United States Department of Labor
Employees' Compensation Appeals Board

M.H., Appellant	)	
and	)	**Docket No. 19-0290**
	)	**Issued: June 18, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Brandon, FL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., 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 November 20, 2018 appellant, through counsel, filed a timely appeal from an October 12, 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 15 percent permanent impairment of her right upper extremity for which she previously received a schedule award.

FACTUAL HISTORY

OWCP accepted that on May 28, 2015 appellant, then a 63-year-old city carrier assistant, sustained a right shoulder and upper arm acromioclavicular (AC) sprain as a result of picking up a case of flats to load into her delivery vehicle while in the performance of duty.

In medical reports dated September 1, 2015, Dr. Stuart A. Goldsmith, an attending orthopedic surgeon, noted that he had been treating appellant since her May 2015 right shoulder injury. He indicated her current complaint of right and left shoulder pain. Dr. Goldsmith reported examination findings, which included normal range of motion (ROM) of the cervical spine, shoulders, elbows, wrists, and fingers. Appellant had pain in her left shoulder in the subacromial region and with abduction and external rotation. The neurovascular status was normal. The peripheral pulses were intact. There were no signs of instability demonstrated. Dr. Goldsmith discussed the findings of shoulder x-rays. He provided a clinical impression of impingement syndrome with sprain/strain and addressed appellant's light-duty work restrictions. On October 1, 2015 Dr. Goldsmith noted that her right shoulder was better, but she had left shoulder pain. He related that his physical examination did not demonstrate any true weakness or stiffness. Dr. Goldsmith reported that appellant felt that she could not move her arm. He related, however, that there was really nothing further for him to offer her now four months after her injury. Dr. Goldsmith found that appellant had bilateral shoulder pain. He assessed her as having stable unspecified rotator cuff tear/rupture of the unspecified shoulder, not trauma. Dr. Goldsmith determined that appellant had reached maximum medical improvement (MMI). He concluded that she had zero percent permanent impairment.

On December 9, 2015 appellant filed a claim for a schedule award (Form CA-7).[3]

OWCP subsequently received a medical report dated January 7, 2016 by Dr. Samy F. Bishai, an orthopedic surgeon. Dr. Bishai noted a history of the accepted May 28, 2015 employment injury and appellant's medical treatment. He indicated that she presented complaining of a great deal of pain and restricted and limited ROM of her right and left shoulders. On physical examination the right shoulder Dr. Bishai reported tenderness overlying the anterior, lateral, and posterior aspects of the right shoulder joint. He also reported ROM measurements, which included 80 degrees of flexion, 10 degrees of extension, 80 degrees of abduction, 15 degrees of adduction, 40 degrees of external rotation, and 15 degrees of internal rotation. Dr. Bishai reviewed right shoulder magnetic resonance imaging scan results. He diagnosed internal derangement, rotator cuff syndrome, and degenerative arthritis of the AC joint of the right shoulder joint and impingement syndrome of the right shoulder. Dr. Bishai determined that appellant had reached MMI on the date of his examination. He evaluated her right shoulder permanent

[3] A Notification of Personnel Action (PS Form 50) indicated that appellant voluntarily resigned from the employing establishment effective February 11, 2016.

impairment using the ROM rating methodology found in Table 15-34, 475 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] Dr. Bishai found that 80 degrees of flexion yielded nine percent impairment, 10 degrees of extension yielded two percent permanent impairment, 80 degrees of abduction yielded six percent impairment, 15 degrees of adduction yielded one percent impairment, 15 degrees of internal rotation yielded four percent impairment, and 40 degrees of external rotation yielded two percent impairment. He added these impairment ratings to conclude that appellant had 24 percent permanent impairment of the right upper extremity due to her accepted May 28, 2015 employment injury.

On July 13, 2016 OWCP routed Dr. Bishai's report, a statement of accepted facts (SOAF), and the case file to Dr. Jovito Estaris, a physician Board-certified in occupational medicine serving as an OWCP district medical adviser (DMA), for review to determine whether appellant sustained permanent impairment of her accepted conditions and date of MMI in accordance with the sixth edition of the A.M.A., *Guides*.

In a July 20, 2016 report, Dr. Estaris recommended an independent medical examination based on the marked difference between the ROM findings and impairment ratings of Dr. Goldsmith and Dr. Bishai.

On December 13, 2016 QTC Medical Services, OWCP's scheduler, referred appellant, together with a SOAF, the medical record, and a set of questions, to Dr. Glenn L. Scott, a Board-certified orthopedic surgeon, for a second opinion regarding the extent of her employment-related right upper extremity permanent impairment.

In a January 3, 2017 impairment evaluation, Dr. Scott related a history of the accepted May 28, 2015 employment injury and appellant's medical treatment. He discussed her complaints of continued pain and stiffness in the right shoulder, particularly with stress at limits of motion and with strenuous or repetitive exercise. On examination of the right shoulder Dr. Scott reported tenderness to palpation over the AC joint and directly over the acromion. He found that appellant was able to initiate and hold abduction against resistance, although she complained about pain in doing so. Dr. Scott further found no significant difference in response to either the full can or empty can test and no indication of instability about the shoulder. The right AC joint was mildly hypertrophic with tenderness over the bicipital groove distally. Dr. Scott measured ROM on several repetitions to better establish accurate range and found 95 degrees of flexion, 15 degrees of extension, 80 degrees of abduction, 20 degrees of adduction, 65 degrees of external rotation, and 35 degrees of internal rotation. He noted some guarding at times that was inconsistent. Dr. Scott provided impressions of right AC arthritis and impingement, rotator cuff and biceps tendinosis, traumatic aggravation of the above conditions, and adhesive capsulitis. He determined that appellant had reached MMI. Dr. Scott opined that she had preexisting AC arthritis probably with some degree of impingement, although there was no history of any previous injury or prior treatment and the conditions upon which her impairment were based secondary to traumatic aggravation of these conditions and causally related to the workplace injury in question. He evaluated appellant's right shoulder permanent impairment using the ROM rating methodology

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

found in Table 15-34, 475 of the sixth edition of the A.M.A., *Guides*. Dr. Scott determined that 95 degrees of flexion represented 3 percent impairment, 15 degrees of extension represented 2 percent impairment, 80 degrees of abduction represented 9 percent impairment, 20 degrees of adduction represented 1 percent permanent impairment, 65 degrees of external rotation represented 0 percent impairment, and 35 degrees of internal rotation represented 4 percent permanent impairment, totaling 20 percent permanent impairment of the right upper extremity. He advised that the prominent difference in ROM noted on examinations by Dr. Goldsmith and later by Dr. Bishai were related to the onset of adhesive capsulitis in the interim which persisted at the present time.

On August 14, 2017 Dr. Estaris, the DMA, again reviewed the medical evidence of record, including the reports of Dr. Bishai and Dr. Scott. He noted that the diagnosis-based impairment (DBI) methodology of the A.M.A., *Guides* was not applicable in this case. Dr. Estaris advised that the diagnoses of impingement syndrome and partial rotator cuff tear could not be used as the criteria for the classes in these diagnosis required normal motion which was not found in this case. He indicated that Dr. Scott had measured ROM several times, but only mentioned one set of measurements in his report. Dr. Estaris also indicated that Dr. Scott's ROM measurements did not follow the recommendation of the A.M.A., *Guides* to round numbers ending in zero either up or down. He evaluated appellant's right shoulder permanent impairment using the ROM rating methodology found in Table 15-34, page 475. Dr. Estaris found that 100 degrees of flexion yielded 3 percent impairment, 80 degrees of abduction yielded 6 percent impairment, 20 degrees of extension yielded 1 percent impairment, 20 degrees of adduction yielded 1 percent impairment, 40 degrees of internal rotation yielded 4 percent impairment, and 70 degrees of external rotation yielded 0 percent impairment, totaling 15 percent right upper extremity permanent impairment. He noted that, under Table 15-35, page 477, the ROM grade modifier was grade 2. Dr. Estaris assigned a grade modifier 2 for functional history adjustment due to pain on normal activity under Table 15-7, page 406. He referenced Table 15-36, page 477 for functional history grade adjustment for ROM. Dr. Estaris explained that, since the modifiers were both two, they were equal and there was no change. He concluded that appellant had 15 percent permanent impairment of her right upper extremity. Dr. Estaris determined that she had reached MMI on January 3, 2017, the date of Dr. Scott's impairment evaluation.

OWCP, by decision dated September 28, 2017, granted appellant a schedule award for 15 percent permanent impairment of the right arm based on the opinion of Dr. Estaris. The period of the award ran for 46.8 weeks from January 3 to November 26, 2017.

On October 12, 2017 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative.

By decision dated January 10, 2018, an OWCP hearing representative set aside OWCP's September 28, 2017 decision and remanded the case for further development. He found that the acceptance of appellant's claim should be expanded to include right shoulder adhesive capsulitis, aggravation of AC joint arthritis, shoulder impingement, and rotator cuff and bicep tendinitis based on Dr. Scott's report. The hearing representative further found that, as her accepted conditions could alternatively be rated using the DBI methodology, OWCP should undertake further development in compliance with FECA Bulletin No. 17-06.

On January 12, 2018 OWCP expanded the acceptance of appellant's claim to include primary osteoarthritis, adhesive capsulitis, impingement syndrome, and bicipital tendinitis of the right shoulder.

In a report dated January 23, 2018, Dr. Estaris again reviewed the medical evidence and a revised SOAF. He provided a DBI impairment rating of four percent permanent impairment citing to Table 15-5, page 402 of the sixth edition of the A.M.A., *Guides*, for a diagnosis of right shoulder rotator cuff tendinitis. Dr. Estaris noted that appellant's diagnosis of right shoulder rotator cuff tendinitis equated to a class 1 impairment with a default value of three for residual loss, functional, and moderate motion deficit. Utilizing Table 15-7, page 406, he assigned a grade modifier 1 for functional history (GMFH) due to pain on increased activity and stiffness of shoulder. Utilizing Table 15-8, page 408, Dr. Estaris assigned a grade modifier 2 for physical examination (GMPE) due to moderate limitation of ROM (total motion deficit of 20 percent). He noted that a grade modifier for clinical studies (GMCS) was not applicable. Applying the net adjustment formula, Dr. Estaris subtracted 1, 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 1 ((1-1) + (2-1)).[5] Application of the net adjustment formula meant that movement was warranted one place to the right of class 1 default value grade C to grade D or four percent permanent impairment based on Table 15-5, page 402. Therefore, the DBI methodology of rating of permanent impairment for appellant's right shoulder rotator cuff tendinitis amounted to four percent of the right upper extremity. Dr. Estaris also evaluated her permanent impairment under the ROM methodology found in Table 15-34 on page 475. He found that appellant's flexion of 100 (95) degrees yielded 3 percent permanent impairment, 20 (15) degrees of extension yielded 1 percent permanent impairment, 80 degrees of abduction yielded 6 percent permanent impairment, 20 degrees of adduction yielded 1 percent permanent impairment, 40 (35) degrees of internal rotation yielded 4 percent permanent impairment, and 70 (65) degrees of external rotation yielded 0 percent permanent impairment, totaling 15 percent right upper extremity permanent impairment. Dr. Estaris utilized Tables 15-35 and 15-36, page 477, and assigned a grade modifier 2 for 15 percent permanent ROM impairment. He noted that the grade modifier 1 for functional history was less than the ROM grade modifier. Dr. Estaris related that there was no change and, thus, concluded that appellant had 15 percent right upper extremity permanent impairment, based on the higher ROM method. He explained that the difference between his 15 percent right upper extremity impairment rating and Dr. Scott's 20 percent right upper extremity impairment rating was Dr. Scott's error in assigning impairment for abduction and extension. Dr. Estaris noted that, under Table 15-34, page 475, 20 to 80 degrees of abduction represented six percent impairment and not nine percent impairment as found by Dr. Scott. He further noted that measured extension was 15 degrees which he rounded up to 20 degrees. Dr. Estaris indicated that 20 degrees of extension was not contained in Table 15-34. He maintained that Dr. Scott's use of a two percent impairment rating for extension was not an appropriate finding for 20 degrees of extension. Dr. Estaris related that his use of a one percent impairment rating was the more appropriate number. He noted that the measured ROM was closer to 30 degrees. Dr. Estaris reiterated that the date of MMI was January 3, 2017.

[5] *Id*. at 411.

By decision dated February 23, 2018, OWCP denied appellant's claim for an increased schedule award based on Dr. Estaris' January 23, 2018 assessment.

On March 5, 2018 counsel, on behalf of appellant, requested a telephonic hearing before an OWCP hearing representative, which was held on August 16, 2018.

By decision dated October 12, 2018, a second OWCP hearing representative affirmed the February 23, 2018 schedule award decision. He found that the weight of the medical evidence rested with Dr. Estaris' January 23, 2018 report and established that appellant had no more than 15 percent permanent impairment of the right upper extremity.

LEGAL PRECEDENT

The schedule award provision 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, functions, and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[8] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[9]

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

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]

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[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

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

[9] *Id.*

[10] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.* at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (March 2017).

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

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

[13] *Supra* note 5.

Regarding the application of the ROM or DBI 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 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 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."[15]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[16]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than 15 percent permanent impairment of her right upper extremity for which she previously received a schedule award.

OWCP received a January 7, 2016 report from Dr. Bishai, an attending physician, who opined that appellant had 24 percent right upper extremity permanent impairment based on the loss of ROM methodology for the evaluation of permanent impairment. In a January 3, 2017 report, Dr. Scott, an OWCP referral physician, also used the ROM methodology for calculating appellant's 20 percent right upper extremity permanent impairment. However, neither physician

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

[15] *Id.*

[16] *See supra* note 10 at Chapter 2.808.6(e) (March 2017).

provided three sets of ROM measurements as provided in FECA Bulletin No. 17-06.[17] As a result, the reports of Dr. Bishai and Dr. Scott do not comply with the A.M.A., *Guides* and their reports are of limited probative value.[18]

The Board finds that Dr. Estaris, OWCP's DMA, properly determined that appellant had no more than 15 percent permanent impairment of her right upper extremity. Utilizing the ROM methodology found in Table 15-34, page 475 of the *Guides*, Dr. Estaris found that 100 (95) degrees of flexion represented 3 percent impairment, 20 (15) degrees of extension represented 1 percent impairment, 80 degrees of abduction represented 6 percent impairment, 20 degrees of adduction represented 1 percent permanent impairment, 40 (35) degrees of internal rotation represented 4 percent impairment, and 70 (65) degrees of external rotation represented 0 percent impairment, totaling 15 percent right upper extremity permanent impairment. He explained that the difference between his 15 percent impairment rating and Dr. Scott's 20 percent impairment rating was due to Dr. Scott's error in assigning impairment ratings for loss of abduction and extension. Dr. Estaris noted that, according to Table 15-34 on page 475, 20 to 80 degrees of abduction represented six percent impairment and not nine percent impairment as found by Dr. Scott. He further noted that he rounded up the measured extension of 15 degrees to 20 degrees while Dr. Scott's finding of 20 degrees of extension was not contained in Table 15-34. Dr. Estaris maintained that his finding of one percent impairment for loss of extension, rather than Dr. Scott's two percent impairment was appropriate as the measured ROM was closer to 30 degrees. Furthermore, he provided a DBI impairment rating of four percent permanent impairment for appellant's diagnosis of right shoulder rotator cuff tendinitis. Dr. Estaris found that the diagnosis of right shoulder rotator cuff tendinitis under Table 15-5, page 402, yielded a class 1 impairment with a default value of three for residual loss, functional, and moderate motion deficit. He assigned grade modifiers for functional history (GMFH 1)[19] and physical examination (GMPE 2),[20] and the net adjustment (1) resulted in a change from the default value of one percent (grade C) to four percent (grade D) permanent impairment of the right upper extremity.[21] Dr. Estaris explained that the ROM rating resulted in the greater percentage of permanent impairment than the DBI rating and, under the A.M.A., *Guides*, the method producing the higher rating must be used. He concluded that this resulted in 15 percent right upper extremity permanent impairment based upon the ROM rating method.

The Board finds that appellant has not established more than 15 percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

On appeal counsel contends that OWCP's October 12, 2018 decision is contrary to fact and law. For the foregoing reasons, the Board finds that the weight of the medical evidence establishes

[17] *Supra* note 14.

[18] *See S.R.*, Docket No. 18-1307 (issued March 27, 2019).

[19] A.M.A., *Guides* 406, Table 15-7.

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

[21] Net Adjustment (1) (GMFH 2 - CDX 1) + (GMPE 1 - CDX 1). *See* Section 16.3d, A.M.A., *Guides* 518-21 (6th ed. 2009).

that appellant had no more than 15 percent permanent impairment of her right upper extremity for which she received a schedule award.

Appellant may request a schedule award or an increased schedule award at any time based on evidence of a new exposure or medical evidence showing a progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than 15 percent permanent impairment of her right upper extremity for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the October 12, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 18, 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