United States Department of Labor
Employees' Compensation Appeals Board

D.B., Appellant	)	
and	)	**Docket No. 18-0409**
	)	**Issued: October 28, 2019**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, Chicago, IL, Employer	)	

Appearances:
Steven W. Etzler, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On December 19, 2017 appellant, through counsel, filed a timely appeal from a July 18, 2017 merit decision of the Office of Workers' Compensation Programs. Pursuant to the Federal Employees' Compensation Act (FECA)[2] 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 greater than four percent impairment of her left upper extremity, for which she previously received a schedule 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 set forth below.

On September 20, 2005 appellant, then a 51-year-old transportation security screener, filed an occupational disease claim (Form CA-2) alleging that she had developed swelling of her left elbow and left shoulder pain due to factors of her federal employment including working in baggage screening. OWCP accepted her claim for left lateral epicondylitis of the elbow region and a left calcifying tendinitis of the shoulder on November 10, 2005.

On May 10, 2010 Dr. Aaron Anderson, a Board-certified orthopedic surgeon, submitted a two percent whole person permanent impairment rating.

In a letter dated May 20, 2010, Dr. Bharat Pithadia, Board-certified in orthopedic medicine, opined that appellant had not reached maximum medical improvement (MMI) and he was therefore unable to provide an impairment rating at that time.

On July 6, 2010 Dr. Pithadia noted that appellant had visited Dr. Anderson, who had attempted to calculate an impairment rating for her, but his report was lost. He opined that, from what he was told, that she was at MMI, but he would defer the impairment rating to Dr. Anderson.

On February 28, 2013 appellant filed a claim for a schedule award (Form CA-7).

With her request, appellant submitted a June 27, 2011 report from Dr. Michael J. Spence, Board-certified in physical medicine and rehabilitation. On examination of the shoulders Dr. Spence noted an active range of motion (ROM) of the left shoulder of 90 degrees with forward flexion, 90 degrees with abduction, 45 degrees with external rotation, and 60 degrees with internal rotation. Appellant's right shoulder active ROM was recorded as 100 degrees with forward flexion, 105 degrees with abduction, 60 degrees with external rotation, and 70 degrees with internal rotation. Both shoulders tested positive for impingement and tenderness at the acromioclavicular joint. Dr. Spence further noted an active ROM of the left elbow from 0 to 80 degrees. The active ROM of appellant's right elbow was from 0 to 100 degrees. Her bilateral elbow ROM was limited secondary to pain and tenderness at the common extensor origin. Dr. Spence opined that appellant had reached MMI on May 10, 2010 at the time of her examination by Dr. Anderson and that, using Table 15-34 on page 475 with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), he calculated that she had 12 percent left upper extremity permanent impairment using the ROM method.

[3] Docket No. 15-1348 (issued March 17, 2017).

Regarding appellant's elbow conditions, Dr. Spence utilized the ROM method found at Table 15-33 on page 474 of the A.M.A., *Guides* to find eight percent left upper extremity permanent impairment for her left elbow. With regard to her carpal tunnel condition, he utilized the ROM method found on Table 15-23, page 449 of the A.M.A., *Guides*, to find three percent left upper extremity permanent impairment. Dr. Spence found a rating of permanent impairment of the whole person.

OWCP forwarded the case record and a statement of accepted facts (SOAF) to a district medical adviser (DMA) on March 14, 2013. In a report dated June 29, 2013, Dr. Morley Slutsky, a Board-certified occupational medicine physician serving as a DMA, calculated a permanent impairment rating of three percent for the left elbow utilizing Dr. Spence's June 27, 2011 report, but he mistakenly based his calculation on the measurements for the right elbow.

On June 28, 2013 OWCP again forwarded the case record and the SOAF to the DMA for calculation of appellant's percentage of left elbow permanent impairment. On June 29, 2013 the DMA opined that she had reached MMI on June 27, 2011, which was the date of the evaluation by Dr. Spence. He calculated appellant's final left upper extremity permanent impairment as four percent, the sum of three percent impairment for the left shoulder and one percent impairment of the left elbow. The DMA noted that the diagnosis-based impairment (DBI) rating methodology was preferred under the sixth edition of the A.M.A., *Guides* and assigned left elbow lateral epicondylitis and left shoulder partial thickness rotator cuff tear with residual dysfunction as the most impairing diagnoses in the elbow and shoulder regions, respectively. In calculating the impairment rating for the left shoulder, he noted a grade modifier for functional history (GMFH) of 1, as there was no documented functional modification for self-care activities. The grade modifier for physical examination (GMPE) was also 1, as there was tenderness to palpation and positive impingement testing, but did not include ROM measurements as Dr. Spence documented only one motion per joint movement. There was no grade modifier for clinical studies (GMCS) as they were used to place appellant into the correct diagnosis class. The DMA found a final left upper extremity permanent impairment of three percent for the left shoulder diagnosis. In calculating the impairment rating for the left elbow, the DMA noted a GMPE of 1, noting tenderness to palpation, but he did not assign other grade modifiers. He explained that GMFH may be used only for the largest impairment in the extremity, which in this case was the shoulder, and that diagnostic studies were used to place appellant into the correct diagnosis. The DMA found a final left upper extremity permanent impairment rating of one percent of the left elbow diagnosis, which combined with the shoulder resulted in four percent permanent impairment of the left upper extremity.

By decision dated April 7, 2014, OWCP granted appellant a schedule award for four percent permanent impairment of her left upper extremity finding that the weight of the medical evidence was assigned to the opinion of the DMA as he had correctly applied the A.M.A., *Guides* to Dr. Spence's examination findings.

On September 17, 2014 appellant requested reconsideration.

In support of her request for reconsideration, appellant attached a letter from Dr. Spence dated June 2, 2014 in which he noted that he had reviewed the report of the DMA and disagreed with his refusal to apply the ROM method of rating permanent impairment of the upper extremities.

OWCP forwarded Dr. Spence's letter to the DMA on November 5, 2014, asking him to comment on whether it caused him to alter his prior impairment ratings. The DMA again noted that the DBI method was the preferred rating method, he questioned appellant's actual ROM deficits, he critiqued Dr. Spence's ROM testing, and he reiterated his prior final upper extremity impairment ratings.

By decision dated December 11, 2014, OWCP denied modification of its prior decision finding that appellant had not submitted sufficient medical evidence to establish a greater rating of permanent impairment.

On June 2, 2015 appellant, through counsel, filed a timely appeal with the Board.

By decision dated March 17, 2017, the Board set aside and remanded OWCP's December 11, 2014 decision. The Board found that, in light of conflicting interpretation by OWCP of the sixth edition of the A.M.A., *Guides*, with respect to upper extremity impairment ratings, it was incumbent on OWCP, through its implementing regulations and/or internal procedures, to establish a consistent method for rating such impairment.

Upon return of the case record, on June 21, 2017, OWCP forwarded a SOAF and appellant's case file to Dr. William Tontz, Jr., a Board-certified orthopedic surgeon serving as a DMA. It noted that the DMA should 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* identified a diagnosis that could alternatively be rated by the ROM method. OWCP explained that, if the A.M.A., *Guides* allowed 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. It further explained that, if the rating physician provided an assessment using the ROM method and the A.M.A., *Guides* allowed for the use of that method for the diagnosis in question, the DMA should independently calculate the impairment using both rating methods and to identify the higher rating.

In a report dated July 18, 2017, the DMA referenced the June 27, 2011 ROM measurements of Dr. Spence for appellant's left shoulder. He reasoned that because appellant had significantly diminished ROM in her left shoulder, the ROM method was the preferred methodology for calculating permanent impairment for her accepted left shoulder condition. The DMA noted that the June 27, 2011 examination also demonstrated significantly diminished ROM in appellant's left elbow. He opined that according to Table 15-5, page 403 of the A.M.A., *Guides*, and based on the examination, clinical history, and diagnostic studies, her impairment rating of the left shoulder would correspond to three percent upper extremity impairment and a grade D modifier for a total of three percent upper extremity permanent impairment of the left shoulder. He noted that under the same Table he found that for appellant's elbow, for lateral epicondylitis, a 1 percent rating with a grade C modifier. As such, the total left upper extremity impairment was four percent. The DMA assigned May 10, 2010 as the date appellant was at MMI.

By decision dated July 18, 2017, OWCP denied appellant's claim for an increased schedule award finding that the DMA's July 18, 2017 report correctly applied the A.M.A., *Guides* as to her permanent impairment for her accepted conditions.

LEGAL PRECEDENT

The schedule award provisions of FECA,[4] and its implementing federal regulations,[5] 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.[6] For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.[7]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers of GMFH, GMPE, and GMCS.[8] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9] OWCP procedures provide that, after obtaining all necessary medical evidence, that file should be routed to a DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of the permanent impairment specified.[10]

The A.M.A., *Guides* also provide that the ROM impairment method of calculating permanent functional impairment 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. 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.[11] 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.[12]

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id*. at § 10.404(a).

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); *id*. at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017).

[8] *L.T.*, Docket No. 18-1031 (issued March 5, 2019); A.M.A., *Guides*, 383-492.

[9] *Id*. at 411.

[10] *R.B.*, Docket No. 18-1308 (issued January 10, 2019); *P.R.*, Docket No. 18-0022 (issued April 9, 2018); *supra* note 7 at Chapter 2.808.6f (March 2017).

[11] A.M.A., *Guides* 473.

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

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).
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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*."[13] (Emphasis in the original.)
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> 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 rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence."[14]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[15]

ANALYSIS

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

Preliminarily, the Board notes that it is unnecessary for the Board to consider the evidence appellant submitted prior to the issuance of OWCP's December 11, 2014 decision because the

[13] 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).

[14] *Id*.

[15] *L.T., supra* note 8; *B.R.*, Docket No. 17-0294 (issued May 11, 2018).

Board considered that evidence in its March17, 2017 decision. Findings made in prior Board decisions are *res judicata* absent any further review by OWCP under section 8128 of FECA.[16]

On remand from the Board OWCP forwarded a copy of Dr. Spence's report, along with the medical file and a SOAF, to Dr. Tontz, serving as a DMA, who calculated appellant's permanent impairment under Table 15-5 of the A.M.A., *Guides* for the diagnosis of shoulder tendinitis. However, Dr. Tontz did not indicate which table was used to determine her percentage of permanent impairment due to her diagnosis of left lateral epicondylitis of the elbow region.

The Board notes that Table 15-5, the Shoulder Regional Grid, does allow, by asterisk, that tendinitis be alternatively evaluated by the ROM methodology.[17] Under FECA Bulletin No. 17-06, "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.]"

The Board finds that the DMA properly provided a rating utilizing the ROM method as allowed under Table 15-5 of the A.M.A., *Guides*, however, the DMA should have independently calculated appellant's impairment rating using both the ROM and DBI methods and identified the higher rating for OWCP. The Board finds that the DMA rating report of Dr. Tontz is deficient because it did not consider her left shoulder and left elbow permanent impairments under both rating methods followed by the selection of the higher impairment rating as mandated by FECA Bulletin No. 17-06.

The case will therefore be remanded for further development consistent with OWCP procedures found in FECA Bulletin No. 17-06.[18] Following this and such other development deemed necessary, OWCP shall issue an appropriate decision.

CONCLUSION

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

[16] *J.T.*, Docket No. 18-1757 (issued April 19, 2019).

[17] *See* A.M.A., *Guides* 402, Table 15-5. *See also B.N.*, Docket No. 17-1923 (issued April 17. 2018).

[18] The most recent physical examination findings of record are those of Dr. Spence from his examination of appellant on June 27, 2011. *See supra* note 7.

ORDER

IT IS HEREBY ORDERED THAT the July 18, 2017 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: October 28, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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