United States Department of Labor
Employees' Compensation Appeals Board

E.M., Appellant	)	
	)	
and	)	**Docket No. 19-0469**
	)	**Issued: July 24, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Jackson, MS, Employer	)	

Appearances:
Appellant, pro se
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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On December 28, 2018 appellant filed a timely appeal from a December 18, 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 his burden of proof to establish more than 24 percent permanent impairment of his 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 of the case as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On May 11, 2006 appellant, then a 52-year-old postal driver, sustained a traumatic injury while in the performance of duty due to forcefully pulling the stuck door of a general purpose container. OWCP accepted his claim for bilateral complete rotator cuff ruptures and sprain of his right shoulder/upper arm (rotator cuff). On October 15, 2007 it granted appellant a schedule award for 16 percent permanent impairment of his right upper extremity.[3]

On June 11, 2013 appellant underwent OWCP-authorized right shoulder surgery, including reverse total shoulder arthroplasty and tenodesis of his biceps tendon. On February 6, 2014 Dr. Daniel P. Dare, a Board-certified orthopedic surgeon, reported that the right-sided arthroplasty was "doing actually quite well."

In August 2014, appellant filed a claim for an increased schedule award (Form CA-7).

By decision dated November 19, 2014, OWCP denied his claim, noting that Dr. Dare had not responded to its August 12, 2014 request to provide a right upper extremity impairment rating under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

OWCP subsequently referred appellant's case to Dr. Howard P. Hogshead, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA) for OWCP, and requested that he provide an opinion on right upper extremity permanent impairment under the standards of the sixth edition of the A.M.A., *Guides*. On January 9, 2015 Dr. Hogshead applied the diagnosis-based impairment (DBI) rating method, found at Table 15-5 of the sixth edition of A.M.A., *Guides*, and determined that appellant's right total shoulder arthroplasty represented 24 percent permanent impairment of his right upper extremity. As appellant had already received a schedule award for 16 percent impairment of his right upper extremity, he was entitled to an award for an additional 8 percent.

In March 2015, appellant submitted an undated report from Dr. Dare, who provided an opinion that appellant had 24 percent permanent impairment of his right upper extremity due to his right total shoulder arthroplasty.

By decision dated June 22, 2015, a representative of OWCP's Branch of Hearings and Review reversed the November 19, 2014 denial of an increased schedule award and directed OWCP to pay benefits for an additional eight percent based on the opinions of Dr. Dare and

[2] Docket No. 15-1633 (issued October 27, 2015).

[3] The October 15, 2007 decision also granted nine percent of the left upper extremity.

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

Dr. Hogshead. By decision dated July 8, 2015, OWCP issued a schedule award for an additional eight percent permanent impairment of appellant's right upper extremity.

Appellant submitted a September 29, 2015 report from Dr. Dare who reported physical examination findings from that date. Dr. Dare advised that appellant was able to lift his arms and place them behind his head and low back. He observed that appellant's right total shoulder arthroscopy was well healed.

Appellant appealed OWCP's July 8, 2015 decision to the Board and, by decision dated October 27, 2015,[5] the Board set aside the July 8, 2015 decision and remanded the case to OWCP for further development. The Board found that both Dr. Dare and Dr. Hogshead had provided incomplete impairment ratings due to their failure to calculate grade modifiers per Chapter 15 of the sixth edition of the A.M.A., *Guides*. The Board directed OWCP, upon remand, to obtain a supplemental report from Dr. Hogshead, the DMA, which addressed this deficiency.

Upon remand, OWCP referred appellant's case to Dr. Morley Slutksy, a Board-certified occupational medicine physician serving as a DMA, and requested that he provide a right upper extremity permanent impairment rating under the sixth edition of the A.M.A., *Guides.*

In a May 9, 2016 report, Dr. Slutsky provided an impairment rating based on the findings of Dr. Dare's September 29, 2015 report. He applied the DBI rating method and found that, under Table 15-5 on page 405, appellant's right total shoulder arthroscopy (Class 2) warranted a 24 percent default value for permanent impairment of his right upper extremity.[6] Dr. Slutsky determined that, per the standards on page 405 through 411, appellant had a functional history grade modifier of 1, physical examination grade modifier of 2, and clinical studies grade modifier of 2. Application of the net adjustment formula, found on page 411, required movement one space to the left of the default value on Table 15-5, and therefore the total permanent impairment of appellant's right upper extremity was 22 percent.[7]

By decision dated May 23, 2016, OWCP found that appellant did not meet his burden of proof to establish more than 24 percent permanent impairment of his right upper extremity, for which he previously received schedule awards. It determined that Dr. Slutsky's finding of 22 percent permanent impairment of appellant's right upper extremity did not support an increased schedule award as appellant had already been compensated for 24 percent permanent impairment.

On September 4, 2018 appellant filed a claim for an increased schedule award. In a development letter dated October 3, 2018, OWCP requested that he submit additional evidence in support of his claim for an increased schedule award. It provided appellant 30 days to submit such evidence.

[5] *Supra* note 2.

[6] Dr. Slutsky asserted that the DBI rating method was the preferred rating method for evaluating permanent impairment under the A.M.A., *Guides*.

[7] Dr. Slutsky determined that appellant's date of maximum medical improvement was September 29, 2015, the date of Dr. Dare's physical examination.

Appellant subsequently submitted an October 15, 2018 report from Dr. Dare, who reported findings of the physical examination he conducted on that date. These findings included range of motion (ROM) findings for appellant's right shoulder. Dr. Dare opined, without elaboration, that appellant had 18 percent permanent impairment of his right upper extremity, a degree of impairment he acknowledged was less than the 24 percent permanent impairment for which he previously received schedule awards.

By decision dated December 18, 2018, OWCP again found that appellant did not meet his burden of proof to establish more than 24 percent permanent impairment of his right upper extremity. It determined that Dr. Dare's finding of 18 percent permanent impairment of appellant's right upper extremity did not support an increased schedule.

LEGAL PRECEDENT

The schedule award provisions of FECA[8] and its implementing federal regulations,[9] 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.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[11]

With respect to the upper extremities, the sixth edition requires identifying the impairment class for the class of diagnosis (CDX), 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]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "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

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id.* at § 10.404(a).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[12] A.M.A., *Guides* at 383-412.

[13] *Id.* at 411.

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 impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)[14]

The Bulletin further advises:

"If the rating physician provided an assessment using the DBI 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 [in]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."[15]

ANALYSIS

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

The Board has previously found that OWCP had inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation had been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[16] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[17] In *T.H.*, the Board concluded that OWCP physicians are at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and DMAs use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board observed that physicians interchangeably cited to language in the first printing or the second printing when justifying use of either ROM or DBI

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

[15] *Id*.

[16] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

[17] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

methodology. The Board therefore found that OWCP should develop a consistent method for calculating permanent impairment for upper extremities, which could be applied uniformly.

As noted-above, FECA Bulletin No. 17-06 provides that, if the rating physician provided an assessment using the DBI method and the A.M.A., *Guides* allows 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.[18]

The Board therefore finds that this case requires further development of the medical evidence. Since Dr. Slutsky provided a rating of appellant's right shoulder impairment under the DBI rating method and evaluation of loss of ROM due to appellant's diagnosed right shoulder condition is allowed (by asterisk) pursuant to Table 15-5 of the A.M.A., *Guides*, Dr. Slutsky should have independently calculated appellant's impairment using both the ROM and DBI methods and identified the higher rating for the CE. If the medical evidence of record is insufficient for Dr. Slutksy to render a rating using the ROM or DBI method, he should advise as to the medical evidence necessary to complete the rating.[19]

This case will therefore be remanded for application of FECA Bulletin No. 17-06. After such further development of the medical evidence as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[18] *See supra* note 16.

[19] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the December 18, 2018 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded to OWCP for action consistent with this decision.

Issued: July 24, 2019
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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