United States Department of Labor
Employees' Compensation Appeals Board

J.D., Appellant	)	
and	)	**Docket No. 19-0527**
	)	**Issued: September 5, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Prescott, AZ, Employer	)	

Appearances:
Appellant, pro se
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 January 3, 2019 appellant filed a timely appeal from an August 7, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the August 7, 2018 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 additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met her burden of proof to establish more than 30 percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On May 5, 2000 appellant, then a 57-year-old rural mail carrier, filed a traumatic injury claim (Form CA-1) alleging that on that day she sustained a right shoulder injury when delivering mail to a broken mailbox that she caught before it fell while in the performance of duty. She returned to limited duty on May 6, 2000. OWCP accepted the claim for right shoulder strain, right rotator cuff tear, and other affections of the right shoulder region, and paid wage-loss compensation benefits. Appellant underwent OWCP-authorized surgical procedures of the right shoulder on August 15, 2000 and November 27, 2001.[3]

By decision dated October 29, 2010, OWCP granted appellant a schedule award for 22 percent permanent impairment of the right upper extremity. The award ran for 68.64 weeks for the period September 24, 2009 to January 17, 2011.

On March 17, 2018 appellant filed a claim (Form CA-7) for an increased schedule award. In support of her claim, she submitted a March 12, 2018 report from Dr. Delbert M. Maddox, an osteopath specializing in orthopedic surgery. Dr. Maddox indicated that appellant had a permanent right shoulder condition, but noted that he did not have a copy of her final medical evaluation.

On April 12, 2018 OWCP referred appellant to Dr. Michael A. Steingart, an osteopath Board-certified in orthopedic surgery, for a second opinion evaluation regarding permanent impairment of her right upper extremity. In an April 27, 2018 report, Dr. Steingart discussed her medical history, provided physical examination findings, and determined that maximum medical impairment (MMI) was reached on December 11, 2009. To determine the degree of impairment, he utilized the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] Dr. Steingart calculated seven percent permanent impairment under the diagnosis-based impairment (DBI) methodology. Under Table 15-5, Shoulder Regional Grid, of the A.M.A., *Guides*,[5] he assigned class 1 full thickness rotator cuff tear with a default value of five percent. Dr. Steingart assigned a grade modifier for functional history (GMFH) of 4 under Table 15-7[6] based on appellant's *Quick*DASH score of 87, a grade modifier for physical examination (GMPE) of 4 under Table 15-8[7] due to limb atrophy, and a grade modifier

[3] The August 15, 2000 right shoulder surgery involved an arthroscopy, open rotator cuff repair, and open Mumford procedure and a subacromioplasty. The November 27, 2001 right shoulder procedure involved arthroscopic debridement and lysis of adhesions, as well as repair of the right rotator cuff.

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

[5] *Id.* at 403.

[6] *Id.* at 406.

[7] *Id.* at 408.

for clinical studies (GMCS) of 4 under Table 15-9[8] based on severe radiculopathy. He indicated that this resulted in seven percent permanent impairment. However, Dr. Steingart opined that the DBI methodology was not the appropriate indicator for appellant's impairment due to her loss of shoulder motion.

Dr. Steingart also provided range of motion (ROM) findings based on three measurements and calculated 38 percent right upper extremity permanent impairment under the ROM methodology. Under Table 15-34,[9] shoulder ROM, he found that 70 degrees of flexion yielded nine percent impairment, 10 degrees of extension yielded two percent permanent impairment, 80 degrees of abduction yielded six percent impairment, 10 degrees of adduction yielded two percent impairment, 20 degrees of internal rotation yielded eight percent impairment, and 20 degrees of external rotation yielded nine percent impairment. Dr. Steingart combined those impairment ratings to conclude that appellant had 36 percent permanent impairment of the right upper extremity. He then found that, under Table 15-36,[10] a functional history grade adjustment was necessary as the GMFH compared to the ROM International Classification of Functioning, Disability and Health (ICF) class was 1 higher. Dr. Steingart calculated that the total ROM loss was 36 x 5 percent or 1.8, which rounded up to 2. He then added the 36 percent permanent impairment to the 2 percent functional history grade adjustment for a total right upper extremity permanent impairment of 38 percent. Dr. Steingart opined that the ROM methodology should be used as it provided the higher impairment rating.

On May 23, 2018 OWCP routed Dr. Steingart's report, a statement of accepted facts, and the case file to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for review to determine whether appellant sustained additional permanent impairment in accordance with the A.M.A., *Guides* and the date of MMI.

In a May 29, 2018 report, Dr. Harris, the DMA, reviewed the medical evidence of record and determined that MMI was reached on April 27, 2018, the date of Dr. Steingart's report. He reported that under the DBI methodology appellant had 12 percent upper extremity permanent impairment. The DMA indicated that under Table 15-5, the impairment resulted from her "having undergone arthroscopic surgery including excision of distal clavicle." He noted that appellant had documented motion loss of the right shoulder and that Table 15-5 allowed for impairment to be alternatively assessed under section 15.7, ROM impairment. The DMA used Dr. Steingart's impairment findings and found, under Table 15-34, that she had 27 percent upper extremity permanent impairment based on the ROM methodology. He indicated that any discrepancies between his calculations and Dr. Steingart's was due to misapplication of the impairment values under Table 15-34, specifically noting difference in impairment values provided by Dr. Steingart for external and internal rotation of the shoulders. The DMA found that 70 degrees of flexion yielded nine percent impairment, 10 degrees of extension yielded two percent permanent impairment, 80 degrees of abduction yielded eight percent impairment, 10 degrees of adduction yielded two percent impairment, 20 degrees of internal rotation yielded four percent impairment,

[8] *Id.* at 410.

[9] *Id*. at 475.

[10] *Id.* at 477.

and 20 degrees of external rotation yielded two percent impairment for a combined 27 percent permanent impairment. Under Table 15-36,[11] he opined that appellant had an additional three percent permanent impairment as she had greater functional loss than one would normally expect for this loss of motion. The DMA concluded that she had 30 percent total right upper extremity permanent impairment, based on the ROM methodology which yielded the greatest impairment.

By decision dated August 7, 2018, OWCP granted appellant an increased schedule award of 8 percent, for a total right upper extremity permanent impairment of 30 percent. It determined that the DMA's opinion represented the weight of the medical evidence and established that she had a total right upper extremity permanent impairment of 30 percent. As appellant had previously received a schedule award for 22 percent permanent impairment of the right upper extremity, she was entitled to an additional schedule award of 8 percent. The increased award ran for 24.96 weeks for the period April 27 to October 18, 2018.

LEGAL PRECEDENT

The schedule award provisions of FECA[12] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[13] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides,* published in 2009.[14]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's ICF.[15] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by GMFH, GMPE, and GMCS.[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[17]

[11] *Id*.

[12] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[13] *D.S.*, Docket No. 18-1816 (issued June 20, 2019); *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000). *See also* 5 U.S.C. § 8107.

[14] *D.T.*, Docket No. 12-0503 (issued August 21, 2012); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[15] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, ICF: A Contemporary Model of Disablement.

[16] *Id.* at 383-492.

[17] *D.S., supra* note 13; *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

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 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.)"[18]

The Bulletin further advises that 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.[19]

ANALYSIS

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

Appellant's treating physician, Dr. Steingart, found that she had 38 percent permanent impairment of the right upper extremity. Under Table 15-34, Shoulder ROM, he found that 70 degrees of flexion yielded nine percent impairment, 10 degrees of extension yielded two percent permanent impairment, 80 degrees of abduction yielded six percent impairment, 10 degrees of adduction yielded two percent impairment, 20 degrees of internal rotation yielded eight percent impairment, and 20 degrees of external rotation yielded nine percent impairment. Dr. Steingart combined those impairment ratings to conclude that appellant had 36 percent permanent impairment of the right upper extremity. He then found that, under Table 15-36, a functional history grade adjustment was necessary, which he calculated as two percent.

Consistent with its procedures,[20] OWCP referred the matter to a DMA for an opinion regarding appellant's permanent impairment in accordance with the A.M.A., *Guides*. In a May 29, 2018 report, Dr. Harris, the DMA, utilized the physical examination findings provided by Dr. Steingart in his April 27, 2018 report and provided impairment calculations. He concurred with Dr. Steingart that the ROM methodology yielded the highest result. Under the ROM

[18] FECA Bulletin No. 17-06 (issued May 8, 2017; *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

[19] *Id.*

[20] *See* Federal (FECA) Procedure Manual, *supra* note 14 at Chapter 2.808.6(f) (February 2013).

methodology the DMA calculated 30 percent permanent impairment of the right upper extremity. Under Table 15-34, he found that appellant had 27 percent upper extremity permanent impairment based on the ROM methodology. The DMA found that 70 degrees of flexion yielded 9 percent impairment, 10 degrees of extension yielded 2 percent permanent impairment, 80 degrees of abduction yielded 8 percent impairment, 10 degrees of adduction yielded 2 percent impairment, 20 degrees of internal rotation yielded 4 percent impairment, and 20 degrees of external rotation yielded 2 percent impairment for a combined 27 percent permanent impairment. Under Table 15-36, he determined that appellant had an additional 3 percent permanent impairment for a total of 30 percent right upper extremity permanent impairment.

The Board finds that neither Dr. Steingart nor the DMA have properly calculated appellant's permanent impairment. The primary diversion in the physicians' application of Table 15-34 relates to a rating for shoulder external rotation. Dr. Steingart measured appellant's external ROM at 20 degrees. He determined that external rotation of 20 degrees was nine percent impairment, while the DMA determined that it was two percent. The Board observes that the Table 15-34 for shoulder ROM external rotation does not easily comport with the identification of the appropriate impairment rating. Neither physician explained how the ratings of 9 percent (greater than or equal to 60 degrees internal rotation) and 2 percent (50 degrees external rotation to 30 percent internal rotation) were found in Table 15-34, or noted the proper application of Table 15-34 for this measurement. Additionally, utilizing the Combined Values Chart, Appendix A, pages 604 and 605, the Board is unable to determine how the ROM measurements as applied in Table 15-34 equate to the final ratings of either Dr. Steingart or the DMA.

Therefore, the Board finds that neither rating of record is sufficiently rationalized to support a final permanent impairment rating. OWCP procedures provide that, following a consult with a DMA as to the extent of permanent impairment, if there is insufficient medical evidence to make a decision on the rating of impairment, a referral to a second opinion specialist should be made.[21]

The Board will therefore remand the case to OWCP for referral to a second opinion physician to further develop the medical evidence as to the extent of appellant's right upper extremity permanent impairment. OWCP shall specifically request that the physician provide detailed medical rationale as to the application of Table 15-34 to a measurement of 20 percent external rotation, explaining how the Table assigns the proper impairment value. It shall also specifically request that the second opinion physician explain the final upper extremity impairment rating following application of the Combined Values Chart. Following this and any further development as is deemed necessary, OWCP shall issue a *de novo* decision.

[21] *See* Federal (FECA) Procedure Manual, *supra* note 14 at Chapter 2.810.9(b)(6) (September 2010).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the August 7, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: September 5, 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