United States Department of Labor
Employees' Compensation Appeals Board

M.D., Appellant	)	
	)	**Docket No. 18-1073**
and	)	**Issued: January 18, 2019**
	)	
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Washington, DC, 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 May 1, 2018 appellant filed a timely appeal from an April 13, 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 more than 12 percent permanent impairment of the right upper extremity, for which he 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 facts relevant to this appeal are set forth below.

On January 29, 2015 appellant, then a 40-year-old internal revenue agent, filed an occupational disease claim (Form CA-2) alleging that on October 3, 2014 he first became aware of his right rotator cuff injury and first realized that his condition was caused by his federal employment. He claimed that, while he was assembling documents for review he felt a very sharp pain go through his right shoulder while using a hole puncher to perforate case file documents.

OWCP accepted the claim for sprain of the right shoulder and upper arm; acromioclavicular (AC) and disorder of the bursae and tendons in the right shoulder region, unspecified; complete right rotator cuff rupture; and right brachial neuritis or radiculitis, not otherwise specified. It authorized a right shoulder arthroscopy with subacromial decompression and distal clavicle resection which was performed on July 7, 2015 by Dr. Steven H. Bernstein, an attending Board-certified orthopedic surgeon. OWCP paid wage-loss compensation benefits on the periodic rolls.

Appellant returned to full-time work with restrictions on June 18, 2016.

On June 28, 2016 appellant filed a claim for a schedule award (Form CA-7).

In support of his schedule award claim, appellant submitted a June 17, 2016 report from Dr. Bernstein in which he noted that appellant had been evaluated on June 15, 2016. On physical examination Dr. Bernstein utilized the diagnosis-based impairment (DBI) methodology to determine the degree of permanent impairment. He indicated that, in accordance with Table 15-5, page 402 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] appellant's rotator cuff contusion with impingement and residual loss, equated to five percent permanent impairment of the right upper extremity. Dr. Bernstein further indicated that an AC joint injury/disease equated to eight percent upper extremity permanent impairment. Utilizing the Combined Values Chart on page 604, he calculated 13 percent permanent impairment of the right upper extremity and 8 percent whole person impairment. Dr. Bernstein awarded an additional four percent impairment each for pain, weakness, and loss of endurance and function. He found no additional impairment for atrophy. Dr. Bernstein concluded that appellant had a combined 29 percent total right upper extremity permanent impairment.

On July 21, 2016 Dr. Jovito Estaris, Board-certified in occupational medicine, acting as an OWCP district medical adviser (DMA) reviewed the medical record, including Dr. Bernstein's report. He noted appellant's diagnoses of impingement syndrome and AC disease. The DMA used the range of motion (ROM) method. He referenced Dr. Bernstein's ROM measurements and

[2] Docket No. 17-1424 (issued October 25, 2017).

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

applied Table 15-34, page 475 of the A.M.A., *Guides*. The DMA found 3 percent impairment each for flexion and abduction, no impairment for external rotation, and 4 percent impairment for internal rotation, totaling 10 percent impairment. He assigned a grade modifier 1 for loss of ROM under Table 15-35, page 477. The DMA found a grade modifier 1 for decreased total ROM according to Table 15-36, page 477. He assigned a grade modifier 2 for functional history for pain with normal activity based on Table 15-7, page 406. The DMA then calculated 10.5 percent permanent impairment of the right upper extremity which was rounded up to 11 percent. He explained that his impairment rating was markedly lower than Dr. Bernstein's impairment rating because Dr. Bernstein had rated two diagnoses under the DBI method and had combined the impairment ratings. The DMA referenced page 387 of the A.M.A., *Guides*, which directed that, if a patient had two significant diagnoses, the examiner should use the diagnosis with the highest causally-related impairment for the impairment calculation. He also noted that Dr. Bernstein awarded additional impairment ratings for pain, weakness, and loss of endurance and function which was not acceptable under the sixth edition of the A.M.A., *Guides*. The DMA determined that appellant had reached maximum medical improvement (MMI) on June 17, 2016, the date of Dr. Bernstein's evaluation.

OWCP, by letter August 4, 2016, requested that appellant obtain a supplemental report from Dr. Bernstein regarding the extent of his permanent impairment based on the physician's review of the DMA's report.

In an August 19, 2016 letter, Dr. Bernstein reviewed the DMA's report and disagreed with his use of the ROM methodology to calculate appellant's impairment rating. He contended that this methodology was inappropriate and inadequate as it failed to capture the degree of appellant's pain, difficulty, and impairment. Dr. Bernstein restated his prior finding that appellant had 29 percent right arm impairment.

The DMA, on September 20, 2016, reviewed Dr. Bernstein's August 19, 2016 report. He reiterated why his use of the ROM methodology to calculate appellant's impairment rating was more appropriate under the A.M.A., *Guides*. The DMA also restated why Dr. Bernstein's impairment rating was not acceptable under the A.M.A., *Guides*.

By decision dated October 4, 2016, OWCP granted appellant a schedule award for 11 percent permanent impairment of the right upper extremity, based on the opinion of the DMA. The period of the award ran from June 18, 2016 to February 13, 2017.[4]

On November 4, 2016 appellant requested reconsideration.

By decision dated February 2, 2017, OWCP reviewed the merits of appellant's claim and denied modification of its October 4, 2016 decision. It found that the weight of the medical evidence remained with the DMA's opinion.

[4] On November 30, 2016 appellant accepted a lump-sum payment of the schedule award.

Appellant appealed to the Board on June 15, 2017. By decision dated October 25, 2017, the Board set aside the February 2, 2017 decision.[5] The Board found that OWCP had inconsistently applied Chapter 15 of the A.M.A., *Guides* regarding the proper use of either the DBI or ROM methodology in assessing the extent of permanent impairment. The Board remanded the case for OWCP to issue a *de novo* decision after development of a consistent method for calculating permanent impairment of the upper extremities.[6]

Following remand, on December 11, 2017 OWCP requested that appellant submit an additional report from Dr. Bernstein including a review of a newly prepared the statement of accepted facts (SOAF) and an evaluation of his prior impairment rating based on the reprinted 2009 sixth edition A.M.A., *Guides*. Appellant was afforded 30 days to submit the requested evidence.

By letter dated January 10, 2018, appellant responded to OWCP's December 11, 2017 development letter. He contended that OWCP's DMA's opinion could not carry the weight of the medical evidence. Appellant noted that he had not received a copy of the SOAF, which inaccurately noted that he had preexisting cervical radiculitis, AC joint arthrosis, and a herniated cervical disc. He asserted that Dr. Bernstein's 29 percent right arm extremity impairment rating was sufficient to establish his entitlement to a greater schedule award.

On February 15, 2018 OWCP requested that its DMA review his July 21 and September 21, 2016 reports and Dr. Bernstein's impairment rating of June 17, 2016 and explain how their right upper extremity impairment calculations were determined under the reprinted 2009 sixth edition A.M.A., *Guides*. In pertinent part, it indicated that the DMA must reference all pertinent objective and subjective findings, identify the methodology used by the rating physician, and advise whether the applicable tables in the A.M.A., *Guides* identify a diagnosis that can alternatively be rated by ROM. If the A.M.A., *Guides* allows 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. If the rating physician provided an assessment using the ROM method and the A.M.A., *Guides* allows for use of ROM diagnosis in question, the DMA was to independently calculate the impairment using both the ROM and DBI methods and identify the higher rating. OWCP noted that, if it was clear to the evaluator evaluating loss of ROM that the loss had an organic basis, three independent measurements should be documented/recorded and the greatest ROM should be used for the determination of permanent impairment. If the medical evidence of record was insufficient to render a rating based on the ROM method, where allowed, the DMA was advised to note the medical evidence necessary to complete the ROM rating method and render an impairment rating using the DBI method, if possible, given the available evidence.

On February 19, 2018 the prior DMA for OWCP reviewed the SOAF and medical record. The DMA utilized the DBI method to determine the degree of appellant's permanent impairment. He indicated that, in accordance with Table 15-5, page 403 of the sixth edition of the A.M.A., *Guides*, appellant's AC joint arthropathy with impingement syndrome status post distal clavicle

[5] *Supra* note 2.

[6] *Supra* note 1.

resection equated to a class 1 impairment with a default value of 10 percent upper extremity impairment.[7] Utilizing Table 15-7, page 406, the DMA assigned a grade modifier 2 for functional history due to pain with regular activity, increase on lifting arm.[8] He assigned a grade modifier of 2 for physical examination under Table 15-8, page 408 due to a tender shoulder with limitation of ROM and positive impingement tests.[9] The DMA noted that a grade modifier for clinical studies was not applicable as a magnetic resonance imaging scan showed AC joint arthropathy, which was used in the diagnosis and proper placement in the regional grid. Applying the net adjustment formula, he subtracted 2, the numerical value of the class, from the numerical value of the grade modifier for each applicable component (functional history and physical examination) and then added those values, resulting in a net adjustment of 2 ((2-1) + (2-1)).[10] Application of the net adjustment formula meant that movement was warranted two places to the right of class 1 default value grade C to grade E based on Table 15-5.[11] Therefore, the DBI method of rating of permanent impairment for appellant's right AC joint arthropathy with impingement syndrome amounted to 12 percent of the right upper extremity.[12]

The DMA noted that the ROM method was applicable in this case. However, he indicated that there was only one set of measurements of ROM of the right shoulder. The DMA noted that three independent measurements of ROM of the involved joint was required to use the ROM method. He reviewed Dr. Bernstein's June 15, 2016 impairment evaluation and noted his 29 percent right upper extremity impairment rating. The DMA related that proper use of the A.M.A., *Guides* explained any discrepancies between his own impairment evaluation and Dr. Bernstein's impairment evaluation. He indicated that Dr. Bernstein provided impairment ratings for two conditions of the same joint, five percent impairment for impingement syndrome of right shoulder and eight percent impairment for AC joint arthropathy of the same shoulder. The DMA maintained that this was not the recommended rating by the sixth edition of the A.M.A., *Guides* and related that page 387 provided that if a patient had two significant diagnoses, for instance, rotator cuff tear and biceps tendinitis, the examiner should use the diagnosis with the highest causally related impairment rating for the impairment calculation. He further related that page 389 provided that if more than one diagnosis could be used, the highest causally-related impairment rating should be used, which was generally the more specific diagnosis. Typically, one diagnosis would adequately characterize the impairment and its impact on activities of daily living (ADL). The DMA maintained that the highest causally related impairment rating was for the AC joint arthropathy. Dr. Bernstein had added four percent impairment ratings for disability due to pain, weakness, and loss of endurance, and loss of function. He indicated that these impairment ratings were not found

[7] A.M.A., *Guides* 411, Table 15-5.

[8] *Id.* at 406, Table 15-7.

[9] *Id.* at 408, Table 15-8.

[10] *Id.* at 411.

[11] *Supra* note 5.

[12] *Id.*

in the sixth edition of the A.M.A., *Guides*. The DMA again concluded that appellant had reached MMI on June 15, 2016, the date of Dr. Bernstein's evaluation.

By decision dated February 22, 2018, OWCP vacated its February 2, 2017 decision. It found that its DMA properly determined that appellant had an additional 1 percent impairment of his right upper extremity, totaling 12 percent permanent impairment of his right upper extremity.

By decision dated April 13, 2018, OWCP granted appellant an additional schedule award of one percent right upper extremity permanent impairment. This was above the previously paid 11 percent right upper extremity award, for a total right upper extremity permanent impairment of 12 percent. The additional award ran for a total of 3.12 weeks of compensation covering the period February 14 to March 7, 2017.

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.[13] 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 standard for evaluating schedule losses.[14] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[15] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[16]

The sixth edition requires identifying 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).[17] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

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.[18] If the ROM method is used as a stand-alone approach,

[13] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[14] *Id.* at § 10.404. *See also Ronald R. Kraynak,* 53 ECAB 130 (2001).

[15] *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 and Permanent Disability Claims*, Chapter 2.808.5 (March 2017).

[16] *Isidoro Rivera,* 12 ECAB 348 (1961).

[17] A.M.A., *Guides* 401-19.

[18] *Id.* at 461.

the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[19] Adjustments for functional history may be made if the evaluator determines that the resulting degree of permanent impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[20]

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.[21] 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:

> "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.)[22]
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> The Bulletin further advises:
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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.
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> "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

[19] *Id.* at 473.

[20] *Id.* at 474.

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

[22] *Id.*

the rating. After receipt of the second opinion physician's evaluation, the CE should route that report to the DMA for a final determination."[23]

ANALYSIS

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

On prior appeal the Board remanded the case for OWCP to reevaluate the extent of appellant's permanent impairment of his right upper extremity after it determined a consistent method for rating upper extremity impairments under the sixth edition of the A.M.A., *Guides*. On remand OWCP indicated that FECA Bulletin No. 17-06 provides that, if the A.M.A., *Guides* allowed both the DBI and ROM methods for calculating an identified diagnosis, the method that yielded the higher impairment rating should be used.[24]

On June 28, 2016 appellant's treating physician, Dr. Bernstein, noted that appellant sustained 29 percent permanent impairment of his right upper extremity pursuant to the A.M.A., *Guides*. He used the DBI method to rate appellant's permanent impairment. Dr. Bernstein diagnosed rotator cuff contusion with impingement and residual loss under Table 15-5, page 402 of the sixth edition of the A.M.A., *Guides*,[25] appellant's loss equated to five percent permanent impairment of the upper extremity. He further indicated that an AC joint injury/disease equated to eight percent upper extremity impairment. Utilizing the Combined Values Chart on page 604, Dr. Bernstein calculated 13 percent impairment of the upper extremity. He awarded an additional four percent permanent impairment each for pain, weakness, and loss of endurance and function. Dr. Bernstein found no additional impairment for atrophy. He concluded that appellant had 29 percent total upper extremity permanent impairment. Dr. Bernstein advised that appellant could return to his internal revenue field agent position with restrictions.

On February 19, 2018 OWCP's DMA reviewed Dr. Bernstein's impairment findings. He noted that, since three independent ROM calculations were not of record, it was not possible to evaluate appellant's permanent impairment utilizing the ROM methodology. Pursuant to FECA Bulletin No. 17-06, the DMA proceeded to evaluate appellant's impairment using the DBI methodology.

However, as noted by the DMA, while an alternative ROM calculation for appellant's diagnosis was allowed under the A.M.A., *Guides*, there was only one set of ROM calculations of record. Pursuant to FECA Bulletin No. 17-06, if the ROM method of rating permanent impairment is allowed, after review of the DBI rating, the DMA should advise as to the medical evidence necessary to complete the ROM method of rating if the medical evidence of record is insufficient to rate appellant's impairment using ROM. If the claimant's treating physician has provided an impairment rating, the claims examiner should then write to the treating physician advising of the

[23] *Id.*

[24] *Supra* note 19. FECA Bulletin No. 17-06 (issued May 8, 2017). *See also D.F.*, Docket No. 17-1474 (issued January 23, 2018).

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

medical evidence necessary to complete the rating. If the necessary evidence is not received within 30 days, OWCP is to refer appellant for a second opinion evaluation. In the present case, it did not follow the procedures outlined in FECA Bulletin No. 17-06 after the DMA advised that the necessary evidence of three independent ROM findings were not of record to rate appellant's permanent impairment utilizing the ROM methodology. For this reason, this case must be remanded for OWCP to complete the proper procedures outlined in FECA Bulletin No. 17-06 to rate appellant's upper extremity permanent impairment. After such further development as necessary, OWCP shall issue a *de novo* decision.[26]

CONCLUSION

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

ORDER

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

Issued: January 18, 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

[26] *See T.M.*, Docket No. 18-0182 (issued July 26, 2018).