United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	**Docket No. 19-0483**
	)	**Issued: October 10, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Albany, NY, 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:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On January 2, 2019 appellant, through counsel, filed a timely appeal from a November 26, 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.

ISSUE

The issue is whether appellant has met his burden of proof to establish permanent impairment of his right upper extremity warranting a schedule award.

[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*.

FACTUAL HISTORY

On September 24, 1996 appellant, then a 38-year-old mail processing clerk, injured his neck and right upper extremity while in the performance of duty.[3] OWCP accepted his traumatic injury claim (Form CA-1) for right shoulder sprain and cervical radiculopathy.

On May 26, 2015 Dr. Frederick J. Fletcher, a Board-certified orthopedist, noted that appellant had reached maximum medical improvement (MMI).

On December 17, 2015 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated March 16, 2016, OWCP advised appellant of the deficiencies of his claim and requested that he submit an impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

By decision dated May 25, 2016, OWCP denied appellant's schedule award claim finding that the medical evidence of record was insufficient to establish permanent impairment of a scheduled member or function of the body.

On May 6, 2016 Dr. Fletcher indicated that his orthopedic group did not perform impairment rating evaluations.

On June 3, 2016 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative.

Appellant submitted a June 8, 2016 report from Dr. Stewart A. Kaufman, a Board-certified orthopedist, who diagnosed sprain of the cervical spine and sprain of the right shoulder. Dr. Kaufman opined that appellant had reached MMI on October 17, 2003. He provided an impairment evaluation in accordance with the sixth edition of the A.M.A., *Guides*.[5] Pursuant to Table 15-34, Shoulder Range of Motion, page 475 of the A.M.A., *Guides*, findings for the right shoulder flexion of 90 degrees for three percent impairment, extension of 30 degrees for one percent impairment, abduction of 65 degrees for six percent impairment, adduction of 30 degrees for one percent impairment, internal rotation of 40 degrees for four percent impairment, and external rotation of 55 degrees for two percent impairment. Dr. Kaufman noted that appellant's *Quick*DASH score was 72.5. He opined, utilizing the range of motion (ROM) method for rating permanent impairment that appellant had 17 percent permanent impairment of the right upper extremity in accordance with the A.M.A., *Guides*.

By decision dated November 16, 2016, an OWCP hearing representative vacated the May 25, 2016 decision and remanded the case for further medical development. She instructed

[3] Appellant was injured pulling a hamper full of magazines out of a machine.

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

[5] *Id*.

OWCP to refer appellant's case and Dr. Kaufman's report to an OWCP district medical adviser (DMA) to provide an assessment of appellant's permanent impairment in accordance with the A.M.A., *Guides*.

On February 13, 2017 Dr. James W. Butler, Board-certified in occupational and aerospace medicine and serving as a DMA, reviewed the medical evidence of record and indicated that he did not have sufficient information to make an informed decision. He specifically noted that he did not know what the shoulder or cervical spine injuries were, and he did not have electromyogram (EMG) results.

On March 28, 2017 OWCP referred appellant for a second opinion evaluation with Dr. Kevin Scott, a Board-certified orthopedic surgeon. In an April 12, 2017 report, Dr. Scott reviewed the medical record, a statement of accepted facts (SOAF), and a list of questions regarding appellant's permanent impairment. He related appellant's complaints of numbness and tingling into his hands and some shoulder pain. Appellant's physical examination of the right shoulder revealed abduction of 150 degrees, flexion of 150 degrees, internal rotation of 60 degrees, and external rotation of 60 degrees. With regard to his cervical spine he had 40 degrees of extension, 40 degrees of flexion, palpable tenderness along the cervical spine area, negative Spurling maneuver, and deep tendon reflexes of 2+ bilaterally at his elbow and wrist. Dr. Scott noted that MMI had occurred on April 12, 2017. He opined that he did not have enough information on the right shoulder, such as an operative report or a diagnosis from an imaging study, to provide a permanent impairment rating. Dr. Scott opined that pursuant to the A.M.A., *Guides* Chapter 17, Table 17-6 for Functional History Adjustment: Spine on page 575, Table 17-7 for Physical Examination Adjustment: Spine on page 576, and Table 17-9 for Clinical Studies Adjustment: Spine on page 581, appellant had six percent whole person impairment.

An EMG study dated May 17, 2017 revealed moderate-to-severe carpal tunnel syndrome on the right side, but no evidence of cervical impingement.

On June 1, 2017 appellant underwent a magnetic resonance imaging (MRI) scan of the cervical spine which revealed C4-5 left lateral recess and left neural foraminal stenosis, C5-6 right neural foraminal stenosis, and C6-7 mild left neural foraminal stenosis.

On July 20, 2017 OWCP requested that Dr. Scott provide a permanent impairment rating pursuant to Chapter 15 of the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*. It indicated that he provided a rating for whole person permanent impairment which was not accepted by OWCP. OWCP further requested that Dr. Scott note the documentation he would need to provide a rating for the right shoulder.

Appellant underwent right upper extremity MRI scan on September 13, 2017 which revealed: mild-to-moderate supraspinatus tendinopathy with multiple small partial articular surface tears of the distal tendon, likely chronic; mild infraspinatus tendinopathy with tiny interstitial tear along the distal tendon; small interstitial tear extending into the musculotendinous junction, likely chronic; mild subscapularis tendinopathy; proximal long head biceps tendinopathy with partial longitudinal interstitial tear, likely chronic; and mild-to-moderate osteoarthritis especially in the acromioclavicular joint.

In a report dated July 21, 2017, Dr. Scott indicated that his April 12, 2017 cervical examination and EMG findings revealed no evidence of nerve root impingement and no evidence of cervical radiculopathy. Therefore, the impairment rating for the cervical spine would be zero. With regard to the right shoulder, Dr. Scott referenced a September 13, 2017 MRI scan which revealed mild-to-moderate osteoarthritis of the acromioclavicular joint and glenohumeral joint, a partial tear of his infraspinatus, and supraspinatus tear of the longhead of the biceps. He rated appellant utilizing the diagnosis-based impairment (DBI) methodology under the A.M.A., *Guides* for arthritis utilizing Table 15-5 on page 405, and placed him into a class of diagnosis (CDX) 1 and assigned a grade modifier of 1 for functional history (GMFH), a grade modifier of 1 for physical examination (GMPE), and found a grade modifier of 2 for clinical studies (GMCS) which showed a partial tear of the rotator cuff. Using the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Scott calculated that appellant had a net adjustment of (1-1) + (1-1) + (2-1) = +1, equaling a grade D. Based on these calculations, he concluded that appellant had seven percent permanent impairment of the right upper extremity.

On November 17, 2017 OWCP requested that Dr. Scott provide clarification of his impairment rating, and specifically indicate whether there was a connection between the right shoulder sprain on September 24, 1996 and the MRI scan findings of September 13, 2017. It further requested that he provide an impairment rating pursuant to *The Guides Newsletter*.

In a second supplemental report dated November 22, 2017, Dr. Scott indicated that he had not been provided medical records for the initial injury on September 24, 1996 and therefore he could not comment on a connection between the most recent MRI scan of September 13, 2017 and the original injury. He further noted that using *The Guides Newsletter*, appellant had zero percent impairment. Dr. Scott advised that appellant's permanent impairment of the right upper extremity remained at seven percent.

On February 17, 2018 the DMA reviewed Dr. Scott's April 12, July 21, and November 22, 2017 reports. He disagreed with the determination of Dr. Scott. The DMA noted that there was no evidence of cervical radiculopathy on either the EMG findings or Dr. Scott's examination. Therefore, he opined that there would be no rating for an injury to the cervical spine. With regard to the right shoulder, a right shoulder MRI scan 21 years post-injury showed normal changes one would expect as part of the aging process. The DMA advised that there was nothing to show that appellant's right shoulder sprain had not resolved or that he experienced long-term residuals of the injury in 1996. He indicated that Dr. Scott's seven percent upper extremity impairment was based on arthritis, which was not a direct result of the sprain, and therefore his rating should be discounted. The DMA further reviewed the evaluation of Dr. Kaufman who assigned 17 percent impairment for loss of ROM of the right shoulder and determined that he too based his impairment rating on arthritic changes that could not be associated with the accepted sprain. He noted that a simple sprain/strain had resolved and would not cause problems 21 years later. The DMA found zero percent permanent impairment of the right upper extremity. He found the date of MMI to be in April 2005.

By decision dated March 28, 2018, OWCP denied appellant's schedule award claim.

On April 3, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review, which was held on September 12, 2018.

By decision dated November 26, 2018, the hearing representative affirmed the March 28, 2018 decision.

LEGAL PRECEDENT

The schedule award provisions 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 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.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment CDX condition, which is then adjusted by GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10] OWCP 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 permanent impairment specified.[11]

The A.M.A., *Guides* also provide that the 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.[12] 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 added.[13] Adjustments for functional history may be made if the evaluator

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id*. at § 10.404(a).

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

[10] A.M.A., *Guides* 411.

[11] *See P.R.*, Docket No. 18-0022 (issued April 9, 2018); Federal (FECA) Procedure Manual, *supra* note 9 at Chapter 2.808.6f (March 2017).

[12] A.M.A., *Guides* 461.

[13] *Id*. at 473.

determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[14]

Regarding the application of 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*."[15] (Emphasis in the original.)

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."[16]

Neither FECA nor its implementing regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[17] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[18] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment. It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the procedure manual.[19]

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

[14] *Id*. at 474.

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

[16] *Supra* note 15; *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G., id*.

[17] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b).

[18] Federal (FECA) Procedure Manual, *supra* note 9 at Chapter 2.808.5(c)(3) (March 2017).

[19] *Id*. at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.5, Exhibit 4 (January 2010).

of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[20]

ANALYSIS

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

OWCP accepted that appellant sustained a right shoulder sprain and cervical radiculopathy due to a September 24, 1996 employment injury. On December 17, 2015 appellant filed a claim for a schedule award.

Appellant submitted a June 8, 2016 report from Dr. Kaufman who diagnosed sprain of the cervical spine and sprain of the right shoulder. Dr. Kaufman provided findings on examination, including ROM measurements of the right shoulder. He determined that appellant had 17 percent permanent impairment of the right upper extremity pursuant to Table 15-34 of the A.M.A., *Guides*,[21] due to loss of ROM of the shoulder. However, the DMA opined that Dr. Kaufman's June 8, 2016 impairment rating of 17 percent permanent impairment of the right shoulder due to loss of ROM was based on arthritis and could not be associated with the accepted right shoulder sprain.

Similarly, OWCP referred appellant for a second opinion examination to Dr. Scott who in reports dated April 12, July 21, and November 22, 2017 diagnosed mild-to-moderate osteoarthritis of the acromioclavicular joint and glenohumeral joint and a partial tear of his infraspinatus, and supraspinatus tear of the longhead of the biceps. Dr. Scott noted findings on examination. He rated appellant utilizing the DBI methodology under the A.M.A., *Guides* for arthritis utilizing Table 15-5 on page 405. Dr. Scott calculated that appellant had seven percent permanent impairment of the right upper extremity. On February 17, 2018 the DMA evaluated the second opinion reports from Dr. Scott dated April 12, July 21, and November 22, 2017, and discounted Dr. Scott's evaluation as it was related to arthritis and not related to the accepted right shoulder sprain.

The Board finds that OWCP did not follow the procedures outlined in FECA Bulletin No. 17-06. As noted above, FECA Bulletin No. 17-06 provides detailed instructions for obtaining sufficient evidence to conduct a complete impairment evaluation.[22] It indicates that, if the rating physician provides an assessment using the ROM method, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating. FECA Bulletin No. 17-06 further provides that the evaluator should obtain three independent measurements for ROM and that the greatest measurement should be used to determine the extent of impairment.[23] FECA Bulletin No. 17-06 indicates that OWCP should instruct the physician to

[20] *See* Federal (FECA) Procedure Manual, *supra* note 9 at Chapter 2.808.6(f) (February 2013).

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

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

[23] *Id*.

obtain three independent measurements.[24] As OWCP did not follow the procedure set forth in the A.M.A., *Guides* and FECA Bulletin No. 17-06, the Board will remand the case for OWCP to further develop the ROM measurements of the upper extremity in accordance with the A.M.A., *Guides*. After it obtains the evidence necessary to complete the rating as described above, the case should be referred to the DMA to independently calculate using both ROM and DBI methods and identify the higher rating.[25] Following this and such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the November 26, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further proceedings consistent with this decision of the Board.

Issued: October 10, 2019
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

[24] *Id*.

[25] *See J.V.*, Docket No. 18-1052 (issued November 8, 2018); *M.C.*, Docket No. 18-0526 (issued September 11, 2018).