United States Department of Labor
Employees' Compensation Appeals Board

P.T., Appellant	)	
and	)	**Docket No. 18-0968**
	)	**Issued: October 23, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Milwaukee, WI, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 10, 2018 appellant filed a timely appeal from a March 26, 2018 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 her burden of proof to establish more than seven percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

OWCP accepted that on October 21, 1997 appellant, then a 42-year-old mail handler, sustained a right rotator cuff tear, right biceps rupture, disorder of right shoulder bursae/tendons,

[1] 5 U.S.C. § 8101 *et seq.*

right shoulder/rotator cuff/arm sprain, right shoulder joint pain, and right rotator cuff repair due to dropping a heavy mailbag she was carrying.[2]

By decision dated August 1, 2008, OWCP granted appellant a schedule award for seven percent permanent impairment of her right upper extremity. The award ran for 21.84 weeks from January 3 to June 4, 2002 and was based on a July 23, 2008 report of Dr. Amon Ferry, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA) for OWCP. He had evaluated physical examination findings obtained by Dr. Carole Vetter, an attending Board-certified orthopedic surgeon, and calculated appellant's permanent impairment based upon limited range of motion (ROM) of her right shoulder. In this regard, Dr. Ferry applied the standards of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

Appellant continued to work in modified-duty positions per work restrictions provided by Dr. Vetter. These restrictions limited her participation in overhead work and placed limits on the weight she could lift.

On August 8, 2017 appellant filed a claim for compensation (Form CA-7) seeking an increased schedule award due to her accepted employment injury.

In an August 8, 2017 development letter, OWCP requested that appellant submit additional evidence in support of her claim, including an attending physician's opinion calculating her permanent impairment under the standards of the sixth edition of the A.M.A., *Guides*.[4]

Appellant submitted an August 22, 2017 report from Dr. Vetter who noted that appellant sustained a right rotator cuff tear and developed a rupture of the long head of her right biceps. Dr. Vetter detailed the findings of the physical examination she conducted on August 22, 2017, noting that appellant could actively abduct her right shoulder to about 100 degrees (with pain), externally rotate it to about 20 degrees, and internally rotate it to about the level of her hips. She noted that appellant reported that most of the time her right shoulder pain rated 8 on a scale of 10 and that her pain increased with activity.

In a September 12, 2017 report, Dr. Vetter noted that appellant's right rotator cuff tear resulted in 7 percent permanent impairment of her right upper extremity, and opined that her right biceps rupture gave her an added 3 percent permanent impairment of her right upper extremity, resulting in a total right upper extremity impairment of 10 percent. She indicated that, for the three percent rating related to the right biceps rupture, she referenced Table 15-5 and Table 15-6 of the sixth edition of the A.M.A., *Guides* and applied the diagnosis-based impairment (DBI) rating

[2] After her October 21, 1997 employment injury, appellant worked in modified-duty positions without wage loss. She initially chose to have her right shoulder condition treated with nonoperative methods. Documents in the case record suggest that appellant later underwent OWCP-approved right rotator cuff repair surgery and OWCP has accepted this condition, but the case record does not contain a report of the surgery. Appellant retired from the employing establishment effective November 1, 2013.

[3] A.M.A., *Guides* (5th ed. 2001).

[4] *Id.* at (6th ed. 2009).

method. Under Table 15-6, appellant's right biceps rupture was a moderate problem with respect to functional history and physical examination. Dr. Vetter determined that, under Table 15-7, appellant had a moderate functional deficit due to pain and symptoms with normal activities and that, under Table 15-8, she had a moderate physical examination deficit due to moderate tenderness and moderate loss of active right shoulder ROM.

On March 19, 2018 OWCP referred appellant's case to Dr. David Garelick, a Board-certified orthopedic surgeon, to serve in his capacity as a DMA. It requested that he review the medical evidence of record, including Dr. Vetter's reports, and provide an opinion on the extent of appellant's permanent impairment under the sixth edition of the A.M.A., *Guides.*

In a March 18, 2018 report, Dr. Garelick discussed Dr. Vetter's reports and indicated that he agreed with her assessment under the DBI rating method that appellant had seven percent permanent impairment of her right upper extremity due to her right rotator cuff tear.[5] He further opined that, under the DBI rating method, it was not appropriate to include the right upper extremity permanent impairment rating of three percent for appellant's right biceps rupture. Dr. Garelick explained that section 15.2e on page 390 of the sixth edition of the A.M.A., *Guides* indicates that it is not uncommon for several diagnosed conditions to be present simultaneously in the shoulder, and provides that the evaluator is expected to choose the most significant diagnosis and to rate only that diagnosis using the DBI rating method. Therefore, appellant's total right upper extremity permanent impairment under the DBI rating method was seven percent. Dr. Garelick then indicated that he was providing an assessment of her right upper extremity permanent impairment under the ROM rating method. He noted that Dr. Vetter only measured appellant's right shoulder ROM one time for each motion. Dr. Garelick asserted that FECA Bulletin No. 17-06 required three independent measurements of each shoulder motion to be taken in order to qualify for a permanent impairment rating under the ROM method. He noted, "Given this was not done in this case, the ROM method may not be used." Dr. Garelick concluded that appellant was not entitled to schedule award compensation in addition to that already received for seven percent permanent impairment of her right upper extremity.

By decision dated March 26, 2018, OWCP found that appellant did not meet her burden of proof to establish more than seven percent permanent impairment of her right upper extremity, for which she previously received a schedule award. It based its determination on Dr. Garelick's March 18, 2018 report.

LEGAL PRECEDENT

The schedule award provision of FECA,[6] and its implementing federal regulations,[7] 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,

[5] Dr. Garelick indicated that, under Table 15-5 of the sixth edition of the A.M.A., *Guides*, appellant's right rotator cuff tear had a five percent default value and that application of the net adjustment formula required movement (two spaces to the right of the default value on Table 15-5) to the seven percent permanent impairment value.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

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.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

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).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

Section 15.2e of the sixth edition of the A.M.A., *Guides* indicates that it is not uncommon for several diagnosed conditions to be present simultaneously in the shoulder, and provides that the evaluator is expected to choose the most significant diagnosis and to rate only that diagnosis using the DBI rating method.[12]

Regarding the application of ROM or DBI impairment 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 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).[13]

[8] *Id.* at § 10.404(a).

[9] 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).

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

[11] *Id.* at 521.

[12] *See id.* at 390, Section 15.2e.

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

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.
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> "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.
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> "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."[14]

FECA Bulletin No. 17-06 further provides that, 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. Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physician's evaluation, the CE should route that report to the DMA for a final determination.[15]

[14] *Id*.

[15] *Id.*

ANALYSIS

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

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 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 DMAs 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 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 DBI rating method, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.[18]

The Board therefore finds that this case requires further development of the medical evidence. On March 18, 2018 Dr. Garelick, the DMA, indicated that he had reviewed the reports of Dr. Vetter, the attending physician, and determined that appellant had seven percent permanent impairment of her right upper extremity due to her right rotator cuff tear, as calculated under the DBI rating method.[19] Since Dr. Vetter provided a rating using the DBI rating method, Dr. Garelick was required to independently calculate appellant's impairment using both the DBI and ROM methods and identify the higher rating for the CE.[20] He indicated that the record did not contain adequate ROM findings to conduct a permanent impairment rating under the ROM method. As noted above, FECA Bulletin No. 17-06 provides detailed instructions for obtaining sufficient evidence to conduct a complete permanent impairment evaluation, including referral for a second opinion evaluation in some cases. However, such instructions were not carried out in the present

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

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

[18] *See supra* note 14.

[19] Dr. Garelick agreed with Dr. Vetter's rating under the DBI method in this regard, but he disagreed with her that a three percent rating should be included for right upper extremity permanent impairment related to appellant's right biceps rupture. Dr. Garelick noted that the sixth edition of the A.M.A., *Guides* indicates that it is not uncommon for several diagnosed conditions to be present simultaneously in the shoulder, and provides that the evaluator is expected to choose the most significant diagnosis and to rate only that diagnosis using the DBI rating method. *See supra* note 12.

[20] *See supra* note 14.

case and therefore this case requires further development of the medical evidence in accordance with FECA Bulletin No. 17-06.[21]

This case will therefore be remanded for application of the new OWCP 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 March 26, 2018 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: October 23, 2018
Washington, DC

Christopher J. Godfrey, 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] *See supra* notes 14 and 15.