United States Department of Labor
Employees' Compensation Appeals Board

C.C., Appellant	)	
and	)	**Docket No. 17-0484**
	)	**Issued: April 5, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 3, 2017 appellant, through counsel, filed a timely appeal from an October 13, 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 has established greater than five percent permanent impairment of the right upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are set forth below.

OWCP accepted that on September 9, 2010 appellant, then a 49-year-old letter carrier, sustained a right shoulder sprain, right rotator cuff sprain, and right-sided brachial neuritis/radiculitis when he attempted to lift a tub of mail. In a September 9, 2010 emergency room report, Dr. Steve L. Andrews, an attending Board-certified family practitioner, diagnosed cervical radiculopathy due to the accepted employment injury. Dr. Gregory Daly, an attending osteopath Board-certified in family practice, diagnosed a right-sided cervical paraspinal sprain on September 13, 2010. Dr. Daly later found a partial supraspinatus tendon tear based on a November 1, 2010 magnetic resonance imaging (MRI) scan study.

A March 23, 2011 MRI scan of the cervical spine showed mild degenerative changes, with a trace diffuse disc bulge at C4-5, and a mild diffuse disc bulge at C6-7 causing trace right-sided foraminal narrowing.

On May 3, 2012 Dr. Erling Ho, an attending Board-certified orthopedic surgeon, performed an arthroscopic right rotator cuff repair, glenohumeral debridement, and subacromial decompression. OWCP authorized the procedure. Dr. Ho found that he had attained maximum medical improvement (MMI) as of May 13, 2013.

On June 14, 2013 appellant filed a claim for a schedule award (Form CA-7). In support of his claim, he submitted an August 13, 2013 report from Dr. Neil Allen, an attending Board-certified neurologist and internist, noting findings on a July 2, 2013 examination. Dr. Allen related appellant's symptoms of neck and right shoulder pain, weakness, and restricted motion. Referring to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*),[4] he noted that the impairment caused mild interference with activities of daily living, a Disabilities of the Arm, Shoulder and Hand (*Quick*DASH) score of 43, and a pain disability questionnaire (PDQ) score of 91. On physical examination, Dr. Allen noted three cm atrophy of the right brachium, increased tone throughout the right upper trapezius, reflexes at 1/5 in the C5-6 dermatome, reduced cutaneous sensation in the right C5 dermatome with two-point discrimination intact, tenderness in the long head of the biceps tendon, and 4/5 weakness of abduction and external rotation in the right shoulder. He observed the following

[3] Docket No. 15-1459 (issued October 22, 2015).

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

ranges of right shoulder motion: 170 degrees flexion; 61 degrees extension; 152 degrees abduction; 55 degrees adduction; 34 degrees internal rotation; 77 degrees external rotation.

Regarding right shoulder impairment, Dr. Allen referred to Table 15-5[5] to assess a class 1 Class of Diagnosis (CDX) impairment for a rotator cuff injury, with a default value of three percent. He noted a grade modifier for Functional History (GMFH) of 2 for a *Quick*DASH score of 43, pain with normal activity, a grade modifier for findings on Physical Examination (GMPE) of 3 for consistently documented palpatory findings, moderate motion deficit according to Table 15-34,[6] and muscle atrophy in the brachium, and a grade modifier for Clinical Studies (GMCS) of 2 for the preoperative MRI scan showing the supraspinatus tear. Applying the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), Dr. Allen calculated a five percent impairment of the right upper extremity. Referring to proposed Table 1 of *The Guides Newsletter* July/August 2009, and Table 15-14,[7] he found a class of diagnosis impairment for a mild motor deficit at C5, with a default value of four percent. He noted a grade modifier for functional history of 1 for a PDQ of 91 and pain with strenuous activity. Dr. Allen calculated a total 13 percent permanent impairment of the right arm, 5 percent for the right shoulder, 4 percent for motor impairment, and 4 percent for sensory impairment.

In a March 31, 2014 report, an OWCP medical adviser opined that Dr. Allen's rating did not conform to Table 17-2[8] of the A.M.A., *Guides* as there was no documented intervertebral cervical disc herniation or alteration affecting the right upper extremity. He explained that appellant did not have cervical nerve root impingement. The medical adviser agreed with Dr. Allen that appellant had five percent permanent impairment of the right upper extremity according to Table 15-5 for shoulder impairment. He opined that appellant attained MMI as of May 11, 2013, as found by Dr. Ho.

By decision dated April 9, 2014 and reissued on April 17, 2014, OWCP granted appellant a schedule award for five percent permanent impairment of the right upper extremity.

Appellant disagreed and, in a May 6, 2014 letter, through counsel, requested a telephonic hearing before an OWCP hearing representative, held December 16, 2014. At the hearing, counsel argued that OWCP's medical adviser failed to consider the accepted brachial neuritis in calculating the percentage of impairment.

By decision dated March 4, 2015, an OWCP hearing representative affirmed the April 17, 2014 schedule award, finding that OWCP's medical adviser thoroughly reviewed Dr. Allen's findings. Appellant then appealed to the Board.

[5] Table 15-5, page 401 of the sixth edition of the A.M.A., *Guides* is entitled "Shoulder Regional Grid: Upper Extremity Impairments."

[6] Table 15-34, page 475 of the sixth edition of the A.M.A., *Guides* is entitled "Shoulder Range of Motion."

[7] Table 15-14, page 425 of the sixth edition of the A.M.A., *Guides* is entitled "Sensory and Motor Sensitivity."

[8] Table 17-2, page 564 of the sixth edition of the A.M.A., *Guides* is entitled "Cervical Spine Regional Grid."

By decision dated October 22, 2015,[9] the Board set aside OWCP's March 4, 2015 decision, finding that the medical adviser failed to consider the brachial plexus deficits documented by Dr. Allen. The Board emphasized that appellant had not claimed nor had OWCP accepted a cervical spine condition. Rather, the issue was whether there was impairment of the brachial plexus in any location. The Board remanded the case to OWCP to obtain a supplemental report from OWCP medical adviser regarding the appropriate percentage of permanent impairment attributable to the accepted brachial neuritis/radiculitis, to be followed by issuance of a *de novo* decision.

On December 3, 2015 OWCP requested that its medical adviser submit a supplemental report addressing whether the brachial neuritis/radiculitis observed by Dr. Allen warranted an additional percentage of permanent impairment to the right upper extremity. It requested that the medical adviser "thoroughly discuss any points of disagreement" with Dr. Allen's August 12, 2013 opinion. OWCP provided an updated statement of accepted facts for the medical adviser's review.

In a December 16, 2015 supplemental report, OWCP's medical adviser opined that appellant had no impairment of the right arm due to cervical nerve root compression. He noted that the March 23, 2011 cervical MRI scan, Dr. Allen's clinical findings, and "associated records involving the cervical spine and brachial plexus" did not demonstrate any cervical nerve root compression. The medical adviser emphasized that Dr. Allen had not obtained an electromyography (EMG) study to substantiate either the diagnosis of cervical nerve root compression or brachial plexus involvement. He, therefore, found that the April 17, 2014 schedule award for five percent permanent impairment of the right upper extremity should remain unchanged.

By decision dated January 5, 2016, OWCP found that appellant had not established greater than five percent permanent impairment of the right upper extremity, as previously awarded on April 17, 2014. It accorded the weight of the medical evidence to OWCP's medical adviser's interpretation of Dr. Allen's clinical findings.

In a January 11, 2016 letter, counsel requested a telephonic hearing, which was held before an OWCP hearing representative on August 29, 2016. During the hearing, he contended that OWCP's medical adviser one again failed to consider the accepted brachial plexus neuritis/radiculitis in determining the percentage of permanent impairment of the right upper extremity.

By decision dated October 13, 2016, an OWCP hearing representative affirmed OWCP's January 5, 2016 decision. She found that OWCP's medical adviser properly applied the appropriate portions of the A.M.A., *Guides* to Dr. Allen's objective clinical findings and the imaging studies of record.

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

[9] Docket No. 15-1459 (issued October 22, 2015).

vested the authority to implement the FECA program with the Director of OWCP.[10] 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.[11] 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.[12]

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).[13] 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.[14]

ANALYSIS

The issue on appeal is whether appellant has established greater than five percent permanent impairment of the right 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 had 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 had been followed regarding the proper use of the diagnosis-based impairment (DBI) or the range of motion (ROM) methodology when assessing the extent of permanent impairment for schedule award purposes.[15] The purpose of the use of uniform standards is to ensure consistent

[10] *See* 20 C.F.R. §§ 1.1-1.4.

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

[12] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[13] *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).

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

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

results and to ensure equal justice under the law to all claimants.[16] In *T.H.*, the Board concluded that OWCP physicians were 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 observed that physicians interchangeably cited to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians were inconsistent in the application of the A.M.A., *Guides*, the Board found that OWCP could no longer ensure consistent results and equal justice under the law for all claimants.[17]

In order to ensure a consistent result and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the October 13, 2016 decision. Utilizing a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and after 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.[18]

CONCLUSION

The Board finds that the case is not in posture for decision.

IT IS HEREBY ORDERED THAT the October 13, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision of the Board.[19]

Issued: April 5, 2018
Washington, DC

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

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

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

[17] *Supra* note 15.

[18] *See* FECA Bulletin No. 17-06 (May 8, 2017).

[19] Colleen Duffy Kiko, Judge, participated in the preparation of this decision but was no longer a member of the Board after December 11, 2017.