United States Department of Labor
Employees' Compensation Appeals Board

C.H., Appellant	)	
and	)	**Docket No. 16-1881**
	)	**Issued: March 17, 2017**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Northport, NY, 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
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On September 22, 2016 appellant, through counsel, filed a timely appeal from a July 29, 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 this case.

[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.*

ISSUE

The issue is whether appellant established more than two percent permanent impairment of the left upper extremity, for which he previously received a schedule award**.**

FACTUAL HISTORY

OWCP accepted that on December 10, 2001 appellant, then a 47-year-old medical clerk, sustained left shoulder, upper arm, and acromioclavicular strains and a neck strain when he braced a wheelchair to prevent a patient from falling.[3] The record also indicates that he had previously sustained an unspecified trapezial strain in July 1999 when he tried to prevent a coworker from falling.[4]

A November 14, 2005 magnetic resonance imaging (MRI) scan of the cervical spine showed multilevel degenerative disc disease with central canal stenosis and compression at C4-5. Dr. Edward C. Weissman, an attending Board-certified internist, opined on June 16, 2006 that the C4-5 stenosis and cord compression contributed to appellant's left shoulder pain. He found appellant totally disabled for work.

Appellant resigned from federal employment on July 18, 2006.[5]

A January 31, 2008 MRI scan of the left shoulder demonstrated mild tendinopathy, a possible supraspinatus tear, degenerative changes, mild impingement, and mild fraying of the superior labrum.

On October 21, 2011 appellant claimed a schedule award (Form CA-7). In support of his claim, he submitted a January 5, 2012 report from Dr. Stuart A. Goodman, an attending Board-certified neurologist. Dr. Goodman reviewed medical records and provided a history of injury. He related appellant's symptoms of chronic neck and left shoulder pain. On examination, Dr. Goodman observed tenderness and mild spasm of the paracervical muscles and left shoulder, and difficulty with moving the left arm through full ranges of motion at shoulder level. He diagnosed residual sprains of the left shoulder and neck with radicular features. Referring to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent*

[3] OWCP initially denied the claim by decision dated May 8, 2007. Following additional development, OWCP's Branch of Hearings and Review reversed the May 8, 2007 decision on July 27, 2007.

[4] Any claim regarding this matter is not before the Board on the present appeal.

[5] Following his resignation from federal employment, appellant claimed wage-loss compensation commencing March 14, 2006. OWCP developed these claims as a recurrence of disability. By decision dated October 31, 2007, it denied appellant's claim for recurrence of disability as causal relationship was not established. On June 3, 2010 appellant requested an oral hearing. OWCP denied his request for hearing in a July 7, 2010 decision, as it was made more than 30 days following the October 31, 2007 decision. In an October 12, 2010 letter, appellant requested reconsideration. By decision dated October 28, 2010, OWCP denied reconsideration, finding that the request was untimely filed and failed to demonstrate clear evidence of error.

Impairment (hereinafter, A.M.A., *Guides*), Dr. Goodman found 23 percent impairment of the left upper extremity due to a class 1 cervical spine sprain according to Table 17-2.[6]

An OWCP medical adviser reviewed Dr. Goodman's report on May 19, 2002 and found that he had misapplied the A.M.A., *Guides*, as a class 1 cervical sprain would correlate to three to five percent impairment of the arm according to Table 15-11.[7] He calculated three percent impairment of the left upper extremity using Table 15-5 at page 403.[8] The medical adviser opined that appellant had reached maximum medical improvement (MMI) as of December 7, 2002, one year from the date of injury.

On January 24, 2013 OWCP obtained a supplemental report from Dr. Goodman, who reiterated that appellant had 23 percent impairment of the left upper extremity due to cervical spine impairment. An OWCP medical adviser reviewed Dr. Goodman's new report on September 21, 2013. The medical adviser opined that as appellant had no objective cervical radiculopathy, it was inappropriate to rate his impairment using Table 17-2, which pertained only to impairments caused by cervical spine involvement. The medical adviser found three percent impairment of the left arm due to the accepted left shoulder sprain.

On August 15, 2014 OWCP obtained a second opinion from Dr. Robert A. Smith, a Board-certified orthopedic surgeon. Dr. Smith reviewed the medical record and a statement of accepted facts. He noted that appellant had previously undergone an anterior cervical discectomy and fusion from C3 to C5 on September 26, 2013, unrelated to the claim. Dr. Smith noted that a February 12, 2014 postsurgical electromyogram showed cervical radiculopathy, but that this was not attributable to the accepted injury as there was no evidence of radiculopathy prior to the surgery. On examination he found no spasm, rigidity, or limited motion in the cervical spine or left shoulder. Dr. Smith opined that the accepted cervical sprain had resolved without residuals, but that the left shoulder and acromioclavicular sprain remained active. He found that appellant had attained MMI regarding the 2001 injuries. Referring to Table 15-5, page 403, of the A.M.A., *Guides*, Dr. Smith assessed a class 1 Class of Diagnosis (CDX) impairment for a painful injury with residual symptoms and inconsistent clinical findings. He selected a grade modifier for Functional History (GMFH) of 1, a grade modifier for Physical Examination (GMPE) of 1, and a grade modifier for Clinical Studies (GMCS) of 1. Applying the net adjustment formula, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (1-1) + (1-1) + (1-1), Dr. Smith found a net adjustment of zero, leaving the class 1 CDX at the default grade of three percent. He opined that appellant had three percent impairment of the left arm due to residuals of the accepted left shoulder and acromioclavicular sprain.

An OWCP medical adviser reviewed Dr. Smith's report on November 7, 2014 and concurred with his findings and calculations with the exception of the GMPE. The medical adviser opined that appellant had a GMPE of zero as Dr. Smith had not performed proper range

[6] Table 17-2, page 564 of the A.M.A., *Guides* (6th ed. 2009) is titled "Cervical Spine Regional Grid." This table rates whole person impairment.

[7] Table 15-11, page 420 of the A.M.A., *Guides* is titled "Impairment Values Calculated From Upper Extremity Impairment."

[8] Table 15-5, page 403 of the A.M.A., *Guides* is titled "Shoulder Regional Grid: Upper Extremity Impairments."

of motion testing.[9] Therefore, any difficulty with range of motion was not ratable. Applying the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (1-1) + (0-1) + (1-1) resulted in a net adjustment of -1, lowering the default three percent CDX to two percent. The medical adviser therefore found two percent impairment of the left upper extremity.

By decision dated September 1, 2015, OWCP issued a schedule award for two percent impairment of the left upper extremity, based on OWCP's medical adviser's review of Dr. Smith's opinion.

In a September 21, 2015 letter, counsel requested a telephonic hearing, held on June 17, 2016. At the hearing, he asserted that new medical evidence established a greater percentage of permanent impairment. Counsel subsequently provided a May 9, 2016 report from Dr. Robert W. Macht, a general surgeon. Dr. Macht described the accepted December 7, 2001 injury and related appellant's symptoms of cervical spine and left shoulder pain and stiffness, with intermittent paresthesias into the left hand. Appellant completed a *Quick*DASH questionnaire with a score of 75. On examination, Dr. Macht noted limited motion of the left shoulder, with forward elevation at 160 degrees, backwards elevation at 50 degrees, abduction at 150 degrees, adduction at 50 degrees, external rotation at 40 degrees and internal rotation at 80 degrees. He diagnosed a "traumatic injury to left shoulder with tendinitis, tendinopathy and partial thickness tear." Dr. Macht opined that the range of motion methodology for assessing permanent impairment was preferable to the diagnosis-based impairment (DBI) methodology for assessing permanent impairment. He found that according to Table 15-34,[10] appellant had three percent impairment of the left upper extremity due to loss of forward elevation, three percent for limited adduction, and two percent impairment for loss of external rotation, totaling eight percent impairment. Dr. Macht opined that appellant's *Quick*DASH score of 75 equaled a grade 3 GMFH. He also assessed a grade 1 modifier for loss of range of motion according to Table 15-35.[11] Dr. Macht explained that appellant had a grade 2 GMFH, according to Table 15-36,[12] and the "range of motion impairment is multiplied by 10 percent." He therefore found nine percent impairment of the left arm.

By decision dated July 29, 2016, an OWCP hearing representative affirmed the September 1, 2015 decision, finding that Dr. Macht's opinion was based on an incomplete medical history. The hearing representative noted that Dr. Macht had not reviewed the medical record, failed to mention the September 26, 2013 surgery, and he diagnosed conditions that OWCP had not accepted. Therefore, Dr. Macht's report was of no probative value in establishing the percentage of permanent impairment.

[9] The medical adviser failed to account for or explain the importance of other physical examination findings in Dr. Smith's examination report.

[10] Table 15-34, page 475 of the A.M.A., *Guides* is titled "Shoulder Range of Motion."

[11] Table 15-35, page 477 of the A.M.A., *Guides* is titled "Range of Motion Grade Modifiers."

[12] Table 15-36, page 477 of the A.M.A., *Guides* is titled "Shoulder Range of Motion."

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.[13] 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.[14] 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.[15]

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).[16] 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.[17]

ANALYSIS

The issue on appeal is whether appellant established more than two percent permanent impairment of the left upper extremity, for which he 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

[13] *See* 20 C.F.R. §§ 1.1-1.4.

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

[15] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[16] *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).

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

purposes.[18] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[19] 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.[20]

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 July 29, 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 that this case is not in posture for decision

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

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

[20] *Supra* note 18.

ORDER

IT IS HEREBY ORDERED THAT the July 29, 2016 decision of the Office of Workers' Compensation Programs is set aside, and the case remanded for further action consistent with this decision**.**

Issued: March 17, 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