United States Department of Labor
Employees' Compensation Appeals Board

E.H., Appellant	)	
	)	**Docket No. 17-1931**
and	)	**Issued: May 2, 2018**
	)	
U.S. POSTAL SERVICE, ALAMO HEIGHTS POST OFFICE, San Antonio, TX, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 5, 2017 appellant filed a timely appeal from a March 6, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] 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 the claim.

[1] Under the Board's *Rules of Procedure*, an appeal must be filed within 180 days from the date of issuance of an OWCP decision. An appeal is considered filed upon receipt by the Clerk of the Appellate Boards. *See* 20 C.F.R. § 501.3(e)-(f). One hundred and eighty days from March 6, 2017, the date of OWCP's last decision was Saturday, September 2, 2017. The regulations specify that the last day of the period so computed shall be included, unless it is a Saturday, Sunday, or federal holiday. As he following day, Monday, September 4, 2017, was a federal holiday, the period ranto the close of the next business day, which was Tuesday, September 5, 2017. *See* 20 C.F.R. § 501.3. Since using September 12, 2017, the date the appeal was received by the Clerk of the Appellate Boards would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is September 5, 2017, rendering the appeal timely filed. *See* 20 C.F.R. § 501.3(f)(1).

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has established greater than 11 percent permanent impairment of the right upper extremity and 4 percent permanent impairment of her left upper extremity, for which she previously received schedule awards.

FACTUAL HISTORY

On October 13, 2004 appellant, then a 41-year-old distribution clerk, filed an occupational disease claim (Form CA-2) alleging that, since December 10, 2003, repetitive upper extremity motions required by the performance of her federal employment duties caused or aggravated bilateral rotator cuff tears.[3] OWCP accepted that she sustained a complete left rotator cuff tear, left shoulder effusion, right rotator cuff sprain, and bilateral upper arm sprains while in the performance of duty.[4] It paid appellant wage-loss compensation on the supplemental rolls from July 29, 2004 to September 14, 2006, and March 17 to November 16, 2015. OWCP also paid medical benefits.

On June 19, 2003 appellant underwent right shoulder arthroscopic subacromial decompression and mini-open rotator cuff repair of the supraspinatus tendon. She retired from the employing establishment effective July 28, 2004. Appellant remained under medical care.

On February 5, 2007 appellant filed a claim for a schedule award (Form CA-7). In support of her claim, she provided an impairment rating dated January 4, 2007 by Dr. Marc T. Taylor, a physician Board-certified in plastic surgery and otolaryngology. Dr. Taylor opined that appellant had attained maximum medical improvement (MMI). Referring to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*)[5] then in effect, Dr. Taylor found that appellant had four percent permanent impairment of the left upper extremity and six percent permanent impairment of the right upper extremity due to limited motion in both shoulders.

By decision dated March 28, 2007, OWCP granted appellant a schedule award for four percent permanent impairment of the left upper extremity and six percent permanent impairment of the right upper extremity. The period of the award ran from October 13, 2006 to May 19, 2007.

[3] Under OWCP File No. xxxxxx265, OWCP accepted that appellant sustained bilateral rotator cuff sprains.

[4] By decision dated December 14, 2004, OWCP denied appellant's occupational disease claim as the medical evidence of record was insufficient to establish a causal relationship between the identified work factors and the claimed bilateral shoulder conditions. Appellant requested an oral hearing before an OWCP hearing representative, held on July 25, 2005. By decision dated October 20, 2005, an OWCP hearing representative set aside OWCP's December 14, 2004 decision and remanded the case for additional development of the medical evidence of record. On November 14, 2005 OWCP accepted appellant's claim for bilateral rotator cuff sprain/strains. In a June 15, 2006 letter, OWCP "rescinded" its November 14, 2005 decision. In an August 4, 2008 telephone memorandum (Form CA-110), OWCP notified appellant that the June 15, 2006 informational letter was not a final decision and did not affect the posture of her claim.

[5] 5th ed. (2001).

A June 18, 2013 magnetic resonance imaging (MRI) scan of appellant's left shoulder demonstrated subscapularis and biceps tendon tears with maceration of the superior labrum. A June 18, 2013 MRI scan of her right shoulder showed a recurrent supraspinatus tendon tear, subscapularis tendon tear, complex tearing of the superior labrum, maceration of the posterior labrum, and linear tearing of the superior half of the anterior labrum.

In a report dated June 28, 2013, Dr. Richard Eldon Duey, an attending Board-certified orthopedic surgeon, diagnosed a recurrent right rotator cuff tear, right subacromial spur, and left rotator cuff tear. On March 17, 2015 he performed an authorized revision of a subacromial decompression of appellant's right shoulder, a revision rotator cuff repair of the right supraspinatus tendon, arthroscopic right biceps tenotomy, and arthroscopic excision of a one centimeter portion of the right distal clavicle.

A June 7, 2016 MRI scan of appellant's left shoulder showed a full-thickness supraspinatus tendon tear and infraspinatus tendinosis. A June 7, 2016 MRI scan of her right shoulder showed postsurgical changes versus partial residual or recurrent tears, and subacromial subdeltoid bursitis.

On June 17, 2016 appellant claimed an additional schedule award (Form CA-7) for permanent impairment of both upper extremities. In support of her claim, she submitted a June 6, 2016 impairment rating from Dr. Salvador P. Baylan, an attending Board-certified physiatrist. Dr. Baylan reviewed medical records and summarized appellant's treatment history. He found that appellant had attained maximum medical improvement (MMI) effective that day. Dr. Baylan administered a *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) questionnaire scored at 56.8, and an Oswestry Disability Index of 60 percent, indicating a severe disability which affected activities of daily living. On examination of appellant's left shoulder, he found acromioclavicular tenderness, grip strength at 40 pounds, and 4/5 strength in external rotation, internal rotation, abduction, and forward flexion. Dr. Baylan found left shoulder flexion limited to 115 degrees, extension at 45 degrees, abduction at 80 degrees, adduction at 25 degrees, external rotation at 90 degrees, and internal rotation at 45 degrees. In the right shoulder, he observed well-healed incision, old surgical scar, 4/5 strength in external rotation, internal rotation, abduction, and forward flexion, and grip strength at 35 pounds. Dr. Baylan found right shoulder flexion limited to 90 degrees, extension at 45 degrees, abduction at 65 degrees, adduction at 10 degrees, external rotation at 70 degrees, and internal rotation at 15 degrees.

Referring to the sixth edition of the A.M.A., *Guides*, Dr. Baylan calculated the percentage of permanent impairment based on loss of range of motion (ROM), "the preferred method of impairment rating as a standalone method." For both upper extremities, he found a grade modifier for Functional History (GMFH) of 2, a grade modifier of 2 for loss of ROM according to Table 15-35,[6] and an additional GMFH for limited ROM according to Table 15-36.[7]

[6] Table 15-35, page 477 of the sixth edition of the A.M.A., *Guides* is entitled "Range of Motion Grade Modifiers."

[7] Table 15-36, page 477 of the sixth edition of the A.M.A., *Guides* is entitled "Functional History Grade Adjustment: Range of Motion."

Regarding right shoulder impairment, Dr. Baylan assessed the following percentage of impairment due to limited ROM according to Table 15-34[8]: three percent for flexion at 90 degrees, six percent for abduction at 65 degrees, one percent for adduction at 10 degrees, and eight percent for internal rotation at 15 degrees. He combined these percentages to equal 18 percent permanent impairment of the right upper extremity. Dr. Baylan assessed the following percentages of impairment of the left shoulder according to Table 15-34: six percent for flexion at 45 degrees, six percent for abduction at 80 degrees, one percent for adduction at 25 degrees, and six percent for internal rotation at 45 degrees. He combined these percentages to equal 19 percent permanent impairment of the left upper extremity. Dr. Baylan calculated that as the GMFH was 2 and the "[g]rade of motion grade modifier" was also grade 2, "2-2 = 0 Net modifier."

On July 5, 2016 OWCP requested that an OWCP medical adviser review the medical record and an updated statement of accepted facts (SOAF), and comment specifically on Dr. Baylan's impairment rating. It requested that the medical adviser calculate the percentage of permanent impairment of both upper extremities. OWCP noted that "[i]f applicable, include an explanation as to why the method chosen was used in lieu of another allowable method (*e.g.*, Diagnosis Based Impairment vs. Range of Motion)."

In a report dated September 6, 2016, Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, noted that Dr. Baylan's impairment rating was not included for his review. He also requested that OWCP specify the percentage of permanent impairment previously awarded for both upper extremities.

On September 21, 2016 appellant underwent a right shoulder arthrogram with arthrocentesis and aspiration to rule out infection of the joint capsule.

In a letter dated September 22, 2016, OWCP provided Dr. Baylan's report to OWCP's medical adviser. It requested that he provide an impairment rating with references to the applicable criteria of the A.M.A., *Guides* and a clear explanation of his calculations.

On September 26, 2016 Dr. Garelick reviewed the evidence of record and concurred that appellant had attained MMI. He suggested that Dr. Baylan's June 6, 2016 impairment rating should be disregarded as column 1, page 387 of the A.M.A., *Guides* provided that ROM should determine actual impairment only when it was not possible to define it otherwise, and there were diagnosis-based impairments (DBI) for both upper extremities. Regarding the left upper extremity, Dr. Garelick found a permanent DBI for impingement syndrome according to Table 15-5 of the A.M.A., *Guides*,[9] with the default value of three percent moved one place to the right to four percent based on a GMFH of two for the *Quick*DASH score of 56.8. He therefore found that no additional schedule award was applicable in addition to the four percent previously awarded for permanent impairment of the left upper extremity. Regarding the right upper extremity, Dr. Garelick assessed 10 percent permanent impairment for distal clavicle resection according to

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

[9] Table 15-5, page 401-05 of the sixth edition of the A.M.A., *Guides* is titled "Shoulder Region Grid: Upper Extremity Impairments."

Table 15-5, with an adjustment of one place to the right based on a GMFH of two for the *Quick*DASH score of 56.8, to equal 11 percent permanent impairment of the right arm.

By decision dated November 1, 2016, OWCP granted appellant a schedule award for an additional 5 percent permanent impairment of the right upper extremity, totaling 11 percent, with 0 percent additional permanent impairment of the left upper extremity beyond the 4 percent permanent impairment previously awarded.

On November 15, 2016 appellant requested a review of the written record before an OWCP hearing representative. She contended that OWCP's medical adviser failed to review the complete medical record and that the ROM rating method was more appropriate to her clinical presentation than the DBI method. Appellant submitted additional evidence.

In support of her claim, appellant provided a May 2, 2014 cervical MRI scan and Dr. Duey's March 17, 2015 operative note.

In a report dated October 27, 2016, Dr. Robert Hartzler, a Board-certified orthopedic surgeon, diagnosed a right rotator cuff tear. On November 29, 2016 he diagnosed right supraspinatus tendinosis with periscapular myofascial triggering.

In reports dated from November 30, 2016 to February 10, 2017, Dr. Ephraim K. Brenman, an osteopathic physician specializing in pain management, diagnosed a right rotator cuff sprain, partial thickness right rotator cuff tear and full-thickness left rotator cuff tear.

A right shoulder arthrogram performed on February 3, 2017 demonstrated a high-grade partial-thickness intrasubstance and articular-sided retear within the posterior fibers of the supraspinatus tendon into the anterior fibers of the infraspinatus tendon, and mild fatty arthropathy of the infraspinatus and supraspinatus muscles, status post subscapularis repair without retear, and status post biceps tendon tenodesis, distal clavicular resection, and acromioplasty.

By decision dated March 6, 2017, an OWCP hearing representative affirmed OWCP's November 1, 2016 schedule award determination, finding that the additional medical evidence submitted did not establish a greater percentage of permanent impairment of either upper extremity than that previously awarded. He accorded the weight of the medical evidence to Dr. Garelick, as he had reviewed the complete medical record and provided a well-rationalized opinion based on an appropriate application of the A.M.A., *Guides*. The hearing representative found Dr. Baylan's opinion of diminished probative value as there was insufficient evidence that he performed the required three active ROM measurements.

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.[10] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use

[10] *See* 20 C.F.R. §§ 1.1-1.4.

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

OWCP accepted that appellant sustained bilateral shoulder, rotator cuff, and upper arm sprains. On February 5, 2007 appellant claimed a schedule award. By decision dated March 28, 2007, OWCP granted her a schedule award for four percent permanent impairment of the left upper extremity and six percent permanent impairment of the right upper extremity.

On June 17, 2016 appellant claimed an additional schedule award based on an impairment rating dated June 6, 2016 by Dr. Baylan, a Board-certified physiatrist. Dr. Baylan assessed 18 percent permanent impairment of the right upper extremity and 19 percent permanent impairment of the left upper extremity based on diminished ROM in both shoulders.

OWCP's medical adviser, Dr. Garelick, a Board-certified orthopedic surgeon, agreed that appellant had attained MMI. He contended, however, that Dr. Baylan's impairment rating should be disregarded as it was based on the ROM rating methodology although appellant had an identifiable DBI in each upper extremity. Dr. Garelick opined that appellant had 11 percent permanent impairment of the right upper extremity based on distal clavicle resection, and 4 percent permanent impairment of the left upper extremity based on impingement syndrome. Based on

[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).

Dr. Garelick's review of Dr. Baylan's clinical findings, on November 1, 2016, OWCP granted appellant a schedule award for an additional five percent impairment of the right upper extremity, affirmed by decision dated March 6, 2017.

The Board has found that OWCP 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.[15] The purpose of the use of uniform standards is to ensure consistent 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 the 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]

Utilizing a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and 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 this case is not in posture for decision.

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

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

[17] *Supra* note 15.

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 6, 2017 is set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: May 2, 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