United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 19-0282**
	)	**Issued: August 2, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Pembroke Pines, FL, 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
JANICE B. ASKIN, Judge

JURISDICTION

On November 19, 2018 appellant, through counsel, filed a timely appeal from a September 25, 2018 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.[3]

[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.*

[3] The Board notes that following the September 25, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish more than two percent permanent impairment of her left lower extremity, for which she previously received a schedule award; and (2) whether she has met her burden of proof to establish more than 16 percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On September 5, 2003 appellant, then a 40-year-old mail clerk, filed a traumatic injury claim (Form CA-1) alleging that she hurt her hands and knees when she slipped and fell by the water cooler on that day while in the performance of duty. OWCP initially accepted the claim for left wrist strain, left shoulder strain, left ankle strain, and bilateral wrist tendinitis. It subsequently expanded acceptance of the claim to include left knee meniscus tear, cervical disc bulge at C4-5, bilateral wrist strain, complete rotator cuff rupture of the right shoulder, and temporary degenerative lumbar disc disease. Appellant underwent OWCP-approved left shoulder surgery in October 2007 and left knee surgery in July 2008.[4] She retired effective March 8, 2011.

On August 5, 2016 appellant filed a claim for a schedule award (Form CA-7). In an August 5, 2016 report, Dr. Samy F. Bishai, an orthopedic surgeon, provided a history of injury and physical examination findings. He indicated that appellant had reached maximum medical improvement (MMI) for her left shoulder and left knee injuries on August 3, 2016,[5] but had not reached MMI for her neck and back conditions. Dr. Bishai used the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[6] to rate appellant's left shoulder and left knee impairments. For the left shoulder, he used the range of motion (ROM) methodology and found, under Table 15-34, page 475, that appellant had 24 percent left upper extremity impairment. For the left knee, Dr. Bisahi also used the ROM methodology and calculated, under Table 16-23, page 549, that appellant had 20 percent left lower extremity permanent impairment. He provided his impairment calculations within his report.

On December 7, 2016 Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), reviewed Dr. Bishai's permanent impairment rating along with the medical evidence of record. He questioned Dr. Bishai's findings, noting that prior treatment reports had not indicated the objective evidence cited in Dr. Bishai's report. The DMA further noted that Dr. Bishai relied on ROM impairment ratings for both the left shoulder and left knee, but it was his opinion that the A.M.A., *Guides* preference was for use of the diagnosis-based impairment (DBI) methodology whenever possible. He recommended that OWCP have appellant undergo a second opinion evaluation.

OWCP referred appellant to Dr. Peter J. Millheiser, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a January 17, 2017 report, Dr. Millheiser reviewed a statement

[4] Appellant also underwent L5-S1 disc surgery in March 2011 and May 2012 (revision), but there is no indication whether these procedures were authorized by OWCP.

[5] This appears to be a typographical error as Dr. Bishai examined appellant on August 5, 2016.

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

of accepted facts (SOAF) as well as the medical evidence, and conducted a physical examination. He diagnosed meniscal tear left knee, cervical spine sprain, bilateral wrist sprains with tendinitis, medial meniscus tear left knee, and complete rotator cuff tear of left shoulder. For the left shoulder, Dr. Millheiser noted a restriction of motion with abduction and flexion to 90 degrees, external rotation of 30 degrees, and internal rotation of 80 degrees. He also found positive O'Brien and impingement tests. Findings for the right shoulder were not provided. Dr. Millheiser found the right wrist unremarkable. For the left wrist, he noted dorsiflexion of 60 degrees, volar flexion of 50 degrees, radial deviation of 5 degrees, and ulnar deviation of 10 degrees. Hypesthesia and positive Tinel's were noted. In a January 17, 2017 addendum report, Dr. Millheiser discussed multiple shoulder and lumbar magnetic resonance imaging (MRI) studies and noted cervical examination findings. Under the A.M.A., *Guides*, he calculated a combined 23 percent permanent impairment of the left upper extremity using the ROM methodology, noting that he did not have appellant's operative report. This was comprised of 14 percent impairment for the left shoulder and 10 percent for the left wrist. Dr. Millheiser also calculated 2 percent left lower extremity impairment for the left medial meniscectomy and 0 percent impairment for the left lower extremity due to the ankle injury using the DBI methodology. He provided examination findings on which he based his impairment calculations and cited to tables within the A.M.A., *Guides*.

In a March 7, 2017 impairment report, Dr. Millheiser opined, under the ROM methodology, that appellant had 10.5 percent impairment for the left shoulder and 10 percent impairment for the left wrist. He also found two percent lower extremity impairment for the left knee injury. Dr. Millheiser advised that MMI was reached in 2009 for the left shoulder and left knee injuries, but that MMI had not been reached for the lumbar spine. He provided examination findings on which he based his impairment calculations and cited to tables within the A.M.A., *Guides*.

In a March 14, 2017 report, the DMA reviewed the medical evidence of record along with Dr. Millheiser's permanent impairment reports. Using the DBI methodology for the left knee, he found, under Table 16-3, page 509, the knee regional grid, that appellant's partial medial meniscectomy was class of diagnosis (CDX) of 1 with default grade C impairment value of two percent. Under Table 16-6, Table 16-7, and Table 16-8 of the A.M.A., *Guides,* the DMA found a grade modifier clinical studies (GMCS) of 1, a grade modifier physical examination (GMPE) of 0, and that a grade modifier functional history (GMFH) was not applicable. He applied the net adjustment formula and determined that (GMPE – CDX)(0-1) + (GMCS – CDX)(1-1) resulted in a net adjustment of -1, which moved the default value grade C to a grade B or two percent impairment.

The DMA opined that Dr. Millheiser correctly used Table 15-34 as a stand-alone ROM rating as Table 15-5, Shoulder Regional Grid, allowed Table 15-34 to be used as a stand-alone impairment rating when normal motion was not present, which was the case at hand. Using ROM methodology for the left upper extremity, he calculated a combined left upper extremity permanent impairment of 16 percent, advising that Dr. Millheiser had not correctly determined appellant's shoulder and wrist impairments. For the left shoulder, the DMA found under Table 15-34, page 475, that flexion of 90 degrees equaled three percent impairment; extension within normal limits (WNL**)** equaled zero percent impairment; abduction of 90 degrees equaled three percent impairment; adduction WNL equaled zero percent impairment; internal rotation of 80 degrees equaled zero percent impairment; and external rotation of 30 degrees equaled two percent impairment, for a combined eight percent left shoulder permanent impairment. Under Table 15-

35, page 477, he found a grade modifier of 1 and indicated that there was no further adjustment. For left wrist loss of motion, under Table 15-32, page 473, the DMA found that flexion 50 degrees equaled three percent impairment; extension 60 degrees equaled zero percent impairment; radial deviation 5 degrees equaled two percent impairment[7] and ulnar deviation 10 degrees equaled four percent impairment, for a nine percent total wrist impairment. Using the Combined Values Chart, page 604, he combined the 8 percent shoulder impairment with the 9 percent wrist impairment for a combined left upper extremity permanent impairment of 16 percent. The DMA opined that MMI occurred on March 7, 2017, the date of Dr. Millheiser's permanent impairment evaluation.

By decision dated April 14, 2017, OWCP granted appellant a schedule award for 2 percent left lower extremity permanent impairment and 16 percent left upper extremity permanent impairment. The date of MMI was noted to be March 7, 2017. The award ran for 55.68 weeks for the period March 7, 2017 to March 31, 2018.

On April 26, 2017 appellant, through counsel, requested a telephonic hearing, which was held on October 12, 2017. No new evidence pertaining to permanent impairment was received.

By decision dated January 5, 2018, an OWCP hearing representative affirmed OWCP's April 14, 2017, but modified the date of MMI to January 17, 2017, the date of Dr. Millheiser's permanent impairment evaluation. She found that there was no conflict in medical opinion between the impairment ratings of Dr. Bishai and Dr. Millheiser.

In a revised decision dated January 18, 2018, OWCP reissued appellant's schedule award for 2 percent permanent impairment of the left lower extremity impairment and 16 percent permanent impairment of the left upper extremity. The award ran for 55.68 weeks for the period March 7, 2017 to March 31, 2018. The date of MMI was found to be January 17, 2017.[8]

On January 23, 2018 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative, which was held on July 12, 2018. No additional evidence pertaining to permanent impairment was received.

By decision dated September 25, 2018, an OWCP hearing representative affirmed the January 18, 2018 schedule award decision.

LEGAL PRECEDENT -- ISSUE 1

Under section 8107 of FECA[9] and section 10.404 of OWCP's implementing regulations,[10] schedule awards are payable for permanent impairment of specified body members, functions, or organs. FECA, however, does not specify the manner in which the percentage of impairment shall

[7] Under Table 13-32, wrist range of motion, a radial deviation 0 degrees equals four percent impairment and a radial deviation 10 degrees equals two percent impairment. As there is no category for a radial deviation five percent, the DMA provided two percent impairment.

[8] As the date of MMI was January 17, 2017, the Board finds that it is harmless error for the period of the schedule award to begin on March 3, 2017. *See G.G.*, Docket No. 12-1106 (issued November 2, 2012).

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

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.[11] As of May 1, 2009, the sixth edition is used to calculate **s**chedule awards.[12]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability, and Health (ICF).[13] In addressing lower extremity impairments, the sixth edition requires identification of the impairment class of the CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[14] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[15] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores. Section 16.2a of the A.M.A., *Guides*, provides that, if the class selected is defined by physical examination findings or clinical studies results, these same findings may not be used as grade modifiers to adjust the rating.[16]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through a DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides*, with a DMA providing rationale for the percentage of impairment specified.[17]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met her burden of proof to establish more than two percent permanent impairment of her left lower extremity, for which she previously received a schedule award.

To determine the permanent impairment of appellant's left knee, both Dr. Millheiser and the DMA identified a CDX of 1 for a partial medial meniscectomy repair under Table 16-3 on page 509 of the A.M.A., *Guides*, which yielded a default (C) value of two percent. The DMA then applied grade modification procedures of the A.MA., *Guides* to the physical findings provided by Dr. Millheiser and found, under Table 16-6, Table 16-7, and Table 16-8 of the A.M.A., *Guides*, GMCS of 1; GMPE of 0; and excluded GMFH. The net adjustment formula (GMPE – CDX)(0-1)

[11] *Id*. at § 10.404(a).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Exhibit 4 (January 2010).

[13] A.M.A., *Guides* (6th ed. 2009), page 3, Section 1.3, The International Classification of Functioning, Disability, and Health (ICF): A Contemporary Model of Disablement.

[14] *Id*. at 493-553

[15] *Id.* at 521.

[16] *Id.* at 500.

[17] *See* Federal (FECA) Procedure Manual, *supra* note 12 at Chapter 2.808.6(f) (March 2017). *See also F.K.*, Docket No. 18-1700 (issued May 9, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 414 (2006).

+ (GMCS – CDX)(1-1) resulted in a net adjustment of -1, which moved the default (C) value a grade B or two percent impairment. It is therefore found that appellant has no more than two percent permanent impairment of the left lower extremity.

On appeal counsel contends that a conflict in medical opinion existed between Dr. Bishai and Dr. Millheiser with regards to appellant's permanent impairment. The DMA initially reviewed Dr. Bishai's August 2016 report and found that the physical findings on which Dr. Bishai based his impairment ratings were not supported by the record. As the findings on which Dr. Bishai based his impairment assessment were not supported by the record, his impairment rating is of little probative value and is thus insufficient to cause a conflict in the medical opinion evidence.[18]

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

LEGAL PRECEDENT -- ISSUE 2

Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment for the CDX, which is then adjusted by grade modifiersbased on GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX). The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[19] OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of permanent impairment specified.[20]

The A.M.A., *Guides* also provide that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[21] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[22] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[23]

[18] *See D.A.*, Docket No. 18-0779 (issued December 12, 2018); *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[19] *See* A.M.A., *Guides* 387.

[20] *See J.B.*, Docket No. 18-1509 (issued May 2, 2019); *P.R.*, Docket No. 18-0022 (issued April 9, 2018); Federal (FECA) Procedure Manual, *supra* note 12 at Chapter 2.808.6f (March 2017).

[21] A.M.A., *Guides* 461.

[22] *Id.* at 473.

[23] *Id.* at 474.

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.)[24]
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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 should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[25]

ANALYSIS -- ISSUE 2

The Board finds that the case is not in posture for decision as to whether appellant has more than 16 percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

The Board finds that OWCP has not properly developed the evidence with regard to left upper extremity permanent impairment. The DMA utilized Dr. Millheiser's physical examination findings to determine that appellant had 16 percent permanent impairment of the left upper extremity based upon the ROM methodology. However, Dr. Millheiser's reports are of diminished probative value as the record does not establish that he provided three ROM measurements as required by the A.M.A., *Guides*.[26] Accordingly, the DMA cannot use Dr. Millheiser's ROM findings to rate appellant's left shoulder or left wrist permanent impairment.

The Board also finds that the DMA did not rate appellant's left shoulder or left wrist under the DBI method as required by FECA Bulletin No. 17-06. This additional step is required so that

[24] FECA Bulletin No. 17-06 (issued May 8, 2017). *See also L.G.*, Docket No. 18-0519 (issued March 8, 2019); *D.F.*, Docket No. 17-1474 (issued January 23, 2018); *D.B.*, Docket No. 17-1526 (issued April 6, 2018).

[25] *Id.*

[26] A.M.A., *Guides* 464.

a determination can be made as to which methodology resulted in the highest rating of permanent impairment.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[27] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[28] Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in a manner that will resolve the relevant issues in the case.[29]

The complete case record, including surgical reports and diagnostic test results, shall be forwarded, along with an updated SOAF, to Dr. Millheiser for a supplemental report regarding appellant's left upper extremity permanent impairment utilizing both the ROM and DBI methods. Following this and any other such further development as may be deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's schedule award claim for left upper extremity impairment in accordance with the A.M.A., *Guides* and FECA Bulletin No. 17-06.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than two percent permanent impairment of her left lower extremity, for which she previously received a schedule award. The Board further finds that the case is not in posture for decision as to whether she had established more than 16 percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

[27] *See L.G.*, Docket No. 18-0519 (issued March 8, 2019); *T.C.*, Docket No. 17-1906 (issued May 25, 2018); *Melvin James*, 55 ECAB 406 (2004).

[28] *See L.G., id.*; *Richard E. Simpson*, 55 ECAB 490 (2004).

[29] *See L.G.*, *supra* note 27; *B.A.*, Docket No. 17-1360 (issued January 10, 2018).

ORDER

IT IS HEREBY ORDERED THAT the September 25, 2018 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part and the case is remanded for further development consistent with this decision of the Board.

Issued: August 2, 2019
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board