United States Department of Labor
Employees' Compensation Appeals Board

W.D., Appellant	)	
and	)	**Docket No. 15-0497**
	)	**Issued: February 17, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 7, 2015 appellant, through counsel, filed a timely appeal from an August 26, 2014 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 established greater than eight percent impairment of the left upper extremity and one percent permanent impairment of the right upper extremity, for which he received schedule awards.

FACTUAL HISTORY

OWCP accepted that on June 19, 2010 appellant, then a 50-year-old mail handler, sustained an acromioclavicular, infraspinatus, and supraspinatus sprains of the left shoulder while lifting heavy boxes. Appellant stopped work on the date of injury. Under OWCP File No. xxxxxx717, OWCP had previously accepted, on April 6, 2004, bilateral elbow contusions.

Dr. David C. Raab, an attending osteopath Board-certified in sports medicine, followed appellant beginning on July 2, 2010. He diagnosed a large rotator cuff tear of the supraspinatus and subscapularis tendons of the left shoulder, a tear of the long head of the biceps tendon, and an intramuscular biceps tear.[3] On July 26, 2010 Dr. Raab performed an OWCP authorized arthroscopic rotator cuff repair of the left shoulder with subacromial decompression and debridement, and open biceps tenodesis of the long head of the biceps. He held appellant off work due to continuing instability in the left shoulder. On December 28, 2010 Dr. Raab performed an open revision to repair a recurrent left rotator cuff tear. Dr. Raab submitted progress notes through July 2011.

On July 5, 2011 OWCP referred appellant, a statement of accepted facts SOAF, and the medical record to Dr. Robert F. Draper, Jr., a Board-certified orthopedic surgeon, for a second opinion examination. The SOAF listed the June 19, 2010 left shoulder injury, but not the bilateral elbow contusions accepted under OWCP File No. xxxxxx717. Dr. Draper submitted a July 15, 2011 report, finding that appellant had attained maximum medical improvement. He noted residual weakness of the left bicep. Dr. Draper opined that appellant could return to modified duty, with no lifting above the shoulder with the left arm, and limitations on pulling, pushing, and lifting.

OWCP requested that Dr. Raab review Dr. Draper's report. In an August 5, 2011 report, Dr. Raab opined that appellant had not yet attained maximum medical improvement, but that appellant was able to return to full-time modified duty, with no reaching above shoulder level, and lifting limited to five pounds.

Appellant returned to full-time modified-duty work on October 20, 2011. Dr. Raab submitted periodic progress reports. On June 5, 2012 Dr. Richard I. Zamarin, a Board-certified orthopedic surgeon in practice with Dr. Raab, opined that appellant had attained maximum medical improvement.

[3] June 29, 2010 magnetic resonance imaging (MRI) scan studies showed a superior labral tear from anterior to posterior (SLAP), a lesion of the left shoulder, and swelling of the medial and lateral aspect of the left elbow, without tendon or muscular injury.

On January 17, 2013 appellant claimed a schedule award (Form CA-7). He submitted a January 9, 2012 report from Dr. Arthur Becan, an orthopedic surgeon retained to perform an impairment rating. Dr. Becan reviewed medical records, noting appellant's April 6, 2004 bilateral elbow injuries and the June 19, 2010 left shoulder injury. On examination of the left shoulder, he noted a positive drop test, positive impingement sign, and positive drop-off sign. Dr. Becan performed range of motion testing, with each maneuver performed three times. He found forward elevation limited to 120 degrees, abduction at 110 degrees, cross-over adduction at 50 degrees, and internal and external rotation at 70 degrees. Dr. Becan observed 3/5 weakness in the supraspinatus, deltoids, and biceps, and 4/5 triceps weakness. On examination of the left elbow, he noted no tenderness of effusion, no instability, and a negative Tinel's sign at the ulnar nerve. Range of motion testing; with three trials of each maneuver demonstrated flexion-extension at 10 to 130/145 degrees, and pronation and supination at 0 to 70/80 degrees. Dr. Becan diagnosed a left rotator cuff tear, biceps muscle tear, labral tear, aggravation of acromioclavicular arthropathy, biceps tendinopathy, post surgical status, recurrent rotator cuff tear, labral tear and degeneration, and post-traumatic adhesive capsulitis of the left elbow. He attributed the diagnoses to the combined effects of the April 6, 2004 and June 19, 2010 injuries. Dr. Becan also found tenderness over the medial condyle of the right elbow.

Referring to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*), Dr. Becan using the range of motion, opined that appellant had attained maximum medical improvement. He noted that the range of motion rating method under section 15.7 was the appropriate means of evaluating appellant's left shoulder and left elbow impairment. Regarding the left shoulder, Dr. Becan found that according to Table 15-34,[4] flexion limited to 120 degrees equaled three percent impairment of the left upper extremity, abduction at 110 degrees equaled an additional three percent impairment, and internal rotation at 70 degrees equaled two percent impairment. He totaled these impairments to equal eight percent, and assessed a grade modifier of 1 for physical examination, according to Table 15-35.[5] Dr. Becan also assessed a grade modifier of 2 for functional history, according to Table 15-7,[6] increasing the impairment by five percent according to Table 15-36.[7] He calculated that the left shoulder impairment remained at eight percent.

Regarding the left elbow, Dr. Becan found three percent impairment for flexion limited to 130 degrees, one percent impairment for pronation at 70 degrees, and one percent impairment for supination limited to 70 degrees, according to Table 15-33.[8] He totaled these impairments to equal five percent impairment of the left upper extremity. Dr. Becan assessed a grade modifier

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

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

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

[7] Table 15-36, page 477 of the sixth edition of the A.M.A., *Guides* is entitled "Functional History Grade Adjustment: Range of Motion."

[8] Table 15-33, page 474 of the sixth edition of the A.M.A., *Guides* is entitled "Elbow/Forearm Range of Motion."

of 1 for physical examination, according to Table 15-35, and a grade modifier of 2 for functional history according to Table 15-36. After applying the net adjustment he found seven percent impairment for the left elbow. Dr. Becan then combined the eight percent permanent impairment for the left shoulder and seven percent impairment for the left elbow to equal 14 percent permanent impairment of the left upper extremity.

Dr. Becan also found one percent impairment of the right arm due to medial epicondylitis, according to Table 15-4.[9] Dr. Becan noted a grade modifier of 2 for functional history, a grade modifier of 1 for physical examination, and no applicable grade modifier for clinical studies. Applying the net adjustment formula he found a net adjustment of zero, leaving the default class of diagnosis at grade C, equal to one percent permanent impairment of the right arm due to medial epicondylitis.

On January 25, 2013 an OWCP medical adviser reviewed Dr. Becan's impairment rating and a January 24, 2013 SOAF, which listed the accepted left shoulder injury but not the accepted bilateral elbow contusions. He concurred with Dr. Becan's finding of eight percent permanent impairment due to limited motion of the left shoulder. The medical adviser found, however, that there was no applicable impairment of the left elbow as it was "not an accepted condition" according to the SOAF.

By decision dated February 19, 2013, OWCP issued a schedule award for eight percent permanent impairment of the left upper extremity. Counsel disagreed with the decision, and requested a hearing by letter dated February 25, 2013.

By decision dated and finalized May 7, 2013, an OWCP hearing representative vacated the February 19, 2013 schedule award determination, finding that the SOAF provided to the medical adviser omitted the accepted left elbow injury under OWCP File No. xxxxxx717, which had received a five percent impairment rating of the left arm on October 22, 2012. The hearing representative remanded the case to OWCP to combine OWCP File No. xxxxxx717 with the present claim, prepare revised SOAF listing the accepted bilateral elbow and left shoulder injuries, and refer appellant to an appropriate specialist for a new impairment rating.

By decision dated June 24, 2013, under OWCP File No. xxxxxx717, OWCP granted appellant a schedule award for one percent permanent impairment of the right arm, due to sequelae of the April 6, 2004 right elbow contusion.

On remand of the case, OWCP doubled OWCP File No. xxxxxx717 with the present claim, and prepared an amended SOAF noting the accepted April 6, 2004 bilateral elbow contusions. It referred appellant, the medical record, and the new SOAF to Dr. Steven J. Valentino, a Board-certified orthopedic surgeon, for a second opinion examination.

Dr. Valentino provided an August 21, 2013 report. He reviewed the medical record and the new SOAF, and opined that appellant had reached maximum medical improvement. On examination of the left shoulder, Dr. Valentino found "full range of motion about the shoulders,

[9] Table 15-4, page 399 of the sixth edition of the A.M.A., *Guides* is entitled "Elbow Regional Grid: Upper Extremity Impairments."

elbows, wrists, and hands," weakness in the left rotator cuff with biceps prominence, and 4/5 weakness in the shoulder abductors. He opined that under the diagnosis-based impairment (DBI) method and according to Table 15-5, page 403 of the A.M.A., *Guides*,[10] appellant had a class 1 diagnosis for full thickness tear of the left rotator cuff equal to five percent impairment of the left arm. Dr. Valentino noted a grade modifier of 2 for functional history for pain with normal activity, and a grade modifier of 1 for findings on physical examination due to one centimeter muscle atrophy. He found a net adjustment of plus one, raising the default class of diagnosis from C to D, equaling six percent impairment of the left upper extremity.

As Dr. Valentino had not addressed whether appellant had left elbow impairment, OWCP requested that he submit an addendum report. In a September 12, 2013 letter, he opined that appellant's elbow contusions had resolved without residuals, and were therefore not ratable.

The medical adviser reviewed Dr. Valentino's reports on November 5, 2013, and concurred with the six percent impairment rating, "an increase of one percent over the previous award of five percent."

In a November 6, 2013 memorandum, OWCP requested that the medical adviser clarify whether he believed appellant had a lesser impairment than the eight percent awarded on February 19, 2013. It also requested that the medical adviser review a revised SOAF dated November 6, 2013, noting the accepted left shoulder and bilateral elbow injuries and the doubling of the claims. In a November 28, 2013 response, the medical adviser found that appellant had eight percent permanent impairment of the left upper extremity as previously awarded. He found no permanent impairment of the right upper extremity, based on Dr. Valentino's addendum report.

By decision dated January 6, 2014, OWCP found that appellant had not established more than eight percent permanent impairment of the left upper extremity, as awarded on February 19, 2013 under the present claim, or one percent permanent impairment of the right upper extremity, as awarded on June 24, 2013 under OWCP File No. xxxxxx717.

In a January 10, 2014 letter, counsel requested a hearing, held June 11, 2014. At the hearing, he contended that Dr. Valentino's report could not represent the weight of the medical evidence as he did not have access to a complete SOAF that listed both the accepted shoulder injury and bilateral elbow injuries. Also, counsel alleged that Dr. Valentino had not provided range of motion measurements, or assessed each plane of motion of the upper extremities. Following, the hearing, appellant submitted medical appointment slips dated from October to December 2013. He also provided his June 26, 2014 statements, asserting that Dr. Valentino had not performed a complete range of motion examination.

By decision dated and finalized August 26, 2014, the hearing representative affirmed the January 6, 2014 decision, finding that appellant had not established more than eight percent impairment of the left upper extremity and one percent impairment of the right upper extremity, for which he received schedule awards. The hearing representative found that Dr. Valentino's

[10] Table 15-5, page 403 of the sixth edition of the A.M.A., *Guides* is entitled "Shoulder Regional Grid: Upper Extremity Impairments."

report was sufficiently detailed to represent the weight of the medical evidence, despite not providing range of motion measurements.

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 OWCP.[11] 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.[12] FECA, however, does not specify the manner by which the percentage loss 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.[13]

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).[14] 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.[15]

ANALYSIS

The issue on appeal is whether appellant has established greater than an eight percent impairment of the left upper extremity and a one percent impairment of the right upper extremity, for which he received schedule awards.

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

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[11] *See* 20 C.F.R. §§ 1.1-1.4.

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

[13] 20 C.F.R. § 10.404. *See also, Ronald R. Kraynak,* 53 ECAB 130 (2001).

[14] 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).

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

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 DBI or the range of motion methodology when assessing the extent of permanent impairment for schedule award purposes.[16] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[17] 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 DBI 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 DBI methodology. Because OWCP's own physicians are inconsistent 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.[18]

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 August 26, 2014 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.

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

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

[18] *Supra* note 16.

ORDER

IT IS HEREBY ORDERED THAT the August 26, 2014 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.[19]

Issued: February 17, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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