United States Department of Labor
Employees' Compensation Appeals Board

K.S., Appellant	)	
and	)	**Docket No. 17-1922**
	)	**Issued: July 12, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Jersey City, NJ, Employer	)	

Appearances:
Michael D. Overman, 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 12, 2017 appellant, through counsel, filed a timely appeal from a June 12, 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 to consider 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 more than 24 percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On June 2, 1997 appellant, then a 42-year-old mail hander, filed a traumatic injury claim (Form CA-1) alleging that, on May 29, 1997, she was keying on a sack sorting machine when a 60-pound parcel came down the shoot and struck her in the back of her left shoulder and back of her left upper arm. On July 24, 1997 OWCP accepted her claim for left shoulder strain.[3] On January 11, 2007 it expanded acceptance of the claim to include the additional condition of cervical sprain.

In a report dated January 30, 2007, appellant's attending physician, Dr. Anil K. Sharma, a Board-certified in pain medicine and anesthesiology, diagnosed complex regional pain syndrome (CRPS) of the left upper extremity. He opined that this condition was related to appellant's initial shoulder injury which had occurred almost 10 years prior.

On February 9, 2007 OWCP referred appellant for a second opinion evaluation with Dr. Zohar Stark, a Board-certified orthopedic surgeon. In his February 22, 2007 report, Dr. Stark found that her left shoulder sprain had resolved, but he noted neurogenic pain originating from her cervical area.

In a letter dated June 29, 2007, OWCP referred appellant for an impartial medical examination with Dr. Ian Fries, a Board-certified orthopedic surgeon, to resolve the conflict between Drs. Sharma and Stark, regarding appellant's current medical diagnosis and its relationship to her accepted employment injuries. In his August 14, 2007 report, Dr. Fries noted the accepted left shoulder and cervical strains and also diagnosed chronic degenerated C6-7 disc, probable adhesive capsulitis left shoulder, global left upper extremity pain, nonphysiological etiology, and unconfirmed total loss of sensation in left ring and little fingers. He found that appellant had 22 percent permanent impairment of the left upper extremity based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

Counsel requested a schedule award for appellant's left upper extremity permanent impairment on December 24, 2008 and provided a report dated October 14, 2008 from Dr. Arthur Becan, an orthopedic surgeon. Dr. Becan diagnosed chronic post-traumatic cervical strain and sprain, brachial plexus stretch injury to the left upper extremity, left carpal tunnel syndrome, herniated C6-7 disc, labral tear of the left shoulder, aggravation of impingement syndrome of the left shoulder, rotator cuff tendinopathy of the left shoulder, post-traumatic adhesive capsulitis of the left shoulder, and chronic post-traumatic adhesive capsulitis of the left shoulder. He found that

[3] The acceptance decision references a right shoulder strain, but this appears to be a typographical error given that appellant's claim form described only a left shoulder injury.

[4] A.M.A., *Guides*, 5th ed. (2001).

appellant had 40 percent permanent impairment of the left upper extremity under the fifth edition of the A.M.A., *Guides*.

OWCP's medical adviser, Dr. Henry J. Magliato, a Board-certified orthopedic surgeon, reviewed Dr. Becan's report on February 4, 2009 and recommended an additional impartial medical examination due to the "considerable conflict of medical opinion between these various examiners."

Appellant filed a schedule award claim (Form CA-7) on February 18, 2009.

In a letter dated January 5, 2010, OWCP requested that Dr. Becan evaluate appellant's percentage of permanent impairment under the sixth edition of the A.M.A., *Guides* (2009).

On February 5, 2010 Dr. Becan updated his October 14, 2008 report and found that appellant had a class 2 left brachial plexus impairment with mild sensory deficit and CRPS or 20 percent impairment. He also found that she had loss of range of motion (ROM) of the left shoulder at 90 degrees of flexion and 80 degrees of abduction for nine percent permanent impairment. Dr. Becan combined appellant's upper extremity impairments to conclude that appellant had 32 percent permanent impairment of the left upper extremity and that she had reached maximum medical improvement (MMI) on October 14, 2008.

On March 26, 2010 OWCP referred Dr. Becan's updated medical report back to its medical adviser, Dr. Magliato. In his March 29, 2010 report, Dr. Magliato applied Table 15-26 of the A.M.A., *Guides*[5] to Dr. Becan's findings and determined that appellant had a class 1 impairment with mild sensory deficit of the C7 nerve root. He utilized the grade modifiers as determined by Dr. Becan and reached an impairment rating of 13 percent of the left upper extremity due to the brachial plexus injury. Dr. Magliato further found that appellant had 9 percent impairment of the left shoulder due to loss of ROM[6] and combined these ratings to reach 21 percent impairment of the left upper extremity. He found that Dr. Becan's impairment rating of 32 percent permanent impairment was too high and was based on the incorrect higher brachial plexus injury, rather than the accepted cervical sprain although he "did compute values for the [b]rachial [p]lexus itself." Dr. Magliato found that appellant reached MMI on October 14, 2008.

On April 14, 2010 OWCP requested clarification from Dr. Magliato, noting that the accepted conditions were sprain of the left shoulder and sprain of the neck. It asked whether appellant had experienced a brachial plexus injury as a result of the May 29, 1997 employment injury. Dr. Magliato responded on April 16, 2010 and noted that he awarded nine percent permanent impairment due to loss of ROM of appellant's shoulder. He opined that appellant had not sustained an accepted brachial plexus injury and that Dr. Becan improperly included 13 percent permanent impairment for brachial plexus injury in his permanent impairment rating for schedule award purposes.

[5] A.M.A., *Guides*, 454, Table 15-26.

[6] *Id.*, at 477, Table 15-35.

OWCP found a conflict of medical opinion between Dr. Becan and Dr. Magliato, and on August 16, 2010 referred appellant, along with a statement of accepted facts (SOAF) and the medical record, for an impartial medical examination with Dr. Michael H. Gordon, a Board-certified orthopedic surgeon.

In his September 25, 2010 report, Dr. Gordon noted appellant's history of injury on May 29, 1997. He reviewed her medical records and performed a physical examination. Dr. Gordon noted that appellant's physical examination findings, including left shoulder ROM with three measures of each, abduction of 50, 60, and 50 degrees on the left, adduction of 20, 25, and 20 on the left, forward flexion of 50, 50, and 60 on the left, internal rotation of 20, 20, and 30 on the left, external rotation of 20, 10, and 5 on the left, and extension of 30, 20, and 30 degrees on the left.

Dr. Gordon applied the sixth edition of the A.M.A., *Guides* to his findings on physical examination considering appellant's accepted conditions of cervical strain and sprain of the left shoulder. He noted that ROM was used primarily as a physical examination adjustment factor and only to determine actual impairment values when a grid permitted its use. Dr. Gordon further noted that ROM rating could not be combined with other approaches under the A.M.A., *Guides*. He found that appellant did not exhibit CRPS in her upper left extremity in accordance with the A.M.A., *Guides*. Dr. Gordon reviewed the criteria including continuing pain disproportionate to any inciting event, vasomotor changes, pseudomotor changes, trophic changes, and radiographic studies. He determined that appellant exhibited none of these findings and further explained that in his experience if she had severe loss of motor strength, then she would also exhibit significant atrophy, which was not present on physical examination. Dr. Gordon found no objective criteria for CRPS as set forth in the A.M.A., *Guides*.[7] He further noted that the lack of atrophy in the left upper extremity and lack of trophic changes were inconsistent with appellant's complaints of total loss of sensation in the left little finger and ring finger. Dr. Gordon concluded, based on his experiences and the objective findings at the time of examination, that there was no CRPS due to her accepted employment injuries. He further found that appellant's physical examination did not support either peripheral nerve involvement or brachial plexopathy on the left. Dr. Gordon noted that there were no electromyograph findings compatible with these diagnoses and that her objective findings did not support either of these diagnoses.[8]

Dr. Gordon applied Table 15-5 of the A.M.A., *Guides*,[9] to address appellant's diagnosed condition of shoulder sprain and applied the ROM criteria. He found that flexion on the left of 50 degrees was nine percent permanent impairment of the upper extremity.[10] Dr. Gordon determined that 30 degrees of extension was 1 percent permanent impairment of the upper extremity, that 50 degrees of abduction was 6 percent permanent impairment of the upper extremity, adduction of 25 degrees was 1 percent permanent impairment, internal rotation of 20 degrees was 4 percent

[7] A.M.A., *Guides* 453-54, Table 15-24; Table 15-25; Table 15-26.

[8] Dr. Gordon did not address or make findings regarding appellant's date of MMI.

[9] A.M.A., *Guides* 401, Table 15-5.

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

permanent impairment and external rotation of 20 degrees was 2 percent permanent impairment to reach 23 percent permanent impairment of appellant's left upper extremity.[11]

In a letter dated November 22, 2011, counsel noted that there was an outstanding schedule award request and that appellant had attended an impartial medical examination with Dr. Gordon. On February 3, 2012 he requested action from OWCP on her request for a schedule award. In a letter dated May 2, 2012, counsel requested that OWCP, at a minimum, grant appellant a schedule award for 23 percent permanent impairment of her left upper extremity in accordance with Dr. Gordon's report.

OWCP responded on May 16, 2012 and noted that Dr. Gordon's report was improperly reviewed by Dr. Magliato and that this report must be reviewed by a different OWCP medical adviser.[12] In a letter dated May 30, 2012, it reported that Dr. Gordon did not indicate that appellant had reached MMI and that no further action could be taken on her schedule award claim until she provided detailed medical evidence establishing that she had reached MMI.

In a letter dated June 28, 2012, counsel protested that Dr. Becan found that she had reached MMI years prior and that Dr. Gordon was silent on this issue. In a letter dated March 1, 2013, he again requested a final decision addressing appellant's permanent impairment. On March 29, 2013 OWCP again indicated that she had not reached MMI. Counsel responded on May 3, 2013 and noted that Dr. Becan found that appellant had reached MMI on October 14, 2008.

In a letter dated April 2, 2014, OWCP found a conflict of medical opinion evidence between Drs. Becan and Magliato regarding appellant's diagnosed condition. It referred her, a SOAF, and a list of questions to Dr. Ian Fries, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the disagreement. In a letter dated April 11, 2014, counsel informed OWCP that Dr. Fries had previously examined appellant on August 8, 2007.

In a letter dated October 6, 2014, OWCP referred appellant, a SOAF, and a list of questions to Dr. Robert Dennis, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the issues of her diagnosis and the extent of her impairment for schedule award purposes.

Dr. Dennis completed a report on December 10, 2014 reviewing the SOAF, noting appellant's history of injury, and her medical treatment. He performed a physical examination and noted that she was not providing her full effort. Dr. Dennis opined that appellant's muscle and strength testing was so erratic and inconsistent that much of test results had to be discarded because the variation was outside the range of acceptable. He examined her cervical spine and found no evidence of clinical pathology in the cervical spine that related to any ongoing radiculopathy. Dr. Dennis examined appellant's brachial plexus and found no evidence of atrophy or weakness in any of the muscles of the left upper extremity. He concluded that the variation of evidence of weakness of the left hand was totally voluntary and that appellant had no sensory deficit. Dr. Dennis diagnosed resolved cervical sprain, osteoarthritis, and degenerative changes in the

[11] *Id.*

[12] The Board review of the case record does not establish that it includes a report from Dr. Magliato reviewing Dr. Gordon's report.

cervical spine which preexisted her employment injury, herniated discs at C6-7 which were not symptomatic, resolved carpal tunnel syndrome, shoulder sprain, impingement syndrome still persistent with adhesive capsulitis, labral tear, persistent tendinopathy of the left shoulder, reflex sympathetic dystrophy or CRPS completely resolved, and no current evidence of persistent neurological damage to the brachial plexus. He found that appellant reached MMI on October 14, 2008.

In regard to appellant's left shoulder, Dr. Dennis found no residual functional impairment regards to a neural deficit relating to either radiculopathy, brachial plexus pathology, or sympathetic dystrophy. He noted that her ROM in her left shoulder was abnormal. Dr. Dennis reported 80 degrees or shoulder flexion, 30 degrees, of shoulder extension, 80 degrees of shoulder abduction, 5 degrees of shoulder adduction, 5 degrees of external rotation, and 10 degrees of internal rotation. He noted that these motion deficits were reproducible and were measured no less than five times, and then he reported the average. Dr. Dennis concluded that appellant's loss of ROM in her left shoulder was consistent with adhesive capsulitis and longstanding lack of full motion. He applied the diagnosis-based estimates of the A.M.A., *Guides* and determined that she had no more than five percent permanent impairment of her left upper extremity. Dr. Dennis found that appellant had 18 percent permanent impairment based on loss of ROM of the left upper extremity.

OWCP referred Dr. Dennis' report to an OWCP medical adviser, Dr. Andrew Merola, a Board-certified orthopedic surgeon, on March 10, 2015. In his March 13, 2015 report, Dr. Merola requested clarification of the net adjustment formula and calculations used by Dr. Dennis to reach his impairment rating.

Dr. Dennis completed an addendum on April 27, 2015 and opined that he had already provided the requested information. He noted that he agreed with Dr. Magliato's methodology and provided an excerpt from his March 29, 2010 report. On August 13, 2015 OWCP referred Dr. Dennis' supplemental report to Dr. Magliato. In his August 18, 2015 report, Dr. Magliato found Dr. Dennis' impairment rating confusing and requested further clarification.

In a letter dated September 14, 2015, OWCP requested a second supplemental report from Dr. Dennis. Dr. Dennis responded on October 7, 2015 and concluded: "I am inclined not to reexplain what has already been explained very thoroughly to be best of my ability on two, and now three, separate occasions."

In a report dated January 12, 2016, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, serving as OWCP medical adviser, found that appellant had 24 percent upper extremity impairment, based on loss of ROM. He found 9 percent permanent impairment for loss of shoulder flexion, 1 percent permanent impairment for loss of shoulder extension, 6 percent permanent impairment for loss of shoulder abduction, 2 percent permanent impairment for adduction, 4 percent permanent impairment for loss of internal rotation, and 2 percent permanent impairment for loss of external rotation.[13] Dr. Harris listed appellant's date of MMI as December 10, 2014.

[13] *Supra* note 10.

By decision dated February 23, 2016, OWCP granted appellant a schedule award for 24 percent permanent impairment of the left upper extremity.

Counsel requested an oral hearing before an OWCP hearing representative on March 2, 2016. In a letter dated July 8, 2016, he amended his request to a review of the written record. Counsel requested a new impartial medical examination as Dr. Dennis did not clarify his opinion.

By decision dated August 24, 2016, OWCP's hearing representative found that OWCP had improperly developed appellant's schedule award claim. He noted that the schedule award granted was not based on Dr. Dennis' rating and that Dr. Dennis' rating was not sufficiently rationalized to resolve the conflict. The hearing representative noted that OWCP improperly referred Dr. Dennis' report to Dr. Magliato. OWCP's hearing representative found that Dr. Gordon was properly designated as an impartial medical examiner. He further found that there was no evidence that Dr. Magliato had reviewed Dr. Gordon's report. OWCP's hearing representative remanded the case for an OWCP medical adviser to review Dr. Gordon's report and noted that there was no issue regarding appellant's date of MMI.

OWCP's medical adviser, Dr. Morley Slutsky, a Board-certified occupational medicine specialist, reviewed the medical evidence on November 1, 2016 and found that Dr. Gordon appropriately applied the A.M.A., *Guides* to reach a final left upper extremity impairment of 23 percent impairment of the left upper extremity based on loss of ROM.

By decision dated February 17, 2017, OWCP found that appellant had no more than 24 percent impairment of her left upper extremity for which she had previously received a schedule award. On February 28, 2017 counsel requested an oral hearing from OWCP's Branch of Hearings and Review. At the oral hearing on May 9, 2017, he argued that appellant's schedule award should include impairment ratings for CRPS and brachial plexopathy.

By decision dated June 12, 2017, OWCP's hearing representative found Dr. Gordon's report represented the special weight of the medical evidence and found that appellant had no more than 23 percent permanent impairment of her left upper extremity warranting a schedule award.

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 FECA program with the Director of OWCP.[14] 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.[15] 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

[14] *See* 20 C.F.R. §§ 1.1-1.4.

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

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.[16] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[17] 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.[18]

The A.M.A., *Guides* provide a diagnosis-based impairment (DBI) method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF) for upper extremity impairments. The evaluator identifies 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).[19] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[20]

The A.M.A., *Guides* also provide that ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[21] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[22] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[23]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology based versus the ROM methodology for rating of upper extremity impairments.[24] Regarding the application of ROM or DBI methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "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

[16] 20 C.F.R. § 10.404. *See C.J.*, Docket No. 17-1570 (issued February 9, 2018); *Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

[18] *C.J.*, *supra* note 16; *Isidoro Rivera*, 12 ECAB 348 (1961).

[19] A.M.A., *Guides* 405-18.

[20] *Id.*

[21] *Id.* at 461.

[22] *Id.* at 473.

[23] *Id.* at 474.

[24] FECA Bulletin No. 17-06. This Bulletin was effective for all decisions issued by OWCP on and after May 8, 2017.

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 impairment evaluation, the district medical adviser (DMA) should identify: (1) the methodology used by the rating physician (*i.e.*, DBI or ROM), and (2) whether the applicable tables in Chapter 15 of the A.M.A., *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the* A.M.A., *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).[25]

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 should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[26]

ANALYSIS

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

OWCP accepted appellant's claim for left shoulder strain and cervical sprain. The issue is whether appellant sustained more than 24 percent permanent impairment of her left upper extremity for which she previously received a schedule award.

Dr. Gordon rated appellant's permanent impairment of the left shoulder pursuant to Table 15-34 of the A.M.A., *Guides*, for loss of shoulder ROM.[27] The Board notes that Table 15-5, the Shoulder Regional Grid, does allow, by asterisk, that shoulder strain or sprain be alternatively evaluated as a ROM impairment.[28] Under FECA Bulletin No. 17-06.5, 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 should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the [claims examiner].

Because Dr. Gordon provided a rating based upon appellant's loss of ROM which was allowed (for a diagnosed condition followed by an asterisk) under Table 15-5 of the A.M.A., *Guides*, DMA Dr. Slutsky, should have independently calculated appellant's impairment using both the ROM and DBI method and identified the higher rating for the claims examiner. If the medical evidence of record was insufficient for the DMA to render a rating using the ROM

[25] A.M.A., *Guides* 477.

[26] *Id.*

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

[28] *Id.* at 401, Table 15-5.

methodology, the DMA should have advised as to the medical evidence necessary to complete the rating.[29]

This case will therefore be remanded for further development consistent with OWCP procedures found in FECA Bulletin No. 17-06. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the June 12, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision.

Issued: July 12, 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

[29] *Id.*