United States Department of Labor
Employees' Compensation Appeals Board

G.G., Appellant	)	
and	)	**Docket No. 16-1686**
	)	**Issued: September 13, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Boston, MA, Employer	)	

Appearances:
Ron Watson, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 15, 2016 appellant, through his representative, filed a timely appeal from a May 4, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the Federal Employees' Compensation Act[3] (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] Appellant also filed a timely request for oral argument in this case. By order dated January 11, 2017 the Board, after exercising it discretion denied his request for oral argument as oral argument would further delay issuance of a Board decision and not serve a useful purpose. *Order Denying Request for Oral Argument*, Docket No. 16-1686 (issued January 11, 2017).

[3] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has more than seven percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board.[4] The facts of the case as presented in the prior appeal are incorporated herein by reference. The relevant facts are as follows.

On December 27, 2002 appellant, then a 41-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on December 26, 2002 he sustained a right shoulder injury when he slipped on ice. By decision dated February 13, 2003, OWCP accepted the claim for right shoulder sprain.

On May 5, 2010 appellant filed a recurrence claim (Form CA-2a) alleging a return/increase of disability. By decision dated October 7, 2010, OWCP accepted his recurrence claim which was expanded to include complete right rotator cuff rupture and subsequently, postoperative infection.

OWCP authorized surgery for right shoulder arthroscopy and biceps tendon repair and on December 16, 2010, appellant underwent right shoulder arthroscopy with extensive debridement, lysis of adhesions, biceps tenodesis, subacromial decompression with acromioplasty, rotator cuff repair, and distal clavicle excision. It approved a subsequent February 3, 2011 surgery resulting from a postoperative infection. Appellant then underwent a right shoulder arthroscopy with extensive debridement, complete synovectomy, loose body removal, and subacromial decompression. On February 8, 2011 he underwent an additional surgery for drainage of a pus collection in the subcutaneous tissues anteriorly. Appellant returned to full-time work on July 11, 2011. The record reflects that he received compensation benefits on the periodic rolls from December 19, 2010 until July 10, 2011.

On January 11, 2012 appellant filed a claim for a schedule award (Form CA-7). In support of his schedule award claim, he submitted a December 28, 2011 medical report from his treating physician, Dr. Byron V. Hartunian, a Board-certified orthopedic surgeon. In his report, Dr. Hartunian diagnosed acromioclavicular (AC) joint disease of the right shoulder, rotator cuff injury with full-thickness rotator cuff tear status post repair of the right shoulder, and biceps tendon tear status post tenodesis of the right shoulder. Using the diagnosis-based impairment (DBI) methodology and Table 15-5, in the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Hartunian opined that appellant had 22 percent permanent impairment of the right upper extremity. The rating was based on AC joint disease for 12 percent permanent impairment, rotator cuff tear for 7 percent permanent impairment, and biceps tendinitis and weakness for 5 percent permanent impairment.

On September 6, 2012 OWCP routed Dr. Hartunian's report, a statement of accepted facts (SOAF), and appellant's case record to Dr. Morley Slutsky, an OWCP medical adviser

[4] Docket No. 14-0359 (issued June 22, 2015).

Board-certified in occupational medicine, for an opinion regarding the extent of appellant's permanent impairment of the right upper extremity. In a September 6, 2012 report, Dr. Slutsky noted that appellant had a number of diagnoses which could be rated for permanent impairment. He related, however, that Dr. Hartunian improperly rated multiple conditions when only the diagnosis which produced the greatest potential impairment in accordance with section 15.2(e) and 15.3(f) of the A.M.A., *Guides* could be used. Dr. Slutsky found that the diagnosis of AC joint arthrosis status post distal clavicle resection had the greatest potential for impairment and agreed with Dr. Hartunian's 12 percent permanent impairment rating for this condition. He concluded that appellant's total right upper extremity impairment was 12 percent.

In a December 31, 2012 supplemental report, Dr. Hartunian reviewed Dr. Slutsky's report and disagreed with his conclusion that only one diagnosis could be used to calculate appellant's permanent impairment of the upper right extremity. While he agreed with Dr. Slutsky that the AC joint arthrosis status post clavicle excision was the highest ratable condition, he argued that ratings for the rotator cuff and biceps tendon tear should be combined due to the complex nature of the injuries. Dr. Hartunian again concluded that appellant was entitled to a schedule award for 22 percent permanent impairment of the right upper extremity.

On March 20, 2013 OWCP referred appellant to Dr. Kenneth J. Glazier, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict regarding the extent of permanent impairment between Dr. Hartunian and Dr. Slutsky.

In an April 16, 2013 medical report, Dr. Glazier provided a medical history and findings on physical examination. He agreed with Dr. Slutsky's assessment that only the highest rated diagnosis should be used, based on the A.M.A., *Guides*. Dr. Glazier opined, however, that the more appropriate diagnosis was the rotator cuff tear due to the lack of symptoms and findings at the AC joint. Pursuant to the DBI method, using Table 15-5, he calculated seven percent right upper extremity permanent impairment based on appellant's rotator cuff injury.

On May 7, 2013 OWCP requested that Dr. Robert Y. Pick, an OWCP medical adviser and Board-certified orthopedic surgeon, review the record regarding appellant's schedule award claim.

In a May 26, 2013 report, Dr. Pick agreed with Dr. Glazier's finding that appellant had seven percent permanent impairment of the right upper extremity. He noted that the impairment rating was based on the rotator cuff because it was the salient and major impairment, as opposed to the AC joint.

By decision dated June 28, 2013, OWCP granted appellant a schedule award for seven percent permanent impairment of the right upper extremity, finding that the weight of the medical evidence rested with Dr. Glazier's impartial medical evaluation. The date of maximum medical improvement (MMI) was noted as July 11, 2011. The award covered a period of 21.84 weeks from July 11 to December 10, 2011.

Appellant, through his representative, appealed to the Board on December 2, 2013. By decision dated June 22, 2015, the Board set aside OWCP's June 28, 2013 decision granting appellant a schedule award for seven percent permanent impairment of the right upper extremity

and remanded the case for further development. The Board found that the opinion of Dr. Glazier, serving as the impartial medical examiner, was of reduced probative value and failed to resolve the conflict in medical opinion as to whether appellant's schedule award should be based upon a single diagnosis and because his findings were internally inconsistent regarding findings on physical examination of the AC joint.[5]

Following the Board's June 22, 2015 remand, OWCP referred appellant, a SOAF, the case file, a medical conflict statement, and a series of questions to Dr. Murray Goodman, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve the continued conflict of medical opinion regarding the extent of appellant's permanent impairment of his right upper extremity. It requested Dr. Goodman discuss any points of disagreement and resolve the conflict as to whether appellant's permanent impairment should be based on a single diagnosis or multiple diagnoses, pursuant to the A.M.A., *Guides*.[6]

In a November 30, 2015 medical report, Dr. Goodman discussed appellant's medical history and review of diagnostic testing. He noted that, on December 16, 2010, appellant underwent a right shoulder arthroscopic debridement, subacromial decompression, rotator cuff repair, and distal clavicle resection, but a complete repair of the rotator cuff could not be accomplished. Postoperatively, appellant developed a wound infection and underwent surgery again in February 2011. Physical examination findings of the right shoulder revealed nonfocal tenderness, range of motion (ROM) findings of 130 degrees of forward flexion, 180 degrees of abduction, mild snapping, external rotation at 60 degrees, internal rotation at 50 degrees, mild pain, and mild weakness on resisted abduction and external rotation. Dr. Goodman identified diagnoses of right shoulder sprain, complete rotator cuff rupture of the right shoulder, and postoperative infection which were causally related to appellant's work injury. He also noted a diagnosis of AC joint arthritis of the right shoulder which he opined was a preexisting condition, but could have predisposed him to or increased his risk of the work injury. Dr. Goodman explained that MMI had been obtained following the surgery.

Dr. Goodman opined that appellant had seven percent permanent impairment of the right upper extremity in accordance with the A.M.A., *Guides* (6th ed. 2009).[7] He explained that, with respect to the shoulder, it is not uncommon for rotator cuff tears, superior labrum from anterior to posterior lesion or other labral lesions, and biceps tendon pathology to be present simultaneously. Dr. Goodman noted that the evaluator was expected to choose the most significant diagnosis and rate only that diagnosis using the DBI method.[8] Utilizing Table 15-5 Shoulder Regional Grid for Upper Extremity Impairments, Dr. Goodman identified the most significant diagnosis as rotator cuff injury, full thickness tear under a class one impairment for residual loss.[9] He noted that it was not appropriate to utilize AC joint injury or disease because

[5] *Id.*

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

[7] *Id*.

[8] *Id.* at 390, section 15.2e.

[9] *Id.* at 403.

although the AC joint arthritis was present, it was a preexisting condition, not related to his work injury, and not accepted by OWCP. Dr. Goodman assigned for functional history a grade modifier of 2 based on a *Quick*DASH score of 56.67[10] and physical examination a grade modifier of 2.[11] Clinical studies were not utilized because the magnetic resonance imaging scan was used to establish the impairment class. Dr. Goodman applied the net adjustment formula which resulted in two, moving appellant to grade E with an adjusted impairment rating of seven percent permanent impairment of the right upper extremity.[12]

On January 29, 2016 OWCP routed Dr. Hartunian's December 28, 2011 report, Dr. Slutsky's September 6, 2012 report, Dr. Goodman's November 30, 2015 report, a SOAF, and the case file to Dr. Taisha S. Williams, an OWCP district medical adviser (DMA), for an opinion on Dr. Goodman's impairment rating. It noted that the case was referred for an impartial medical examination in order to resolve a conflict of medical opinion between Dr. Hartunian and Dr. Slutsky with regard to the percentage of permanent impairment of the right upper extremity. OWCP identified the accepted conditions of adhesive capsulitis of the right shoulder, complete rotator cuff tear or rupture of the right shoulder, sprain of right shoulder and upper arm, and postoperative infection.

In a February 28, 2016 medical report, Dr. Williams reported that Dr. Goodman correctly applied the criteria/tables in the A.M.A., *Guides* and noted the correct date of MMI.

In a May 4, 2016 *de novo* decision, OWCP found that, based upon the report of Dr. Goodman appellant was not entitled to additional schedule award for permanent impairment of the right upper extremity.

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.[13] 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.[14] 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

[10] *Id.* at 406, Table 15-7.

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

[12] *Id.* at 411.

[13] *See* 20 C.F.R. §§ 1.1-1.4.

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

implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[15]

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).[16] 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.[17]

ANALYSIS

OWCP accepted appellant's claim for sprain of right shoulder and upper arm, adhesive capsulitis of the right shoulder, complete rotator cuff tear or rupture of the right shoulder, and postoperative infection. The issue is whether appellant sustained more than seven percent permanent impairment of the upper right extremity, for which he previously received a schedule award. The Board finds that this case is not in posture for decision.

In its June 22, 2015 decision, the Board found that the conflict in medical evidence between the opinions of Dr. Slutsky and Dr. Hartunian was well defined in their reports. Dr. Hartunian contended that appellant's unusual medical history and array of symptoms required that a schedule award include multiple diagnoses while Dr. Slutsky found that appellant's symptoms and impairment were accurately reflected in a single diagnosis. As Dr. Glazier, serving as the impartial medical examiner, failed to explain or resolve this conflict, the Board set aside OWCP's June 28, 2013 decision and remanded the case for further medical development.

On remand OWCP requested Dr. Goodman, serving as the impartial medical examiner, discuss any points of disagreement and resolve the conflict of whether the permanent impairment is based on a single diagnosis or multiple diagnoses. In his November 30, 2015 report, Dr. Goodman utilized the DBI method and identified the diagnosis as rotator cuff injury, full-thickness tear with residual loss under a class 1 impairment and opined that appellant was entitled to seven percent permanent impairment of the upper right extremity. Dr. Williams, serving as an OWCP DMA, reviewed this referee report and agreed with his findings.

[15] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

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

The issue on appeal is whether appellant has more than seven percent permanent impairment of his right 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 had been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[18] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[19] In *T.H.*, the Board concluded that OWCP physicians were 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 observed that physicians interchangeably cited to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians were inconsistent in the application of the A.M.A., *Guides*, the Board found that OWCP could no longer ensure consistent results and equal justice under the law for all claimants.[20]

In order to ensure a consistent result and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the May 4, 2016 decision. Utilizing a consistent method for calculating permanent impairment for upper extremities applied uniformly, and after 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 that this case is not in posture for a decision.

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

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

[20] *Supra* note 18.

ORDER

IT IS HEREBY ORDERED THAT the May 4, 2016 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: September 13, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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