United States Department of Labor
Employees' Compensation Appeals Board

T.R., Appellant	)	
and	)	**Docket No. 17-1961**
	)	**Issued: December 20, 2018**
DEPARTMENT OF JUSTICE, FEDERAL CORRECTIONAL COMPLEX, Coleman, FL, Employer	)	

Appearances:
Capp P. Taylor, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 20, 2017 appellant, through counsel, filed a timely appeal from a July 19, 2017 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 met his burden of proof to establish greater than five percent permanent impairment of the left upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On March 2, 2004 appellant, then a 42-year-old lieutenant, was involved in an employment-related incident.[3] OWCP accepted his traumatic injury claim (Form CA-1) for left rotator cuff syndrome. On May 25, 2010 it also accepted the claim for left shoulder impingement syndrome.[4] On August 30, 2004 appellant underwent OWCP-approved left shoulder surgery.[5]

On September 22, 2016 appellant filed a claim for a schedule award (Form CA-7).

By development letters dated September 28 and October 4, 2016, OWCP acknowledged receipt of appellant's Form CA-7 claim for a schedule award. It advised him of the information needed to support his claim including a detailed narrative medical report from his treating physician, based on a recent examination that sets forth an opinion on maximum medical improvement (MMI) and a rating of permanent impairment in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[6]

In support of his claim, appellant submitted an October 7, 2015 impairment rating report from Dr. Samy F. Bishai, an orthopedic surgeon. Dr. Bishai examined appellant and provided a history of injury, physical examination findings, a list of diagnoses related to the employment injury, and an assessment of permanent impairment. As to the left shoulder he reported tenderness overlying the anterior, lateral, and posterior aspects of the left shoulder joint; range of motion showed flexion to 80 degrees where normal is 150 degrees; extension is 15 degree where normal is 40 degrees; abduction is 80 degrees where normal is 150 degrees; adduction is 15 degrees where normal is 150 degrees; and external rotation of 45 degrees where normal is 90 degrees and internal rotation is 20 degrees where normal is 40 degrees. He diagnosed rotator cuff syndrome of the left shoulder joint, left shoulder impingement syndrome, severe supraspinatus tendinitis of the left shoulder, and status postoperative arthroscopic surgery for treatment of shoulder impingement syndrome and rotator cuff syndrome and tears. Dr. Bishai also noted that appellant had a severe

[3] Appellant's left shoulder was injured moving a mattress.

[4] The employing establishment accommodated appellant with light-duty work on an intermittent basis from the date of the injury until May 15, 2005, when he was placed on total disability. Appellant was referred for vocational rehabilitation efforts and on February 23, 2010, he worked as an editor/writer for a magazine with wages of $400.00 per week. On September 4, 2014 OWCP terminated appellant's wage-loss compensation effective that date. It found that he no longer had residuals of the injury. By decision dated July 2, 2015, OWCP's hearing representative affirmed the September 4, 2014 decision.

[5] Appellant underwent arthroscopic labrum repair of the shoulder (SLAP) repair, arthroscopic supraspinatus rotator cuff debridement, arthroscopic subacromial decompression, and subacromial pain catheter placement.

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

disability because of the marked reduction in the range of motion of the left shoulder joint and the difficulty of doing activities of daily living. He related that appellant was forced to retire on medical disability because of the severity of his condition and the marked reduction in the range of motion and the severe pain he experienced in his left shoulder joint.

Dr. Bishai referred to the sixth edition of the A.M.A., *Guides* and explained that he utilized the stand-alone range of motion (ROM) methodology for calculating permanent impairment because appellant's loss of range of motion of the left shoulder joint had become the primary disability for the patient due to the residuals from the injury of his shoulder injury of March 5, 2004. He referred to Table 15-34 for shoulder range of motion and indicated that it dealt with impairment ratings related to the deficits of the range of movement of the shoulder joint.[7] Dr. Bishai explained that flexion was 80 degrees which corresponded to nine percent upper extremity impairment, extension was to 15 degrees, which corresponded to two percent upper extremity impairment, abduction to 80 degrees, which corresponded to six percent upper extremity impairment, adduction to 15 degrees, which corresponded to one percent upper extremity impairment, internal rotation to 20 degrees, which corresponded to four percent upper extremity impairment, and external rotation was 45 degrees, which corresponded to two percent upper extremity impairment. Dr. Bishai explained that all the values were added, not combined, since they were dealing with one and the same joint, according to the A.M.A., *Guides.* He explained that the impairments of (9+2+6+1+4+2) corresponded to a total of 24 percent left upper extremity impairment due to loss of shoulder range of motion (ROM) under the A.M.A., *Guides*.[8] Dr. Bishai opined that MMI had been reached on October 7, 2015.

OWCP's district medical adviser (DMA), Dr. Jovito Estaris, specializing in occupational medicine, reviewed the claim on November 8, 2016. He noted that a functional capacity evaluation (FCE) performed on March 28, 2005, revealed measurements for range of motion that showed: flexion of 124 degrees, extension of 55 degrees, abduction of 87 degrees, internal rotation of 55 degrees, and external rotation of 62 degrees. The DMA had noted that an April 15, 2014 second opinion report of Dr. Jonathan Black, a Board-certified orthopedic surgeon, revealed continued pain over the left shoulder with certain activities. He advised that the range of motion of the left shoulder on that date revealed full range of motion with strength testing of 5 out of 5 in all muscle groups. The DMA noted that appellant could return to preinjury work duty. He reviewed Dr. Bishai's October 7, 2015 report and noted that "inexplicably," his measurement of ranges of motion was remarkably different from previous physicians. The DMA noted his measurements, but advised that there were not three sets of measurements as recommended by the A.M.A., *Guides*. He also noted that most of the measurements did not end in 0. The DMA explained that there was a gap as to when the measurements were taken, but the usual course of events was either stability of range of motion or mild improvement. He recommended another evaluation by an independent medical examiner, who was a Board-certified orthopedic surgeon. The DMA recommended not accepting the evaluation rating of Dr. Bishai and waiting for a second opinion.

[7] Table 15-34, A.M.A., *Guides* 475 (6th ed. 2009).

[8] Table 15-34, A.M.A., *Guides* 475.

On November 14, 2016 OWCP referred appellant for a second opinion examination with Dr. Richard C. Smith, a Board-certified orthopedic surgeon, for purposes of obtaining an impairment rating as recommended by the DMA.

In a December 8, 2016 report, Dr. Smith noted appellant's history of injury and treatment and examined appellant. He noted that the accepted condition was left rotator cuff syndrome and left shoulder impingement syndrome. Dr. Smith provided findings which included subjective complaints of left shoulder pain with weakness and numbness. He also found pain with overhead motion. Dr. Smith found objective findings to include: restricted flexion and abduction as well as internal and external rotation of the left shoulder, tenderness of the supraspinatus, and x-rays that showed postoperative changes.

Dr. Smith utilized the diagnosis-based impairment (DBI) methodology for rating permanent impairment, referred to Table 15-5,[9] and utilized the shoulder regional grid to find a class 1 for diagnosis of impingement syndrome. He referred to Table 15-7[10] for functional history and noted that appellant would have a grade modifier of 2 for pain symptoms with normal activity. Dr. Smith referred to Table 15-8[11] and determined that appellant qualified for a grade modifier of 2 for a moderate problem with instability and decreased range of motion. He also referred to clinical studies in Table 15-9[12] and found a grade modifier 1. Dr. Smith utilized the net adjustment formula, the grade modifier of 2 for functional history minus the class 1 and found 1. He noted the grade modifier for the physical examination of 2 minus the class 1 would be 1 and the clinical studies would be 1 minus the class 1, or 0. Dr. Smith found the net adjustment of +2. He referred to Table 15-10[13] and found a net adjustment of 2, which would take him from a default grade of C to an E. Dr. Smith utilized Table 15-5[14] with a class 1 due to some residual loss of function with normal motion and explained that appellant went from a default grade of C, which was 3 percent to the right, or 5 percent permanent impairment. He explained that the DBI methodology more accurately depicted appellant's condition and took into consideration his loss of motion. Dr. Smith also explained that he did not disagree with Dr. Bishai's calculation, but he believed that the DBI method "better reflects the claimant's overall condition." He indicated that appellant reached MMI on December 8, 2016.

On March 7, 2017 OWCP requested clarification and an addendum report from the DMA, Dr. Estaris.

In a May 3, 2017 report, the DMA noted that he had reviewed the reports of second opinion physician Dr. Smith, and treating physician Dr. Bishai. Dr. Estaris explained that the range of motion measurements from Dr. Smith were 100 degrees of flexion and abduction to 90 degrees.

[9] A.M.A., *Guides* 402.

[10] *Id.* at 406.

[11] *Id.* at 408.

[12] *Id.* at 410.

[13] *Id.* at 402.

[14] *Id.*

He noted that Dr. Bishai found 80 degrees of flexion and 80 degrees of abduction. Dr. Estaris also indicated that the impairment rating of Dr. Smith was made using the DBI methodology with rotator cuff syndrome with impingement of the left shoulder. He concluded that appellant had five percent left upper extremity permanent impairment, utilizing the same method as Dr. Smith.

By letters dated June 3, and July 5 and 10, 2017, counsel requested an update regarding the status of appellant's schedule award claim.

On July 5, 2017 OWCP received an undated addendum from the DMA. He explained that the missing data was using the ROM method for impairment. The DMA explained that his review of the ranges of motion measured by both Drs. Smith and Bishai were inconsistent and opined that there were significant differences between the two measurements. He explained that neither physician followed the A.M.A., *Guides* for impairment ROM rating because there were not three sets of measurements. Furthermore, Dr. Bishai's measurements contained some numbers which did not end in zero. He opined that use of the ROM methodology was not possible in the case. Dr. Bishai recommended another independent examination by a Board-certified orthopedic surgeon to provide an impairment rating based on the ROM method utilizing the guidelines imposed by the A.M.A., *Guides.*

By decision dated July 19, 2017, OWCP granted appellant a schedule award for five percent impairment of the left upper extremity. The award covered a period of 15.6 weeks, from December 8 to March 27, 2017. OWCP based the award on the second opinion's December 8, 2016 rating and the DMA's May 3, 2017 impairment rating, noting that the DMA determined that appellant's physician had "incorrectly applied the [*Guides*]…."

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.[15] 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.[16] 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.[17]

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

[15] *See* 20 C.F.R. §§ 1.1-1.4.

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

[17] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

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).[18] 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.[19]

The sixth edition requires identifying the impairment for the class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).[20] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[21]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "As the [A.M.A.,] *Guides* caution that, if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
>
> "Upon initial review of a referral for upper extremity evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, the DBI or ROM) and (2) whether the applicable tabled in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original).[22]
>
> The Bulletin further advises:
>
> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA

[18] *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 2.808.6a (March 2017).

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

[20] A.M.A., *Guides* 494-531.

[21] *Id.* at 521.

[22] FECA Bulletin No. 17-06 (issued May 8, 2017).

should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[23]

ANALYSIS

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

Following development of this schedule award claim the DMA, Dr. Estaris, provided an addendum, which was undated, but received on July 19, 2017 in which he explained that data was missing for the ROM impairment calculations.[24] He indicated that he had reviewed of the ranges of motion measured by both Drs. Smith and Bishai and found that they were inconsistent because there were significant differences between the two measurements. He explained that neither physician followed the A.M.A., *Guides* for ROM impairment rating because there were not three sets of measurements. Furthermore, the DMA noted Dr. Bishai's measurements contained some numbers which did not end in zero. He explained that an ROM impairment rating was not possible in the case and recommended another independent examination by a Board-certified orthopedic surgeon to provide an impairment rating based on the ROM method utilizing the guidelines imposed by the A.M.A., *Guides.*

The Board finds that OWCP in its July 19, 2017 decision noted that OWCP had merely noted the DMA's May 3, 2017 report. However, it made no mention of his undated addendum received on July 5, 2017. Thus, his recommendation to further develop the medical evidence was not followed. The Board notes that proceedings under FECA are not adversarial in nature, and OWCP is not a disinterested arbiter. The claimant has the burden of proof to establish entitlement to compensation. However, OWCP shares responsibility in the development of the evidence to see that justice is done.[25] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[26] As the DMA recommended further development to include an independent examination to provide an impairment rating based on the ROM method utilizing the guidelines imposed by the A.M.A., *Guides,* further development is needed.

On remand OWCP should further develop the medical evidence of record in accordance with the recommendations of the DMA and FECA Bulletin No. 17-06,[27] and obtain an opinion as to the extent of permanent impairment of the right upper extremity causally related to his March 2, 2004 employment injury after obtaining proper range of motion measurements. OWCP should request the examining physician to conduct appropriate examination of the extremities, including providing the absent range of motion measurements as indicated by the DMA. Following this and

[23] *Id.*

[24] The record reflects that he provided the addendum on July 19, 2017.

[25] *William J. Cantrell*, 34 ECAB 1223 (1983).

[26] *Richard F. Williams*, 55 ECAB 343, 346 (2004).

[27] *Supra* note 23.

any other further development as deemed necessary, it 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 July 19, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: December 20, 2018
Washington, DC

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

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

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