United States Department of Labor
Employees' Compensation Appeals Board

B.N., Appellant	)	
and	)	**Docket No. 17-1923**
	)	**Issued: April 17, 2018**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Southeastern, PA, 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 September 12, 2017 appellant, through counsel, filed a timely appeal from a May 18, 2017 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 to consider 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 more than 12 percent permanent impairment of her left upper extremity and 6 percent permanent impairment of her right upper extremity, for which she previously received schedule awards.

On appeal counsel argues that the impartial medical examiner failed to consider the range of motion (ROM) method in calculating appellant's bilateral upper extremity permanent impairment.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts of the case as presented in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On June 13, 2007 appellant, then a 58-year-old clerk, filed an occupational disease claim (Form CA-2) alleging that she developed bilateral carpal tunnel syndrome and tendinitis due to repetitive work duties of sweeping mail and picking up magazines and parcels.[4] On July 18, 2008 OWCP accepted the claim for bilateral carpal tunnel syndrome and authorized carpal tunnel release surgery, which were performed on April 24, 2008 for the left wrist and June 4, 2008 for the right wrist.[5] It paid appellant wage-loss compensation on the supplemental rolls commencing April 25, 2008 and on the periodic rolls commencing July 6, 2008.

By decision dated November 18, 2009, OWCP granted appellant a schedule award for two percent permanent impairment of each upper extremity. By decision dated June 23, 2010, it granted him a schedule award for an additional six percent permanent impairment of the left arm, for a total eight percent left upper extremity permanent impairment, and an additional four percent permanent impairment of the right arm, for a total of six percent right upper extremity permanent impairment. By decision dated March 5, 2012, OWCP granted appellant a schedule award for an additional 2 percent permanent impairment of the left arm, for a total of 10 percent the left upper extremity permanent impairment. Appellant subsequently requested an additional schedule award.

By decision dated May 1, 2013, OWCP denied appellant's claim for an additional schedule award. On November 29, 2013 an OWCP hearing representative affirmed the May 12, 2013 decision. By decision dated January 8, 2014, OWCP again denied appellant's request for an additional schedule award.

[3] Docket No.14-0937 (issued October 20, 2014).

[4] Appellant has a prior occupational disease claim (Form CA-2), in which OWCP accepted that she sustained left shoulder calcific tendinitis with rotator cuff impingement commencing November 1, 2004 due to her repetitive work duties of sweeping mail and picking up magazines and parcels. OWCP assigned that claim File No. xxxxxx627. Appellant underwent authorized left shoulder arthroscopic surgery on February 14, 2006. OWCP File No xxxxxx627 has been administratively combined with the present claim, OWCP File No. xxxxxx886, with File No. xxxxx886 serving as the master file.

[5] Appellant retired from the employing establishment, effective February 1, 2013.

On March 18, 2014 appellant appealed to the Board. By decision dated October 20, 2014, the Board set aside OWCP's November 29, 2013 and January 8, 2014 decisions.[6] The Board found that there remained an unresolved conflict in the medical opinion evidence between Dr. David Weiss, appellant's treating osteopathic physician, and OWCP's second opinion physician, Dr. Smith, a Board-certified orthopedic surgeon. The Board instructed OWCP to refer appellant to an impartial medical examiner for a reasoned medical opinion with respect to appellant's employment-related permanent impairment of the upper extremities under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[7] as well as an opinion regarding the proper date of MMI. The Board further instructed OWCP to issue an appropriate decision after such further development of the evidence as necessary.

On November 13, 2014 OWCP referred appellant to Dr. Evan Kovalsky, a Board-certified orthopedic surgeon, to resolve the conflict in the medical opinion.

In a December 18, 2014 report, Dr. Kovalsky diagnosed bilateral carpal tunnel syndrome, left shoulder calcific tendinitis, and left shoulder impingement, based upon a review of the medical evidence, statement of accepted facts (SOAF), and physical examination. Using Table 15-5 and the diagnosis of left shoulder impingement, he found appellant had two percent left shoulder permanent impairment. Next, Dr. Kovalsky found six percent bilateral upper extremity permanent impairment based on the diagnosis of bilateral wrist neuropathy compression. He noted his agreement with Dr. Smith's impairment rating.

By decision dated March 12, 2015, OWCP granted appellant an additional schedule award for 2 percent permanent impairment of her left upper extremity for her shoulder condition, for a total 12 percent left upper extremity permanent impairment.

By decision dated March 31, 2015, OWCP denied appellant's claim for an additional schedule award for her bilateral carpal tunnel syndrome. It found that the medical evidence of record was insufficient to warrant additional upper extremity impairment. OWCP noted that appellant's final right upper extremity permanent impairment rating was three percent, which was less than the six percent previously awarded.

On April 7, 2015 counsel requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. On May 18, 2015 appellant requested review of the written record in lieu of an oral hearing.

In a letter dated December 22, 2015, OWCP requested that Dr. Kovalsky provide clarification regarding the score he used for history citing page 433 of the A.M.A., *Guides*.

[6] *Supra* note 3.

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

Dr. Kovalsky responded on January 15, 2016 that the necessary rationale had been provided in his report and he attached the worksheets used in determining appellant's permanent impairment.

In a February 23, 2016 report, a district medical adviser (DMA) reviewed Dr. Kovalsky's report and the medical evidence of record and determined that appellant had five percent left upper extremity permanent impairment and three percent right upper extremity permanent impairment.

By decision dated April 5, 2016, OWCP denied appellant's claim for an additional schedule award, finding that the evidence of record established that she had 8 percent left upper extremity permanent impairment, which was less than the 12 percent previously awarded, and 3 percent right upper extremity permanent impairment, which was less than the 6 percent previously awarded.

In a letter dated April 11, 2016, appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. The request was subsequently converted to a request for review of the written record.

By decision dated August 15, 2016, the hearing representative set aside the April 5, 2016 decision as he found the conflict in the medical opinion evidence regarding appellant's permanent impairment had not been resolved. He remanded the case to OWCP to obtain further clarification from Dr. Kovalsky. If clarification was not provided, OWCP was instructed to refer appellant for a new impartial medical examination.

On remand OWCP referred appellant to Dr. Richard Mandel, a Board-certified orthopedic surgeon, to resolve the conflict in the medical opinion.

In a September 28, 2016 report, Dr. Mandel, based upon a review of the medical evidence, SOAF, and physical examination, calculated four percent left upper extremity permanent impairment and three percent right upper extremity permanent impairment. A physical examination revealed limited bilateral shoulder ROM, normal muscle bulk mass and negative Tinel's sign. Dr. Mandel used the diagnosis-based method (DBI) to determine appellant's permanent impairment for the conditions of bilateral carpal tunnel syndrome and left shoulder tendinitis. Using Table 15-23 of the A.M.A., *Guides*, he assigned a grade modifier of 1 for test findings, a grade modifier of 0 for physical examination findings, which resulted in a three percent permanent impairment for each upper extremity for carpal tunnel syndrome. Next, Dr. Mandel used Table 15-5 and assigned a class 1 for her left shoulder condition of calcific tendinitis and impingement. He assigned a grade modifier of 0 for physical examination and a grade modifier of 1 for clinical studies based upon a September 7, 2005 magnetic resonance imaging scan. Applying the net adjustment formula resulted in a minus 1, resulting in a class 0 or grade C, resulting in one percent left shoulder permanent impairment. Combining the one percent left shoulder permanent impairment and the three percent permanent impairment for left carpal tunnel, resulted in four percent left upper extremity permanent impairment.

On October 14, 2016 a DMA reviewed Dr. Mandel's impairment rating and concurred with his rating of four percent left upper extremity permanent impairment.

By decision dated October 18, 2016, OWCP denied appellant's claim for an additional schedule award.

On October 25, 2016 counsel requested an oral hearing before an OWCP hearing representative, which was held on February 28, 2017.

In a January 10, 2017 report, Dr. Weiss provided an updated impairment rating. ROM of the left shoulder included 90 degrees elevation, 90 degrees abduction, 65 degrees cross over adduction, 75 degrees external rotation, and 70 degrees internal rotation. Dr. Weiss noted positive Hawkins' impingement sign and O'Brien's test. He determined that appellant had 9 percent right upper extremity permanent impairment and 17 percent left upper extremity permanent impairment using Table 15-7 at 406, Table 15-23 at 449, Table 15-34 at 377, and Table 15-36 at 477 of the A.M.A., *Guides.* Dr. Weiss used ROM to determine appellant's permanent impairment due to accepted left shoulder condition and the table for entrapment neuropathy to determine appellant's permanent impairment for her accepted bilateral carpal tunnel syndrome. Using Table 15-7 at 406 and Table 15-23 at 449 he assigned a grade modifier of two for test findings, a grade modifier of three for history and physical examination, a functional history adjustment/*Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) of 90, resulting in a total of nine percent permanent impairment of each upper extremity. Using Table 15-34 at 475 Dr. Weiss found a three percent permanent impairment due to 90 degrees flexion, a three percent permanent impairment due to 90 degrees abduction, and two percent permanent impairment due to 70 degrees internal rotation, which resulted in a grade modifier of 1 using Table 15-35 at 477. Using Table 15-7 at 406 he assigned a grade modifier of four based on her symptoms and *Quick*DASH of 90. Next, Dr. Weiss used Table 15-36 at 477 to increase appellant's impairment by 15 percent and net adjustment of 9 percent. Combining appellant's left shoulder impairment rating and left median nerve impairment ratings resulted in a total of 17 percent left upper extremity permanent impairment.

By decision dated May 18, 2017, an OWCP hearing representative affirmed the October 18, 2016 decision denying appellant's claim for an additional schedule award.

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 American Medical Association, *Guides to the Evaluation of Permanent*

[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 of compensation. 5 U.S.C. § 8107(c)(1).

Impairment as the appropriate standard for evaluating schedule award losses.[10] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[11]

The A.M.A., *Guides* provide a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF) for upper extremity impairments. The evaluator identifies the impairment for the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[12] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX).[13]

The A.M.A., *Guides* also provide that ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[14] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[15] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[16]

OWCP issued FECA Bulletin No. 17-06 to explain the use of DBI methodology *versus* ROM methodology for rating of upper extremity impairments.[17] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating the 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).

[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 Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013).

[12] A.M.A., *Guides* 385-419; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[13] *Id.*

[14] *Id.* at 461.

[15] *Id.* at 473.

[16] *Id.* at 474.

[17] FECA Bulletin No. 17-06. This Bulletin was effective for all decisions issued by OWCP on and after May 8, 2017.

"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 rate by ROM. *If the [A.M.A.,] 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.)[18]

The Bulletin further advises:

"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."[19]

ANALYSIS

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

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome and left shoulder calcific tendinitis with rotator cuff impingement. The issue is whether appellant sustained more than 12 percent permanent impairment of the left upper extremity and 6 percent permanent impairment of the right upper extremity, for which she previously received schedule awards.

Dr. Mandel evaluated appellant's permanent impairment under Table 15-5 of the A.M.A., *Guides*, for tendinitis, under the shoulder regional grid. A DMA reviewed Dr. Mandel's report and concurred with his impairment rating. Dr. Weiss rated appellant's permanent impairment of the left shoulder pursuant to Table 15-34 of the A.M.A., *Guides* for loss of shoulder ROM.

The Board notes that Table 15-5, the Shoulder Regional Grid, does allow, by asterisk, that tendinitis be alternatively evaluated by as a ROM impairment.[20] Under FECA Bulletin No. 17-06 "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 [claims examiner]."

Because Dr. Weiss provided a rating based upon appellant's loss of ROM which was allowed (for a diagnosed condition followed by an asterisk) under Table 15-5 of the A.M.A., *Guides*, a DMA should have independently calculated appellant's impairment rating using both the ROM and DBI method and identified the higher rating for the claims examiner. If the medical

[18] *Id.*

[19] *Id.*

[20] *See* A.M.A., *Guides* 402, Table 15-5.

evidence of record was insufficient for a DMA to render a rating using the ROM methodology, a DMA should have advised as to the medical evidence necessary to complete the rating.[21]

The case will therefore be remanded for further development consistent with OWCP procedures found in FECA Bulletin No. 17-06. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds this case not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 18, 2017 is set aside and the case is remanded for further proceedings consistent with the above opinion.

Issued: April 17, 2018
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

[21] *Supra* note 15.