United States Department of Labor
Employees' Compensation Appeals Board

S.H., Appellant	)	
and	)	**Docket No. 15-0407**
	)	**Issued: March 24, 2017**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, Chicago, IL, 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:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 11, 2014 appellant, through counsel, filed a timely appeal from a November 4, 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 the 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 permanent impairment of a scheduled member, warranting a schedule award.

FACTUAL HISTORY

On September 25, 2004 appellant, then a 34-year-old security screener injured her left arm and shoulder when lifting bags at work. OWCP accepted her claim for left arm pain, left shoulder tendinitis, adhesive capsulitis of the left shoulder, and left carpal tunnel syndrome.[3] It authorized a left carpal tunnel release performed on January 20, 2005 and left shoulder arthroscopic surgery performed on September 28, 2006. Appellant stopped work on September 26, 2004, but returned to work on March 8, 2005 and worked intermittently thereafter. On September 13, 2008 she stopped work completely.

Appellant was treated by Dr. Alfonso Mejia, a Board-certified orthopedic surgeon, from October 21 to December 2, 2004 for left arm pain and numbness after a work-related lifting incident. On January 20, 2005 Dr. Mejia performed a left carpal tunnel release and diagnosed left carpal tunnel syndrome. On September 28, 2006 he performed a left shoulder arthroscopic acromioplasty, and diagnosed left shoulder impingement. A magnetic resonance imaging scan of the left shoulder dated February 18, 2006 revealed rotator cuff tendinitis. Appellant was treated by Dr. Herbert Engelhard, III, a Board-certified orthopedist, for neck and bilateral arm pain since her work injury in 2004. Dr. Engelhard noted that conservative treatment had failed. On April 29, 2009 he performed anterior cervical discectomies at C4-5 and C5-6, anterior cervical arthrodesis at C4-5 and C5-6, and diagnosed cervical radiculopathy. On January 26, 2012 Dr. Engelhard performed an anterior cervical discectomy at C6-7 and arthrodesis from C6-7.[4] An electromyogram (EMG) dated March 8, 2011 showed evidence of a chronic cervical polyradiculopathy on the left, involving the C7-T1 dermatomes.

Thereafter, in the course of developing the claim, OWCP referred appellant to several second opinion physicians and to an impartial medical adviser with regard to whether she had ongoing residuals of the accepted conditions. The referee physician, Dr. Jaroslaw B. Dzwinyk, a Board-certified orthopedist, in a report dated July 26, 2012, noted that examination of both shoulders revealed no swelling, no atrophy, active elevation was full to 180 degrees bilaterally, internal rotation to the T8 spinous process bilaterally, passive range of motion (ROM) of both shoulders was unrestricted, and the impingement sign was positive bilaterally. He opined that appellant did not have residuals of the September 1 and 25, 2004 work injuries and could return to her regular work duties.

On August 15, 2012 OWCP proposed to terminate appellant's wage-loss compensation and medical benefits based on the referee physician's report. In an October 22, 2012 decision, it

[3] Appellant filed a claim for injuries sustained on or about September 1, 2004, which was accepted for right carpal tunnel syndrome and right shoulder sprain, File No. xxxxxx915. This claim was consolidated with the current claim before the Board.

[4] OWCP did not authorize the cervical surgeries.

terminated her wage-loss compensation and medical benefits, effective that date, finding that the medical evidence of record established that she had no continuing residuals of her accepted conditions. Appellant requested a hearing. On April 30, 2013 an OWCP hearing representative affirmed the October 22, 2012 decision.

Appellant continued to be treated by Dr. Engelhard from October 3, 2012 to March 8, 2013 for cervical and lumbar radiculopathy. On March 8, 2013 Dr. Engelhard opined that she reached maximum medical improvement and was stabilized.

On August 5, 2013 appellant filed a claim for a schedule award (Form CA-7).

In an August 7, 2013 letter, OWCP requested that appellant's treating physician evaluate the extent of her permanent impairment of the arms under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[5]

Appellant submitted an October 30, 2013 report from Dr. Neil Allen, a Board-certified neurologist and internist, based on an August 15, 2013 examination. Dr. Allen reviewed the history of injury and treatment. On right shoulder examination he found a mild/moderate global tenderness, negative for anterior and posterior instability, neurovascular examination was intact over the shoulder, and muscle strength was normal. For the left shoulder, there was severe global tenderness. Appellant was negative for anterior and posterior instability. Neurovascular examination was intact over the shoulder joint. Muscle strength was normal in the deltoid, triceps, biceps, and internal rotators. It was 4/5 in the external rotators. The right wrist had no atrophy. Soft touch and sharp/dull discrimination intact over the entire hand and radial pulses were intact bilaterally. Muscle strength was normal except grip strength rated at 3/5. The Phalen's and Tinel's sign at the carpal tunnel was negative. For the left wrist and hand, Dr. Allen noted no atrophy, moderate global tenderness, and intact soft touch and sharp/dull discrimination over the palmar surface of the hand. Radial pulses were intact bilaterally. Muscle strength was 3/5 for flexion and extension as well as grip strength, while it was normal for radial and ulnar deviation. Phalen's and Tinel's sign at the carpal tunnel was negative.

Dr. Allen used the ROM methodology to rate shoulder impairment.[6] He noted 110 degrees of right arm flexion was three percent impairment, 50 degrees of extension was no impairment, 105 degrees of abduction was three percent impairment, 40 degrees of adduction was no impairment, 50 degrees of internal rotation was two percent impairment, and 70 degrees of external rotation was no impairment. These totaled eight percent right arm permanent impairment. For the left shoulder, 105 degrees of flexion was three percent impairment, 60 degrees of extension was no impairment, 105 degrees of abduction was three percent impairment, 40 degrees of adduction was no impairment, 65 degrees of internal rotation was two percent impairment, and 75 degrees of external rotation was no impairment. These totaled eight percent left arm permanent impairment.

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

[6] *Id*. at 475, Table 15-34.

Dr. Allen noted the diagnosis-based impairment (DBI) methodology was used to rate right and left wrist impairment. He referenced the Wrist Regional Grid at Table 15-4, page 399 of the A.M.A., *Guides*. Dr. Allen noted "the DBI is a class one impairment with a default value of one percent upper extremity impairment." He assigned a functional history adjustment of two based on a *Quick*DASH score of 80, appellant's reports of pain with less-than-normal activity, and being able to perform self-care activities with modification but unassisted. The physical examination adjustment[7] was a grade modifier one (moderate palpatory findings, consistently documented, without observed abnormalities, motion mildly reduced in wrist flexion, negative for atrophy). The clinical studies adjustment[8] was not used as these were not available for review. Dr. Allen concluded that appellant had nine percent permanent impairment of each arm based on eight percent impairment of the shoulder region and one percent impairment of the wrist region. He asserted that the ROM method was the most accurate way to assess impairment in the shoulder region. Dr. Allen noted that he used the DBI method for the wrists, instead attempting to rate carpal tunnel syndrome as appellant's medical records lacked evidence of clinical diagnostic testing for carpal tunnel syndrome.

In a December 9, 2013 report, an OWCP medical adviser disagreed with Dr. Allen's impairment determination based on the motion measurements recorded. The medical adviser noted that on January 20, 2005 appellant underwent a left carpal tunnel release and in September 2006, she had a subacromial decompression on the left shoulder. He further noted that she subsequently had two cervical spine surgeries that were not work related. The medical adviser noted that, because there was DBI for shoulder tendinitis, the ROM method should not be used by Dr. Allen. He further noted that the impartial examination by Dr. Dzwinyk noted normal ROM for both shoulders and wrists without any significant neurological findings. The medical adviser noted the EMG completed March 8, 2011 identified no evidence of carpal tunnel syndrome, but instead showed electrophysiological evidence of a chronic cervical polyradiculopathy on the left involving the C7-Tl dermatomes. He found no objective evidence for any upper extremity impairment due to the shoulder or wrist conditions.

In a decision dated February 6, 2014, OWCP denied appellant's claim for a schedule award.

On February 10, 2014 appellant requested an oral hearing which was held on August 18, 2014.

By decision dated November 4, 2014, an OWCP hearing representative affirmed the February 6, 2014 decision.

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

[7] *Id*. at Table 15-8, p. 408.

[8] *Id*. at Table 15-9, p. 410.

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 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 OWCP properly denied appellant's request for 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

[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).

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

[12] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

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

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

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]

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 November 4, 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.

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

[16] *Supra* note 14.

ORDER

IT IS HEREBY ORDERED THAT the November 4, 2014 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.[17]

Issued: March 24, 2017
Washington, DC

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

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

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