# United States Department of Labor
# Employees' Compensation Appeals Board

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| **J.O., Appellant** | ) | |
| **and** | ) | **Docket No. 16-0805** |
| | ) | **Issued: February 13, 2017** |
| **U.S. POSTAL SERVCIE, POST OFFICE, Saint Charles, IL, Employer** | ) | |

*Appearances:*
*Alan J. Shapiro, Esq.*, for the appellant[1]
*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 March 10, 2016 appellant, through counsel, filed a timely appeal from a February 3, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (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 five percent permanent impairment of the left upper extremity.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id*. An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id*.; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq*.

## ***FACTUAL HISTORY***

On August 29, 2011 appellant, then a 44-year-old city carrier, filed a traumatic injury claim (Form CA-1) alleging that on that date she sprained her left arm in the performance of duty. OWCP accepted the claim for a sprain of the shoulder and upper arm at the left rotator cuff, other specified disorders of the bursae and tendons of the left shoulder region, and a complete left rotator cuff rupture.

On May 2, 2012 Dr. Arif Saleem, a Board-certified orthopedic surgeon, performed a left rotator cuff repair, subacromial decompression, distal clavicle excision, and biceps tendon tenotomy. On December 10, 2012 he performed a capsular release of the left shoulder to treat adhesive capsulitis. Appellant was returned to work in a modified letter carrier position.[3]

Dr. Saleem on October 18, 2013 noted that appellant had undergone a left shoulder rotator cuff repair on May 2, 2012 and a capsular release on December 10, 2012. He opined that she had reached maximum medical improvement (MMI) on April 3, 2013 and released her from care.

On December 6, 2013 appellant filed a claim for a schedule award (Form CA-7).

In an impairment evaluation dated December 30, 2013, Dr. Neil Allen, a Board-certified internist and neurologist, discussed appellant's complaints of pain and loss of motion in her left shoulder. He found that she had reached MMI. On examination Dr. Allen measured muscle strength of 4/5 of the left internal rotators. Referencing Table 15-34 on page 475 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), he utilized the range of motion (ROM) methodology to find left shoulder impairment. Dr. Allen found that 125 degrees flexion equaled three percent impairment, 30 degrees extension equaled one percent impairment, 80 degrees abduction equaled six percent impairment, 30 degrees internal rotation equaled four percent impairment, and 45 degrees adduction and 80 degrees external rotation equaled no impairment. He combined the impairments in loss of shoulder motion to find 14 percent permanent impairment of the left upper extremity. Dr. Allen applied a grade modifier of 2 for loss of motion and a grade modifier of 3 for functional history to find a total left upper extremity permanent impairment of 15 percent. He noted that the A.M.A., *Guides* allowed the use of the ROM method as an alternative calculation for a rotator cuff tear and advised that for appellant it "reflected a more accurate impairment than the DBI [diagnosis-based impairment] method."

Dr. Saleem evaluated appellant on March 26, 2014 for left arm, neck, hand, and shoulder blade numbness and tingling. He diagnosed cervical radiculitis and a history of prior shoulder surgeries. Dr. Saleem related, "In terms of [appellant's] shoulder, rating her recovery, I think I can[not] really do that until her neck is resolved."

On July 3, 2014 Dr. Saleem recommended a cervical magnetic resonance imaging (MRI) scan. He measured ROM for the left shoulder as 170 degrees forward elevation, 100 degrees

[3] By decision dated October 17, 2013, OWCP reduced appellant's wage-loss compensation to zero based on its finding that her actual earnings as a modified city carrier effective July 13, 2013 fairly and reasonably represented her wage-earning capacity.

abduction, and 40 degrees external rotation. Dr. Saleem found radiculopathy through the left arm and diagnosed cervical radiculitis.

The MRI scan study of the cervical spine, obtained on July 30, 2014, revealed a small disc herniation at C4-5 without stenosis and a disc protrusion at C5-6 with mild foraminal stenosis on the right, both more prominent than on a prior study, and a small central protrusion at C3-4.

An OWCP medical adviser reviewed the record on September 15, 2014 and found that the ROM findings obtained by Dr. Saleem on July 3, 2014 exceeded those obtained by Dr. Allen. Using Table 15-5 on page 403 of the A.M.A., *Guides,* he identified the diagnosis as a rotator cuff tear with residual loss which yielded a default value of five percent under the DBI method of calculating permanent impairment. The medical adviser indicated that applying grade modifiers would not alter the award. He found that appellant reached MMI on April 3, 2013 "when the treatment for the shoulder was concluded and attention was shifted to the neck as the pain generator."

By decision dated April 1, 2015, OWCP granted appellant a schedule award for five percent permanent impairment of the left upper extremity. The period of the award ran for 15.6 weeks from August 10 to November 27, 2013.

On April 9, 2015 appellant, through counsel, requested a telephone hearing.

On October 28, 2015 Dr. Eugene P. Lopez, a Board-certified orthopedic surgeon, requested that OWCP expand acceptance of appellant's claim to include a cervical disc herniation with radiculopathy.

At the telephone hearing, held on November 19, 2015, counsel contended that OWCP's medical adviser should have found seven percent impairment under the A.M.A., *Guides* given his use of the DBI method. He also contended that OWCP medical adviser should have determined whether Dr. Allen properly provided an impairment rating rather using his own findings.

By decision dated February 3, 2016, the hearing representative affirmed the April 1, 2015 decision.

## ***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 the Office of Workers' Compensation Programs.[4] 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.[5] FECA, however, does not specify the manner by which the percentage loss

[4] *See* 20 C.F.R. §§ 1.1-1.4.

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

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.[6]

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*." 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).[7] 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.[8]

## ***ANALYSIS***

The issue on appeal is whether appellant has more than five percent permanent impairment of the left 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 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.[9] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[10] 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

[6] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[7] 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); Federal (FECA) Procedure Manual,.

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

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

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

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.[11]

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 February 3, 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 February 3, 2016 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 13, 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

[11] *Supra* note 9.