United States Department of Labor
Employees' Compensation Appeals Board

L.P., Appellant	)	
and	)	**Docket No. 15-0929**
	)	**Issued: February 16, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Providence, RI, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On March 23, 2015 appellant filed a timely appeal from a March 2, 2015 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.

ISSUE

The issue is whether appellant has established greater than 14 percent impairment of the left upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

OWCP accepted that on October 15, 1992 appellant, then a 41-year-old mail handler, while emptying a mail hamper sustained a left shoulder sprain, left rotator cuff tear, cervical

[1] 5 U.S.C. § 8101 *et seq.*

strain, and displacement of a cervical disc without myelopathy. He stopped work shortly after the injury and received total disability compensation beginning on December 11, 1992.

Dr. Norman Kornwitz, an attending Board-certified orthopedic surgeon, performed a left rotator cuff repair and subacromial decompression[2] on April 19, 1993, as authorized by OWCP. On May 5, 1994 Dr. James E. McLennan, an attending Board-certified neurosurgeon, performed a C4-5 and C5-6 anterior resection with interbody fusion, authorized by OWCP.[3]

Following a brief return to modified duty in January 1995, appellant again stopped work. He continued to receive total disability compensation. Appellant was followed by Dr. W. Lloyd Barnard, Jr., an attending Board-certified orthopedic surgeon, who provided reports through February 14, 1996 noting anterior left shoulder crepitus and a positive impingement sign.

On February 25, 2000 OWCP obtained a second opinion regarding appellant's cervical spine from Dr. R. John Groves, a Board-certified orthopedic surgeon, who opined that appellant required a repeat cervical discectomy and fusion. In an August 24, 2000 report, Dr. McLennan, an attending Board-certified neurosurgeon, countered that appellant should not undergo additional cervical spine surgery as imaging studies demonstrated a stable C6-7 disc without nerve root compression.

OWCP found a conflict in medical opinion between Dr. Groves, for the government, and Dr. McLennan, for appellant. Dr. Peter Pizzorella, a Board-certified orthopedic surgeon and independent medical specialist, was selected to resolve the conflict. He submitted a December 14, 2000 report, noting that appellant ambulated with two Canadian crutches due to pain complaints throughout his spine and extremities. On examination, Dr. Pizzorella observed restricted shoulder motion secondary to pain, no atrophy in either arm, restricted cervical spinal motion, lumbosacral pain and limitation, and diffuse sensory loss in the C4 to T2 dermatomes on the right. He diagnosed status post laminectomy cervical disc pain, and pain throughout the spine and extremities. Dr. Pizzorella recommended a program for chronic pain.

An April 2, 2002 magnetic resonance imaging (MRI) scan showed a stable C4-6 fusion, osteophytic spurring at C5-6 with foraminal stenosis, and a right-sided osteophytic complex at C6-7 impinging the spinal cord and causing right foraminal narrowing. April 3, 2002 electromyogram and nerve conduction velocity studies showed moderate left carpal tunnel syndrome and right-sided C7 radiculopathy.

On August 23, 2002 Dr. Curtis Doberstein, an attending Board-certified neurosurgeon, observed diminished sensation in the C7 dermatome of the left hand.

In August 31, 2009 and September 2, 2010 reports, Dr. Antonio J. Villasan, an attending osteopathic physician, found that appellant had attained maximum medical improvement and

[2] The operative report is not of record.

[3] In a December 15, 1994 report, Dr. Albert Weyman, attending cardiothoracic surgeon, observed a "[g]ood range of left shoulder motion," but with pain.

opined that appellant was permanently and totally disabled due to left shoulder and cervical spine pain.

On October 30, 2013 appellant a filed claim for a schedule award (Form CA-7). In a November 7, 2013 letter, OWCP advised him of the additional evidence needed to establish his claim, including an impairment rating from his attending physician utilizing the tables and grading schemes of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).[4]

As appellant failed to submit an impairment rating from his physicians, OWCP obtained a second opinion examination from Dr. Gilbert Shapiro, a Board-certified orthopedic surgeon. In a February 28, 2014 report, Dr. Shapiro reviewed the medical record and a statement of accepted facts. On examination, he noted left arm weakness from disuse, diminished biceps, triceps, and brachioradialis reflexes, surgical scars on the left shoulder, a history of bilateral knee surgeries, and a partial gastrectomy. Dr. Shapiro also observed restricted motion of the left shoulder. He diagnosed degenerative disc disease, status post C4-5 and C5-6 disc resection and fusion, status post left shoulder strain, and status post left rotator cuff tear and repair. Dr. Shapiro opined that the range of motion (ROM) rating method under section 15.7 of the A.M.A., *Guides* was preferable to the diagnosis-based impairment (DBI) method due to appellant's postsurgical status and the original diagnosis of a shoulder sprain. Referring to Table 15-34,[5] he found three percent impairment of the left upper extremity for forward flexion at 150 degrees, six percent impairment for abduction at 80 degrees, zero percent impairment for extension at 80 degrees, one percent impairment for adduction at 10 degrees, two percent impairment for external rotation at 50 degrees, and two percent impairment for internal rotation at 60 degrees. Dr. Shapiro found that these ROM equaled 14 percent permanent impairment of the left arm. He concluded that the ROM deficits required assessment of a grade 2 modifier according to Table 15-35,[6] and that appellant's pain profile warranted a grade 2 modifier for functional history according to Table 15-36.[7] Applying the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Shapiro calculated a net modifier of zero, leaving the total upper extremity impairment at 14 percent. He commented that he was unable to evaluate any radicular impairment of the left arm as there had been no imaging studies since the April 3, 2002 MRI scan. Dr. Shapiro noted that the right-sided C7 radiculopathy and left carpal tunnel syndrome shown in April 2002 studies were no longer present.

On April 14, 2014 an OWCP medical adviser concurred with Dr. Shapiro's assessment of 14 percent permanent impairment of the left upper extremity. The medical adviser found that

[4] A.M.A., *Guides* (6th ed. 2009) A December 13, 2013 functional capacity evaluation demonstrated that appellant could perform sedentary work.

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

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

[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."

appellant attained maximum medical improvement as of February 18, 2014, the date of Dr. Shapiro's evaluation.

By decision dated April 25, 2014, OWCP granted appellant a schedule award for 14 percent permanent impairment of the left upper extremity. The period of the award ran from April 6, 2014 to February 5, 2015.

Appellant disagreed with the schedule award and on May 14, 2014 requested an oral hearing, held December 15, 2014. At the hearing, he contended that Dr. Shapiro did not perform a thorough examination and that OWCP discounted Dr. Shapiro's 22 years of medical treatment for multiple orthopedic, musculoskeletal, psychiatric, neurologic, gastric, and dermatologic conditions.

Following the hearing, appellant submitted a June 24, 2013 report from Dr. Thomas Jean, an attending Board-certified internist, who diagnosed osteoarthritis of the right shoulder and left knee, bipolar I, a neurocognitive disorder, an umbilical hernia, alcoholism, gastric disorders, eczema, cardiac issues, and a history of left rotator cuff repair. March 25, 2014 left shoulder x-rays showed postoperative and degenerative changes without acute abnormality.[8] Appellant also submitted his statement alleging that he had undergone two left shoulder surgeries on unspecified dates. Additionally, he provided letters from two family members describing his debilitation.

By decision dated March 2, 2015, an OWCP hearing representative affirmed the April 25, 2014 schedule award, finding that the additional evidence submitted failed to establish more than 14 percent permanent impairment.

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.[9] 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.[10] 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

[8] Appellant also submitted more than 800 pages of medical records, prescription monitoring reports, and chart notes dated from 1998 to 2014, principally from clinic physicians at the Department of Veterans' Affairs. These documents did not address his left shoulder.

[9] *See* 20 C.F.R. §§ 1.1-1.4.

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

regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[11]

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).[12] 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.[13]

ANALYSIS

The issue on appeal is whether appellant has established greater than 14 percent impairment of the left upper extremity, for which he previously 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 DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[14] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[15] 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 ROM 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 ROM 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.[16]

[11] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[12] 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).

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

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

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

[16] *Supra* note 14.

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 March 2, 2015 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 March 2, 2015 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: February 16, 2017
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board