United States Department of Labor
Employees' Compensation Appeals Board

T.P., Appellant	)	
and	)	**Docket No. 18-0460**
	)	**Issued: July 2, 2018**
U.S. POSTAL SERVICE, POST OFFICE, St. Louis, MO, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On January 4, 2018 appellant, through counsel, filed a timely appeal from a November 27, 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 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 met her burden of proof to establish more than two percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On April 14, 2015 appellant filed a traumatic injury claim (Form CA-1), under OWCP File No. xxxxxx561, alleging that, on April 10, 2015, she sustained a left upper extremity injury due to lifting a package while at work. She stopped work on April 10, 2015 and returned to limited-duty work on April 15, 2015 without wage loss. Appellant returned to full-duty work on July 28, 2015.

On June 10, 2015 OWCP initially accepted that appellant sustained a left shoulder sprain on April 10, 2015.[3]

In an August 25, 2015 report, Dr. William C. Kostman, an attending Board-certified orthopedic surgeon, detailed the findings of the physical examination he performed on that date. He reported range of motion (ROM) findings for appellant's shoulders: flexion (180 degrees, bilaterally), abduction (100 degrees, bilaterally), and external rotation (70 degrees on the left and 80 degrees on the right). Dr. Kostman did not measure internal rotation or adduction in degrees. He noted that appellant had a mildly positive impingement sign for the left shoulder and that there was diffuse tenderness to palpation throughout the left shoulder. Dr. Kostman determined that appellant had reached maximum medical improvement (MMI).

Counsel argued that Dr. Kostman's August 25, 2015 report showed that appellant had employment-related tendinitis of her left shoulder. On June 14, 2016 OWCP expanded the accepted conditions to include tendinitis of the left shoulder rotator cuff.

On September 26, 2016 appellant filed a claim for a schedule award (Form CA-7) due to her accepted left shoulder conditions.

In a July 1, 2016 report, Dr. Neil Allen, an attending Board-certified internist and neurologist, detailed the findings of the physical examination he conducted on July 1, 2016. He noted that appellant had tenderness to palpation of the anterior joint of her left shoulder, but that there was no instability or crepitus of the shoulder. Appellant exhibited 5/5 muscle strength and intact sensation in her left upper extremity. Dr. Allen indicated that ROM findings for her left shoulder were obtained in sets of three: flexion (140, 140, and 140 degrees), extension (50, 45, and 45 degrees), abduction (110, 100, and 102 degrees), adduction (60, 70, and 70 degrees), internal rotation (90, 88, and 90 degrees), and external rotation (90, 88, and 90 degrees). He evaluated the permanent impairment of appellant's left upper extremity under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent*

[3] OWCP had previously accepted, under OWCP File Nos. xxxxxx012 and xxxxxx966, respectively, that appellant sustained lateral collateral ligament strains of her right knee due to December 19, 2013 and November 14, 2014 employment incidents. After appellant sustained her April 10, 2015 left shoulder injury, OWCP accepted, (under OWCP File No. xxxxxx675, that she sustained cervical, thoracic, and lumbar strains due to a December 2, 2015 employment incident. OWCP combined the files for these four claims and designated OWCP File No. xxxxxx561 (regarding the April 10, 2015 left shoulder injury) as the master file.

Impairment (A.M.A., *Guides*).[4] Dr. Allen indicated that she had a *Quick*DASH score of 55. He applied the diagnosis-based impairment (DBI) method of rating upper extremity permanent impairment under Table 15-5 on page 402, noting that appellant's left shoulder tendinitis condition equaled a class 1 condition with a three percent default value (under the category for individuals who had residual loss of the shoulder, but were functional). Dr. Allen found that she had a functional history grade modifier of 2, a physical examination grade modifier of 1, and a clinical studies grade modifier of 2. He found that application of the net adjustment formula yielded a +2 result, which required movement two spaces to the right of the three percent default value on Table 15-5. Therefore, the total permanent impairment of appellant's left upper extremity was five percent. Dr. Allen determined that appellant reached MMI as of July 1, 2016.

OWCP referred the case to Dr. James W. Butler, a Board-certified occupational medicine physician serving as an OWCP district medical adviser (DMA). It requested that he review the medical evidence of record, including Dr. Allen's July 1, 2016 report, and provide an opinion regarding the permanent impairment of appellant's left upper extremity under the sixth edition of the A.M.A., *Guides*.

In a December 13, 2016 report, Dr. Butler determined that appellant had two percent permanent impairment of her left upper extremity under the standards of the sixth edition of the A.M.A., *Guides*. He applied the DBI method of rating upper extremity permanent impairment under Table 15-5 on page 402, noting that her left shoulder tendinitis condition equaled a class 1 condition with a one percent default value (under the category for individuals with a history of painful injury or occupational exposure with residual symptoms, but no consistent objective findings). Dr. Butler found that appellant had a functional history grader modifier of 2 (based on the *Quick*DASH score of 55, as reported by Dr. Allen) and a clinical studies grade modifier of 1. He determined that a physical examination modifier was not applicable because the ROM measurements reported by Dr. Allen differed from those reported by Dr. Kostman on August 25, 2015. Dr. Butler noted that the sixth edition of the A.M.A., *Guides* provided that, where ROM measurements between multiple examiners were inconsistent, such measurements should not be used. He found that application of the net adjustment formula yielded a +1 result, which required movement one space to the right of the one percent default value on Table 15-5. Therefore, the total permanent impairment of appellant's left upper extremity was two percent. Dr. Butler determined that appellant reached MMI as of August 25, 2015, the date of Dr. Kostman's examination.

By decision dated February 9, 2017, OWCP granted appellant a schedule award for two percent permanent impairment of her left upper extremity. The award ran for 6.24 weeks from August 25 and October 7, 2015 and was based on Dr. Butler's December 13, 2016 impairment rating.

On February 15, 2017 appellant, through counsel, requested a telephone hearing with a representative of OWCP's Branch of Hearings and Review.

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

During the hearing held on August 2, 2017, counsel argued that there was a conflict in the medical opinion evidence between Dr. Allen and Dr. Butler regarding the extent of the permanent impairment of appellant's left upper extremity.

After the hearing, appellant submitted a May 30, 2017 report from Dr. Allen who noted that he disagreed with Dr. Butler's impairment rating.[5] Dr. Allen argued that Dr. Kostman did not properly obtain ROM findings for appellant's left shoulder on August 25, 2015. He asserted that the ROM findings he obtained on July 1, 2016 were accurate and should be included in the impairment rating as an element of the physical examination grade modifier. Dr. Allen then repeated his impairment rating evaluation from July 1, 2016 and again concluded that appellant had five percent permanent impairment of her left upper extremity.

By decision dated September 15, 2017, OWCP's hearing representative affirmed OWCP's February 9, 2017 decision. The hearing representative indicated that the weight of the medical evidence regarding the permanent impairment of appellant's left upper extremity continued to rest with the opinion of the DMA, Dr. Butler.

On November 6, 2017 appellant, through counsel, requested reconsideration of OWCP's September 15, 2017 decision.

In a September 21, 2017 report, Dr. Allen determined that appellant had eight percent permanent impairment of her left upper extremity under the sixth edition of the A.M.A, *Guides*.[6] He indicated that he had calculated the permanent impairment of her left upper extremity using the ROM impairment rating method under Table 15-34 on page 475 and found that she had 8.4 percent permanent impairment of her left upper extremity which rounded down to 8 percent permanent impairment.[7] Dr. Allen determined that the ROM impairment rating method should be used because it provided the highest percentage for permanent impairment of the left upper extremity.

By decision dated November 27, 2017, OWCP denied modification of its September 15, 2017 decision. It found that the weight of the medical evidence regarding the permanent impairment of appellant's left upper extremity continued to rest with the opinion of Dr. Butler.

LEGAL PRECEDENT

The schedule award provisions of FECA,[8] and its implementing federal regulations,[9] set forth the number of weeks of compensation payable to employees sustaining permanent

[5] Dr. Allen characterized the report as an "addendum to report dated July 1, 2016."

[6] Dr. Allen characterized the report as an "addendum to report dated July 1, 2016."

[7] Dr. Allen used the ROM findings for the left shoulder that he obtained on July 1, 2016. He indicated that, under Table 15-34, appellant had three percent impairment of the left upper extremity due to 140 degrees of flexion, three percent impairment due to 110 degrees of abduction, and two percent impairment due to 70 degrees of internal rotation. Calculation of an adjustment for the functional history grade modifier under Table 15-35 and Table 15-36 on page 477 changed this impairment figure from 8 percent to 8.4 percent.

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

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.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[11]

The sixth edition requires identifying the impairment class for the Class of Diagnosis (CDX), 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) + (GMCS - CDX).[13]

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* [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)."[14]
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> 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."
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> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* do not allow for the use of ROM for the diagnosis in question, the DMA should independently calculate impairment using the DBI method and clearly explain in the report, citing applicable tables in Chapter 15 of the [A.M.A.,]

[10] *Id.* at § 10.404(a).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (March 2017).

[12] A.M.A., *Guides* 494-531.

[13] *Id.* at 521.

[14] FECA Bulletin No. 17-06 (issued May 8, 2017).

Guides, that ROM is not permitted as an alternative rating method for the diagnosis in question."[15]

ANALYSIS

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

OWCP accepted appellant's claim for left shoulder sprain and tendinitis of the left shoulder rotator cuff. The issue on appeal is whether appellant has met her burden of proof to establish more than two percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

The Board has previously 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 DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[16] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[17] 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 DMAs use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. The Board therefore found that OWCP should develop a consistent method for calculating permanent impairment for upper extremities, which could be applied uniformly.

As noted above, FECA Bulletin No. 17-06 provides that, if the rating physician provided an assessment using the ROM method and the A.M.A., *Guides* allows 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 OWCP's claims examiner.[18]

The Board, therefore, finds that this case requires further development of the medical evidence. Since Dr. Allen provided a rating based upon appellant's loss of ROM of the left shoulder, which is allowed (by asterick) pursuant to Table 15-5 of the A.M.A., *Guides*, the DMA should have independently calculated her impairment using both the ROM and DBI methods and identified the higher rating for OWCP's claims examiner. If the medical evidence of record was not sufficient for the DMA to render a rating using the ROM or DBI method, he or she should advise as to the medical evidence necessary to complete the rating.[19]

[15] *Id*.

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

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

[18] *See supra* note 15.

[19] *Id.*

This case will therefore be remanded for application of OWCP's procedures found in FECA Bulletin No. 17-06. After such further development of the medical evidence as necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the November 27, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: July 2, 2018
Washington, DC

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

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board