United States Department of Labor
Employees' Compensation Appeals Board

J.T., Appellant	)	
and	)	**Docket No. 15-1330**
	)	**Issued: February 10, 2017**
U.S. POSTAL SERVICE, NORTHEAST ANNEX, Springfield, IL, 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 May 27, 2015 appellant filed a timely appeal from a May 5, 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 to review the merits of this case.

ISSUE

The issue is whether appellant has more than two percent permanent impairment of his left upper extremity causally related to the accepted impingement syndrome.

FACTUAL HISTORY

On December 22, 2011 appellant, then a 49-year-old carrier, filed an occupational disease claim (Form CA-2) alleging that his chronic left shoulder pain was a result of the physical demands of his federal employment. OWCP accepted his claim for left shoulder impingement.

[1] 5 U.S.C. § 8101 *et seq.*

Appellant filed a claim for a schedule award (Form CA-7). On May 13, 2014 Dr. Michael D. Watson, a Board-certified orthopedic surgeon, evaluated appellant's impairment. He related appellant's history and described his findings on physical examination of the left shoulder. Appellant was tender on the acromioclavicular joint. He had a positive Hawkins sign. There was 100 degrees forward flexion, 40 degrees extension, 30 degrees adduction, 90 degrees abduction, 20 degrees external rotation, and 50 degrees internal rotation.

Dr. Watson diagnosed adhesive capsulitis and chronic impingement syndrome of the left shoulder, objectively demonstrated by an imaging study. He determined that appellant had 14 percent permanent impairment due to loss of shoulder motion. Using he range of motion (ROM) method, under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009). Dr. Watson found six percent impairment for loss of flexion and extension, five percent impairment for loss of abduction and adduction, and three percent impairment for loss of external and internal rotation. These added up to 14 percent total impairment of the left upper extremity. Dr. Watson cited to specific figures in the A.M.A., *Guides*.

Dr. David H. Garelick, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed Dr. Watson's evaluation of the left upper extremity. He advised that the diagnosis-based impairment (DBI) method should be used rather than the ROM. For these reasons, Dr. Garelick suggested that Dr. Watson's rating be disregarded. "In large part, this is based on the fact that Table 15-5 in the A.M.A., *Guides* clearly outlines appropriate [permanent partial impairment] as it relates to impingement syndrome in the shoulder."

Citing Table 15-5, page 402, of the A.M.A., *Guides*, Dr. Garelick noted a default impairment value of one percent for impingement syndrome. Given the ROM deficiencies, however, he adjusted the rating to two percent. Dr. Garelick noted that appellant had previously received 10 percent impairment rating of the left upper extremity for tenosynovitis in the wrist and hand as well as for carpal tunnel syndrome. Combining this prior rating with the 2 percent rating for impingement syndrome, he concluded that appellant had 12 percent total permanent impairment of his left upper extremity.

On July 17, 2014 OWCP issued a schedule award for an additional two percent impairment of appellant's left upper extremity.

Appellant requested a hearing. An OWCP hearing representative set aside this decision and remanded the case for further development of the medical evidence. She noted that the ROM method may be selected as an alternative approach in rating impairment under certain circumstances. The hearing representative noted that the A.M.A., *Guides* required the evaluator to consider both the DBI method and ROM method and to choose the method that yielded the higher impairment value. She also noted that Dr. Garelick failed to explain how he calculated each grade modifier in his diagnosis-based approach. The hearing representative remanded the case for an accurate statement of accepted facts reflecting all accepted conditions and a thorough review by the medical adviser.

Dr. Watson advised that the ROM method should be used because it yielded the larger impairment rating. For that reason, he stood by his original evaluation.

Appellant noted that OWCP's findings were not specific about what was needed. "I request a specific itemized list of what needs to be changed."

Dr. Garelick explained that the sixth edition of the A.M.A., *Guides* differed from previous editions in that ROM was typically used as a grade modifier, rather than as a basis for an impairment rating. He cited page 387 of the A.M.A., *Guides*: "ROM is used primarily as a physical examination adjustment factor and only to determine actual impairment values in the rare case when it is not possible to otherwise define impairment; this is a significant change from prior editions."

Dr. Garelick therefore applied the DBI method. As before, the default impairment value for impingement syndrome was one percent. This was a class 1 diagnosis, denoting a mild problem. Functional history was also mild, as pain was previously reported to be at the extremes of motion while reaching away from the body, and appellant could perform his job without difficulty. Physical examination findings were moderate due to the ROM deficits and clinical studies were moderate, as they showed rotator cuff tendinosis. The moderate physical examination findings and clinical studies moved the default impairment value to 2 percent due to the adjustment factors, or 12 percent total impairment in addition to the previously awarded 10 percent impairment for tenosynovitis in the wrist and hand and carpal tunnel syndrome.

OWCP asked Dr. Garelick for a supplemental report. It noted that specific functional impairments, such as loss of flexion and extension, should be itemized and stated in terms of a percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*. OWCP further requested: "If you find deficiencies in the medical record, please be advised of the specific criteria that must be part of the record in order to make a sound medical determination on the issue of permanent impairment. I will then contact Dr. Watson with your specific recommendations."

Dr. Michael Hellman, an orthopedic surgeon and OWCP medical adviser, explained that he based his rating on the diagnosis of impingement syndrome, which was the most impairing diagnosis in the shoulder region. He did not use a functional history modifier, as this was already awarded for appellant's wrist tenosynovitis in a previous impairment rating. Dr. Hellman applied a moderate physical examination modifier, as the other medical adviser had reported moderate ROM deficits and the clinical studies showing rotator cuff tendinosis was mild. These modifiers adjusted the default impairment value for impingement syndrome to two percent.

Dr. Hellman addressed ROM:

> "I disagree with Dr. Watson's impairment rating. The A.M.A., *Guides* specifically state that [DBI] ratings should be utilized whenever possible, and that [ROM] impairment ratings are primarily used as a physical examination grade modifier (page 387). Dr. Watson is incorrect in stating that whatever impairment is higher should be used. He did not city any page number within the A.M.A., *Guides* that states this policy, and to my knowledge, this policy is never mentioned within the A.M.A., *Guides*."

In a decision dated May 5, 2015, OWCP affirmed the additional 2 percent impairment for the left shoulder which equaled 12 percent total impairment of the left upper extremity: 10 percent under OWCP File No. xxxxxx455 (for tenosynovitis in the left wrist and hand as well as left carpal tunnel syndrome) and 2 percent for impingement syndrome of the left shoulder.

On appeal, appellant argues that Dr. Watson was the only physician to examine his shoulder for permanent loss. "I also appeal the 10 percent upper extremity loss of my left wrist (File No. xxxxxx455) when this is about my right shoulder loss (File No. xxxxxx463)."

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.[2] 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.[3] 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.[4]

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).[5] 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.[6]

[2] *See* 20 C.F.R. §§ 1.1-1.4.

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

[4] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[5] 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).

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

ANALYSIS

The issue on appeal is whether appellant has more than two percent permanent impairment of his left upper extremity causally related to the accepted impingement syndrome.

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.[7] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[8] 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.[9]

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 5, 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 that this case is not in posture for decision.

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

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

[9] *Supra* note 7.

ORDER

IT IS HEREBY ORDERED THAT the May 5, 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: February 10, 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