [s]ection 15.7."[26]

The Board finds that OWCP has inconsistently applied Chapter 15 of the sixth edition when granting schedule awards for upper extremity claims. No consistent interpretation has been followed regarding the proper use of the DBI or the ROM methodology when issuing an upper extremity schedule award. The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[27] As is highlighted in this case, even OWCP physicians are at odds over the proper methodology for rating upper extremity impairment. The Board has observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, physicians interchangeably cite to language in the first printing or the second printing when justifying use of either ROM or DBI. When OWCP's own physicians are inconsistent or inaccurate in the application of the A.M.A., *Guides*, OWCP can no longer ensure consistent results and equal justice under the law for all claimants.

In light of the conflicting language of the sixth edition as noted above, it is incumbent upon OWCP through its implementing regulations and/or internal procedures to establish a consistent method for rating upper extremity impairment. In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will remand the case to OWCP for development of a consistent method for calculating permanent impairment for upper extremities to be applied uniformly. Following this and such other development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an upper extremity schedule award.

CONCLUSION

The Board finds this case not in posture for decision.

[25] The A.M.A., *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three measurements should be obtained and the greatest ROM should be used for the determination of impairment.

[26] *Id*. at 481.

[27] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

ORDER

IT IS HEREBY ORDERED THAT the September 23, 2013 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: November 25, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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