United States Department of Labor
Employees' Compensation Appeals Board

D.B., Appellant	)	
and	)	**Docket No. 14-2056**
	)	**Issued: February 2, 2017**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Washington, DC, 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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On September 29, 2014 appellant filed a timely appeal from a September 10, 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 15 percent permanent impairment of the right upper extremity for which she previously received a schedule award.

FACTUAL HISTORY

On October 14, 2009 appellant, then a 52-year-old nursing assistant, injured her right shoulder when she was changing a patient and pulling him up in the bed. OWCP accepted her

[1] 5 U.S.C. § 8101 *et seq.*

claim for sprain of the right shoulder and upper arm, right rotator cuff, and other affections of the right shoulder region. Appellant did not stop work at that time.

Appellant was treated by Dr. Stephen D. Webber, a Board-certified orthopedic surgeon, from September 29, 2009 to July 20, 2010 for a previous right shoulder injury which occurred on September 14, 2009 when she was lifting a patient. Dr. Webber diagnosed adhesive capsulitis and frozen shoulder. He recommended surgery. Appellant declined surgery due to her diabetes and anesthesia side effects. A magnetic resonance imaging (MRI) scan of the right shoulder dated December 23, 2009 revealed an intact rotator cuff with no definite labral abnormalities.

Appellant came under the treatment of Dr. M.E. Rankin, a Board-certified orthopedic surgeon, on February 3, 2011, who diagnosed disorder of the bursae of the right shoulder and contusion of the right shoulder region. Dr. Rankin noted that she had reached maximum medical improvement (MMI) with nonoperative measures.

On February 25, 2011 appellant filed a claim for a schedule award (Form CA-7). On March 9, 2011 OWCP requested that she have her physician evaluate the extent of the permanent impairment of her right arm under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*).[2]

In an April 3, 2011 report, Dr. M.E. Rankin noted treating appellant since February 2011 for right shoulder pain that began after she strained her shoulder while lifting a patient. He noted she had a rotator cuff tear as evinced by history, physical examination, and MRI scan. Dr. Rankin recommended a right shoulder arthroscopy but appellant again declined due to a history of sleep apnea and fear of anesthesia. He opined that she had reached MMI. Dr. Rankin noted appellant's complaints of right shoulder pain, weakness, and limited range of motion. He noted range of motion figures for the right shoulder for elevation was 90 degrees, abduction was 80 degrees, external rotation was 60 degrees, and internal rotation was 20 degrees. Dr. Rankin noted 4/5 rotator cuff muscle strength and intact sensation in the dermatomal distribution of C4-T1. He noted increased signal in the anterior 25 percent of the supraspinatus tendon and acromioclavicular joint arthrosis. Dr. Rankin diagnosed chronic right shoulder impingement and supraspinatus tendon tear. He opined, using the range of motion method, that under Table 15-35, A.M.A., *Guides* 475, and after applying applicable modifiers, appellant had 18 percent right arm permanent impairment due to loss of shoulder range of motion.

In a report dated April 15, 2011, Dr. E.A. Rankin, a Board-certified orthopedic surgeon and an associate of Dr. M.E. Rankin, treated appellant for continued right shoulder pain. He noted right shoulder examination findings that included right shoulder flexion of 170 degrees, abduction of 160 degrees, external rotation of 70 degrees, and internal rotation of 20 degrees.

In a May 12, 2011 report, Dr. Christopher R. Brigham, Board-certified in occupational medicine and OWCP's medical adviser, reviewed the medical record and evaluated the medical evidence under the range of motion method and disagreed with Dr. M.E. Rankin's impairment determination based on the motion measurements recorded. He noted that more recent motion

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

measurements recorded on April 15, 2011 demonstrated greater capabilities and that those newer measurements of range of motion should be used. The medical adviser explained under the range of motion method that the motion measurements recorded by Dr. E.A. Rankin on April 15, 2011 resulted in 10 percent permanent impairment of the right arm which increased to 11 percent after applying applicable modifiers. He noted that appellant had reached MMI on April 3, 2011.

In a decision dated May 26, 2011, OWCP granted appellant a schedule award for 11 percent permanent impairment of the right upper extremity. The award ran from April 3 to November 29, 2011.

Appellant requested an oral hearing which was held on October 21, 2011. She submitted a report from Dr. E.A. Rankin dated December 8, 2011. Dr. E.A. Rankin noted findings of the right shoulder of no deformity, swelling, erythema, atrophy, or crepitus with range of motion and no tenderness to palpation of the supraspinatus or biceps tendons. He noted range of motion findings for both shoulders: flexion was 70 degrees, abduction was 50 degrees, external rotation was 30 degrees, and internal rotation was 0 degrees. Dr. E.A. Rankin diagnosed disorder of the bursae of the shoulder region bilaterally and rotator cuff sprain, bilaterally complicated by adhesive capsulitis (frozen shoulder). He noted that appellant had not reached MMI as she had declined surgery. Dr. E.A. Rankin found that appellant had 20 percent permanent impairment of both the right shoulder and the left shoulder.[3] He noted that appellant was diabetic and a frozen shoulder could occur spontaneously with patients with diabetes mellitus. Dr. E.A. Rankin noted that appellant had a class 2 diagnoses, with a grade modifier of 2 for functional history, a grade modifier of 3 for physical examination, and a grade modifier of 2 for clinical studies. He applied the net adjustment formula for 20 percent impairment of the bilateral upper extremities.

In a decision dated January 25, 2012, an OWCP hearing representative affirmed the decision dated May 26, 2011. The hearing representative noted that Dr. E.A. Rankin's December 8, 2011 report noted that appellant had not reached MMI. The hearing representative noted that a schedule award could not be determined or paid until a claimant had reached MMI.

Appellant disagreed with the hearing representative's decision. She submitted a February 27, 2012 report from Dr. M.E. Rankin, who noted that his colleague, Dr. E.A. Rankin, provided an impairment rating of 20 percent upper extremity permanent impairment. Dr. M.E. Rankin copied the impairment rating provided by Dr. E.A. Rankin in his December 8, 2011 report and indicated that appellant had reached MMI. On May 2, 2012 appellant filed a claim for an additional schedule award (Form CA-7).

In a May 19, 2012 report, Dr. Lawrence A. Manning, a Board-certified orthopedic surgeon and a medical adviser, noted that, while Dr. M.E. Rankin's February 27, 2012 report found 20 percent arm impairment, he failed to provide measurements for all the planes of motion. He recommended that Dr. Rankin assess shoulder range of motion for internal rotation, external rotation, flexion, extension, abduction, and adduction. He also noted that Dr. E.A. Rankin's rating did not correlate with the accepted conditions. Dr. Manning believed that the RANGE OF MOTIONmethod would provide a greater impairment rating than the DBI method.

[3] The only schedule award claim currently before the Board is for appellant's right shoulder.

In a December 7, 2012 letter, OWCP requested that appellant have her physician evaluate her permanent impairment of her right arm under the A.M.A., *Guides*.[4] It specifically requested her physician to note if MMI had been reached and to provide a description of any restriction of movement in terms of degrees of retained active motion.

On December 18, 2012 Dr. E.A. Rankin provided a supplemental impairment rating report. He noted findings for range of motion for the right and left shoulder of abduction of 120 degrees, flexion of 120 degrees, external rotation of 50 degrees, internal rotation of 30 degrees, extension of 10 degrees, adduction of 10 degrees, and strength testing of 4/5. Dr. Rankin diagnosed disorder of the bursae of the shoulder region, adhesive capsulitis of the shoulder, and sprain and strain of other specified sites of the shoulder and upper arm. He noted MMI occurred in December 2011. Dr. Rankin noted that appellant had a class 2 diagnosis, a grade modifier of 2 for functional history, a grade modifier of 3 for physical examination, and a grade modifier of 2 for clinical studies. He applied the net adjustment formula for 20 percent permanent impairment of the bilateral upper extremities.[5]

In a March 14, 2013 report, Dr. Manning reviewed the medical record and disagreed with Dr. E.A. Rankin's impairment determination. He noted that Dr. E.A. Rankin failed to correctly calculate impairment based on the motion measurements recorded. The medical adviser noted that based on the motion measurements recorded by Dr. Rankin on December 18, 2012, appellant sustained 15 percent permanent impairment of the right upper extremity. The following impairment was calculated pursuant to Table 15-34 of the A.M.A., *Guides*: flexion of 120 degrees would equal three percent impairment, extension of 10 degrees would equal two percent impairment, abduction of 120 degrees would equal three percent impairment, adduction of 10 degrees would equal one percent impairment, external rotation of 50 degrees would equal two percent impairment, and internal rotation of 30 degrees would equal four percent impairment.[6] The medical adviser added the range of motion values to equal 15 percent permanent impairment of the right arm in accordance with the A.M.A., *Guides*. He noted that, based on the diagnoses given for the accepted condition, appellant would fit in a class 1 category. The medical adviser noted that Dr. Rankin had provided a rating of 20 percent impairment of the right upper extremity based on a class 2, grade C impairment. However, this finding did not correlate with the accepted conditions in the statement of accepted facts. He noted that, as appellant previously had a schedule award for 11 percent permanent impairment of the right arm, she had four percent additional impairment in that arm. The medical adviser noted the date of MMI was April 3, 2011.

In a decision dated March 27, 2013, OWCP granted appellant a schedule award for an additional four percent permanent impairment of the right arm. It noted that, while the medical adviser found a total of 15 percent right arm impairment, this included the 11 percent permanent impairment for which she had previously received a schedule award. The period of the award was from November 30, 2011 to February 25, 2012.

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[4] *Id*.

[5] Dr. E.A. Rankin essentially restated the prior impairment rating provided in his December 8, 2011 report.

[6] A.M.A., *Guides* 475.

Appellant requested an oral hearing which was held on June 26, 2014. She submitted reports from Dr. Ayasha Williams-Sharron, Board-certified in physical medicine, dated May 12 to July 23, 2014, who treated her for bilateral shoulder pain. Dr. Williams-Sharron diagnosed bilateral shoulder pain, bilateral shoulder osteoarthritis, and chronic pain. She noted treating appellant for chronic pain management.

In a decision dated September 10, 2014, the hearing representative affirmed the decision dated March 27, 2013.

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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* 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]

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

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

ANALYSIS

The issue on appeal is whether appellant has more than 15 percent permanent impairment of the right upper extremity for which she 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 range of motion 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 range of motion 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 range of motion 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 September 10, 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.

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

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

[14] *Supra* note 9.

ORDER

IT IS HEREBY ORDERED THAT the September 10, 2014 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: February 2, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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