United States Department of Labor
Employees' Compensation Appeals Board

E.N., Appellant	)	
and	)	**Docket No. 14-0471**
	)	**Issued: February 10, 2017**
U.S. POSTAL SERVICE, NEWARK AIR MAIL CENTER, Newark, NJ, Employer	)	

Appearances:
Thomas R. Uliase, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 26, 2013 appellant, through counsel, filed a timely appeal from a September 27, 2013 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 established greater than four percent permanent impairment of the right upper extremity, for which she received 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.*

On appeal counsel contends that OWCP should not have accorded the weight of the medical evidence to Dr. Andrew Carollo, a Board-certified orthopedic surgeon and the impartial medical examiner, as he was unable to clarify his opinion as requested. He also asserts that Dr. Carollo used the range of motion rating method without explaining why the diagnosis-based method was not appropriate.

FACTUAL HISTORY

OWCP accepted that on January 31, 2000 appellant, then a 64-year-old ramp clerk, sustained multiple contusions and a right rotator cuff tear when she slipped and fell on ice while entering her workstation.

In a May 24, 2000 report, Dr. Victor Daibo, an attending Board-certified orthopedic surgeon, diagnosed a torn right rotator cuff, traumatic epicondylitis of the right elbow, and acute low back syndrome. He opined that appellant's rotator cuff tear required surgical repair. In a September 19, 2000 report, Dr. Daibo provided a history of the January 31, 2000 injury and noted the failure of conservative treatment. He also noted that a magnetic resonance imaging (MRI) scan showed a complete right rotator cuff tear. On August 28, 2001 Dr. Daibo performed an open repair of the right rotator cuff, acromioplasty of the right shoulder and an injection into the right epicondyle.

In a December 30, 2002 report, Dr. James M. Lee, an attending Board-certified orthopedic surgeon, diagnosed right radial epicondylitis and status post right rotator cuff tear. He submitted progress notes through July 2006 observing continued weakness and crepitation in the right shoulder. In a July 28, 2003 report, Dr. Lee opined that appellant's right lateral epicondylitis was not work related. Appellant remained off work from February 28, 2005 onward.

On June 16, 2008 appellant filed a claim for a schedule award Form CA-7. In support of her claim, she submitted a March 21, 2007 report from Dr. Nicholas Diamond, an attending osteopathic physician, who opined that she had attained maximum medical improvement. Dr. Diamond noted appellant's difficulties with activities of daily living and chronic 10/10 pain in her right shoulder. On examination he noted an eight centimeter surgical scar over the anterior right shoulder capsule, posterior cuff tenderness, click and crepitus on circumduction, positive drop, O'Brien, Yergason, Speed and lift-off tests, and tenderness over the right medial epicondyle. Dr. Diamond recorded the following ranges of motion of the right shoulder: forward elevation 155/180 degrees; abduction at 145/180 degrees; crossover abduction at 60/75 degrees; internal rotation at 60/90 degrees and external rotation at 90/90 degrees. He diagnosed status post-traumatic right rotator cuff tear with open repair and unresolved post-traumatic right elbow lateral epicondylitis. Dr. Diamond opined that appellant had 18 percent permanent impairment of the right arm under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) then in effect.[3]

In a September 28, 2009 report, Dr. Diamond updated his impairment rating utilizing the sixth edition of the A.M.A., *Guides*. Regarding the right upper extremity, he found three percent impairment due to limited shoulder flexion, three percent impairment due to limited abduction

[3] Dr. Diamond reiterated this impairment rating in a May 20, 2009 report.

and two percent impairment due to limited internal rotation according to Table 15-34.[4] Dr. Diamond added these impairments to equal eight percent permanent impairment. Referring to Table 15-35,[5] he found a class 1 range of motion impairment, with a grade modifier for Functional History (GMFH) of 3 as appellant was unable to work. Dr. Diamond subtracted class 1 range of motion impairment from the three percent impairment for GMFH to equal 2, increasing the eight percent range of motion impairment by five percent, equaling .04. He also found one percent impairment of the right arm due to limited elbow supination and an additional one percent impairment due to limited elbow pronation according to Table 15-35, equaling an additional two percent impairment. Dr. Diamond added the 8 and 2 percent impairments to total 10 percent permanent impairment of the right upper extremity.[6] He explained in a November 23, 2009 report that as appellant had significantly limited right shoulder motion, it was more appropriate to rate impairment using the range of motion method rather than the diagnosis-based method.[7]

On March 15, 2010 OWCP obtained a second opinion report from Dr. Andrew Hutter, a Board-certified orthopedic surgeon. On examination, Dr. Hutter noted a full range of motion of the right shoulder and right elbow, with minimal tenderness over the lateral epicondyle. In an April 23, 2010 supplemental report, he opined that appellant had no orthopedic disability regarding her right elbow. Dr. Hutter noted that, based on Table 15-5, page 403, her status post rotator cuff repair was a class 1 impairment, equaling five percent impairment of the right upper extremity. On May 24, 2010 an OWCP medical adviser reviewed Dr. Hutter's report and found four percent permanent impairment of the right upper extremity based on the right shoulder injury. In an August 2, 2010 supplemental report, Dr. Hutter concurred with the medical adviser's finding of four percent impairment of the right upper extremity. On September 12, 2010 a second OWCP medical adviser concurred with the four percent impairment rating for the right arm.

OWCP found a conflict of medical opinion between Dr. Hutter, for the government and Dr. Diamond, for appellant, regarding the appropriate percentage of permanent impairment. It selected Dr. Andrew Carollo, a Board-certified orthopedic surgeon, to resolve the conflict. Dr. Carollo submitted a December 1, 2010 report in which he reviewed the medical record and statement of accepted facts, opining that appellant had reached maximum medical improvement on August 28, 2002, one year after the rotator cuff repair. On examination he found internal rotation of the right arm limited to 25/55 degrees, with full abduction, adduction, flexion, extension, and external rotation. Dr. Carollo diagnosed status post repair of a right rotator cuff tear. He explained that, as appellant had normal ranges of right shoulder motion except for limited internal rotation, Table 15-34 was the most appropriate rating method. Dr. Carollo noted that "applying the grade modifier pertaining to [appellant's] level of internal rotation, her upper extremity impairment is four percent." In a September 26, 2011 report, an OWCP medical adviser concurred with Dr. Carollo's assessment.

[4] Table 15-34, page 475 of the A.M.A., *Guides* is entitled "Shoulder Range of Motion."

[5] Table 15-35, page 477 of the A.M.A., *Guides* is entitled "Range of Motion Grade Modifiers."

[6] In a September 29, 2009 report, an OWCP medical adviser reviewed Dr. Diamond's reports. He found seven percent impairment of the right upper extremity according to the sixth edition of the A.M.A., *Guides*.

[7] In a June 10, 2010 report, Dr. Diamond reiterated his assessment of 10 percent impairment of the right arm.

By decision dated October 14, 2011, OWCP granted appellant a schedule award for four percent impairment of the right upper extremity, based on Dr. Carollo's opinion.

In an October 19, 2011 letter, appellant requested a hearing, held February 27, 2012. At the hearing, counsel contended that Dr. Carollo's opinion required clarification as to whether the diagnosed right lateral epicondylitis was work related. In a February 23, 2012 statement, appellant asserted that Dr. Carollo did not review the medical record before examining her.

Following the hearing, counsel submitted a February 13, 2012 report from Dr. Diamond, assessing the percentage of impairment using the diagnosis-based rating method. Dr. Diamond found that according to Table 15-5,[8] appellant had a class 1 class of diagnosis (CDX) for a full thickness rotator cuff tear with residual loss of motion. He found a functional history of 2 according to Table 15-7,[9] a grade modifier for Physical Examination (GMPE) of 2 according to Table 15-8[10] and a grade modifier for Clinical Studies (GMCS) of 4 according to Table 15-9.[11] Applying the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) or (2-1) + (2-1) + (4-1) resulted in a net adjustment of 5, raising the default class of diagnosis of five percent to seven percent. Dr. Diamond then noted one percent impairment of the right upper extremity due to limited pronation of the right elbow and one percent impairment due to limited supination of the right elbow according to Table 15-35, equaling an additional two percent permanent impairment of the right arm, for a total permanent impairment of nine percent.

In a March 28, 2012 decision, an OWCP hearing representative set aside the October 14, 2011 decision and remanded the case for OWCP to obtain a supplemental report from an OWCP medical adviser regarding whether appellant had a greater percentage of impairment due to restricted motion. The medical adviser was to "discuss the difference between the range of motion based impairment and the diagnosis-based impairment."

On remand of the case, an OWCP medical adviser provided a July 26, 2012 report, opining that Dr. Carollo's 2010 opinion should carry the weight of the medical evidence as it was three years more recent than Dr. Diamond's 2007 findings on which he based his February 13, 2012 impairment rating.

In a September 18, 2012 decision, OWCP found that appellant had no more than four percent permanent impairment of the right arm for which she received a schedule award.

In a September 24, 2012 letter, appellant requested a hearing. By decision dated December 12, 2012, the hearing representative found that the case was not in posture for decision and set aside OWCP's September 18, 2012 decision to obtain a supplemental report

---

[8] Table 15-5, page 401 of the sixth edition of the A.M.A., *Guides* is entitled "Shoulder Regional Grid: Upper Extremity Impairments."

[9] Table 15-7, page 406 of the sixth edition of the A.M.A., *Guides* is entitled "Functional History Adjustment: Upper Extremities"

[10] Table 15-8, page 408 of the sixth edition of the A.M.A., *Guides* is entitled "Physical Examination Adjustment: Upper Extremities."

[11] Table 15-9, page 410 of the sixth edition of the A.M.A., *Guides* is entitled "Clinical Studies Adjustment: Upper Extremities."

from Dr. Carollo. The hearing representative found that Dr. Carollo's opinion required clarification regarding why he utilized the range of motion rating method and not the diagnosis-based method. Dr. Carollo was also directed to address the diagnosed right elbow epicondylitis and any other preexisting conditions affecting the right upper extremity.

On remand, Dr. Carollo provided a January 17, 2013 supplemental report. He noted that it was his "choice to use the range of motion method" and that Table 15-34 was self-explanatory. Dr. Carollo also noted that he did not find any impairment of the right elbow. On February 7, 2013 an OWCP medical adviser concurred with Dr. Carollo's remarks.

By decision dated March 15, 2013, OWCP found that appellant failed to establish more than four percent permanent impairment of the right upper extremity for which she previously received a schedule award. It found that Dr. Carollo's opinion continued to represent the weight of the medical evidence.

In a March 22, 2013 letter, appellant requested an oral hearing, which was held on July 15, 2013. At the hearing, counsel contended that Dr. Carollo failed to explain why he did not use the diagnosis-based impairment rating method "which would have provided a seven percent rating for the full thickness tear after all grade modifiers were considered." Counsel contended that OWCP should rely on a July 9, 2013 report from Dr. David Weiss, an attending osteopath, associated with Dr. Diamond.

In a July 9, 2013 report, Dr. Weiss noted reviewing prior medical reports and explained that the range of motion rating method was more appropriate to appellant's presentation than Dr. Carollo's diagnosis-based rating. He noted that right elbow impairment could be rated according to Table 15-4, "which notes that a history of painful injury with residual symptoms without consistent objective findings would be entitled to an impairment. Dr. Carollo also noted that [appellant] had some minor discomfort in the elbow." Dr. Weiss repeated Dr. Diamond's February 23, 2012 rating for the right shoulder, but opined that the right elbow represented one percent impairment of the right arm and not two percent as Dr. Diamond had found. He found that appellant had eight percent permanent impairment of the right upper extremity.

By decision dated September 27, 2013, an OWCP hearing representative affirmed the March 15, 2013 decision, finding that Dr. Carollo's opinion was sufficiently complete and reasoned to represent the weight of the medical evidence.

LEGAL PRECEDENT

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to implement the FECA program with the Director of the Office of Workers' Compensation Programs.[12] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[13] FECA, however, does not specify the manner by which the percentage loss

[12] *See* 20 C.F.R. §§ 1.1-1.4.

[13] For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

of a member, function, or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[14]

The sixth edition of the A.M.A. *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment."* The document included various changes to the original text, intended to serve as an erratum/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[15] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[16]

ANALYSIS

The issue on appeal is whether appellant has established more than four percent permanent impairment of the right upper extremity, for which she received a schedule award.

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

The Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation has been followed regarding the proper use of the diagnosis-based impairment or the range of motion methodology when assessing the extent of permanent impairment for schedule award purposes.[17] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[18] In *T.H.*, the Board concluded that OWCP physicians are at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both diagnosis-based impairment and range of motion methodologies interchangeably without any consistent basis. Furthermore, the Board has observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either range of motion or diagnosis-based impairment methodology. Because OWCP's own physicians are inconsistent

---

[14] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak,* 53 ECAB 130 (2001).

[15] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (February 2013); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[16] *Isidoro Rivera*, 12 ECAB 348 (1961).

[17] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

[18] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

in the application of the A.M.A., *Guides*, the Board finds that OWCP can no longer ensure consistent results and equal justice under the law for all claimants.[19]

In light of the conflicting interpretation by OWCP of the sixth edition with respect to upper extremity impairment ratings, it is incumbent upon OWCP, through its implementing regulations and/or internal procedures, to establish a consistent method for rating upper extremity impairment. In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the September 27, 2013 decision. Following OWCP's development of a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and such other development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an upper extremity schedule award.

CONCLUSION

The Board finds this case not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the September 27, 2013 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.[20]

Issued: February 10, 2017
Washington, DC

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

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

[19] *Supra* note 17.

[20] James A. Haynes, Alternate Judge, participated in the original decision but was no longer a member of the Board effective November 16, 2015.