United States Department of Labor
Employees' Compensation Appeals Board

D.M., Appellant	)	
and	)	**Docket No. 18-0985**
	)	**Issued: November 4, 2019**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Southeastern, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
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 April 16, 2018 appellant, through counsel, filed a timely appeal from a December 26, 2017 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 greater than four percent permanent impairment of the left upper extremity, for which she previously received a scheduled award.

FACTUAL HISTORY

This case has previously been before the Board.[3] 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 February 13, 2012 appellant, then a 45-year-old data collection technician, was involved in a motor vehicle accident while in the performance of duty. She filed a traumatic injury claim (Form CA-1) and OWCP subsequently accepted her claim for the conditions of left shoulder acromioclavicular sprain, left rotator cuff sprain, left shoulder adhesive capsulitis, neck sprain, and lumbosacral sprain. On November 29, 2012 appellant underwent OWCP-authorized left shoulder surgery.[4] OWCP paid her wage-loss compensation on the supplemental rolls through April 3, 2013, at which time she returned to work in a full-time, light limited-duty capacity.

On September 9, 2014 appellant filed a claim for a schedule award (Form CA-7). In support of her claim, she submitted a June 3, 2014 report by Dr. Nicholas P. Diamond, an attending osteopath specializing in neuromuscular medicine and pain management, who noted the history of injury, reviewed the medical record, and performed a physical examination. Dr. Diamond determined that due to range of motion (ROM) findings of flexion of 160 degrees and abduction of 140 degrees she had six percent upper extremity permanent impairment. He applied a grade modifier for functional history of 2, which after net adjustment resulted in six percent left upper extremity permanent impairment due to loss of shoulder ROM methodology under Table 15-34 on page 475 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5]

OWCP routed Dr. Diamond's report along with a copy of the medical record to Dr. Morley Slutsky, Board-certified in occupational medicine and serving as a district medical adviser (DMA). The DMA reviewed the claim on September 12, 2014 and found four percent left upper extremity permanent impairment utilizing the diagnosis-based impairment (DBI) methodology under the A.M.A., *Guides.* The four percent left upper extremity impairment rating was based on a diagnosis for residuals of a partial thickness rotator cuff tear under Table 15-5, Shoulder Regional Grid, on page 402 of the A.M.A., *Guides*.

[3] Docket No. 15-1304 (issued March 22, 2017).

[4] Dr. John A. Pasquella, an orthopedic surgeon specialist, performed an arthroscopic subacromial decompression, acromioplasty, and synovectomy.

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

By decision dated October 20, 2014, OWCP granted appellant a schedule award for four percent permanent impairment of the left upper extremity. The award covered a period of 12.48 weeks, from July 19 through October 14, 2013.

On December 17, 2014 appellant, through counsel, requested reconsideration.

By decision dated March 17, 2015, OWCP denied modification of its prior schedule award decision.

On May 22, 2015 appellant, through counsel, filed an appeal with the Board. By decision dated March 22, 2017, the Board set aside the March 17, 2015 decision.[6] 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 and further development of the medical evidence as to the extent of appellant's permanent impairment.

On July 28, 2017 OWCP referred appellant for an impartial medical examination to Dr. Andrew Gelman, a Board-certified orthopedic surgeon, to resolve a conflict between Dr. Diamond and the DMA regarding the extent of permanent impairment of the left upper extremity.

In a September 5, 2017 report, Dr. Gelman reviewed a statement of accepted facts (SOAF), a copy of the medical record, performed a physical evaluation of appellant, and utilized the A.M.A., *Guides*. He referred to Chapter 15, Section 15.1, to explain that "most impairment values for the upper extremity were calculated using the [DBI] method."[7] Dr. Gelman noted that this was further recognized in Section 15.2 which advised "[ROM] is used primarily as a physical examination adjustment factor and only to determine actual impairment values when a grid permits its use as an option."[8] Dr. Gelman concluded that he would rely on the preferred DBI method as opposed to the ROM methodology.

In performing his physical examination, Dr. Gelman noted that ROM measurements were recorded on multiple occasions allowing appellant to loosen up and with regards to measurements in accordance with the A.M.A., *Guides* methodology. He indicated that the measurements on the left varied. Dr. Gelman also indicated that he had taken the average with regard to the recorded measurements. Regarding the left side, he found active forward flexion of 140 degrees, abduction to 115 degrees, external rotation to 80 degrees, internal rotation to 50 degrees, extension of 65 degrees, and adduction of 50 degrees. Dr. Gelman explained that on multiple occasions with the average taken, the right-side measurements noted active forward flexion of 160 degrees, abduction of 135 degrees, external rotation to 85 degrees, internal rotation to 50 degrees, extension of 85 degrees, and adduction of 50 degrees. He advised that subtle differences on the right side were

[6] *See supra* note 3.

[7] A.M.A., *Guides* 385.

[8] *Id.* at 387.

noted and explained that appellant had better movement both on the asymptomatic right side and minimal with mild discomfort at the extremes on the left side.

Dr. Gelman found a class of diagnosis (CDX) of 1 as reflected in Table 15-5,[9] utilizing the diagnosis of impingement syndrome and/or partial thickness tear categories resulting in a default impairment of three percent. He advised that adjustment grid parameters would then apply and referenced Table 15-7 for functional history adjustment.[10] Dr. Gelman indicated that appellant had a grade modifier of 1 for functional history (GMFH). He also referred to Table 15-8, for a grade modifier of 1 for physical examination (GMPE). Dr. Gelman referred to Table 15-9,[11] for a grade modifier for clinical studies (GMCS) of 2. He calculated a net adjustment of plus 1 and explained that this would move the three percent default rating to four percent upper extremity permanent impairment.

Dr. Gelman noted that, if the ROM methodology was utilized, Table 15-34, Table 15-35, Table 15-36 would apply[12] and result in eight percent permanent impairment. However, with the right shoulder as baseline which was without deficits, this would then equate to a rating of zero percent which he opined would not appear to adequately address appellant's actual level of impairment. Dr. Gelman concluded that, as a result, he relied upon the DBI methodology and opined that appellant had four percent left upper extremity permanent impairment.[13]

By decision dated December 26, 2017, OWCP denied modification of the October 20, 2014 decision finding that the special weight of the evidence should be afforded to Dr. Gelman, as a referee examiner, as he had resolved the existing medical conflict.

LEGAL PRECEDENT

The schedule award provisions of FECA,[14] and its implementing federal regulations,[15] 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

[9] *Id.* at 402.

[10] *Id.* at 406.

[11] *Id.* at 410.

[12] A.M.A., *Guides* 475, 477.

[13] Dr. Gelman noted appellant's lumbar spine condition, but noted that he was not provided documentation to complete a rating of permanent impairment due to the lumbar conditions.

[14] 5 U.S.C. § 8107.

[15] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[16] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[17]

In determining 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. After the CDX is determined the net adjustment formula is applied using GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[18]

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.[19] 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 impairment rating for the diagnosis in question, the method producing the higher rating should be used.*"[20] (Emphasis in the original).

Section 8123(a) of FECA provides in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[21] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such

[16] *Id.* at 10.404(a).

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

[18] *See* A.M.A., *Guides* 411.

[19] 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).

[20] *Id*.

[21] 5 U.S.C. § 8123(a).

specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[22]

ANALYSIS

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

By decision dated March 22, 2017 the Board remanded the case to OWCP for consideration of appellant's permanent impairment following development of a consistent method for rating upper extremity permanent impairment under Chapter 15 of the A.M.A., *Guides*.

On remand OWCP found a conflict in the medical evidence and referred appellant to Dr. Gelman for a referee evaluation on the issue of permanent impairment. Following the referee evaluation, by decision dated December 26, 2017, OWCP found the special weight of the medical evidence was with the opinion of Dr. Gelman and affirmed the schedule award of four percent permanent impairment of the right upper extremity. The Board finds, however, that OWCP has not properly developed the medical evidence as ordered on remand. First, Dr. Gelman was improperly designated as a referee physician as there was no existing conflict at the time of the designation. The Board had already concluded that the record of evidence did not contain a medical opinion of any probative value on the issue of upper extremity permanent impairment. As the attending physician and the DMA were both found to have misapplied the A.M.A., *Guides*, no conflict could exist because the physicians' reports lacked probative value and thus there was no basis for finding a conflict in medical opinion.[23] Second, on remand OWCP was required to develop and then follow a procedure for a consistent application of the A.M.A., *Guides* for upper extremity impairment ratings. On May 8, 2017 FECA Bulletin No. 17-06 was issued. Following issuance of this Bulletin, OWCP was required to develop the medical evidence of record as to the extent of permanent impairment by following the new procedures. No such development occurred in this case.

The Board therefore finds that OWCP improperly developed the evidence as to upper extremity permanent impairment on remand from the Board's prior decision. The case is thus remanded for development of the medical evidence as to appellant's upper extremity permanent impairment by following the procedures set forth in FECA Bulletin No. 17-06, to be followed by a *de novo* decision.

CONCLUSION

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

[22] *L.L.*, Docket No. 19-0214 (issued May 23, 2019); *D.M.*, Docket No. 18-0476 (issued November 26, 2018); *R.H.*, 59 ECAB 382 (2008); *Raymond A. Fondots*, 53 ECAB 637, 641 (2002).

[23] *See J.H.*, Docket No. 18-1207 (issued June 20, 2019).

ORDER

IT IS HEREBY ORDERED THAT the December 26, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision of the Board.

Issued: November 4, 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