United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
and	)	**Docket No. 18-1168**
	)	**Issued: February 8, 2019**
U.S. POSTAL SERVICE, POST OFFICE, PROCESSING & DELIVERY CENTER, Macon, GA, 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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On May 22, 2018 appellant filed a timely appeal from a May 4, 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 two percent permanent impairment of her left upper extremity, for which she has previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On April 14, 2013 appellant, then a 51-year-old mail processing clerk, filed an occupational disease claim (Form CA-2) alleging that she sustained a left shoulder strain while in the performance of duty. In an accompanying statement, she alleged that she injured her left shoulder while lifting and using the delivery bar code sorter. Appellant did not initially stop work. OWCP initially accepted her claim for left shoulder impingement syndrome. After further development, it expanded acceptance of appellant's claim to include partial tear of the left rotator cuff.

In a January 21, 2015 report, Dr. Jeffrey A. Fried, a Board-certified orthopedic surgeon, noted diagnoses of impingement syndrome of left shoulder, rotator cuff syndrome not otherwise specified, and lateral epicondylitis. He opined that appellant had two percent permanent impairment of the upper extremity pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

On February 18, 2015 appellant filed a claim for a schedule award (Form CA-7).

In a report dated February 24, 2015, Dr. James W. Dyer, a Board-certified orthopedic surgeon, acting as OWCP's district medical adviser (DMA), indicated that he agreed with Dr. Fried. He explained that, using the diagnosis-based impairment (DBI) method, pursuant to Table 15-5 on page 401 of the A.M.A., *Guides,* appellant had a class 1, grade C soft tissue injury to her left shoulder causing pain which equaled two percent permanent impairment of her left upper extremity.

On February 26, 2015 OWCP issued appellant a schedule award for two percent permanent impairment of her left upper extremity.

On March 13, 2015 appellant requested a hearing before an OWCP hearing representative. A hearing was held on October 6, 2015. By decision dated December 15, 2015, the hearing representative affirmed the February 26, 2015 schedule award decision, noting that there was no evidence of record that appellant had greater than two percent permanent impairment of the left upper extremity.

On April 27, 2016 appellant filed a Form CA-7 claim for an increased schedule award.

In support of her increased schedule award claim, appellant submitted an October 13, 2015 report from Dr. Samy F. Bishai, an orthopedic surgeon. Dr. Bishai diagnosed internal derangement of the left shoulder, rotator cuff tear and syndrome left shoulder joint, left shoulder

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[2] Docket No. 17-0502 (issued May 22, 2017).

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

impingement syndrome, and status postoperative arthroscopic surgery for treatment of rotator cuff tear and shoulder impingement left shoulder. He used the stand alone range of motion (ROM) method to calculate her permanent impairment under the A.M.A., *Guides*. Dr. Bishai noted that, with regard to appellant's left shoulder, flexion was 80 degrees which equaled nine percent upper extremity permanent impairment. Extension of 20 degrees equaled two percent upper extremity permanent impairment. Dr. Bishai further noted that abduction of 80 degrees equaled six percent upper extremity permanent impairment, and adduction of 20 degrees equaled one percent upper extremity impairment. He noted internal rotation was 20 degrees which equaled four percent upper extremity impairment and external rotation of 45 degrees equaled two percent upper extremity permanent impairment. Dr. Bishai explained that combining these impairment ratings, "since we are dealing with one and the same joint)," totaled 24 percent permanent impairment of the left upper extremity.

On May 10, 2016 OWCP referred the record to Dr. David H. Garelick, Board-certified in orthopedic surgery, and an OWCP DMA, for an impairment rating. In a May 14, 2016 report, Dr. Garelick noted that Dr. Bishai based his rating on the ROM method, and that the A.M.A., *Guides* indicated that the ROM method is to be used primarily as a physical examination adjustment factor and only to determine actual impairment values in the rare case when it is not possible to otherwise define impairment. He concluded that appellant had already been granted a schedule award for two percent permanent impairment of her left upper extremity, and that was the appropriate award.

In a June 8, 2016 report, Dr. Bishai responded to Dr. Garelick's report. He noted that Dr. Garelick had relied upon the opinion of Dr. Fried for his impairment rating, and that the medical adviser had not examined appellant. Dr. Bishai also opined that Dr. Fried's use of the DBI method was not credible since it did not take into consideration the marked reduction of appellant's range of motion. He also raised questions with regard to the date of maximum medical improvement.

In a November 15, 2016 response, Dr. Garelick reviewed Dr. Bishai's comments, but concluded that given that there was a diagnosis for appellant's condition (rotator cuff syndrome which corresponded to tendinitis as noted in Table 15-5), it was clear that the DBI method was appropriate. He again noted that the DBI method was preferable under the sixth edition of the A.M.A., *Guides.*

By decision dated December 2, 2016, OWCP denied appellant's claim for an additional schedule award, finding that the weight of the medical evidence rested with the opinion of OWCP's medical adviser.

On January 9, 2017 appellant filed an appeal with the Board. By decision dated May 22, 2017, the Board found that the case was not in posture for decision and remanded the case to OWCP for further development.[4] The Board found that, in light of the conflicting interpretation by OWCP of the sixth edition with respect to upper extremity impairment ratings, it was incumbent upon OWCP, through its implementing regulations and/or internal procedures, to establish a consistent method for rating upper extremity permanent impairment.

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[4] Docket No. 17-0502 (issued May 22, 2017).

In a September 30, 2017 report, Dr. Garelick noted that appellant's chart was again reviewed for the purpose of determining her left upper extremity permanent impairment, due to her accepted left shoulder condition. He explained that on May 3, 2014 appellant underwent a left shoulder arthroscopy, acromioplasty, and lysis of adhesions. Dr. Garelick noted that appellant was awarded two percent left upper extremity permanent impairment for the left shoulder.

Dr. Garelick explained that Dr. Bishai had recommended a 24 percent left upper extremity rating based on loss of range of motion in the left shoulder. He advised that there was a significant discrepancy between his measurements and those of appellant's other treating physicians and the functional capacity evaluation (FCE), completed on January 6, 2015. Dr. Garelick reiterated that Dr. Bishai's measurements were vastly different from those of the objective providers. He explained that in the FCE, completed on January 6, 2015, range of motion testing revealed 155 degrees of forward flexion, 74 degrees of extension, 152 degrees of abduction, 70 degrees of internal rotation, and 76 degrees of external rotation. Dr. Garelick indicated that Dr. Bishai attempted to explain the differences in the measurements as due to a worsening in appellant's condition, but this was highly unlikely.

Dr. Garelick also noted that he was not in possession of the previous report from Dr. Fried. He explained that his "guess" was that appellant had been awarded two percent left upper extremity permanent impairment based on impingement syndrome with residual symptoms without consistent objective findings. Dr. Garelick referenced Table 15-5 of the A.M.A., *Guides*.[5] He concluded that his rereview of the case reflected that "this award seems certainly reasonable, and I would suggest it stand." Dr. Garelick further indicated that Dr. Bishai only provided one range of motion measurement. He explained that three sets of independent measurements must be taken. Dr. Garelick explained that because this was not done, then the ROM method could not be used. He also explained that, if there was ongoing disagreement, he would suggest that OWCP send appellant to an objective and unaffiliated orthopedic surgeon for an impartial medical examination.

By decision dated December 27, 2017, OWCP denied appellant's claim for an increased schedule award.

On February 13, 2018 appellant requested reconsideration.

In a January 24, 2018 report, Dr. Fried explained that upon further examination and evaluation, he believed the impairment rating was extremely low and should be reconsidered.

By decision dated May 4, 2018, OWCP denied modification of the December 27, 2017 decision. It found that the medical evidence of record was insufficient to establish that appellant had more than two percent permanent impairment of the left upper extremity.

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[5] A.M.A., *Guides* 402.

LEGAL PRECEDENT

The schedule award provisions 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, 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 diagnosed condition 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).

The A.M.A., *Guides* also provides 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. If the ROM method 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. Adjustments for GMFH 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.[11]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology based versus the ROM methodology for rating upper extremity impairment.[12] FECA Bulletin No. 17-06 provides in pertinent 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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[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] A.M.A., *Guides* 411.

[11] *Id.* at 461.

[12] FECA Bulletin No. 17-06. This bulletin was effective for all decisions issued by OWCP on and after May 8, 2017.

> "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.*" (Emphasis in the original.)[13]

The Bulletin further advises:

> "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.

Dr. Bishai provided a rating based upon appellant's loss of range of motion which was allowed (for a diagnosed condition followed by an asterisk) under Table 15-5 of the A.M.A. *Guides*.[15] On remand Dr. Garelick indicated that Dr. Bishai's permanent impairment rating based upon loss of range of motion should be disregarded as he only provided one range of motion measurement, and his measurement differed from previous measurements of record. He explained that three sets of independent measurements must be taken and because this was not done, then the range of motion findings could not be utilized. As Dr. Garelick found that the medical evidence of record was insufficient to render a rating by the ROM method, he should have advised OWCP as to the medical evidence necessary to complete the rating. He should have also independently calculated appellant's impairment using both the ROM and DBI methods and identified the higher rating for the CE.[16] This case will therefore be remanded for further development consistent with the procedures outlined in FECA Bulletin No. 17-06.

Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision on the extent of impairment to appellant's right upper extremity.[17]

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[13] *Id.*

[14] *Id.*

[15] A.M.A., *Guides* 402, Table 15-5.

[16] *Supra* note 12.

[17] *See F.B.*, Docket No. 18-0903 (issued December 7, 2018).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the May 4, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this opinion of the Board.

Issued: February 8, 2019
Washington, DC

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

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board