United States Department of Labor
Employees' Compensation Appeals Board

C.W., Appellant	)	
	)	
and	)	**Docket No. 19-0406**
	)	**Issued: July 10, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Atlanta, GA, Employer	)	

Appearances:
Joanne Marie Wright, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 13, 2018 appellant, through her representative, filed a timely appeal from an August 23, 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 her burden of proof to establish more than 11 percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On July 2, 2014 appellant, then a 57-year-old retired letter carrier, filed an occupational disease claim (Form CA-2) alleging a left shoulder injury due to factors of her federal employment. She indicated that she used her left shoulder to case her route and deliver mail. Appellant noted that she performed a lot of casing, lifting, pushing, and pulling. She noted that she first became aware of her condition on July 9, 2013 and first realized it resulted from factors of her federal employment on July 2, 2014. On the reverse side of the Form CA-2, the employing establishment indicated that appellant was last exposed to her federal employment conditions on November 1, 2013.[3]

After initially denying appellant's claim on October 24, 2014 and February 2, 2015, OWCP accepted her claim for left shoulder impingement, left shoulder internal joint derangement, and left shoulder sprain.

On March 28, 2016 appellant underwent authorized left shoulder arthroscopic rotator cuff repair with subacromial decompression, distal clavicle resection. The operative report noted a preoperative diagnosis of left shoulder full-thickness rotator cuff tear with impingement syndrome.

By decision dated May 19, 2016, OWCP expanded acceptance of appellant's claim to include left shoulder complete rotator cuff tear.

On January 11, 2017 appellant underwent a functional capacity evaluation (FCE) performed by Anthony Meier, a physical therapist, who related her complaints of achy pain and decreased range of motion (ROM). On examination, Mr. Meier noted ROM for the left shoulder of 95 degrees flexion, 35 degrees extension, 60 degrees abduction, 30 degrees internal rotation, and 30 degrees external rotation. Strength was 3/5. It was also noted that appellant demonstrated inconsistence performance with testing and self-limiting behaviors.

In a February 7, 2017 report, Dr. David A. Stokes, a Board-certified orthopedic surgeon, noted that appellant was status post left shoulder arthroscopy. Upon examination of her left shoulder, he observed some capsular tightness and guarding and minimal swelling over the rotator cuff. Dr. Stokes reported ROM testing of forward flexion to 170 degrees, external rotation to 60 degrees, and forward flexion to 150 degrees. He diagnosed partial thickness rotator cuff tear and left full-thickness rotator cuff tear. Dr. Stokes opined that appellant had seven percent whole person impairment.

On March 6, 2017 appellant filed a claim for a schedule award (Form CA-7).

[3] Appellant retired from the employing establishment, effective December 31, 2013.

By development letter dated March 13, 2017, OWCP advised appellant of the type of evidence needed to establish her schedule award claim, including a statement from her attending physician that the accepted condition had reached maximum medical improvement (MMI) and an impairment rating utilizing the appropriate portions of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*).[4] It afforded her 30 days to submit the necessary evidence. In a separate letter of even date, OWCP requested that Dr. Stokes provide a discussion of the rationale for his calculation of appellant's impairment rating based on the proper tables and criteria of the A.M.A., *Guides.*

In an April 4, 2017 amendment note of the February 7, 2017 report, Dr. Stokes indicated that he agreed with the findings of appellant's January 11, 2017 FCE and that she had reached MMI.

In an April 10, 2017 impairment rating report,[5] Dr. Stokes indicated that his impairment rating was based on residual loss of ROM, pursuant to Table 15-5 of the A.M.A., *Guides.* He noted clinical studies of full-thickness rotator cuff tear and a *Quick*DASH score of 55. Dr. Stokes reported that appellant had three percent permanent impairment for 95 degrees flexion, one percent permanent impairment for 45 degrees extension, six percent permanent impairment for 60 degrees abduction, zero percent permanent impairment for 40 degrees adduction, two percent permanent impairment for 30 degrees external rotation, and four percent permanent impairment for 30 degrees internal rotation for a total impairment rating of 16 percent permanent impairment. He noted grade modifier of 2 under Table 15-35 due to ROM and grade modifier of 2 for functional history (*Quick*DASH score of 55). Dr. Stokes explained that because appellant's ROM and functional history adjustment were both the same modifier of 2, no modification of her impairment was required under Table 15-35. Thus, he concluded that she had a final impairment rating of 16 percent left upper extremity permanent impairment and 10 percent whole person impairment.

OWCP referred appellant's schedule award claim to an OWCP district medical adviser (DMA).

In May 29, 2017 report, Dr. James W. Butler, a physician Board-certified in occupational medicine, serving as a DMA, reviewed the medical evidence of record and noted the accepted condition of left shoulder rotator cuff tear. He reported that the ROM method, as used by Dr. Stokes in his April 10, 2017 impairment rating, was not applicable in this case because Dr. Stokes' rating was based on inconsistent ROM measurements. Dr. Butler noted that, according to the physical therapist who conducted appellant's FCE, appellant exhibited self-limiting behaviors, which resulted in inconsistent performance.

Dr. Butler indicated that according to the diagnosis-based impairment (DBI) method, under Table 15-5, Shoulder Regional Grid, appellant had sustained a class 1 impairment (default 10 percent) for acromioclavicular (AC) disease status post distal clavicle resection. He reported grade modifier functional history (GMFH) 1 (ability to perform self-care activities with intermittent pain) and grade modifier clinical studies (GMCS) 2 (moderate pathology). Dr. Butler indicated

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

[5] The report was also signed by Melanie M. Harris and Mr. Meier, physical therapists.

that there was no grade modifier physical examination (GMPE). Applying the net adjustment formula, (1-1) + (2-1), resulted in a net modifier of plus 1, which raised the default 10 percent value to 11 percent permanent impairment of the left upper extremity impairment. Dr. Butler reported an MMI date of January 11, 2017.

By decision dated June 27, 2017, OWCP granted appellant a schedule award for 11 percent permanent impairment of the left upper extremity, based on the DMA's May 29, 2017 report. The period of the award ran for 34.32 weeks from January 11 to September 8, 2017.

On June 14, 2018 appellant requested reconsideration. She asserted that there was a conflict in medical evidence between Dr. Stokes and Dr. Butler regarding her left upper extremity permanent impairment rating and that OWCP had a duty to resolve the conflict before it issued her schedule award.

OWCP received additional reports by Dr. Stokes dated September 1, 2017 and February 16, 2018. Dr. Stokes reported examination findings of some swelling over the left rotator cuff and minimal tenderness limited. He also provided upper extremity ROM measurements. Dr. Stokes diagnosed partial thickness rotator cuff tear.

By decision dated August 23, 2018, OWCP denied modification of the June 27, 2017 schedule award.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing 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. FECA, however, does not specify the manner in which the percentage of loss of a member 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 and the Board has concurred in such adoption.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[9]

In addressing impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated.[10] With respect to the shoulder, reference is made to Table 15-5 (Shoulder Regional

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* at 10.404(a); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

Grid).[11] After a class of diagnosis (CDX) is determined from the Shoulder Regional Grid (including identification of a default grade value), the impairment class is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[12] The net adjustment formula is (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX).[13]

The A.M.A., *Guides* also provide that 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.[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 combined.[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:

> "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).
>
> "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*

[11] A.M.A., *Guides* 401-05.

[12] *Id.* at 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[13] *Id.* at 411.

[14] *Id.* at 461.

[15] *Id.* at 473.

[16] *Id.* at 473-74.

[17] FECA Bulletin No. 17-06 (May 8, 2017; *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

impairment rating for the diagnosis in question, the method producing the higher rating should be used."[18] (Emphasis in the original).[19]

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.

"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 impairment rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.

"Upon receipt of such 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 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 the rating. After receipt of the second opinion physician's evaluation, the CE should route that report to the DMA for a final determination."[20]

ANALYSIS

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

On April 10, 2017 appellant's treating physician, Dr. Stokes, reported that appellant sustained 16 percent permanent impairment of her left upper extremity pursuant to the A.M.A., *Guides.* He indicated that he used the ROM method, Table 15-5, to rate her permanent impairment. Dr. Stokes reported that appellant had 3 percent permanent impairment for 95 degrees flexion, 1 percent permanent impairment for 45 degrees extension, 3 percent permanent impairment for 60 degrees abduction, 0 percent permanent impairment for 40 degrees adduction, 2 percent permanent impairment for 30 degrees external rotation, and 4 percent permanent impairment for 30 degrees internal rotation for a total impairment rating of 16 percent permanent impairment. He explained that because she had a grade modifier of 2 for functional history and loss of ROM, there was no adjustment of her impairment rating of 16 percent left upper extremity impairment.

[18] *Id.*

[19] *Id.*

[20] *Id.*

In a May 29, 2017 report, Dr. Butler, the DMA, reviewed Dr. Stokes' impairment findings. He noted that because Dr. Stokes' impairment rating was based on inconsistent ROM measurements in appellant's January 11, 2017 FCE, it was not possible to evaluate her permanent impairment utilizing the ROM methodology. Dr. Butler then proceeded to evaluate appellant's impairment using the DBI methodology under Table 15-5, Shoulder Regional Grid, and calculated that she had 11 percent permanent impairment of the left upper extremity impairment. He reported an MMI date of January 11, 2017.

The Board notes, however, that a rating based upon appellant's loss of ROM of her upper extremity for AC joint injury or disease is allowed (by asterisk) pursuant to Table 15-5 of the A.M.A., *Guides.*[21] *A*s noted above, pursuant to FECA Bulletin No. 17-06, if the A.M.A., *Guides* allows for a ROM rating for the diagnosis used, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating.[22] Accordingly, Dr. Butler should have independently calculated appellant's impairment using both the DBI and ROM methods and identify the higher rating. Instead, he indicated that the ROM measurements provided by the FCE were inadequate as they were based on inconsistent performance and self-limiting behaviors. The Board notes that, if Dr. Butler found that the ROM measurements were inadequate, FECA Bulletin No. 17-06 provides that OWCP's medical adviser should advise as to the medical evidence necessary to complete the rating.[23]

FECA Bulletin No. 17-06 provides detailed instructions for obtaining sufficient evidence to conduct a complete permanent impairment evaluation, including referral for a second opinion evaluation in some cases. However, OWCP did not follow the procedures outlined in FECA Bulletin No. 17-06 in the present case as it did not advise appellant's treating physician of the necessary evidence of consistent ROM measurements and three independent ROM findings in order to properly rate appellant's permanent impairment utilizing the ROM methodology. As such, OWCP failed to properly develop the medical evidence by requesting that appellant's treating physician provide the medical evidence necessary to calculate an impairment rating in accordance with the guidance in FECA Bulletin No. 17-06.[24] For this reason, the 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. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[21] A.M.A., *Guides* 403, Table 15-5.

[22] *Supra* note 17.

[23] *Id.*

[24] *See B.W.*, Docket No. 18-0901 (issued January 24, 2019); *M.D.*, Docket No. 18-1073 (issued January 18, 2019); *see also F.B.*, Docket No. 18-0903 (issued December 7, 2018).

ORDER

IT IS HEREBY ORDERED THAT the August 23, 2018 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: July 10, 2019
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board