United States Department of Labor
Employees' Compensation Appeals Board

R.W., Appellant	)	
and	)	**Docket No. 16-0043**
	)	**Issued: April 11, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Detroit, MI, 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
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 13, 2015 appellant filed a timely appeal from a September 8, 2015 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 the case.

ISSUE

The issue is whether appellant has more than seven percent permanent impairment of the right upper extremity for which he previously received a schedule award.

FACTUAL HISTORY

On January 8, 2014 appellant, then a 51-year-old mail processing transfer clerk filed a traumatic injury claim (Form CA-1) alleging that on January 7, 2014 he fell on an icy workroom floor and injured his right shoulder. OWCP accepted his claim for sprain of the right upper arm;

[1] 5 U.S.C. § 8101 *et seq.*

sprain of the right shoulder, rotator cuff; and complete rotator cuff rupture. It authorized arthroscopic surgery on the right shoulder which was performed on February 25, 2014. Appellant returned to a light-duty position.

A January 16, 2014 magnetic resonance imaging (MRI) scan of the right shoulder showed full-thickness supraspinatus and infraspinatus tendon tears, partial tear extension into the infraspinatus muscle, rotator cuff tendinosis, partial tear of the biceps long head tendon, surface fraying of the glenoid labrum most pronounced superiorly, glenohumeral joint effusion, contusion/strain of the deltoid muscle, acromioclavicular joint arthropathy, and subacromial spurring.

Appellant was seen by Dr. Homer Linard, an osteopath, on January 27, 2014, for a right shoulder injury. Dr. Linard related the history of appellant's work injury and noted marked tenderness to palpation over the anterior and lateral aspects of the right shoulder, and marked weakness of the rotator cuff when tested against resistance. He noted that an MRI scan revealed a large rotator cuff tear with retraction. Dr. Linard diagnosed torn rotator cuff and adhesive capsulitis of the right shoulder. On February 25, 2014 he performed a right shoulder arthroscopic subacromial decompression and repair of rotator cuff with manipulation under anesthesia. In reports dated June 13 to August 18, 2014, Dr. Linard diagnosed complete rupture of rotator cuff and adhesive capsulitis of the shoulder. He noted that appellant was progressing slowly with physical therapy and was totally disabled from work.

On August 23, 2014 appellant requested a schedule award (Form CA-7).

In a September 3, 2014 letter, OWCP requested that appellant obtain a medical report from his treating physician evaluating the extent of his permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (hereinafter A.M.A., *Guides*).[2]

Appellant submitted additional reports from Dr. Linard dated September 15 and October 13, 2014. Dr. Linard found that the old right shoulder arthroscopy portals were well-healed, no swelling or tenderness of the right shoulder, some weakness of the rotator cuff, neurovascular status was intact, and negative impingement testing. He again diagnosed complete rupture of rotator cuff, adhesive capsulitis of shoulder. Dr. Linard noted that appellant was working unrestricted and had reached maximum medical improvement (MMI). On December 19, 2014 he noted that appellant was at MMI and was discharged from his care, but explained that he did not perform impairment ratings.

On June 10, 2015 OWCP referred appellant for a second opinion to Dr. Emanuel Obianwu, a Board-certified orthopedist, for an impairment rating for appellant's right shoulder in accordance with the A.M.A., *Guides*. In a June 26, 2015 report, Dr. Obianwu noted a history of appellant's work injury and surgery. Upon examination he found tenderness over the anterior and posterior aspect of the right shoulder, but no instability. Dr. Obianwu noted range of motion (ROM), measured three times, for forward flexion was 30 degrees, 30 degrees, and 40 degrees, abduction was 40 degrees, 40 degrees, and 40 degrees, external rotation 20 degrees, 20 degrees,

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

and 20 degrees, internal rotation was 15 degrees, 14 degrees, and 20 degrees, extension was 30 degrees, 30 degrees, and 40 degrees, adduction was 20 degrees, 30 degrees, and 20 degrees. He advised that he did not average these measurements as they were unreliable based on overt symptom magnification.

Dr. Obianwu noted throughout the examination appellant was grimacing, moaning, and bending to avoid right shoulder motion. He noted that such severe impairment in shoulder mobility did not make anatomic sense especially since the treating physician, at the end of 2014, documented passive motion of 140 degrees with active motion of 110 degrees. There was no atrophy of the shoulder muscle groups and severe restriction in right shoulder mobility was inconsistent with the prior findings by the treating physician. X-rays of the right shoulder showed the head of the humerus was well located within the glenoid. Dr. Obianwu diagnosed large right rotator cuff tear and adhesive capsulitis. He opined that MMI had occurred on the one year after the surgery. Dr. Obianwu noted that he would not rate impairment using ROM as there was no obvious pathoanatomic correlation and the measurements were flawed due to symptom magnification. Using the diagnosis-based impairment (DBI) method Dr. Obianwu diagnosed a rotator cuff tear and a superior labrum anterior and posterior tear. He noted, pursuant to Table 15-9, A.M.A., *Guides*, the grade modifier for functional history, physical examination, and clinical studies would each be 2. Dr. Obianwu calculated a net adjustment of +3 for a grade E and an impairment rating of seven percent of the right upper extremity.

In an August 16, 2015 report, an OWCP medical adviser reviewed the medical record and Dr. Obianwu's June 26, 2015 findings. He indicated that the most impairing right shoulder diagnosis was full thickness rotator cuff tear with residual dysfunction. The medical adviser noted that the DBI method was the preferred rating method. Using this method, appellant placed in class 1 for the most impairing diagnosis in the shoulder region of full thickness rotator cuff tear with residual dysfunction. The medical adviser determined appellant's grade modifier for functional history was 1. He noted appellant's shoulder was still symptomatic, but appellant was able to perform self-care activities independently. The medical adviser noted that pursuant to Table 15-7, page 406, A.M.A., *Guides* the evidence was insufficient to support a grade modifier 2 chosen by Dr. Obianwu. Additionally, Dr. Obianwu determined a grade modifier 2 for physical examination; however, appellant had clear evidence of symptom magnification on examination and therefore the grade modifier for physical examination was not applicable, pursuant to Table 15-8, page 408, A.M.A., *Guides*. The medical adviser noted that prior to surgery appellant had a right shoulder MRI scan which demonstrated a complete tear of the rotator cuff and the operative report noted biceps pathology was found. He noted that, based on these findings, the grade modifier for clinical studies was 4 not 2 as noted by Dr. Obianwu, pursuant to Table 15-9, page 410, A.M.A., *Guides.* The medical adviser found a net adjustment of 2 for a final grade E for seven percent permanent impairment of the right upper extremity.

In a decision dated September 8, 2015, OWCP granted appellant a schedule award for seven percent permanent impairment of the right upper extremity. The period of the award was from June 26 to November 25, 2015.

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 implement the FECA program with the Director of OWCP.[3] 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.[4] 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.[5]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. 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).[6] 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.[7]

ANALYSIS

The issue on appeal is whether appellant has more than seven percent permanent impairment of the right upper extremity for which he previously received a schedule award.

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

The Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation has been followed regarding the proper use of the DBI or the ROM

[3] *See* 20 C.F.R. §§ 1.1-1.4.

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

[5] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak,* 53 ECAB 130 (2001).

[6] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[7] *Isidoro Rivera*, 12 ECAB 348 (1961).

methodology when assessing the extent of permanent impairment for schedule award purposes.[8] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[9] In *T.H.*, the Board concluded that OWCP physicians are at odds over the proper methodology for rating upper extremity impairment, having 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, the Board has observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians are inconsistent in the application of the A.M.A., *Guides*, the Board finds that OWCP can no longer ensure consistent results and equal justice under the law for all claimants.[10]

In light of the conflicting interpretation by OWCP of the sixth edition with respect to upper extremity impairment ratings, 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 set aside the September 8, 2015 decision. Following OWCP's development of a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and such other development as may be 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.

[8] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

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

[10] *Supra* note 8.

ORDER

IT IS HEREBY ORDERED THAT the September 8, 2015 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: April 11, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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