United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 18-0457**
	)	**Issued: September 18, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Brandon, FL, Employer	)	

Appearances:
William Hackney, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 2, 2018 appellant, through her representative, filed a timely appeal from a July 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.[3]

[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.*

[3] The Board notes that following the July 26, 2017 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met her burden of proof to establish more than 12 percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On April 21, 2015 appellant, then a 57-year-old sales and services distribution clerk, filed a traumatic injury claim (Form CA-1) alleging that she sustained left shoulder, neck, and upper chest injuries on April 21, 2015 as a result of jacking up a pallet while in the performance of duty. By decision dated November 24, 2015, OWCP accepted her claim for aggravation of internal derangement of the left shoulder, aggravation of impingement syndrome of the left shoulder, aggravation of rotator cuff syndrome of the left shoulder, aggravation of cervical disc syndrome with radiculopathy, aggravation of herniated discs at C2-5, aggravation of cervical degenerative disc disease, and aggravation of radiculopathy into the upper extremities.

On September 15, 2016 appellant filed a claim for a schedule award (Form CA-7).

In a July 5, 2016 report, Dr. Samy F. Bishai, a Board-certified orthopedic surgeon, reviewed appellant's medical record, noted her history of injury, and performed a physical examination for purposes of providing an impairment rating pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] He determined that appellant reached maximum medical improvement (MMI) as of July 5, 2016. For her left shoulder conditions, Dr. Bishai concluded that the range of motion (ROM) methodology for rating permanent impairment, as set forth in Table 15-34[5] was proper because appellant's markedly reduced ROM was her main disability as far as the function of her left shoulder was concerned and that the diagnosis-based impairment (DBI) methodology was inappropriate since it would not take into consideration the markedly reduced ROM of appellant's left shoulder joint. He measured appellant's left shoulder and found 75 degrees flexion which equaled nine percent permanent impairment, 15 degrees extension which equaled two percent, 75 degrees abduction which equaled six percent, 15 degrees adduction which equaled one percent, internal rotation which equaled 2 percent, and 45 degrees external rotation which equaled two percent permanent impairment. Dr. Bishai calculated that appellant therefore had 24 percent permanent impairment of the left upper extremity.

Dr. Bishai also provided a permanent impairment rating of appellant's cervical condition of radiculopathy of the C5 nerve root on her left side. He utilized Table 1 in *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*).[6] He found that appellant had a class of diagnosis (CDX) of 2 based on Table 17-2[7] and assigned a grade modifier of 2 for functional history (GMFH) because appellant had

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

[5] *Id*. at 475.

[6] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 Exhibit 1 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[7] *Id*. at 564.

pain and symptoms with normal activities, a grade modifier of 2 for physical examination (GMPE) based on observable sensory and motor deficits, and found that a grade modifier for clinical studies (GMCS) was not useable. Using the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Bishai calculated that appellant had a net adjustment of (2-2) + (2-2) + (n/a) = zero, equaling a default grade C. Using Table 1 of *The Guides Newsletter*, he further determined that appellant had a moderate sensory deficit at grade C, which equaled two percent permanent impairment and a moderate motor deficit at grade C, which equaled 9 percent permanent impairment, totaling an 11 percent left upper extremity impairment. Based on these calculations, Dr. Bishai used the Combined Values Chart in the A.M.A., *Guides* to find a combined 32 percent permanent impairment of appellant's left upper extremity -- 24 percent for her left shoulder conditions and 11 percent for cervical radiculopathy.

In a September 29, 2016 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), reviewed the medical evidence of record and found multiple reasons that Dr. Bishai's impairment evaluation could not be considered probative for the purpose of assigning permanent impairment. He observed that Dr. Bishai's report lacked sufficient detail to permit the calculation of an impairment rating on the basis of a records review. The DMA provided an opinion that Dr. Bishai had improperly assigned a CDX of 2 for each spinal nerve when a CDX of 1 was available under Table 1 and Table 2 in *The Guides Newsletter* and he explained that this mistake was compounded by assignment of a GMFH of 2 and a GMPE of 2, which produced a net adjustment of zero, when with a CDX of 1 would have been +2 for 1E impairment. He further explained that under Table 1 in *The Guides Newsletter*, the combined sensory and motor impairment is limited to nine percent upper extremity impairment for a single level. The DMA explained that Dr. Bishai had improperly determined combined motor and sensory impairment of 11 percent upper extremity impairment and this cervical spinal nerve impairment exceeded the maximum acceptable value under Table 1. With respect to the left shoulder, he found that Dr. Bishai documented "normal" baseline measurements of ROM to be 150 degrees flexion, 150 degrees abduction, 40 degrees adduction, 90 degrees external rotation, and 40 degrees internal rotation. The DMA explained that pursuant to the A.M.A., *Guides*, page 461, the baseline values (contralateral) shoulder have been subtracted from the injured shoulder's values to determine the actual impairment. In appellant's case, he found that the baseline impairment totaled 11 percent, which would have reduced the actual permanent impairment of the left shoulder from 24 percent to 13 percent. The DMA recommended a second opinion examination to determine the nature and extent of appellant's permanent impairment.

OWCP referred appellant to Dr. William Dinenberg, a Board-certified orthopedic surgeon, for a second opinion examination. In his January 30, 2017 report, Dr. Dinenberg indicated that appellant had been unable to complete an electromyography and nerve conduction velocity (EMG/NCV) study of her bilateral upper extremities and this would be prescribed to help provide an impairment rating for her cervical spine under *The Guides Newsletter*. He opined that without the diagnostic studies he was unable to provide an impairment rating related to appellant's cervical spine condition. Regarding appellant's left shoulder condition, Dr. Dinenberg found that she restricted her ROM secondary to pain and "it may not represent the true endpoint" of her ROM. He obtained active ROM of forward flexion of 70 degrees equaling nine percent permanent impairment, extension of 50 degrees equaling zero percent, external rotation of 70 degrees equaling zero percent, internal rotation of 20 degrees equaling four percent, abduction of 80 degrees equaling six percent, and adduction of 20 degrees equaling one percent permanent impairment. Dr. Dinenberg calculated a total of 20 percent permanent impairment of the left

shoulder secondary to her ROM deficit. He determined that appellant had reached MMI as of January 26, 2017, the date of the second opinion examination.

On May 24, 2017 the DMA, Dr. Katz, reviewed the medical record and found that while Dr. Dinenberg performed the correct method of measurement (three trials of each measurement), he had not listed the motion impairment of the contralateral shoulder as required by the A.M.A., *Guides* to serve as the "normal" baseline value. He therefore found that, referencing Dr. Bishai's July 5, 2016 report, the calculated motion impairment of the right (contralateral) shoulder totaled 11 percent per Table 15-34, equating a net impairment for the left shoulder of nine percent. Upon review of the two impairment records, the DMA opined that Dr. Dinenberg had correctly referenced Table 15-34 for a stand-alone ROM rating. He noted that the ROM impairment of nine percent exceeded the highest available DBI impairment under Table 15-5 for appellant's accepted conditions. The DMA further noted that Dr. Dinenberg declined to render an opinion regarding spinal nerve impairment for the left upper extremity. Dr. Katz, however, found that his review of the records, including the fact that Dr. Dinenberg demonstrated no motor weakness in the upper extremities and some loss of sensation in the left upper extremity, appellant's impairment could be calculated using Table 1 of *The Guides Newsletter* for mild sensory deficits in the C6 and C7 distribution as reflected in Dr. Dinenberg's sensory examination. Regarding appellant's C6 condition, he found that appellant had a CDX of 1 and concurred with Dr. Dinenberg's GMFH of 2 and that GMPE and GMCS were inapplicable because there was no motor deficit. Using the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), the DMA calculated a net adjustment of (2-1) + (n/a) + (n/a) = +1, equaling a class 1, grade D impairment. Based on these calculations, he concluded that appellant had two percent permanent impairment of the left upper extremity related to her spinal nerve condition at C6. Regarding appellant's C7 condition, the DMA found that appellant had a CDX of 1 and concurred with Dr. Dinenberg's GMFH of 2 and that GMPE and GMCS were inapplicable because there was no motor deficit. Using the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), he calculated a net adjustment of (2-1) + (n/a) + (n/a) = +1, equaling a class 1, grade D impairment. Based on these calculations, the DMA concluded that appellant had one percent permanent impairment of the left upper extremity related to her spinal nerve condition at C7. He concluded that appellant's total spinal nerve impairment was 3 percent and her total left upper extremity impairment was 9 percent, equating to a combined 12 percent permanent impairment of the left upper extremity.

In a June 14, 2017 report, Dr. Bishai disagreed with the permanent impairment calculations of Dr. Dinenberg and the DMA. He opined that his impairment rating of 32 percent permanent impairment of the left upper extremity was based on a comprehensive and thorough examination of appellant's neck and radiculopathy which was more severe on the left side.

By decision dated July 26, 2017, OWCP granted appellant a schedule award for 12 percent permanent impairment of the left upper extremity giving the weight to the reports of Dr. Dinenberg and the DMA. The award ran for 37.44 weeks for the period January 26 to October 15, 2017.

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 and the Board has concurred in such adoption.[10] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[11]

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility to see that justice is done.[12] The nonadversarial nature of proceedings under FECA is reflected in OWCP's regulations at section 10.121.[13] Once OWCP undertakes development of the record, it must procure medical evidence that will resolve the relevant issues in the case.[14]

With respect to upper extremity permanent impairment, the A.M.A., *Guides* provide that the ROM impairment method is to be used as a stand-alone rating when other regional grids direct its use or when no other diagnosis-based sections are applicable.[15] 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.[16] Adjustments for GMFH 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.[17]

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id*. at § 10.404(a); *see also Bernard A. Babcock, Jr*., 52 ECAB 143 (2000).

[11] *See D.T.*, Docket No. 12-0503 (issued August 21, 2012); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[12] *K.S.*, Docket No. 18-0845 (issued October 26, 2018); *John J. Carlone*, 41 ECAB 354 (1989).

[13] *See C.F.*, Docket No. 18-1607 (issued March 12, 2019); 20 C.F.R. § 10.121.

[14] *See K.G.*, Docket No. 17-0821 (issued May 9, 2018).

[15] *Supra* note 11 at 461.

[16] *Id.* at 473.

[17] *Id.* at 474.

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating upper extremity impairments.[18] 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).
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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*." (Emphasis in the original.)[19]

The Bulletin further advises:

> "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.[20]
>
> "If the original impairment rating found by the DMA to be insufficient was provided from a second opinion or referee physician (*versus* the claimant's physician), the CE should request a supplemental/clarification report from the second opinion or referee physician to address the medical evidence necessary to complete the impairment assessment. Medical evidence received in response to this request should then be routed back to the DMA for a final determination. The CE should not render a decision on the schedule award impairment rating until the necessary medical evidence has been obtained."[21]

ANALYSIS

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

Appellant's claim has been accepted for left shoulder and cervical spine conditions. In support of her claim for a schedule award, she submitted a rating report by Dr. Bishai dated July 5, 2016 in which he used the ROM methodology to find 24 percent permanent impairment of the left

[18] FECA Bulletin No. 17-06, which was effective for all decisions issued by OWCP on and after May 8, 2017.

[19] *Id.*

[20] *Id.*

[21] *Id.*

upper extremity for the accepted left shoulder conditions. Utilizing *The Guides Newsletter* he also calculated an 11 percent left upper extremity impairment for the accepted cervical conditions. Dr. Bishai used the Combined Values Chart in the A.M.A., *Guides* to find a combined 32 percent permanent impairment of appellant's left upper extremity.

OWCP referred Dr. Bishai's July 5, 2016 report to a DMA, Dr. Katz, who noted his areas of disagreement with the impairment rating report. The DMA noted that he could not provide a ROM impairment rating as Dr. Bishai's ROM measurements were "insufficient" for rating purposes. He utilized the remaining physical examination findings of Dr. Bishai to calculate 13 percent left upper extremity permanent impairment under the DBI method. The DMA recommended a second opinion examination to determine the nature and extent of appellant's permanent impairment.

In a January 30, 2017 second opinion report, Dr. Dinenberg indicated that appellant had been unable to complete an EMG/NCV study and that without the diagnostic studies he was unable to provide an impairment rating related to appellant's cervical spine condition. Regarding appellant's left shoulder condition, he found that she restricted her ROM secondary to pain and "it may not represent the true endpoint" of her ROM. Using the ROM methodology he calculated 20 percent of the left upper extremity for left shoulder.

On May 24, 2017 the DMA, Dr. Katz, reviewed the medical record and noted the deficiencies in the reports of both Dr. Bishai and Dr. Dinenberg and provided his own rating calculations to find 13 percent left upper extremity permanent impairment.

OWCP had properly routed the attending physician's impairment rating report to a DMA for review. The DMA determined that Dr. Bishai had not performed upper extremity ratings under both the ROM and DBI methods, instead he merely noted that the ROM findings would be higher and performed such a rating calculation. Upon his review, the DMA found Dr. Bishai's ROM measurements were insufficient for rating purposes. Although he determined that the attending physician had not properly documented ROM measurements, the missing information was not requested from Dr. Bishai to allow him the opportunity to cure the deficiency.[22] Instead, the DMA recommended a second opinion examination. In the subsequent second opinion examination report Dr. Dinenberg did not provide ratings under both the ROM and DBI methods to determine the method providing the higher rating, and he failed to provide a rating of permanent impairment of the cervical spine conditions. Although these deficiencies were noted in the DMA's review of Dr. Dinenberg's report, no further information was requested by OWCP to cure these deficiencies.

The Board finds that the medical record with regard to the extent of appellant's permanent impairment requires further development consistent with FECA Bulletin No. 17-06 as both Dr. Bishai and Dr. Dinenberg failed to calculate permanent impairment under both the ROM and DBI rating methods to determine which method produced the higher rating. Additionally, when deficiencies in the medical record were noted by the DMA -- including the deficient ROM findings by Dr. Bishai and the lack of diagnostic testing and lack of cervical spine rating by Dr. Dinenberg -- the information was not requested from the physicians to provide an opportunity to cure the deficiencies identified by the DMA.

[22] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (February 2013); *see also* Chapter 2.808.6(f)(2)(c) (February 2013).

This case will therefore be remanded to OWCP 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

ORDER

IT IS HEREBY ORDERED THAT the July 26, 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: September 18, 2019
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board