United States Department of Labor
Employees' Compensation Appeals Board

K.S., Appellant	)	
	)	**Docket No. 20-1397**
and	)	**Issued: March 19, 2021**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Maricopa, AZ, 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:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 20, 2020 appellant filed a timely appeal from a June 2, 2020 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 permanent impairment of her left upper extremity, warranting a schedule award.

FACTUAL HISTORY

This case has previously been before the Board on a different issue.[3] The facts and circumstances of the case as set forth in the Board's decision are incorporated herein by reference. The relevant facts are as follows.

On October 18, 2011 appellant, then a 40-year-old rural mail carrier, filed an occupational disease claim (Form CA-2) alleging that sometime before December 1, 2011, she suffered left elbow and shoulder pain due to repetitive upper extremity motions while casing and delivering mail. OWCP accepted the claim under File No. xxxxxx173 for sprains of the left rotator cuff, shoulder, and upper arm.[4]

On May 16, 2012 Dr. Peter Seipel, an attending Board-certified orthopedic surgeon, performed an authorized arthroscopic debridement of a left rotator cuff tendon tear with arthroscopic subacromial decompression.

On August 30, 2017 appellant filed a schedule award claim (Form CA-7). In support of her claim, she submitted a July 12, 2017 report by Dr. Thomas L. Erickson, a Board-certified orthopedic surgeon, who noted that appellant's left shoulder condition spontaneously worsened in January 2017 with no specific injury. Appellant had not been treated for the left shoulder from April 2013 through June 16, 2017. On examination of the left shoulder, Dr. Erickson found elevation limited to 90 degrees, external rotation at 60 degrees, tenderness to palpation of the subacromial space and acromioclavicular joint, and pain with impingement maneuvers. He reviewed a magnetic resonance imaging (MRI) scan, which demonstrated slight spurring of the anterior acromion without rotator cuff impingement, significant arthritic changes at the acromioclavicular joint, and no visible rotator cuff tears.[5]

In a development letter dated September 21, 2017, OWCP advised appellant of the evidence needed to establish her schedule award claim, including a statement from her attending physician confirming that the relevant conditions had attained maximum medical improvement (MMI), and providing a permanent impairment rating according to the appropriate criteria and tables of the sixth edition of the American Medical Association, *Guides to the Evaluation of*

[3] Docket No. 18-0954 (issued February 26, 2019).

[4] On March 27, 2017 appellant filed an occupational disease claim (Form CA-2) alleging that, sometime prior to January 27, 2017, she sustained a left rotator cuff tear, left shoulder impingement syndrome, bursitis, and tendinitis. OWCP assigned that claim OWCP File No. xxxxxx805. OWCP administratively combined File Nos. xxxxxx805 and xxxxxx173, with the latter serving as the master file.

[5] Appellant also provided an August 15, 2017 report from Scott McMillan, a physician assistant, regarding a fracture of the left fifth metacarpal.

Permanent Impairment (A.M.A., *Guides*).[6] OWCP afforded appellant 30 days to submit the necessary evidence. At counsel's request, in a letter dated October 11, 2017, OWCP allowed appellant an additional 30 days to provide the requested evidence.

In response, appellant submitted a November 28, 2017 report by Dr. Michael P. Ridge, a Board-certified internist, diagnosing a complete non-traumatic rupture of the left rotator cuff. Dr. Ridge administered an injection to the left shoulder.

By decision dated December 21, 2017, OWCP denied the schedule award claim.

On January 5, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. She submitted a December 13, 2017 impairment rating by Dr. Mesfin Seyoum, a Board-certified family practitioner. Dr. Seyoum summarized a history of injury and treatment and reviewed medical records. He related appellant's complaints of chronic, severe left shoulder pain, increased with overhead reaching, heavy lifting, outstretching, and mopping. Dr. Seyoum noted a Pain Disability Questionnaire (PDQ) score of 102, indicative of severe pain-related impairment, and an upper limb *Quick*DASH score of 61, indicative of a severe problem. On examination of the left shoulder, he noted moderate tenderness to palpation, no muscle atrophy, and well-healed arthroscopic portals. Dr. Seyoum noted the following range of left shoulder motion based on the highest of three trials: 130 degrees flexion; 40 degrees extension; 90 degrees abduction; 40 degrees adduction; 80 degrees internal rotation; and 40 degrees external rotation. He opined that MRI scans of the left shoulder obtained on April 17, 2013 and April 11, 2017 demonstrated degenerative acromioclavicular changes without a partial or full-thickness rotator cuff tear. Dr. Seyoum diagnosed a left rotator cuff strain, status-post rotator cuff debridement and arthroscopic subacromial decompression, and acromioclavicular osteoarthritis based on imaging studies. He opined that appellant had attained MMI in February 2017 when last examined by Dr. Ridge. Dr. Seyoum referred to the A.M.A., *Guides* and utilized the diagnosis-based impairment (DBI) rating method to find that, under Table 15-5 (Shoulder Regional Grid: Upper Extremity Impairments), page 402, the class of diagnosis (CDX) for left shoulder tendinitis with residual loss resulted in a class 1 impairment, grade C, with a default value of three percent. Dr. Seyoum assigned a grade modifier for functional history (GMFH) of 4 due to a *Quick*DASH score of 61. He assigned a grade modifier for physical examination (GMPE) of 1 due to moderate palpatory findings and reduced left shoulder range of motion. Dr. Seyoum found that appellant had a grade modifier for clinical studies (GMCS) of 1 as she had positive findings on MRI scans. He utilized the net adjustment formula (GMFH-CDX) + (GMPE – CDX) + (GMCS – CDX) = (4-1) + (1-1) + (1-1) = +3, which resulted in a grade E (maximum), equaling five percent permanent impairment of the left upper extremity.

Dr. Seyoum also calculated an impairment rating based on the range of motion (ROM) rating method. He found that according to Table 15-34 (Shoulder Range of Motion), page 475, appellant had three percent impairment due to left shoulder flexion at 130 degrees, one percent for left shoulder extension limited to 40 degrees, three percent left upper extremity impairment due to shoulder abduction limited to 90 degrees, and two percent due to left shoulder external rotation at 40 degrees. Dr. Seyoum totaled these impairments to equal nine percent permanent impairment

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

of the left upper extremity based on loss of range of shoulder motion. He found a range of motion impairment of 1 due to a nine percent upper extremity impairment based on restricted motion, a GMFH of based on a *Quick*DASH score of six. Applying the net adjustment formula, Dr. Seyoum found a net modifier of +3. He referred to Table 15-36 (Functional History Grade Adjustment: Range of Motion), page 477, to find a total range of motion impairment of 15 percent. Dr. Seyoum multiplied the 9 percent range of motion impairment by 15 percent to equal 1.35, or 1 percent, resulting in a total 10 percent permanent left upper extremity impairment.

By decision dated May 30, 2018, an OWCP hearing representative set aside the December 21, 2017 schedule award determination and remanded the case to OWCP for referral to a district medical adviser (DMA) and issuance of a *de novo* decision.

On July 5, 2018 OWCP forwarded Dr. Seyoum's report, the medical record, and a statement of accepted facts (SOAF) to Dr. Nelson S. Haas, Board-certified in occupational medicine, to serve as a DMA. In a July 15, 2018 report, Dr. Haas reviewed the SOAF and medical record. He opined that according to the DBI rating method, based on the categories of shoulder sprain/strain, shoulder tendinitis, or partial-thickness rotator cuff tear, appellant had a zero percent impairment of the left upper extremity for left shoulder sprain and partial thickness supraspinatus tear as she had no consistent abnormal objective findings. Dr. Haas found a GMFH of 3, and GMPE of 1, and a GMCS of 1. He noted that the GMFH should be excluded as the grade differed by two compared to the GMCS and CDX. Dr. Haas opined that the ROM rating method was not applicable in appellant's case as she had significant discrepancies of range of motion measurements on different dates, and there were no comparative measurements of the right shoulder. He disagreed with Dr. Seyoum's reliance on a grade 4 GMFH as the *Quick*DASH score was incongruent with the DBI diagnosis and class and the GMCS. Dr. Haas concluded that appellant had attained MMI on April 17, 2013.

By decision dated July 20, 2018, OWCP denied the schedule award claim, finding that as the medical evidence of record was insufficient to establish permanent impairment. It accorded the DMA report of Dr. Haas the weight of the medical evidence.

On July 27, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated October 10, 2018, an OWCP hearing representative set aside the July 20, 2018 decision and remanded the case for additional development on the issue of permanent impairment. OWCP directed that Dr. Seyoum review the DMA report and indicate his agreement or disagreement. It afforded appellant 30 days to submit the necessary evidence.

In a November 28, 2018 report, Dr. Seyoum opined that Dr. Haas mischaracterized the worsening of appellant's left shoulder condition as inconsistency. He reiterated that using the DBI method, appellant had, at minimum, three percent impairment of the left upper extremity due to left shoulder tendinitis with residual loss.

On January 24, 2019 OWCP referred appellant, a SOAF, and the medical record to Dr. John R. Klein, a Board-certified orthopedic surgeon, for a second opinion examination to

determine the extent of permanent impairment of appellant's left upper extremity. In a February 19, 2019 report, Dr. Klein reviewed the medical record and SOAF. On examination, he found full flexion of both shoulders, limited extension of the left shoulder, 30 degrees flexion on the left and 50 on the right based on three trials, 170 degrees abduction bilateral, 40 degrees adduction bilateral, internal rotation at 80 degrees bilaterally, and external rotation at 60 degrees bilaterally. Dr. Klein found a normal neurologic and motor examination in both upper extremities. He diagnosed a partial left rotator cuff tear status-post surgery. Dr. Klein referred to the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 15-5, page 402, the CDX for partial thickness rotator cuff injury resulted in a class 1 impairment, grade C, with a default value of one percent. He found a GMFH of 3 and a GMPE of 2, resulting in two percent permanent impairment of the left upper extremity. Dr. Klein opined that appellant had attained MMI.

On March 15, 2019 OWCP referred Dr. Klein's report, a SOAF, and the medical record to Dr. Haas for a DMA review and calculation of the appropriate percentage of permanent impairment of the left upper extremity, if any. In an April 30, 2019 report, Dr. Haas noted that Dr. Klein's clinical findings did not establish any objective abnormalities of the left shoulder. He opined that appellant had zero percent permanent impairment of the left upper extremity utilizing the DBI method, as the GMFH should be excluded from the net adjustment formula as it varied from the CDX and GMCS by 2. Dr. Haas noted that Dr. Klein had relied on inconsistent range of motion measurements, but that the ROM rating method was not applicable to appellant's impairment.

On May 8, 2019 OWCP requested that Dr. Klein submit an additional report clarifying his impairment rating and indicating his agreement or disagreement with Dr. Haas' April 30, 2019 opinion. In a May 31, 2019 supplemental report, Dr. Klein agreed with Dr. Haas that appellant had a "Class 0 impairment of the left upper extremity for sprain and partial thickness supraspinatus tendon tear without consistent objective abnormal findings."

On June 7, 2019 OWCP referred Dr. Seyoum's report and Dr. Klein's reports to DMA Dr. Michael M. Katz, a Board-certified orthopedic surgeon, to clarify the appropriate rating method and whether any of the grade modifiers should be excluded. In an October 26, 2019 report, Dr. Katz opined that "[i]f the grade for functional history differs by two or more grades from that described by the physical examination or clinical studies, the functional history should be assumed to be unreliable. If the functional history is unreliable or inconsistent with other documentation, it is excluded from the grading process." He found, therefore, that appellant's impairment calculation was zero percent, and that appellant had no ratable impairment of the left upper extremity.

By decision dated November 13, 2019, OWCP denied appellant's schedule award claim.

On November 18, 2019 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

OWCP subsequently received a February 28, 2019 report, wherein Dr. Bryan K. Matanky, a Board-certified orthopedic surgeon, noted increased left shoulder symptoms following physical therapy. On examination of the left shoulder, he found restricted motion and tenderness to

palpation. Dr. Matanky diagnosed post-traumatic osteoarthritis, impingement syndrome of the left shoulder, and other symptoms and signs of the musculoskeletal system. He prescribed medication.

During the hearing, held on March 19, 2020, counsel contended that Dr. Klein misconstrued the evidence and did not provide independent rationale regarding the appropriate percentage of permanent impairment. He also contended that the A.M.A., *Guides* permitted use of a GMFH that varied two grades from the CDX and GMCS, and also allowed for a ROM impairment evaluation.

By decision dated June 2, 2020, an OWCP hearing representative affirmed the November 13, 2019 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,[7] and its implementing federal regulations,[8] 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.[9] For decisions issued after May 1, 2009, the sixth edition will be used.[10]

OWCP's 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 permanent impairment in accordance with the A.M.A., *Guides*.[11]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[12] This is called an impartial medical examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[13] When there exist opposing medical reports of virtually equal weight and rationale and the

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id*. at § 10.404(a).

[10] 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, Exhibit 1 (January 2010).

[11] *Id.* at Chapter 2.808.6(e) (March 2017); *see also Tommy R. Martin*, 56 ECAB 273 (2005).

[12] 5 U.S.C. § 8123(a); *see T.C.*, Docket No. 20-1170 (issued January 29, 2021); *R.S.*, Docket No. 10-1704 (issued May 13, 2011).

[13] 20 C.F.R. § 10.321.

case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[14] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides, in 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.)[15]
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> The Bulletin further provides:
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> "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.[16]
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> "Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physicians evaluation, the CE should route that report to the DMA for a final determination."[17]

[14] *T.C., supra* note 12; *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[15] FECA Bulletin No. 17-06 (May 8, 2017); *see also W.H.*, Docket No. 19-0102 (issued June 21, 2019).

[16] *Id.*, *R.L.*, Docket No. 19-1793 (issued August 7, 2020); *E.P.*, Docket No. 19-1708 (issued April 15, 2020).

[17] *Id.*

ANALYSIS

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

OWCP accepted appellant's claim for sprains of the left rotator cuff, shoulder, and upper arm as a result of her December 1, 2011 employment injury. In support of her claim for a schedule award, appellant submitted a December 13, 2017 impairment rating from Dr. Seyoum, a Board-certified family practitioner. Dr. Seyoum used the DBI method to find 5 percent permanent impairment of the left upper extremity, and used the ROM method to find 10 percent permanent impairment of the left upper extremity.

In a July 15, 2018 report, Dr. Haas, the DMA, reviewed Dr. Seyoum's report and disagreed with Dr. Seyoum's impairment rating. He contended that the GMFH should not be included in the net adjustment formula as it was two grades higher than the CDX and GMCS. At OWCP's request, Dr. Seyoum provided a November 28, 2018 supplemental report contending that Dr. Haas had mischaracterized the medical evidence as appellant had at least three percent permanent impairment of the left upper extremity utilizing the DBI rating method. OWCP then obtained a February 19, 2019 second opinion report by Dr. Klein, a Board-certified orthopedic surgeon, who found two percent permanent impairment of the left upper extremity based on the DBI rating method. However, he changed his opinion in a May 31, 2019 supplemental report to agree with Dr. Haas, the DMA, that appellant had no ratable impairment of the left upper extremity. OWCP then referred the record to Dr. Katz, a Board-certified orthopedic surgeon serving as DMA, who provided an October 26, 2019 report opining that appellant had no ratable impairment of the left upper extremity as the GMFH was considered unreliable. In its June 2, 2020 decision, an OWCP hearing representative denied appellant's schedule award claim, based on Dr. Katz review of Dr. Klein's opinion as the weight of the medical evidence.

The Board finds that there is a conflict of medical opinion evidence between Dr. Klein, for the government, and Dr. Seyoum, for appellant, regarding the appropriate percentage of permanent impairment of the left upper extremity. Dr. Klein found that appellant had either 2 percent or 0 percent impairment of the left upper extremity, whereas Dr. Seyoum found 5 percent permanent impairment of the left upper extremity utilizing the DBI rating method, or 10 percent permanent impairment based on the ROM rating method. Thus, pursuant to 5 U.S.C. § 8123(a), the case will be remanded to OWCP for referral of appellant, together with the medical record and an updated SOAF, to a specialist in the appropriate field of medicine for an impartial medical examination to determine the extent and degree of appellant's left upper extremity impairment in accordance with the sixth edition of the A.M.A., *Guides*.[18] After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[18] *M.E.*, Docket No. 19-0452 (issued July 22, 2019).

ORDER

IT IS HEREBY ORDERED THAT the June 2, 2020 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: March 19, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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