United States Department of Labor
Employees' Compensation Appeals Board

P.B., Appellant	)	
and	)	**Docket No. 17-0395**
	)	**Issued: August 2, 2017**
DEPARTMENT OF THE NAVY, MARINE CORPS STATIONS, LOGISTICS BASE, Barstow, CA, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On December 12, 2016 appellant filed a timely appeal from a November 18, 2016 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 to consider the merits of the case.

ISSUES

The issues are: (1) whether appellant has more than seven percent permanent impairment of his left upper extremity, for which he previously received a schedule award; and (2) whether appellant has established right upper extremity impairment for purposes of a schedule award.

On appeal, appellant contends that he has 15 percent permanent impairment to his left upper extremity, for schedule award purposes.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On August 16, 2013 appellant, then a 49-year-old heavy mobile equipment mechanic, filed a traumatic injury claim (Form CA-1) alleging that on August 13, 2013 he injured both of his shoulders while using an eight-pound hammer to remove road arms and torsion bars from an air admittance valve. He did not stop work on the date of injury. OWCP accepted appellant's claim for sprain of the right shoulder and upper arm and other affections of the left shoulder region.

On December 5, 2013 appellant underwent a repair of a chronic rotator cuff tear to the left shoulder and release of the coracoacromial ligament to the left shoulder. He stopped work on the date of the surgery and returned to full-duty work on April 21, 2014.

In an October 2, 2014 report, Dr. Jacob E. Tauber, appellant's treating Board-certified orthopedic surgeon, prepared an impairment rating report in which he listed appellant's diagnosis as status post left rotator cuff repair and subacromial decompression. Using the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009), (A.M.A., *Guides*), Table 15-5, Dr. Tauber opined that appellant had seven percent permanent impairment of the left shoulder due to residuals from his surgery.[2]

On November 24, 2014 appellant filed a claim for a schedule award (Form CA-7).

OWCP referred appellant's case to a district medical adviser (DMA), and in a response dated December 23, 2014, Dr. Ellen Pichey, a Board-certified occupational medicine specialist, and the DMA noted that appellant had a permanent impairment due to a left rotator cuff tear or tendon rupture, class 1 default position C as per Table 15-5 of the A.M.A., *Guides*.[3] Dr. Pichey made an adjustment for a grade modifier of 2 for physical examination and a functional history modifier of 2. She determined that using the net adjustment formula, appellant's default position was modified by 1, and that appellant therefore had seven percent permanent impairment of his left upper extremity. Dr. Pichey noted that there was no evidence of impairment to appellant's right upper extremity.

In a December 11, 2014 report, Dr. Tauber noted that he had previously provided an impairment rating based on appellant's condition which resulted in a rating of seven percent. He noted that his prior rating needed to be amended, as appellant had acromioclavicular pathology as well, which according to Table 15-5 of the A.M.A., *Guides*, affords an additional eight percent permanent impairment of his left upper extremity. Using the Combined Values Chart, Dr. Tauber noted a combined 14 percent left upper extremity permanent impairment rating.

On March 10, 2015 OWCP issued a schedule award for seven percent permanent impairment of the left upper extremity and zero percent permanent impairment of the right upper extremity.

[2] A.M.A., *Guides* 404, Table 15-5.

[3] *Id.*

On March 18, 2015 appellant's, then counsel, requested a telephonic hearing before an OWCP hearing representative. At the hearing, held on October 7, 2015, he contended that OWCP should review the new medical evidence, that the evidence now established an impairment to the right extremity, and that OWCP should further develop the record, as needed.

On August 21, 2015 appellant submitted a July 8, 2015 report by Dr. Mesfin Seyoum, a family practitioner. Dr. Seyoum reviewed appellant's medical history and conducted a physical examination which included measurements for range of motion (ROM). He listed appellant's diagnoses as: (1) status post left shoulder rotator cuff repair and subacromial decompression; (2) left shoulder other affections of the shoulder region; (3) right shoulder sprain/strain; and (4) right shoulder tendinitis. Dr. Seyoum agreed with Dr. Tauber that appellant was entitled to a schedule award for 14 percent permanent impairment of the left shoulder. He further concluded that appellant had five percent permanent impairment of the upper right extremity. Dr. Seyoum based his conclusion on Table 15-5 of the A.M.A., *Guides*[4], with a finding of class 1 grade 3 with three percent upper extremity impairment due to right shoulder tendinitis with residual functional loss. He modified this with a functional history grade modifier of 3 and a physical examination grade modifier of 1, and determined that the net adjustment was +2. Therefore, Dr. Seyoum determined that appellant's right shoulder impairment would be two grades higher, or five percent right upper extremity permanent impairment.

On November 9, 2015 appellant filed a new claim for a schedule award (Form CA-7).

In a November 13, 2015 decision, the hearing representative set aside, in part, the March 10, 2015 decision. She affirmed the finding that appellant was not entitled to a schedule award for right upper extremity impairment as this was not an accepted condition. However, the hearing representative determined that Dr. Tauber's report of December 11, 2014 should be referred to an OWCP medical adviser and that, after such further development as necessary, a new decision should be issued.

On April 12, 2016 OWCP asked its medical adviser to review Dr. Tauber's December 11, 2014 report and comment on his findings.

In an April 13, 2016 report, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as OWCP's medical adviser, reviewed the medical evidence, including Dr. Tauber's December 11, 2014 report. He noted that it had been established that appellant had seven percent impairment of the left upper extremity. Although Dr. Tauber believed that appellant was entitled to an additional eight percent impairment for acromioclavicular joint pathology, Dr. Harris opined that pursuant to the A.M.A., *Guides*, an evaluator is expected to choose the most significant diagnosis and to rate only that diagnosis under the diagnosis-based impairment (DBI) method. He noted that, if clinical studies documented additional symptomatic diagnoses, the grade could be modified according to the clinical studies adjustment table. Dr. Harris contended that Dr. Tauber's methodology was inconsistent with the A.M.A., *Guides* as he provided an impairment rating for both his right rotator cuff tear as well as right acromioclavicular joint pathology. He also noted that appellant did not have any acromioclavicular joint pathology other than magnetic resonance imaging (MRI) scan evidence of degenerative changes in the acromioclavicular joint. Dr. Harris noted that appellant had not

[4] A.M.A., *Guides* 402, Table 15-5.

required any surgical treatment for the degenerative changes in his acromioclavicular joint and Dr. Tauber did not demonstrate any tenderness, instability, or irritability at the acromioclavicular joint.

In a May 2, 2016 decision, OWCP denied appellant's claim for a greater schedule award.

On October 4, 2016 appellant requested reconsideration. In support thereof, he submitted a September 8, 2016 report wherein Dr. Tauber contended that it was grossly unfair to appellant to not include diagnoses that contribute to his complaints of pain which have been objectively confirmed. He noted that in this case appellant had undergone a rotator cuff surgery and a subacromial decompression. Dr. Tauber noted that appellant was now confirmed to have acromioclavicular arthritis, a superior labral anterior posterior (SLAP) lesion, and a frozen shoulder. He noted that appellant had residual symptoms of a SLAP lesion, which would merit four percent upper extremity impairment pursuant to Table 15-5. Dr. Tauber also noted that appellant had acromioclavicular arthritis, which would merit an additional four percent impairment pursuant to Table 15-5. Accordingly, he opined that the rotator cuff surgery and adhesive capsulitis would merit a combined, additional 8 percent impairment a total of 15 percent permanent impairment of the left upper extremity.

Appellant stopped work again on October 7, 2016, due to right shoulder surgery. He has not returned to work.

On November 8, 2016 OWCP again referred the case to an OWCP DMA. In a November 9, 2016 response, the DMA found that appellant had five percent permanent impairment of the right upper extremity and seven percent permanent impairment of the left upper extremity resulting from the August 16, 2013 injury. He noted that the A.M.A., *Guides* provide that the evaluator is expected to choose the most significant diagnosis and rate only that diagnosis using the DBI method. The DMA noted that he calculated appellant's left upper extremity by using a diagnosis based on residuals from the rotator cuff repair, and used a grade modifier to take into account appellant's problem with acromioclavicular joint osteoarthritis. He also noted that the most recent MRI scan failed to document any SLAP or labral pathology. The DMA recommended no increase in appellant's left upper extremity impairment.

By decision dated November 18, 2016, OWCP denied modification of the May 2, 2016 decision, finding that its prior finding of seven percent permanent impairment of his left upper extremity was correct. It noted that, although Dr. Harris found five percent permanent impairment of the right upper extremity, a schedule award for the right upper extremity was not payable at present as appellant had not yet reached maximum medical improvement, noting that appellant had recently undergone right shoulder surgery on October 7, 2016.

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.[5] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of

[5] *See* 20 C.F.R. §§ 1.1-1.4.

use of specified members, functions, and organs of the body.[6] 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.[7]

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).[8] 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.[9]

ANALYSIS

The issue is whether appellant has more than seven percent permanent impairment of his left upper extremity, for which he previously received a schedule award. A secondary issue is whether appellant is entitled to a schedule award for impairment to his right upper extremity.

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 edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation had been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[10] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[11] In *T.H.*, the Board concluded that OWCP physicians were at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and

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

[7] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[8] *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).

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

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

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

DMAs use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board 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 have been 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.[12]

In order to ensure a consistent result and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the November 18, 2016 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.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 18, 2016 is set aside, and the case is remanded for further action consistent with this decision.

Issued: August 2, 2017
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

[12] *Supra* note 10.