United States Department of Labor
Employees' Compensation Appeals Board

C.J., Appellant **and** **DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, Long Beach, CA, Employer**	)	**Docket No. 17-1570** **Issued: February 9, 2018**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On July 11, 2017 appellant filed a timely appeal from a May 31, 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 this case.

ISSUE

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

FACTUAL HISTORY

On September 10, 2012 appellant, then a 42-year-old medical support assistant filed an occupational disease claim (Form CA-2) alleging that she developed a left shoulder injury as a

[1] 5 U.S.C. § 8101 *et seq.*

result of her repetitive employment duties. She did not stop work. By decision dated October 11, 2013, OWCP accepted the claim for rotator cuff tear/syndrome of the left shoulder with arthroscopic repair.

In a June 25, 2012 operative report, Dr. Paul Woodworth, a Board-certified orthopedic surgeon, discussed operative findings pertaining to appellant's left shoulder arthroscopic rotator cuff repair. In a May 15, 2014 operative report, he discussed findings pertaining to appellant's left shoulder arthroscopy, with decompression.

On April 15, 2015 appellant filed a claim for a schedule award (Form CA-7).

By letter dated April 28, 2015, OWCP requested that appellant submit an impairment evaluation from her attending physician in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] It afforded her 30 days to submit the necessary evidence.

In support of her claim, appellant submitted an April 22, 2015 report from Dr. Sangarapil Manoharan, Board-certified in emergency medicine. Dr. Manoharan reported that on May 15, 2014, appellant had undergone left shoulder arthroscopy with decompression. He provided findings on physical examination and diagnosed left rotator cuff tear primary encounter, history of rotator cuff tear repair, and history of arthroscopic shoulder surgery. Dr. Manoharan determined that appellant could return to full-duty work on April 22, 2015.

By decision dated September 14, 2015, OWCP denied appellant's claim for a schedule award as the evidence of record was insufficient to establish permanent impairment of a scheduled member or function of the body.

On October 6, 2015 appellant requested reconsideration of OWCP's decision. In support of her request, she submitted a letter dated May 18, 2015 from Kaiser Permanente which advised that Dr. Manoharan was unable to provide the requested impairment rating.

By decision dated October 8, 2015, OWCP denied appellant's request for reconsideration finding that it neither raised substantive legal questions, nor included relevant and pertinent new evidence sufficient to warrant merit review. The decision noted that the record failed to contain copies of the June 2012 and May 2014 surgery notes which were needed for further consideration of her claim.

On March 2, 2016 appellant again requested reconsideration. In support of her request she submitted an October 19, 2015 medical report from Dr. H. Leon Brooks, a Board-certified orthopedic surgeon.[3]

In the October 19, 2015 medical report, Dr. Brooks provided physical examination findings, a review of diagnostic testing, and he summarized appellant's medical reports

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

[3] The Board notes that on August 13, 2015 OWCP approved authorization for a one-time examination with Dr. Brooks for the purposes of a schedule award rating.

beginning June 25, 2012 and continuing. He discussed the June 25, 2012 and May 15, 2014 operative reports, as well as progress reports following surgical intervention. Dr. Brooks determined that appellant was at maximum medical improvement (MMI) and diagnosed status post rotator cuff repair and decompression of her acromioclavicular (AC) joint. Utilizing Table 15-34 of the A.M.A., *Guides,* Shoulder Range of Motion, he determined that appellant sustained 12 percent permanent impairment of the left upper extremity based on measurements revealing moderate decreased range of motion.[4] Dr. Brooks assigned a grade modifier of 2 using Table 15-35, Range of Motion Grade Modifiers,[5] and a grade modifier of 2 for functional history.[6] He concluded that appellant sustained 12 percent permanent impairment of the left upper extremity[7] which equated to 7 percent whole person impairment.[8]

On July 6, 2016 OWCP routed Dr. Brooks' report, a statement of accepted facts (SOAF), and the case file to Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for review and determination regarding whether appellant sustained a permanent impairment of the left upper extremity and date of MMI.

In a July 8, 2016 report, Dr. Garelick reported that appellant had two left shoulder surgeries, the most recent on May 15, 2014, when she underwent removal of a calcific mass from her subacromial spine. He noted a prior rotator cuff repair with no documentation of a distal clavicle resection. Dr. Garelick reported that he was unclear how Dr. Brooks arrived at the 12 percent impairment rating of the left upper extremity. He speculated that Dr. Brooks had recommended 10 percent impairment for a distal clavicle resection and moved the percentage two places to the right for an overall 12 percent award. Dr. Garelick recommended that Dr. Brooks' impairment rating be disregarded as the decompression appeared to have been a calcific mass within the subacromial space, not the distal clavicle itself. He opined that appellant sustained five percent permanent impairment of the left upper extremity for a full-thickness rotator cuff tear with residual findings, as noted in Table 15-5, Shoulder Regional Grid.[9] Given appellant's essentially normal physical examination, he recommended no change to the award with the net adjustment formula. The date of MMI was noted as April 22, 2015, when appellant was released to full-duty work and presumably released from orthopedic care.

By decision dated July 28, 2016, OWCP vacated the September 14, 2015 denial of appellant's schedule award claim, finding that the medical evidence of record established five percent permanent impairment of the left upper extremity. By decision dated March 7, 2017, it granted appellant a schedule award for five percent permanent impairment of the left upper extremity. The date of MMI was noted as April 22, 2015. Appellant's weekly pay was recorded as $1,073.58 at a 66 2/3 compensation rate amounting to $805.19 weekly. OWCP noted that the

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[4] *Supra* note 2 at 475.

[5] *Id.* at 477.

[6] *Id.* at 406, Table 15-7.

[7] *Id.* at 384.

[8] *Id.* at 420.

[9] *Id.* at 403.

weight of the medical evidence rested with Dr. Garelick, serving as OWCP's DMA, who correctly applied the A.M.A., *Guides* to the examination findings.[10]

On April 3, 2017 appellant requested reconsideration of OWCP's March 7, 2017 schedule award determination. Appellant asserted that OWCP should have requested clarification from Dr. Brooks prior to making its schedule award decision as she believed she was entitled to 12 percent rather than the five percent awarded.[11]

In support of her claim appellant submitted a March 25, 2014 medical report from Dr. Manoharan who provided physical examination findings and diagnosed left rotator cuff tear, adhesive capsulitis of the left shoulder, history of rotator cuff tear repair, and history of shoulder surgeries.

In a March 23, 2017 supplemental report, Dr. Brooks reported that he was providing clarification of his October 19, 2015 report. He indicated that appellant did in fact undergo a subacromial decompression which involved resection of the distal clavicle. Dr. Brooks further indicated that appellant continued to have frequent pain as well as limited range of motion. On objective examination, apart from the significant loss of motion, he noted evidence of positive impingement signs. Dr. Brooks concluded that his impairment rating had not changed from his prior report.

By decision dated May 31, 2017, OWCP denied modification of its March 7, 2017 decision, finding that appellant had established no more than the five percent permanent impairment of her left upper extremity previously awarded.[12]

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

[10] The Board notes that OWCP initially issued a March 3, 2017 schedule award determination finding that appellant sustained four percent permanent impairment of the left upper extremity. OWCP reissued the decision on March 7, 2017 noting that the four percent award was a typographical error and that appellant was in fact awarded five percent for the left upper extremity. It provided an accompanying payment sheet to show that appellant was paid an award for five percent left upper extremity impairment.

[11] Appellant further asserted that OWCP improperly calculated her schedule award at the 66 2/3 compensation rate which should have been calculated at the 75 percent augmented pay rate for having dependents.

[12] The Board notes that on appeal, appellant argued that OWCP awarded her a five percent schedule award based on an improper 66 2/3 compensation rate. While the March 7, 2017 decision incorrectly noted the compensation rate, the accompanying payment sheet correctly identified 75 percent compensation rate and reflected that she received her schedule award at the proper compensation rate.

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

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 Impairment* as the appropriate standard for evaluating schedule losses.[15] 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]

The A.M.A., *Guides* provide a diagnosis-based impairment (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).[18] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[19]

The A.M.A., *Guides* also provide that range of motion (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.[20] 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.[21] 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.[22]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology based *versus* the ROM methodology for rating of upper extremity impairments.[23] Regarding the

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

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

[18] *Supra* note 2 at 405-18.

[19] *Id*.

[20] *Id.* at 461.

[21] *Id.* at 473.

[22] *Id.* at 474.

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

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 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.)[24]
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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."[25]

ANALYSIS

OWCP accepted appellant's claim for rotator cuff tear/syndrome of the left shoulder with arthroscopic repair. The issue is whether appellant sustained more than five percent permanent impairment of the left upper extremity for which she previously received a schedule award. The Board finds this case is not in posture for decision.

Dr. Brooks rated appellant's permanent impairment of the left shoulder pursuant to Table 15-34 of the A.M.A., *Guides*, for loss of shoulder range of motion. DMA Dr. Garelick, on the other hand, evaluated appellant's permanent impairment under Table 15-5 of the A.M.A., *Guides*, for full-thickness rotator cuff tear, under the shoulder regional grid. The Board notes that Table 15-5, the Shoulder Regional Grid, does allow, by asterisk, that a rotator cuff full-thickness tear be alternatively evaluated by as a ROM impairment.[26] Under FECA Bulletin No. 17-06.5, "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]."

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[24] *Supra* note 5.

[25] *Id*.

[26] *See* A.M.A., *Guides* 403, Table 15-5.

Because Dr. Brooks provided a rating based upon appellant's loss of range of motion which was allowed (for a diagnosed condition followed by an asterisk) under Table 15-5 of the A.M.A. *Guides*, DMA Dr. Garelick, should have independently calculated appellant's impairment using both the ROM and DBI method and identified the higher rating for the claims examiner. If the medical evidence of record was insufficient for the DMA to render a rating using the ROM methodology, the DMA should have advised as to the medical evidence necessary to complete the rating.[27]

This 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 that this case is not in posture for a decision.

ORDER

IT IS HEREBY ORDERED THAT the May 31, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision.

Issued: February 9, 2018
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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

[27] *Id.*