United States Department of Labor
Employees' Compensation Appeals Board

J.K., Appellant	)	
and	)	**Docket No. 16-0847**
	)	**Issued: March 24, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Bellmawr, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 21, 2016 appellant, through counsel, filed a timely appeal from a November 4, 2015 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 this case.[3]

[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.*

[3] The Board notes that appellant submitted new evidence following the November 4, 2015 decision. However, since the Board's jurisdiction is limited to evidence that was before OWCP at the time it issued its final decision, the Board may not consider this evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c)(1); *Sandra D. Pruitt*, 57 ECAB 126 (2005).

ISSUE

The issue is whether appellant has more than three percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On October 4, 2007 appellant, then a 46-year-old automation clerk, filed an occupational disease claim (Form CA-2) alleging that she developed stabbing and throbbing pain on the right side of her neck and shoulder area. She first became aware of her condition and realized its relation to her employment on February 3, 2007. Appellant stopped work on October 27, 2007. The employing establishment indicated that she was last exposed to the conditions alleged to have caused her condition on October 17, 2007.[4]

OWCP accepted appellant's claim for temporary aggravation of C5-6 disc herniation. It paid wage-loss compensation benefits. On February 1, 2008 appellant returned to full-time limited duty.

Appellant underwent authorized spinal surgeries on November 29, 2010 and January 24, 2011. She stopped work and filed a claim for recurrence of disability (Form CA-2a) on February 7, 2011. OWCP accepted appellant's recurrence claim and paid wage-loss compensation.

On August 20, 2011 appellant returned to modified duty. She continued to undergo medical treatment and received medical benefits.

On June 30, 2014 appellant was treated by Dr. Arthur Becan, a Board-certified orthopedic surgeon. In an impairment rating report of that date, Dr. Becan accurately described her history of injury. He related appellant's complaints of cervical pain and stiffness on a daily basis and radicular pain down her right upper extremity with tingling into her fingers. Dr. Becan reported that she had a Pain Disability Questionnaire score of 85, which was indicative of moderate cervical spine pain disability, and a *Quick*DASH disability score of 16 percent. Upon physical examination of appellant's cervical spine, he observed posterior midline tenderness extending from C4 to 7 and bilateral paravertebral muscle spasm and tenderness extending on the right. Dr. Becan provided range of motion examination findings. He reported that examination of appellant's right shoulder showed subacromial and bicipital groove tenderness. Range of motion examination revealed elevation and abduction of 170 degrees, crossover adduction of 60 degrees, internal rotation of 70 degrees, and external rotation of 80 degrees. Rotator cuff drop test was mildly positive. Dr. Becan diagnosed chronic cervical sprain and strain, herniated cervical discs at C4-5 and C5-6, bulging cervical discs at C3-4 and C6-7, right C4, C5, and C6 radiculopathy, chronic post-traumatic subacromial impingement syndrome to the right shoulder, and chronic post-traumatic rotator cuff tendinopathy of the right shoulder.

[4] Appellant has a previously accepted traumatic injury claim (Form CA-1) under File No. xxxxxx640. OWCP accepted her claim for cervical radiculitis and right trapezius strain as a result of a February 3, 2007 employment incident.

Dr. Becan opined that according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[5] and the A.M.A., *Guides Newsletter* July/August 2009 edition, appellant was a class 1 for right severe sensory deficit of the right C5 nerve root. He reported grade modifiers of 2 for functional history and clinical studies, which calculated a net adjustment formula of two or four percent right upper extremity impairment. Dr. Becan further indicated that appellant was also a class 1 for right severe sensory deficit of the right C6 nerve root. He reported grade modifiers of 2 for functional history and clinical studies, which resulted in a net adjustment formula of 2 or six percent impairment. Dr. Becan also provided an impairment rating for appellant's right shoulder condition. He related that, according to Table 15-5, page 402, she was a class 1 for right shoulder impingement syndrome with residual loss and noted grade modifiers of 1 for functional history and physical examination and 0 for clinical studies. Dr. Becan calculated that appellant had a net adjustment of -1, which resulted in two percent impairment. He concluded that she had a total rating of 12 percent permanent impairment of the right upper extremity. Dr. Becan reported that appellant reached maximum medical improvement (MMI) on June 30, 2004.

On September 16, 2014 appellant filed a schedule award claim (Form CA-7).

In an October 8, 2014 report, Dr. Morley Slutsky, Board-certified in occupational and preventive medicine and an OWCP medical adviser, reviewed Dr. Becan's June 30, 2014 report and noted that Dr. Becan found upper extremity sensory and motor deficits which differed significantly from other providers of record. He noted the dates of appellant's previous examinations, which showed normal upper extremity strength and sensation. Dr. Slutsky recommended a second opinion evaluation by a neurologist or orthopedic surgeon who was trained in the use of the A.M.A., *Guides.* He opined that if OWCP did not order a second opinion evaluation, the final impairment rating would be zero percent because appellant was found to have normal upper extremity sensation and strength before and after her cervical surgery. Dr. Slutsky reported that when these findings were applied to the A.M.A., *Guides* July/August 2009 *Newsletter*, she had a final rating of zero percent permanent impairment of the upper extremity impairment.

OWCP referred appellant, along with a statement of accepted facts (SOAF) and the record, to Dr. Robert Allen Smith, a Board-certified orthopedic surgeon, for a second opinion examination in order to determine whether she sustained any ratable permanent impairment of her accepted cervical and right upper extremity conditions in accordance with the A.M.A., *Guides* and *Guides Newsletter* July/August 2009 edition.

In an April 27, 2015 report, Dr. Smith reviewed appellant's history, including the SOAF and noted her accepted conditions of cervical radiculitis and right trapezius strain. He related that her symptoms improved after her cervical surgeries, but she still experienced low-grade paresthesia and hypoesthesia in the C5-6 distribution bilaterally. Upon physical examination of appellant's neck, Dr. Smith observed active spinal range of motion and no evidence of spasm, atrophy, trigger points, or deformity. Examination of appellant's shoulder revealed no deformity, atrophy, instability, crepitation, or impingement. Dr. Smith reported that range of

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

motion examination was limited subjectively due to complaints of pain. Neurologic examination was objectively normal except for mild paresthesias and hypoesthesias in the right C5-6 distribution. Dr. Smith noted a date of MMI of January 24, 2011.

Dr. Smith opined that according to the A.M.A., *Guides Newsletter* July/August 2009 edition, appellant had class 1 impairment with a default value of one percent for residual complaints of mild hypoesthesia and numbness in her right C5-6 distribution. He noted that according to Table 15-7 on page 406, she had grade modifiers of 1 for functional history and nerve distribution. After applying the net adjustment formula, Dr. Smith determined that appellant had one percent impairment for C5 sensory loss and one percent impairment for C6 sensory loss for a total impairment of two percent of the upper extremity due to loss of sensation in C5-6. He also referenced Table 15-34, Shoulder Range of Motion Grid, on page 475, and determined that she had six percent right upper extremity impairment due to loss of motion at the right shoulder.[6] Dr. Smith concluded that appellant had a total upper extremity permanent impairment of eight percent.

Dr. Sofia Lam, a Board-certified anesthesiologist, examined appellant and in a May 5, 2015 narrative report accurately described appellant's February 2007 work-related injury and reviewed the medical treatment she received. Upon physical examination of appellant's cervical spine, she observed decreased range of motion on lateral rotation and flexion/extension and tenderness over the cervical facet joint at C3-4, C4-5, C5-6, and C6-7 area. Dr. Lam reported positive Spurling's on the right side and sensory deficit in the right C5, C6, and C7 nerve root distribution. She diagnosed cervical sprain/strain, postcervical laminectomy syndrome with residual radiculopathy, and cervical facet arthropathy with paravertebral spasm.

In a June 5, 2015 report, Dr. Slutsky again reviewed Dr. Becan's June 30, 2014 and Dr. Smith's April 27, 2015 impairment rating reports. He referenced the A.M.A., *Guides Newsletter,* July/August 2009 edition, Table 15-4 and assigned class 1 or one percent for mild C5 sensory loss. Dr. Slutsky noted that according to Table 15-4 appellant was a class 0 for no upper extremity motor loss. He assigned a grade modifier of 1 and applied the net adjustment formula. Dr. Slutsky opined that appellant had zero percent right upper extremity impairment due to her C5 condition. He again utilized Table 15-4 to determine her right upper extremity impairment due to her C6 condition and assigned class 1 or one percent for mild sensory loss and none for motor loss. Dr. Slutsky assigned grade modifiers of 1 for functional history and 2 for clinical studies. He applied the net adjustment formula and determined that appellant had two percent right upper extremity impairment due to her cervical condition. Dr. Slutsky indicated that he disagreed with Dr. Smith's permanent impairment rating of six percent impairment due to her right shoulder condition and explained that he rated her permanent impairment due to the preferred diagnosis-based impairment method whereas Dr. Smith used the less preferred range of motion method.[7] Referencing Table 15-5, Dr. Slutsky indicated that appellant was a class 1 or

[6] Dr. Smith indicated that appellant had a grade modifier of 1 for functional history, which resulted in zero modification after applying the net adjustment formula.

[7] Dr. Smith indicated that he would provide an impairment rating based on range of motion. He referenced Table 15-34, page 475, of the A.M.A., *Guides* and determined that appellant had three percent right upper extremity impairment due to range of motion of her right shoulder.

one percent impairment for a diagnosis of right shoulder sprain. He noted grade modifiers of 1 for functional history and 1 for physical examination. Dr. Slutsky applied the net adjustment formula and reported a right upper extremity impairment rating of one percent for appellant's right shoulder. He combined her impairment ratings for a total of three percent right upper extremity permanent impairment.

In a June 11, 2015 report, Dr. Scott M. Fried, a Board-certified orthopedic surgeon, related appellant's complaints of continued neck pain radiating down her right arm and intermittent tingling in her fingers. He reported that neurological examination of appellant's upper extremities revealed positive Phalen's test on the right and positive Tinel's test at the right wrist. Dr. Fried also noted tenderness of the right lateral epicondyle and the right radial tunnel. He indicated that range of motion of appellant's right shoulder was limited. Examination of appellant's cervical spine showed spasm in the cervical musculature bilaterally and upper trapezial area bilaterally. Range of motion was limited. Dr. Fried diagnosed aggravation of cervical disc at C5-6, cervical radiculitis, disc space narrowing at C4-5 and C5-6, right shoulder capsulitis, right shoulder rotator cuff tendinitis, and right shoulder subacromial impingement. He recommended that appellant remain of work and continue with therapy and activity modification.

In a decision issued June 25, 2015, OWCP granted appellant a schedule award for three percent permanent impairment of the right upper extremity, based on Dr. Slutsky's June 5, 2015 report. The award ran from April 27 to July 1, 2015.

On July 6, 2015 OWCP received appellant's request, through counsel, for a hearing before an OWCP hearing representative.

Dr. Fried continued to treat appellant. In reports dated July 16 to September 28, 2015, signed by Ms. Steiner and him, he indicated that a functional capacity evaluation performed on appellant showed increased symptoms with lifting, carrying, and repetitive activities in the upper extremities. Dr. Fried noted that appellant tolerated keying for five minutes and writing for three minutes. He related her complaints of pain radiating down the left ulnar elbow and ulnar volar forearm. Dr. Fried provided examination findings and diagnoses similar to his previous examination. He recommended that appellant remain off work. Dr. Fried provided a neuromusculoskeletal ultrasound scan of her right upper extremity dated September 2, 2015, which showed right radial neuropathy, median neuropathy, and brachial plexopathy, right trapezius strain, aggravation of cervical disc at C5-6, cervical radiculitis, disc space narrowing at C4-5 and C5-6 with radiculopathy, and right shoulder capsulitis, right rotator cuff tendinitis, and right shoulder subacromial impingement.

On September 15, 2015 a hearing was held. Counsel asserted that OWCP improperly relied on Dr. Slutsky's June 5, 2015 district medical adviser report to carry the weight of medical opinion evidence. He alleged that OWCP should not have disregarded Dr. Becan's June 30, 2014 report, which provided for 12 percent upper extremity permanent impairment, solely on the basis that Dr. Becan applied the range of motion method, instead of the diagnosis-based impairment of the A.M.A., *Guides.* Counsel argued that both methods were permissible to calculate impairment. He asserted that OWCP should have referred appellant's schedule award claim to an impartial medical examiner to resolve the conflict in medical opinion evidence regarding the degree of impairment of her upper extremity.

By decision dated November 4, 2015, an OWCP hearing representative affirmed the June 25, 2015 schedule award decision. She found that the medical evidence of record did not establish that appellant had more than three percent permanent impairment of the right upper extremity, for which she previously received a schedule award. The hearing representative noted that Dr. Slutsky properly performed his role as an OWCP medical adviser and utilized the examination findings as provided in Dr. Smith's April 27, 2015 second opinion report.

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.[8] 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.[9] 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.[10]

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).[11] 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.[12]

ANALYSIS

The issue on appeal is whether appellant has more than three percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

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[8] *See* 20 C.F.R. §§ 1.1-1.4.

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

[10] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[11] *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).

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

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 diagnosis-based impairment or the range of motion methodology when assessing the extent of permanent impairment for schedule award purposes.[13] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[14] 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 diagnosis-based impairment 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 diagnosis-based impairment 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.[15]

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 November 4, 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.

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

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

[15] *Supra* note 13.

ORDER

IT IS HEREBY ORDERED THAT the November 4, 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: March 24, 2017
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board