United States Department of Labor
Employees' Compensation Appeals Board

J.H., Appellant	)	
and	)	**Docket No. 16-0234**
	)	**Issued: April 11, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Sylvania, OH, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 19, 2015 appellant filed a timely appeal from June 19 and October 26, 2015 merit decisions 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.

ISSUE

The issue is whether OWCP properly determined that appellant had more than 10 percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on January 4, 2012 appellant, then a 56-year-old rural carrier, lifted a tub of mail and sustained a left shoulder strain/sprain with adhesive capsulitis.[2]

Dr. Stephen R. Saddemi, an attending Board-certified orthopedic surgeon, diagnosed left shoulder impingement with adhesive capsulitis on February 8, 2012. On April 24, 2012 he performed closed manipulation of the left shoulder under general anesthesia and an intra-articular injection, approved by OWCP. Appellant received wage-loss compensation for work absences. She continued to participate in physical therapy. Dr. Saddemi released appellant to full-time, limited-duty work on August 1, 2012.

As appellant's condition did not improve on September 27, 2012 Dr. Saddemi performed arthroscopic subacromial decompression with bursectomy and acromioplasty, a Mumford procedure with distal clavicle restriction, and manipulation under anesthesia. OWCP authorized these procedures and issued wage-loss compensation for work absences. Appellant returned to full-time, limited-duty work on January 7, 2013. She participated in postoperative physical therapy through June 2013. OWCP paid wage-loss compensation for intermittent work absences. Appellant returned to full duty on February 10, 2014.[3]

On August 18, 2014 appellant filed a claim for a schedule award (Form CA-7). In an August 27, 2014 letter, OWCP notified her of the additional evidence needed to establish her schedule award claim, including a report from her attending physician supporting that she had attained maximum medical improvement (MMI), the diagnosis on which the permanent impairment is based, a detailed description of the permanent impairment, and an impairment rating calculated according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*). Appellant was afforded 30 days to submit such evidence.

In response, appellant provided her September 15, 2014 letter, explaining that Dr. Saddemi did not perform impairment ratings, but could refer her to a physician who did if OWCP would authorize the expense.

On April 10, 2015 OWCP obtained a second opinion from Dr. Emmauel Obianwu, a Board-certified orthopedic surgeon. Dr. Obianwu reviewed the medical record and a statement of accepted facts. On examination, he found forward flexion of the left shoulder at 140 degrees, abduction at 130 degrees, internal rotation at 70 degrees, internal rotation at 40 degrees, extension at 40 degrees, and adduction at 40 degrees. Dr. Obianwu observed tissue tightness at the terminal phases of motion which he attributed to intrinsic capsular tightness. He opined that appellant had attained MMI. Dr. Obianwu diagnosed adhesive capsulitis with impingement of the left shoulder and mild0-to-moderate residual adhesive capsulitis. He opined that appellant

[2] A January 13, 2012 magnetic resonance imaging scan of the left shoulder showed supraspinatus tendinopathy without a full-thickness tear, and hypertrophic degenerative changes of the acromioclavicular joint causing impingement upon the supraspinatus musculotendinous junction).

[3] Dr. Saddemi administered a series of subacromial injections through February 5, 2015.

sustained a permanent impairment due to residual adhesive capsulitis and the Mumford resection of the distal clavicle. Referring to Table 15-5 of the A.M.A., *Guides*,[4] Dr. Obianwu noted a diagnosis-based impairment (DBI) for acromioclavicular joint disease with distal clavicle resection, with a default grade C, equaling 10 percent. Appellant had a grade modifier for Functional History (GMFH) of 1 for symptoms with strenuous activities, a grade modifier for Clinical Studies (GMCS) of 2 for tenderness on palpation with some crepitus, and a grade modifier for Physical Examination (GMPE) of zero. Applying the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or (1-1) + (0-1) + (2-1), Dr. Obianwu calculated a net grade modifier of zero. He therefore found 10 percent permanent impairment of the left arm. Dr. Obianwu also opined that appellant had additional "stand-alone" impairments for range of motion (ROM) loss under Table 15-34[5] of the A.M.A., *Guides*: three percent for flexion at 140 degrees; three percent for abduction at 130 degrees; one percent for extension at 30 degrees; two percent internal rotation at 70 degrees; two percent for external rotation at 40 degrees. He added these percentages to equal 11 percent permanent impairment of the left upper extremity. Dr. Obianwu then combined the 10 percent DBI impairment with the 11 percent impairment for loss of ROM, equaling 21 percent permanent impairment of the left arm.

In an April 24, 2015 addendum, Dr. Obianwu clarified that the correct combined impairment was 20 percent for "two etiological conditions in one extremity or organ system."

An OWCP medical adviser reviewed Dr. Obianwu's impairment rating on May 29, 2015 and opined that it should be disregarded. The medical adviser instead recommended a DBI rating of 10 percent according to Table 15-5,[6] as the distal clavicle resection was the "most impairing" condition. The medical adviser opined that the A.M.A., *Guides* did not allow inclusion of ROM impairments in a DBI rating.

By decision dated June 19, 2015, OWCP issued a schedule award for 10 percent permanent impairment of the left upper extremity, based on OWCP's medical adviser's review of Dr. Obianwu's clinical findings

On August 6, 2015 appellant requested reconsideration. She questioned why OWCP would refer her to Dr. Obianwu and then disregard his opinion. Appellant submitted a September 9, 2015 report from Dr. Saddemi, noting that he administered a subacromial injection that day.

By decision dated October 26, 2015, OWCP denied modification of the June 19, 2015 schedule award determination, finding that Dr. Obianwu misapplied the A.M.A., *Guides* by including ROM deficits in his impairment rating.

[4] Table 15-5, page 403 of the sixth edition of the A.M.A., *Guides* is titled "Shoulder Regional Grid: Upper Extremity Impairments."

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

[6] Table 15-5, page 405 of the sixth edition of the A.M.A., *Guides* is titled "Shoulder Regional Grid: Upper Extremity Impairments."

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.[7] 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.[8] 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.[9]

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).[10] 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.[11]

ANALYSIS

The issue on appeal is whether OWCP properly determined that appellant had more than 10 percent permanent impairment of the left upper extremity, for which she previously received a schedule award. Dr. Obianwu, a Board-certified orthopedic surgeon and second opinion physician, opined that according to the ROM rating method of the A.M.A., *Guides*, the accepted injuries caused 11 percent permanent impairment of the left arm which he combined with 10 percent DBI to yield 20 percent total permanent impairment of the left arm. In contrast, an OWCP medical adviser found that appellant had 10 percent permanent impairment of the left arm using the DBI rating method which excluded deficits due to limited ROM. OWCP issued its June 19, 2015 schedule award for 10 percent permanent impairment of the left upper extremity,

[7] *See* 20 C.F.R. §§ 1.1-1.4.

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

[9] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[10] *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).

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

relying on OWCP's medical adviser's use only of the DBI rating method, as he opined that the distal clavicle resection was more impairing than the ROM deficits and noted that DBI and ROM methods could not be combined.

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 methodology when assessing the extent of permanent impairment for schedule award purposes.[12] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[13] 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.[14]

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 June 19 and October 26, 2015 decisions. 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 that this case is not in posture for decision.

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

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

[14] *Supra* note 12.

ORDER

IT IS HEREBY ORDERED THAT the October 26 and June 19, 2015 decisions of the Office of Workers' Compensation Programs are set aside, and the case is remanded for further action consistent with this decision.

Issued: April 11, 2017
Washington, DC

Christopher J. Godfrey, 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