# United States Department of Labor
# Employees' Compensation Appeals Board

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| **S.L., Appellant** | ) | |
| **and** | ) | **Docket No. 18-0588** |
| | ) | **Issued: October 3, 2018** |
| **U.S. POSTAL SERVICE, TAMPA PROCESSING & DISTRIBUTION CENTER, Tampa, FL, 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 January 25, 2018 appellant filed a timely appeal from an October 27, 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 met his burden of proof to establish more than 14 percent permanent impairment of his left upper extremity and 5 percent permanent impairment of his right upper extremity, for which he previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

## ***FACTUAL HISTORY***

On July 19, 2004 appellant, then a 38-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that repetitive job duties caused bilateral shoulder, neck, hip, and left elbow conditions.

On August 20, 2004 OWCP accepted the claim for cervical, lumbar, and thoracic strains, and tendinitis of both shoulders and paid him partial wage-loss compensation on the supplemental rolls until December 30, 2004 when he stopped work completely. It then paid him disability compensation on the periodic compensation rolls as of August 7, 2005. Appellant did not return to work.

On September 27, 2007 OWCP expanded acceptance of the claim to include left shoulder rotator cuff tear.

On August 21, 2009 OWCP noted *via* letter that appellant was interested in pursuing a schedule award claim. On August 28, 2009 appellant elected Office of Personnel Management (OPM) retirement benefits, effective September 29, 2009. He continues to receive OPM retirement benefits.

In a report dated October 1, 2009, Dr. James W. Dyer, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the medical evidence and advised that, in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[2] based on appellant's left shoulder range of motion (ROM) deficits, he was entitled to 14 percent permanent impairment of the left upper extremity. Dr. Dyer noted that appellant had reached maximum medical improvement (MMI) on September 14, 2009.[3]

By decision dated October 28, 2009, OWCP granted appellant a schedule award for 14 percent permanent impairment of the left upper extremity, for a total of 43.68 weeks, to run from September 29, 2009 to July 31, 2010.

On February 27, 2015 appellant filed an additional schedule award claim (Form CA-7).

In support of his claim for an additional schedule award, appellant submitted a February 4, 2015 report in which Dr. Richard M. Blecha, a Board-certified orthopedic surgeon, provided an impairment evaluation. He described right shoulder flexion of 170/180 degrees, extension 40/50 degrees, abduction 145/170 degrees, adduction 40/40 degrees, internal rotation 80/80 degrees, and external rotation 50/60 degrees. Left shoulder flexion was 165/180 degrees, flexion 165/180 degrees, extension 40/50 degrees, abduction 95/170 degrees, adduction 40/40 degrees, internal rotation 80/80 degrees, and external rotation 60/60/degrees. Dr. Blecha diagnosed osteoarthritis of the left acromioclavicular (ACL) joint. He advised that the ROM method was the appropriate

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

[3] Dr. Dyer based his findings on a September 14, 2009 impairment evaluation performed by Dr. Samy F. Bishai, an attending orthopedic surgeon, who advised that appellant had 14 percent permanent impairment of each upper extremity.

method of evaluating appellant's impairment and concluded that, due to loss of left shoulder motion, he had seven percent permanent impairment of the left shoulder.

In a March 30, 2015 report, Dr. H.P. Hogshead, also Board-certified in orthopedic surgery and an OWCP medical adviser, agreed with Dr. Blecha that appellant had seven percent impairment of the left upper extremity. OWCP's medical adviser noted that, as appellant had previously received a schedule award for 14 percent left upper extremity permanent impairment, he was not entitled to a greater award.

In a July 15, 2015 report, Dr. Bishai described physical examination findings and diagnosed internal derangement of each shoulder, status post surgery on the left elbow, bilateral carpal tunnel syndrome, chronic cervical strain, lumbar disc syndrome, herniated discs at L4-5 and L5-S1, grade 1 posterolisthesis at L5, and impingement syndrome of both shoulder. He utilized Table 15-34, Shoulder Range of Motion, of the sixth edition of the A.M.A., *Guides* and indicated that right shoulder flexion measured 80 degrees, for 9 percent upper extremity impairment, extension measured 15 degrees for 2 percent impairment, abduction measured 80 degrees for 6 percent impairment, adduction measured 20 degrees for 1 percent impairment, internal rotation measured 20 degrees for 4 percent impairment, and external rotation measured 45 degrees for 2 percent impairment. Dr. Bishai then combined the individual ROM impairments for a total 24 percent right upper extremity permanent impairment. Left shoulder ROM demonstrated 70 degrees of flexion for 9 percent upper extremity impairment, 10 degrees of extension measured for 2 percent impairment, 70 degrees of abduction for 6 percent impairment, 15 degrees of adduction for 1 percent impairment, 15 degrees of internal rotation for 4 percent impairment, and 40 degrees of external rotation measured for 2 percent impairment. Dr. Bishai then added the individual ROM impairments for a total 24 percent left upper extremity permanent impairment. He indicated that MMI was reached on July 15, 2015.

OWCP forwarded medical records including Dr. Bishai's July 15, 2015 report to Dr. Michael M. Katz, an OWCP medical adviser who is Board-certified in orthopedic surgery, for review. In a report dated January 21, 2016, Dr. Katz requested that additional medical evidence be provided. In a report dated March 16, 2016, he noted his review of record including the reports of Dr. Blecha, Dr. Hogshead, and Dr. Bishai. Based on the marked variance in impairment found between Dr. Blecha and Dr. Bishai, both attending physicians, Dr. Katz recommended referral to an appropriate Board-certified specialist for a second opinion evaluation.

In August 2016, OWCP referred appellant to Dr. Patrick Horan, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine if appellant was entitled to an additional schedule award.

In a September 12, 2016 report, Dr. Horan noted his review of the medical record. He indicated that, when he asked appellant to raise his right arm, he raised it to 85 degrees and would not go further, stating that it would cause discomfort. Dr. Horan then terminated the evaluation because ROM could not be determined without full participation from the patient. He noted that the A.M.A., *Guides* require full ROM, not full motion without discomfort. OWCP again referred appellant to Dr. Horan on October 20, 2016.

In a November 21, 2016 report, Dr. Horan described physical examination findings. He noted right shoulder flexion to 150 degrees, extension to 40 degrees, abduction to 130 degrees, adduction to 50 degrees, internal rotation to 80 degrees, and external rotation to 90 degrees. Left shoulder flexion was to 160 degrees, extension to 20 degrees, abduction to 110 degrees, adduction to 30 degrees, internal rotation to 40 degrees, and external rotation to 70 degrees. Dr. Horan indicated that MMI was reached on February 4, 2015. He found that appellant had a labral lesion of the right shoulder with residual symptoms of tenderness and minimal loss of ROM, he found that under Table 15-5, Shoulder Regional Grid, appellant had a class 1 diagnosis-based impairment (DBI), with a modifier of 2 for physical examination, for four percent permanent impairment of the right upper extremity. Dr. Horan advised that using the DBI methodology, under Table 15-5, appellant had impingement syndrome of the left shoulder for a class 1 impairment and also had loss of ROM, with modifiers of 2 for physical examination and functional history, for a total five percent permanent impairment of the left shoulder.

On March 3, 2017 OWCP asked its medical adviser, Dr. Katz, to review the record, including Dr. Horan's reports. In a March 20, 2017 report, Dr. Katz referenced his March 16, 2016 report. He noted Dr. Horan's impairment analysis for both shoulders and agreed with his conclusion that appellant was not entitled to an additional schedule award for left upper extremity impairment. Regarding the right shoulder, Dr. Katz noted that Dr. Horan utilized the DBI methodology and found four percent permanent impairment under Table 15-5, and advised that this was supported by the record, yet in his conclusion indicated that appellant had five percent right upper extremity impairment.

By decision dated May 1, 2017, OWCP granted appellant a schedule award for five percent permanent impairment of his right upper extremity (arm), for a total of 15.6 weeks, to run from November 21, 2016 to March 10, 2017.

Appellant requested a hearing before an OWCP hearing representative. By decision dated October 11, 2017, an OWCP hearing representative remanded the case to OWCP. The hearing representative noted that left upper extremity permanent impairment was not addressed in the decision. Regarding the right shoulder, the hearing representative questioned why Dr. Horan's calculations identified four percent impairment, yet OWCP's medical adviser, Dr. Katz, concluded that appellant had five percent permanent impairment of the right upper extremity. The hearing representative further found that, as appellant's condition could alternatively be rated using ROM, OWCP should undertake further development in compliance with FECA Bulletin No. 17-06. Upon return of the case record, OWCP was instructed to obtain a supplementary report from an OWCP medical adviser who was to provide medical rationale that supported all opinions given, including clarifying the disparity between the four percent calculation and the five percent conclusion of right upper extremity impairment. Following this development, OWCP was to issue a *de novo* decision.

Following a request for a clarification of his March 20, 2017 report, in an October 24, 2017 report, Dr. Katz noted that he had reviewed the statement of accepted facts and medical record and referenced his March 20, 2017 report. He indicated that the current report superseded his prior report, which contained a typographical error. OWCP's medical adviser described Dr. Horan's findings under Table 15-5 for both shoulders, noting five percent impairment on the left and four percent on the right. Dr. Katz referenced FECA Bulletin No. 17-06, noting that DBI or ROM

could be used in diagnoses designated by an asterisk, including appellant's bilateral shoulder diagnoses. He further noted that the A.M.A., *Guides* provide that, if ROM is to be used, three independent measurements should be documented, and because Dr. Horan did not report three independent range of motion measurements, he was unable to calculate ROM impairments for the shoulders. Dr. Katz concluded that DBI impairment was therefore proper and indicated that appellant had 4 percent permanent impairment of the right shoulder and 5 percent on the left which was less than the 14 percent previously awarded, with November 21, 2016 the date of MMI.

By decision dated October 27, 2017, OWCP found that appellant was not entitled to schedule awards for upper extremity impairments greater than those he had previously received, *i.e.*, four percent on the left and five percent on the right. It noted that the medical evidence established that he had permanent impairments of five percent on the left and four percent on the right.

## ***LEGAL PRECEDENT***

The schedule award provisions of FECA,[4] and its implementing federal regulation,[5] 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.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

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).[8] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[9]

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

> "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

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id.* at § 10.404(a).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] A.M.A., *Guides*, *supra* note 2 at 383-492.

[9] *Id.* at 411.

determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).

"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.)[10]

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.

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

"If the rating physician provided an assessment using the DBI 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.

"If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence."[11]

## ***ANALYSIS***

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

The record establishes that in an October 11, 2017 decision, an OWCP hearing representative remanded the case to OWCP for application of FECA Bulletin No. 17-06 to appellant's schedule award claim. OWCP then obtained a medical report from its medical adviser

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

[11] *Id*.

Dr. Katz. In an October 24, 2017 report, Dr. Katz referenced FECA Bulletin No. 17-06, and found that, because Dr. Horan did not report three independent ROM measurements for the shoulders, the DBI method should be used to calculate appellant's impairment. He concluded that appellant had four percent permanent impairment of his right upper extremity and five percent of his left upper extremity, less than the previous awards, with November 21, 2016 as the date of MMI.

The Board notes that Dr. Horan rendered his report on November 21, 2016, prior to the issuance of FECA Bulletin No. 17-06, issued on May 8, 2017.[12] There is no evidence in this case that OWCP requested that either appellant or its referral physician Dr. Horan provide a supplemental report containing ROM measurements in accordance with the procedures set forth in the A.M.A., *Guides* and FECA Bulletin No. 17-06. As noted above, FECA Bulletin No. 17-06 provides that, if medical evidence sufficient to make a rating based on ROM is not received within 30 days of the request, OWCP should refer the claimant for a second opinion evaluation to obtain the necessary medical evidence. The Board will, therefore, remand the case for OWCP to refer appellant for a second opinion evaluation, either with Dr. Horan or another appropriate physician, to obtain the evidence necessary to complete the rating as described above.[13] Following this and other further development of the medical evidence deemed necessary, OWCP shall issue a *de novo* decision.[14]

## ***CONCLUSION***

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

[12] *Id*.

[13] *See G.W.*, Docket No. 18-0224 (issued May 9, 2018).

[14] *See R.C.*, Docket Nos. 17-1585 and 17-1815 (issued February 16, 2018).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the October 27, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: October 3, 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