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

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| **S.S., Appellant** | ) | |
| **and** | ) | **Docket No. 19-0766** |
| | ) | **Issued: December 23, 2019** |
| **DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Houston, TX** | ) | |
| **Employer** | ) | |

*Appearances:*
*Leah B. Kille, 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 February 25, 2019 appellant, through counsel, filed a timely appeal from a September 13, 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.

[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 15 percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

## ***FACTUAL HISTORY***

On August 24, 2011 appellant, then a 44-year-old special agent, filed a traumatic injury claim (Form CA-1) alleging that he sustained a neck and right shoulder injury on that date during a training exercise while he was practicing baton strikes in an upward overhead motion. By decision dated April 9, 2012, OWCP accepted the claim for right rotator cuff sprain of shoulder and upper arm and right supraspinatus sprain of shoulder and upper arm. It paid appellant wage-loss compensation on the periodic rolls from May 6, 2012 through May 30, 2015. Appellant underwent OWCP-authorized right shoulder surgery on April 26, 2012, June 7, 2013, and June 27, 2014.

On June 21, 2017 appellant filed a claim for a schedule award (Form CA-7).

In support of his claim, appellant submitted an April 6, 2017 permanent impairment evaluation from Dr. M. Stephen Wilson, a treating orthopedic surgeon. Dr. Wilson reported that appellant sustained a large full-thickness, near full-width tear of the supraspinatus tendon as a result of his work-related injury. He noted status post an April 26, 2012 right shoulder arthroscopic subacromial decompression, mini-open right rotator cuff repair (supraspinatus and infraspinatus), and insertion of biodefense patch, status post a June 7, 2013 right shoulder arthroscopy with synovectomy and mini-open massive rotator cuff repair with ArthroFlex dermal matrix and insertion of biodefense patch, and status post a June 27, 2014 open incision and debridement of the right shoulder. Dr. Wilson determined that appellant had reached maximum medical improvement (MMI).

In accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] Dr. Wilson provided range of motion (ROM) findings based on three measurements and calculated 26 percent right upper extremity permanent impairment using the ROM methodology. In order to establish accurate ROM measurements for the affected extremity, he explained that active ROM of the affected limb, as well as passive ROM of the affected limb and active ROM of the unaffected limb had been considered in the performance of his rating examination.

Under Table 15-34,[4] shoulder ROM, Dr. Wilson found that 120 degrees of flexion yielded three percent permanent impairment, 30 degrees of extension yielded one percent permanent impairment, 110 degrees of abduction yielded three percent impairment, 30 degrees of adduction yielded two percent impairment, 10 degrees of internal rotation yielded eight percent impairment, and 20 degrees of external rotation yielded nine percent impairment. He added those impairment

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

[4] *Id.* at 475.

ratings to conclude that appellant had 26 percent permanent impairment of the right upper extremity. Dr. Wilson found that, under Table 15-36,[5] a functional history grade adjustment was not necessary and appellant remained at 26 percent permanent impairment of the right upper extremity due to his right shoulder injury. He concluded that the ROM methodology should be used in providing appellant's impairment rating.

On July 3, 2017 OWCP routed Dr. Wilson's report, a statement of accepted facts and the case file to Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for an opinion on the date of MMI and permanent impairment of the right upper extremity in accordance with the A.M.A., *Guides*.

In a July 7, 2017 report, Dr. Garelick reviewed the medical evidence of record and determined that MMI was reached on April 6, 2017, the date of Dr. Wilson's examination. He reported that under the diagnosis-based impairment (DBI) methodology for a rotator cuff tear with residual loss, the most that appellant could be awarded was seven percent permanent impairment of the right upper extremity.[6] Thus, Dr. Garelick concluded that the ROM methodology should be used because it provided the higher impairment rating. He used Dr. Wilson's impairment findings and found, under Table 15-34, that appellant had 15 percent permanent impairment of the right upper extremity based on the ROM methodology.[7] Dr. Garelick indicated that the discrepancy between his calculations and Dr. Wilson's was due to misapplication of the impairment values under Table 15-34, specifically noting the difference in impairment values provided by Dr. Wilson for external and internal rotation of the shoulders. He found that 120 degrees of flexion yielded three percent permanent impairment, 30 degrees of extension yielded one percent permanent impairment, 110 degrees of abduction yielded three percent permanent impairment, 30 degrees of adduction yielded two percent permanent impairment, 10 degrees of internal rotation yielded four percent permanent impairment, and 20 degrees of external rotation yielded two percent permanent impairment, for a total 15 percent permanent impairment of the right upper extremity. Dr. Garelick reported that Dr. Wilson incorrectly assigned eight percent permanent impairment for 10 degrees of internal rotation and nine percent permanent impairment for 20 degrees of external rotation. He concluded that appellant had 15 percent total right upper extremity permanent impairment based on the ROM methodology which yielded the greatest impairment.

In an April 25, 2018 medical report, Dr. Wilson reviewed Dr. Garelick's July 7, 2017 report and disagreed with his impairment rating. He explained that Table 15-34[8] of the A.M.A., *Guides* left open for interpretation the percentages for internal and external shoulder rotation as each motion was based upon the motion of the other. Dr. Wilson reported that appellant was severely limited on both internal and external motions which rendered it difficult to determine an actual percentage of impairment as there had to be some extrapolation of numbers since Table 15-34 only provided percentages based on the opposite motion. He noted that, according to Table 15-34, appellant's 10 degrees internal ROM should be eight percent because his external ROM was

[5] *Id.* at 477.

[6] *Id.* at 403, Table 15-5.

[7] *Supra* note 4.

[8] *Id.*

20 degrees. Dr. Wilson reported that the 20 degrees external ROM was not even noted as a possibility as the 10 degrees internal ROM was not an option with which to determine his external motion percentages. Therefore, he determined that the highest impairment rating should be used as the default. Dr. Wilson disagreed with Dr. Garelick's impairment rating four percent for internal rotation and two percent for external rotation. He explained that these numbers could not be correct as appellant's internal rotation was not between 40 to 50 degrees which would be necessary for his external rotation to amount to four percent permanent impairment. Furthermore, Dr. Wilson asserted that appellant's 20 degrees of external rotation would result in an eight percent permanent impairment for internal rotation. As such, he concluded that his 26 percent rating for permanent impairment of the upper right extremity remained unchanged.

In a September 9, 2018 medical report, DMA Dr. Garelick reviewed Dr. Wilson's supplemental April 25, 2018 report and disagreed with his interpretation of the A.M.A., *Guides*. In accordance with Table 15-34, he argued that 20 degrees of external rotation was classified under a grade 1 modifier as it was between 50 degrees of external rotation to 30 degrees of internal rotation. As such, Dr. Garelick opined that two percent permanent impairment should be awarded for this deficiency. He further stated that 10 degrees of internal rotation was classified as a grade 2 modifier which falls between the 10 degrees of external rotation to 40 degrees of internal rotation, amounting to four percent permanent impairment. Dr. Garelick concluded that his opinion remained unchanged and appellant should only be awarded 15 percent permanent impairment of the right upper extremity.

By decision dated September 13, 2018, OWCP granted appellant a schedule award for "15 percent permanent partial impairment of the right upper extremity (arm)." The date of MMI was noted as April 6, 2017 and the period of award ran from April 6, 2017 to February 27, 2018. It found that the weight of the medical evidence regarding the percentage of permanent impairment rested with Dr. Garelick, serving as the DMA, as he had correctly applied the A.M.A., *Guides* to the examination findings.

## ***LEGAL PRECEDENT***

The schedule award provisions of FECA and its implementing regulations 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.[9] 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate

[9] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

standard for evaluating schedule losses.[10] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[11]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13]

The A.M.A., *Guides* also provide that ROM impairment methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other DBI sections are applicable.[14] 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.[15] 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.[16]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology versus the ROM methodology for rating of upper extremity impairments.[17] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "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 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*.[18] (Emphasis in the original.)

[10] 20 C.F.R. § 10.404; *L.T.*, Docket No. 18-1031 (issued March 5, 2019); *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[11] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.5 (March 2017).

[12] A.M.A., *Guides* 383-492.

[13] *Id*. at 411.

[14] *Id.* at 461.

[15] *Id.* at 473.

[16] *Id.* at 474.

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

[18] A.M.A., *Guides* 477.

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."[19]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[20]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[21] This is called an impartial medical examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[22] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[23]

## ***ANALYSIS***

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

In support of his claim, appellant submitted permanent impairment evaluation reports dated April 6, 2017 and April 25, 2018 from Dr. Wilson, his treating physician. Utilizing the ROM methodology, Dr. Wilson opined that appellant sustained 26 percent permanent impairment of the upper right extremity. Consistent with its procedures,[24] OWCP referred the matter to a DMA for an opinion regarding appellant's permanent impairment in accordance with the A.M.A., *Guides.* Dr. Garelick, serving as the DMA, reviewed the reports of Dr. Wilson and determined that the ROM methodology produced the higher rating. However, he disagreed with Dr. Wilson's

[19] *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018); *supra* note 17.

[20] *See supra* note 11 at Chapter 2.808.6(f) (March 2017).

[21] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[22] 20 C.F.R. § 10.321.

[23] *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[24] *Id.*

impairment rating and found that appellant only sustained 15 percent permanent impairment of the right upper extremity based on the ROM methodology.

The primary diversion in the physicians' application of Table 15-34 relates to a rating for shoulder internal and external rotation. Dr. Wilson assigned eight percent permanent impairment for 10 degrees of internal rotation and nine percent permanent impairment for 20 degrees of external rotation. The DMA, however, assigned four percent permanent impairment for 10 degrees of internal rotation and two percent permanent impairment for 20 degrees of external rotation. As both physicians applied the Table 15-34 of the A.M.A., *Guides*, but calculated divergent permanent impairment ratings, the Board finds that there is a conflict in the medical opinion evidence requiring referral to an impartial medical examiner pursuant to 5 U.S.C. § 8123(a).[25]

The Board will therefore remand the case to OWCP for referral to an impartial medical examiner to resolve the conflict in medical opinion as to the extent of appellant's right upper extremity permanent impairment.[26] Following this and any further development as is deemed necessary, OWCP shall issue a *de novo* decision.

## ***CONCLUSION***

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

[25] *Supra* note 21.

[26] *Supra* note 22.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the September 13, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion.

Issued: December 23, 2019
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