United States Department of Labor
Employees' Compensation Appeals Board

M.C., Appellant	)	
and	)	**Docket No. 18-0526**
	)	**Issued: September 11, 2018**
U.S. POSTAL SERVICE, MORGAN STATION, Brooklyn, NY, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 18, 2018 appellant, through counsel, filed a timely appeal from a December 8, 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 his burden of proof to establish more than six percent permanent impairment of the right upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On November 13, 2012 appellant, then a 54-year-old maintenance supply clerk, filed a traumatic injury claim (Form CA-1) alleging that he injured his right shoulder on November 7, 2012 while pushing, pulling, and moving supplies while at work. On February 13, 2013 OWCP accepted the claim for adhesive capsulitis of the right shoulder and paid wage-loss compensation on the supplemental rolls beginning January 4, 2013. It placed appellant on the periodic compensation rolls in January 2014.

By decision dated July 8, 2014, OWCP authorized arthroscopic surgery of the right shoulder to include decompression and debridement. On September 22, 2014 Dr. Arnold B. Wilson, a Board-certified orthopedic surgeon, performed the right shoulder arthroscopic procedure. On September 11, 2015 he advised that appellant could return to work without limitation on October 15, 2015.

In March 2016, OWCP referred appellant to Dr. Donald Heitman, a Board-certified orthopedist, for a second opinion evaluation. In an April 14, 2016 report, Dr. Heitman advised that the accepted condition of adhesive capsulitis had not fully resolved, but that appellant could return to full duty. Appellant returned to full-time, limited duty on June 30, 2016.

By decision dated August 31, 2016, OWCP determined that appellant's actual earnings as a maintenance operations support clerk fairly and reasonably represented his wage-earning capacity with zero loss because his actual earnings met or exceeded the current wages of the job held when injured.

On November 4, 2016 appellant filed a claim for a schedule award (Form CA-7). He submitted a September 27, 2016 report in which Dr. Stewart A. Kaufman, a Board-certified orthopedic surgeon, noted appellant's history of injury, and described appellant's complaint of continued right shoulder pain, and described physical examination findings. Right shoulder range of motion (ROM) findings yielded abduction to 110 degrees, adduction to 25 degrees, flexion to 150 degrees, extension to 35 degrees, internal rotation to 40 degrees, and external rotation to 25 degrees. Left shoulder ROM findings yielded abduction to 145 degrees, adduction to 30 degrees, flexion to 170 degrees, extension to 35 degrees, internal rotation to 80 degrees, and external rotation to 60 degrees. Dr. Kaufman diagnosed sprain of right shoulder with probable rotator cuff tear and Type II acromion, status post surgery. He advised that the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[3] indicated that ROM could be utilized in measuring impairment. Dr. Kaufman found that, under Table 15-34, Shoulder Range of Motion, appellant's right shoulder flexion of 150 degrees yielded 3 percent impairment, extension of 35 degrees yielded 1 percent impairment, abduction of 110

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

degrees yielded 3 percent impairment, adduction of 25 degrees yielded 1 percent impairment, internal rotation of 40 degrees yielded 4 percent impairment, and external rotation of 25 degrees yielded 2 percent impairment which, when added, totaled 14 percent right upper extremity impairment. He advised that this was concordant with appellant's *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) score of 7.

Dr. Arnold B. Wilson, a Board-certified orthopedic surgeon, completed a permanent impairment form report on November 26, 2016. He advised that, pursuant to the A.M.A., *Guides*, appellant had 17.5 percent permanent impairment of the right arm, noting flexion to 145 degrees for 10 percent ROM impairment and mild loss of internal rotation for 7.5 percent ROM impairment. Dr. Wilson indicated that maximum medical improvement (MMI) was reached on November 11, 2016.

OWCP referred the medical record, including the impairment evaluations of Dr. Kaufman and Dr. Wilson, to a district medical adviser (DMA) for review. In a January 28, 2017 report, Dr. Michael M. Katz, the DMA, who is Board-certified in orthopedic surgery, found Dr. Wilson's report of diminished probative value because he did not reference tables or provide worksheets to support his impairment rating. He noted that Dr. Kaufman also provided left shoulder ROM findings that totaled eight percent permanent impairment.[4] Dr. Katz indicated that the A.M.A., *Guides* provided that this impairment should be subtracted from the right shoulder as the left shoulder measurements determined the baseline, which would reduce appellant's right upper extremity impairment to six percent, with September 27, 2016 as the date of MMI.

By letter dated February 6, 2017, OWCP forwarded a copy of Dr. Katz's report to Dr. Kaufman for review. It requested that Dr. Kaufman submit a supplemental report, rating appellant's permanent impairment pursuant to the A.M.A., *Guides.* OWCP noted that, if more than one method of evaluation was allowed in the A.M.A., *Guides*, *e.g.*, diagnosis-based impairment (DBI) or ROM, an explanation for the method chosen should be provided.

In a supplemental report dated February 23, 2017, Dr. Kaufman advised that appellant reached MMI on September 27, 2016, the date of his examination. He again provided appellant's bilateral shoulder ROM measurements. Dr. Kaufman indicated that, if the left shoulder were to be considered the normal member, then appellant's right upper extremity impairment was 6 percent, found by subtracting the 8 percent left shoulder ROM impairment from the 14 percent right shoulder ROM impairment.

OWCP again asked Dr. Katz to review Dr. Kaufman's reports and advised him to reference all pertinent objective and subjective findings including the methodology used, *i.e.*, DBI or ROM, and noted that three independent measures should be documented for ROM with the greatest used to determine impairment.

[4] OWCP's medical adviser indicated that left shoulder abduction to 145 degrees yielded 3 percent impairment, adduction to 30 degrees yielded 1 percent impairment, flexion to 170 degrees yielded 3 percent impairment, extension to 35 degrees yielded 1 percent impairment, and internal rotation to 80 degrees and external rotation to 60 degrees yielded no impairment, for a total left shoulder ROM impairment of 8 percent.

In a May 16, 2017 report, Dr. Katz referenced his January 28, 2017 report. He again found that Dr. Wilson's report lacked sufficient detail and described Dr. Kaufman's ROM measurements. Dr. Katz opined that Dr. Kaufman could appropriately reference Table 15-34 for a stand-alone ROM rating and further noted that page 461 of the A.M.A., *Guides* advised that, if the opposite extremity was neither involved nor previously injured, it must be used to define normal for that individual, and any losses should be made in comparison to the opposite normal extremity. He indicated that, as there was no evidence in the record of contralateral, left shoulder involvement, the injured right shoulder should be compared with the left shoulder. Dr. Katz noted that, in his supplemental report dated February 23, 2017, Dr. Kaufman concurred with his adjustment of appellant's right upper extremity impairment rating. He then compared Dr. Kaufman's ROM measurement and concluded that subtracting 8 percent (left shoulder) from 14 percent (right shoulder) yielded 6 percent right upper extremity permanent impairment due to loss of ROM. Dr. Katz also advised that, by utilizing the DBI method under Table 15-5, Shoulder Regional Grid, appellant had a class 1 impairment for a diagnosis of shoulder impingement with residual loss, which had a default value of 3. He found grade modifiers of 2 for functional history and physical examination, and a clinical studies grade modifier of 1. After applying the net adjustment formula, Dr. Katz indicated that, under the DBI method, appellant had five percent right upper extremity impairment. He advised that appellant's permanent impairment of the right upper extremity was six percent, found by using the ROM method, with September 27, 2016 the date of MMI.

By decision dated June 6, 2017, OWCP granted appellant a schedule award for six percent permanent impairment of the right upper extremity, for a total of 18.72 weeks, to run from September 27, 2016 to February 5, 2017.

Appellant, through counsel, requested a hearing before an OWCP hearing representative on June 26, 2017. No additional evidence was submitted. Appellant was not present at the hearing held on November 7, 2017. Counsel requested that, in light of the Board's finding in the case, *T.H.*,[5] the case should be remanded to an OWCP DMA for comparison of the ROM and DBI methods.

By decision dated December 8, 2017, an OWCP hearing representative noted that Dr. Katz, OWCP's medical adviser, had compared the ROM and DBI methods and concluded that a greater impairment was found utilizing the ROM method. She affirmed the June 6, 2017 schedule award decision.

LEGAL PRECEDENT

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of any employment injury.[6]

[5] Docket No. 14-0943 (issued November 25, 2016).

[6] *J.B.*, Docket No. 17-1907 (issued March 8, 2018).

The schedule award provision of FECA,[7] and its implementing federal regulation,[8] 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.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10]

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).[11] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[12]

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 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.)[13]
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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

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id.* at § 10.404(a).

[10] 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).

[11] A.M.A., *Guides*, *supra* note 3 at 383-492.

[12] *Id.* at 411.

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

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."[14]

ANALYSIS

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

By decision dated June 6, 2017, OWCP granted a schedule award for six percent permanent impairment of the right upper extremity, based on the ROM method. This decision was affirmed by an OWCP hearing representative on December 8, 2017.

Dr. Katz, the DMA, was correct in finding right shoulder impairments utilizing both the DBI method under Table 15-5 for a diagnosis of shoulder impingement with residual loss and under Table 15-34 for ROM deficits. He identified grade modifiers and applied the net adjustment formula, concluding that under Table 15-5 appellant had five percent permanent impairment of the right shoulder under the DBI method.[15] Dr. Katz then analyzed appellant's right shoulder impairment under the ROM method. He correctly indicated that the A.M.A., *Guides* provide that, if the opposite member is not involved or previously injured, any losses should be made in comparison to the opposite normal extremity.[16] By using ROM measurements for both shoulders described by Dr. Kaufman, in his September 27, 2016 report, Dr. Katz concluded that, based on appellant's 14 percent ROM permanent impairment of the right shoulder and 8 percent ROM

[14] *Id*.

[15] A.M.A., *Guides*, *supra* note 3 at 402.

[16] *Id*. at 461.

permanent impairment of the left shoulder, appellant had 6 percent permanent impairment of the right shoulder due to loss of shoulder motion, the greater loss.[17]

The Board, however, notes that FECA Bulletin No. 17-06 provides that, pursuant to the A.M.A., *Guides*, three independent ROM measurements should be obtained, and the greatest ROM should be used for the determination of impairment.[18] Dr. Kaufman rendered his examination on September 17, 2016, prior to the effective date of FECA Bulletin No. 17-06 on May 8, 2017. OWCP did not render its schedule award decision until June 6, 2017. Therefore, as provided in the FECA Bulletin, OWCP should have provided this directive *via* the updated instructions to the rating physician prior to issuing its June 6, 2017 schedule award decision.[19]

There is no evidence in this case that OWCP attempted to obtain a supplemental report from Dr. Kaufman containing three independent measurements of ROM in accordance with the procedures set forth in the A.M.A., *Guides* and FECA Bulletin No. 17-06.[20] The Board will, therefore, remand the case for OWCP to obtain another supplemental report from Dr. Kaufman to obtain the evidence necessary to complete the rating as described above.[21] Following this and further development of the medical evidence deemed necessary, OWCP shall issue a *de novo* decision.[22]

CONCLUSION

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

[17] FECA Bulletin No. 17-06, *supra* note 13.

[18] *Id*.

[19] The Board notes that this specific information was provided in its May 12, 2017 transmittal letter to OWCP's medical adviser requesting an impairment analysis.

[20] *Id*.; A.M.A., *Guides*, *supra* note 3 at 464.

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

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

ORDER

IT IS HEREBY ORDERED THAT the December 8, 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: September 11, 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