United States Department of Labor
Employees' Compensation Appeals Board

W.B., Appellant	)	
and	)	**Docket No. 14-1509**
	)	**Issued: February 14, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Los Angeles, 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
COLLEEN DUFFY KIKO., Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 23, 2014 appellant filed a timely appeal from a May 13, 2014 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 eight percent permanent impairment of the right upper extremity for which he received a schedule award.

FACTUAL HISTORY

On February 25, 2010 appellant, then a 41-year-old motor vehicle operator filed a traumatic injury claim (Form CA-1) alleging that on January 4, 2010, while unloading a truck, he felt a "pop" in his right shoulder. OWCP accepted his claim for sprain of the right shoulder and

[1] 5 U.S.C. § 8101 *et seq.*

upper arm, acromioclavicular; sprain of the right shoulder and upper arm, infraspinatus; sprain of the shoulder and upper arm, supraspinatus; and aggravation/complete right rotator cuff rupture. It authorized arthroscopic surgery on appellant's right shoulder, which was performed on April 27, 2010, August 17, 2011, and December 7, 2012. Appellant received wage-loss compensation for periods of disability and was released to full duty on August 20, 2013.

Appellant came under the treatment of Dr. Sangarapil Mancharan, a Board-certified physiatrist, for a work-related right shoulder injury. Dr. Mancharan diagnosed tear of the right rotator cuff and right shoulder pain. A March 9, 2010 magnetic resonance imaging (MRI) scan of the right shoulder revealed a full thickness tear of the infraspinatus tendon, full thickness tear of the anterior and distal supraspinatus tendon, mild tenosynovitis of the biceps tendon, mild-to-moderate narrowing of the subacromial space, and small effusions of the subacromial and sub deltoid bursa. Appellant was treated by Dr. Grania Feddis, a Board-certified orthopedist, who on April 27, 2010 performed a right shoulder arthroscopic subacromial decompression and rotator cuff repair, and diagnosed right rotator cuff tear.

A March 27, 2011 MRI scan of the right shoulder revealed status postsurgery related to rotator cuff tendon repair with susceptibility artifact in the humeral head, infraspinatus tendon remained torn with severe atrophy of the supraspinatus muscle, and decreased effusion within the subacromial/sub deltoid bursa. Dr. Mancharan also continued to treat appellant.

Appellant came under the treatment of Dr. Julian P. Ballesteros, a Board-certified orthopedist, who, on August 17, 2011 performed right shoulder arthroscopy with repair of the rotator cuff and diagnosed right rotator cuff tear. On December 7, 2012 Dr. Ballesteros performed a repeat right shoulder arthroscopy repair of the rotator cuff and right arm biceps tenodesis of the long head and diagnosed tear of the rotator cuff, history of rotator cuff tear repair, and labral tear of the shoulder. A September 21, 2012 MRI scan of the right shoulder revealed fraying and ulceration of the bursal surface supraspinatus tendon just distal to the musculotendinous junction.

On December 4, 2013 appellant filed a claim for a schedule award (Form CA-7).

In a January 6, 2014 letter, OWCP requested that Dr. Mancharan evaluate the extent of appellant's permanent impairment of the right upper extremity under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*).[2] Dr. Mancharan did not respond to this request.

On March 11, 2014 OWCP referred appellant for a second opinion to Dr. Edward O. Leventen, a Board-certified orthopedist, for an impairment rating for appellant's right shoulder in accordance with the A.M.A., *Guides.* In an April 2, 2014 report, Dr. Leventen noted a history of appellant's work condition and subsequent surgeries. He diagnosed status post arthroscopy with subacromial decompression and rotator cuff repair of the right shoulder in April 2010, August 2011, and December 2012. Dr. Leventen noted eight portal incision scars in the right shoulder, no tenderness to palpation of the right shoulder, no evidence of asymmetry or deltoid muscle atrophy on inspection, and range of motion (ROM) of the right shoulder revealed

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

definite, significant limitation. For the right shoulder for noted flexion at 160 degrees, abduction at 120 degrees, external rotation at 80 degrees, and internal rotation at 70 degrees. Dr. Leventen indicated that ROM of the elbows, wrists, fingers, and thumbs were normal, Phalen and Finkelstein tests were negative, and sensory examination of both upper extremities revealed no hypoesthesia. He advised that appellant had undergone three operations on the right shoulder which attempted to decompress the right shoulder and repair the damage to the rotator cuff. Dr. Leventen noted that appellant had improved, but was left with persistent pain, weakness of the right shoulder and upper extremity, and limitation of motion. He noted that appellant reached maximum medical improvement on March 29, 2012.

Dr. Leventen found that, using the ROM method for calculating upper extremity impairment with regard to the right shoulder, applying Table 15-34, A.M.A., *Guides* 475, he was at eight percent right arm permanent impairment due to loss of shoulder ROM. He referred to Figure 15-34 for shoulder ROM and determined that flexion of 160 degrees would equal three percent impairment, abduction of 120 degrees would equal three percent impairment, adduction of 50 degrees would equal no impairment, external rotation of 80 degrees would equal no impairment, and internal rotation of 70 degrees would equal two percent impairment.[3] Dr. Leventen combined the ROM values and found that appellant had sustained eight percent permanent impairment in accordance with the A.M.A., *Guides*. Finding a ROM grade modifier of one under Table 15-35, page 477, and a functional history grade of two under Table 15-36, page 477, he multiplied total ROM impairment by 0.5 to arrive at 0.4 percent, which did not result in any increased impairment for lost ROM.[4] Dr. Leventen also referred to the diagnosis-based impairment (DBI) method under Table 15-5, for rotator cuff full thickness tear. However, he advised that since there was significant loss of motion the most appropriate method was the ROM method pursuant to Table 15-34, Table 15-35, and Table 15-36.

In a May 8, 2014 report, the medical adviser reviewed the medical record and concurred with Dr. Leventen's April 2, 2014 rating of permanent impairment. The medical adviser indicated that Dr. Leventen properly applied the ROM method for calculating permanent impairment of the upper extremity under the sixth edition of the A.M.A., *Guides* to find eight percent permanent impairment to the right upper extremity for loss of ROM of the right shoulder.

In a decision dated May 13, 2014, OWCP granted appellant a schedule award for eight percent permanent impairment of the right upper extremity. The period of the award was from December 7, 2013 to May 30, 2014.

[3] *Id*. at 475.

[4] In determining adjustments for functional history, page 474 of the A.M.A., *Guides* provides that the functional history net modifier is based on the relative difference between the grade modifier number and the ROM impairment class. This number is determined by subtracting the impairment class number from the functional history grade number. Here, subtracting the impairment class of one from the functional grade of two yields a net modifier of one. Table 15-36, page 477, provides that for a net modifier of one, the total ROM impairment is multiplied by five percent. Five percent times 8 percent equals 0.4 percent. The policy of OWCP is to round the calculated percentage of impairment up or down to the nearest whole number. *See J.P*., Docket No. 08-0832 (issued November 13, 2008).

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 FECA program with the Director of the Office of Workers' Compensation Programs.[5] 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.[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, [s]ixth [e]dition, *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 on appeal is whether appellant has more than eight percent permanent impairment of the right upper extremity for which he 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 methodology when assessing the extent of permanent impairment for schedule award purposes.[10]

[5] *See* 20 C.F.R. §§ 1.1-1.4.

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

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

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

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 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.[12]

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 May 13, 2014 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.

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

[12] *Supra* note 10.

ORDER

IT IS HEREBY ORDERED THAT the May 13, 2014 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.[13]

Issued: February 14, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

[13] James A. Haynes, Alternate Judge, participated in the original decision but was no longer a member of the Board effective November 16, 2015.