United States Department of Labor
Employees' Compensation Appeals Board

D.B., Appellant	)	
and	)	**Docket No. 17-1526**
	)	**Issued: April 6, 2018**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Washington, DC, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 3, 2017 appellant filed a timely appeal from a June 1, 2017 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 over the merits of the case.

ISSUE

The issue is whether appellant has more than 15 percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts and circumstances as set forth in the Board's prior decisions are incorporated herein by reference. The facts relevant to this appeal are set forth below.

On October 14, 2009 appellant then a 52-year-old nursing assistant, injured her right shoulder when she was pulling a patient into a bed. OWCP accepted appellant's traumatic injury claim (Form CA-1) for sprain of the right shoulder and upper arm, right rotator cuff and other affections of the right shoulder region. Appellant did not stop work at that time.

Dr. Stephen D. Webber, a Board-certified orthopedic surgeon, treated appellant from September 29, 2009 to July 20, 2010 for a right shoulder injury which occurred on September 14, 2009 when she was lifting a patient. He diagnosed adhesive capsulitis and frozen shoulder. Although Dr. Webber recommended surgery, appellant declined, noting her diagnosed diabetes and side effects of anesthesia. A magnetic resonance imaging (MRI) scan of the right shoulder dated December 23, 2009 revealed an intact rotator cuff with no definite labral abnormalities.

Appellant came under the treatment of Dr. Marc E. Rankin, a Board-certified orthopedist, on February 3, 2011. He diagnosed disorder of the bursae of the right shoulder and contusion of the right shoulder region. Dr. Marc E. Rankin noted that appellant reached maximum medical improvement (MMI) with nonoperative measures.

On February 25, 2011 appellant filed a claim for a schedule award (Form CA-7). On March 9, 2011 OWCP requested that appellant have her physician evaluate the extent of her permanent impairment of the right arm under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*).[3]

On April 3, 2011 Dr. Marc E. Rankin noted treating appellant since February 2011 for right shoulder pain that began while lifting a patient. Appellant had a rotator cuff tear diagnosed by MRI scan and he recommended a right shoulder arthroscopy. She declined surgery due to a history of sleep apnea and fear of anesthesia. Dr. Marc E. Rankin opined that appellant reached MMI. He noted findings for range of motion (ROM) of the right shoulder for elevation was 90 degrees, abduction was 80 degrees, external rotation was 60 degrees, and internal rotation was 20 degrees. Dr. Marc E. Rankin noted 4/5 rotator cuff muscle strength, intact sensation in the dermatomal distribution of C4-T1. He noted increased signal in the anterior 25 percent of the supraspinatus tendon and acromioclavicular joint arthrosis. Dr. Marc E. Rankin diagnosed chronic right shoulder impingement and supraspinatus tendon tear. He opined that, under Table 15-35, A.M.A., *Guides* 475, and after applying applicable modifiers, appellant had 18 percent right arm permanent impairment due to loss of shoulder ROM.

In a report dated April 15, 2011, Dr. E. Anthony Rankin, a Board-certified orthopedist and an associate of Dr. Marc E. Rankin, treated appellant for continued right shoulder pain. He noted

[2] Docket No. 14-2056 (issued February 2, 2017).

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

right shoulder examination findings that included right shoulder flexion of 170 degrees, abduction of 160 degrees, external rotation of 70 degrees, and internal rotation of 20 degrees.

In a May 12, 2011 report, an OWCP medical adviser reviewed the medical record and disagreed with Dr. Marc E. Rankin's impairment determination based on the motion measurements recorded. The medical adviser noted that more recent motion measurements recorded on April 15, 2011 showed greater motion capabilities and therefore should be used. The medical adviser explained that the motion measurements recorded by Dr. E. Anthony Rankin on April 15, 2011, resulted in 10 percent right arm permanent impairment which increased to 11 percent permanent impairment after applying applicable modifiers. Appellant reached MMI on April 3, 2011.

By decision dated May 26, 2011, OWCP granted appellant a schedule award for 11 percent permanent impairment of the right upper extremity. The award ran from April 3 to November 29, 2011.

Appellant requested an oral hearing which was held before an OWCP hearing representative on October 21, 2011. She submitted a December 8, 2011 report from Dr. E. Anthony Rankin. Dr. E. Anthony Rankin noted range of motion (ROM) findings for both shoulders: flexion was 70 degrees, abduction was 50 degrees, external rotation was 30 degrees and internal rotation was zero degrees. He diagnosed disorder of the bursae of the shoulder region bilaterally and rotator cuff sprain, bilateral complicated by adhesive capsulitis (frozen shoulder). Dr. E. Anthony Rankin noted that appellant had not reached MMI as she had declined surgery. He noted that she was diabetic and a frozen shoulder occurred spontaneously with diabetic patients. Dr. E. Anthony Rankin noted that appellant had 20 percent permanent impairment of the right shoulder and the left shoulder.[4]

By decision dated January 25, 2012, an OWCP hearing representative affirmed the decision dated May 26, 2011. He noted that Dr. E. Anthony Rankin's December 8, 2011 report revealed that appellant had not reached MMI.

Appellant disagreed with the hearing representative's decision. She submitted a report from Dr. Marc E. Rankin dated February 27, 2012 who noted that his colleague, Dr. E. Anthony Rankin, provided an impairment rating of 20 percent upper extremity impairment. Dr. Marc E. Rankin utilized the impairment rating provided by Dr. E. Anthony Rankin in his December 8, 2011 report and indicated that appellant had reached MMI. On May 2, 2012 appellant filed a claim for an additional schedule award (Form CA-7).

In a May 19, 2012 report, an OWCP medical adviser noted that, while Dr. Marc E. Rankin's February 27, 2012 report found 20 percent arm impairment, he did not provide measurements for all the planes of motion. He recommended that Dr. Marc E. Rankin assess shoulder ROM for internal rotation, external rotation, flexion, extension, abduction and adduction. The medical adviser further noted that Dr. E. Anthony Rankin's rating did not correlate with

[4] Dr. Rankin noted that appellant had an unspecified class 2 diagnosis, the grade modifier for functional history was 2, the grade modifier for physical examination was 3, the grade modifier for clinical studies was 2. He applied the net adjustment formula for a class 3, default grade C for 20 percent impairment of the bilateral arms.

appellant's accepted conditions. He opined that the ROM method would provide a greater impairment than the diagnosis-based impairment (DBI) method.

In a December 7, 2012 OWCP letter, OWCP requested that appellant have her physician evaluate her permanent impairment of the right arm under the A.M.A., *Guides*.[5] It specifically requested appellant's physician note whether MMI had been reached and a description of any restriction of movement in terms of degrees of retained active motion.

On December 18, 2012 Dr. E. Anthony Rankin, provided a supplemental impairment rating. He noted findings for ROM for the right and left shoulder for abduction of 120 degrees, flexion of 120 degrees, external rotation of 50 degrees, internal rotation of 30 degrees, extension of 10 degrees, adduction of 10 degrees, and strength testing of 4/5. Dr. E. Anthony Rankin diagnosed disorder of the bursae of the shoulder region, adhesive capsulitis of the shoulder and sprain and strain of other specified sites of the shoulder and upper arm. He noted MMI occurred in December 2011. Dr. E. Anthony Rankin found that appellant had a class 2 diagnosis, the grade modifier for functional history was 2, the grade modifier for physical examination was 3, the grade modifier for clinical studies was 2. He applied the net adjustment formula for a class 3, default grade C for 20 percent impairment of the bilateral upper extremities.[6]

OWCP's medical adviser reviewed the medical record and disagreed with Dr. E. Anthony Rankin's impairment determination. He found that Dr. E. Anthony Rankin did not correctly calculate impairment based on the motion measurements recorded. The medical adviser noted that based on the motion measurements recorded by Dr. E. Anthony Rankin on December 18, 2012, appellant had 15 percent permanent impairment of the right arm. The following impairment was calculated pursuant to Table 15-34 of the A.M.A., *Guides*: flexion of 120 degrees would equal three percent impairment; extension of 10 degrees would equal two percent impairment; abduction of 120 degrees would equal three percent impairment; adduction of 10 degrees would equal one percent impairment; external rotation of 50 degrees would equal two percent impairment; and internal rotation of 30 degrees would equal four percent impairment.[7] The medical adviser added the ROM values to equal 15 percent permanent impairment of the right arm in accordance with the A.M.A., *Guides*. He noted that based on the diagnoses given for the accepted condition appellant would fit in a class 1 category. The medical adviser noted that Dr. E. Anthony Rankin provided a 20 percent permanent impairment rating of the right upper extremity based on a class 2, grade C impairment; however, this finding did not correlate with the accepted conditions in the statement of accepted facts. He noted that, as appellant previously had an award for 11 percent permanent impairment of the right arm, he had 4 percent additional impairment in that arm. The medical adviser noted that the date of MMI was April 3, 2011.

By decision dated March 27, 2013, OWCP granted appellant a schedule award for four percent additional permanent impairment of the right upper extremity. It noted that, while

[5] *Supra* note 3.

[6] Dr. E. Anthony Rankin essentially restated the same impairment rating provided in his December 8, 2011 report.

[7] *Supra* note 3 at 475.

OWCP's medical adviser found a total of 15 percent right arm impairment, this included the 11 percent permanent impairment for which she previously received a schedule award.

Appellant requested an oral hearing which was held before an OWCP hearing representative on June 26, 2014. She submitted reports from Dr. Ayasha Williams-Sharron, Board-certified in physical medicine, dated May 12 to July 23, 2014, who treated her for bilateral shoulder pain. Dr. Williams-Sharron diagnosed bilateral shoulder pain, bilateral shoulder osteoarthritis and chronic pain.

By decision dated September 10, 2014, an OWCP hearing representative affirmed the decision dated March 27, 2013.

Appellant appealed to the Board on September 29, 2014. By decision dated February 2, 2017, the Board set aside the September 10, 2014 decision.[8] The Board found that OWCP had inconsistently applied Chapter 15 of the A.M.A., *Guides* regarding the proper use of either the DBI or ROM methodology in assessing the extent of permanent impairment. The Board remanded the case for OWCP to issue a *de novo* decision after development of a consistent method for calculating permanent impairment of the upper extremities.

On remand, by decision dated June 1, 2017, OWCP denied appellant's claim for an increased schedule award for the right upper extremity. It noted, considering the matter in relation to FECA Bulletin No. 17-06, and found that the evidence did not support more than the 15 percent permanent impairment of the right arm, for which she previously received a schedule award.

LEGAL PRECEDENT

The schedule award provision of FECA,[9] and its implementing federal regulations,[10] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[11] For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.[12]

The sixth edition requires identifying the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH),

[8] *Supra* note 2.

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] *Id*. at § 10.404(a).

[12] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013).

Physical Examination (GMPE), and Clinical Studies (GMCS).[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides, in part:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
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> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)[14]
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> The Bulletin further advises:
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> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[15]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[16]

ANALYSIS

On prior appeal, the Board remanded the case for OWCP to reevaluate the extent of appellant's permanent impairment of her right upper extremity after it determined a consistent method for rating upper extremity impairments under the A.M.A., *Guides*. On remand, OWCP indicated that FECA Bulletin No. 17-06 provides that, if the A.M.A., *Guides* allowed both DBI and ROM methods for calculating an identified diagnosis, the method that yielded the higher

[13] *Supra* note 3 at 494-531.

[14] FECA Bulletin 17-06 (issued May 8, 2017). *See also D.F.*, Docket No. 17-1474 (issued January 23, 2018).

[15] *Id.*

[16] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

impairment rating should be used.[17] In this case, it noted that the medical adviser determined that the use of ROM for rating appellant's impairment provided the higher impairment rating.

On December 18, 2012 appellant's treating physician, Dr. E. Anthony Rankin, noted that appellant sustained 20 percent permanent impairment of her bilateral upper extremities pursuant to the A.M.A., *Guides*.[18] He diagnosed disorder of the bursae of the shoulder region, adhesive capsulitis of the shoulder, and sprain and strain of other specified sites of the shoulder and upper arm. Dr. E. Anthony Rankin noted findings for ROM for the right and left shoulder for abduction of 120 degrees, flexion of 120 degrees, external rotation of 50 degrees, internal rotation of 30 degrees, extension of 10 degrees, adduction of 10 degrees, and strength testing of 4/5. He noted that appellant had a class 2 diagnosis, the grade modifier for functional history of 2, the grade modifier for physical examination of 3, and the grade modifier for clinical studies of 2. Dr. E. Anthony Rankin noted grade modifiers and asserted that this provided "a net adjustment of grade C. class 3. Default is 20 percent" arm impairment.

The Board finds that Dr. E. Anthony Rankin's determination of 20 percent permanent impairment of the right arm is of limited probative value. Although he purports to use a DBI rating for the shoulder region under the A.M.A., *Guides*, Dr. E. Anthony Rankin does not clearly identify the diagnosis in the A.M.A., *Guides* on which he is basing his impairment rating. He also indicates that it is both a class 2 and a class 3 diagnosis with a default, grade C, impairment rating of 20 percent of the arm. However, the shoulder regional grid[19] contains no class 3 diagnoses with a default impairment of 20 percent. Regardless of whether his reference to class 3 was a typographical error, the only class 2 rating in this grid with 20 percent default impairment is for a type IV or higher acromioclavicular (AC) joint separation.[20] Dr. E. Anthony Rankin did not diagnose and OWCP did not accept that appellant sustained this type of AC joint separation. As his impairment rating is not properly based on the A.M.A., *Guides*, it is of limited probative value and OWCP properly referred the matter to its medical adviser.[21]

In his March 14, 2013 report, OWCP's medical adviser advised that, while Dr. E. Anthony Rankin provided 20 percent permanent impairment of the right arm based on a class 2, grade C impairment, the diagnoses given for the accepted condition appellant fit in a class 1 category. He indicated that class 2 diagnoses did not correlate with appellant's accepted conditions. Instead, the medical adviser opined that use of Dr. E. Anthony Rankin's ROM findings would yield a higher impairment rating for appellant. He explained that, based on the motion measurements recorded by Dr. E. Anthony Rankin on December 18, 2012, appellant had 15 percent permanent impairment of the right arm. The medical adviser noted that pursuant to Table 15-34 of the A.M.A., *Guides*: flexion of 120 degrees equaled three percent impairment; extension of 10 degrees equaled two percent impairment; abduction of 120 degrees equaled three percent impairment;

[17] *Supra* note 14.

[18] This appeal pertains only to impairment of the right arm as OWCP has not issued a decision adjudicating whether appellant has a work-related condition or impairment of the left arm. *See* 20 C.F.R. § 501.2(c).

[19] *See supra* note 3 at Table 15-5 at 401-05.

[20] *Id*. at 403.

[21] *See Linda Beale*, 57 ECAB 429 (2006).

adduction of 10 degrees equaled one percent impairment; external rotation of 50 degrees equaled two percent impairment; and internal rotation of 30 degrees equaled four percent impairment.[22] He added the ROM values to equal 15 percent permanent impairment of the right upper extremity in accordance with the A.M.A., *Guides*. The medical adviser noted that appellant was previously awarded 11 percent permanent impairment of the right arm due to the shoulder condition and now had an additional right upper extremity impairment of 4 percent.

On appeal appellant asserts that Dr. E. Anthony Rankin's report's outlined appellant's permanent impairment, and substantiated her claim for a schedule award. However, as noted above, his report failed to clearly explain how he arrived at 20 percent permanent impairment under the A.M.A., *Guides*. Accordingly, Dr. E. Anthony's opinion is of limited probative value.

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has no more than 15 percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED that the June 1, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 6, 2018
Washington, DC

Christopher J. Godfrey, 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

[22] *Supra* note 3 at 475.