United States Department of Labor
Employees' Compensation Appeals Board

J.F., Appellant	)	
and	)	**Docket No. 17-1726**
	)	**Issued: March 12, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Flowery Branch, GA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 7, 2017 appellant filed a timely appeal from the July 14, 2017 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 the claim.

ISSUE

The issue is whether appellant has established greater than 18 percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts and circumstances set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

OWCP accepted that on May 23, 2013 appellant, then a 56-year-old lead customer service clerk, sustained reflex sympathetic dystrophy (RSD) of the right upper limb and an acromioclavicular sprain of the right shoulder and upper arm while in the performance of duty. It paid appropriate compensation benefits and authorized surgery performed by Dr. Jesse E. Seidman, an attending Board-certified orthopedic surgeon on December 18, 2013.[3] Appellant returned to light-duty work on August 14, 2014 and Dr. Seidman then released her to return to full-duty work on January 12, 2015.

On January 21, 2015 appellant filed a claim for a schedule award (Form CA-7). In a January 12, 2015 report, Dr. Seidman noted active abduction and forward flexion of the right shoulder at 140 degrees, external rotation at 40 degrees, internal rotation at 30 degrees, and extension at 50 degrees. He found good motion of the right wrist, slight atrophy in the right hand, and range of motion (ROM) of the proximal interphalangeal (PIP) and metacarpophalangeal (MCP) joints limited to 90 degrees.

An OWCP medical adviser reviewed the evidence of record on February 4, 2015. He found that appellant had attained maximum medical improvement (MMI) as of December 18, 2014, one year after arthroscopic right shoulder surgery. Referring to Table 15-34 in the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*),[4] the medical adviser found, utilizing ROM methodology, three percent impairment of the right upper extremity due to forward elevation limited to 140 degrees, three percent impairment due to shoulder abduction limited to 140 degrees, four percent impairment due to internal rotation limited to 30 degrees, and two percent impairment for external rotation limited to 40 degrees. He combined these percentages to equal 12 percent permanent impairment of the right upper extremity.

In a March 2, 2015 letter, Dr. Seidman found that appellant had attained MMI as of January 12, 2015. He opined that she had 18 percent permanent impairment of the right upper extremity according to unspecified portions of the A.M.A., *Guides.*

An OWCP medical adviser reviewed Dr. Seidman's report on April 10, 2015 and concurred that appellant had 18 percent permanent impairment of the right upper extremity due to limited right shoulder and finger motion. He noted that Dr. Seidman indicated that she had complex regional pain syndrome postoperation with resultant motion deficit of right shoulder as well as finger motion which equaled a total 18 percent right upper extremity impairment. The

[2] Docket No. 16-1462 (issued April 11, 2017).

[3] Dr. Seidman performed arthroscopic debridement of the subscapularis, arthroscopic subacromial decompression, biceps tenotomy, arthroscopic Mumford procedure, and arthroscopic double row rotator cuff repair.

[4] Table 15-34 (Shoulder Range of Motion), p. 475, A.M.A., *Guides* (6th ed. 2009).

medical adviser found that it was appropriate to use the ROM rating method as opposed to a diagnosis-based impairment (DBI) methodology, because appellant's RSD syndrome manifested itself primarily through limited shoulder and hand motion.

By decision dated May 5, 2015, OWCP granted appellant a schedule award for 18 percent permanent impairment of the right upper extremity. The period of the award ran from January 12, 2015 to February 9, 2016.

In a May 18, 2015 letter, appellant requested a telephonic oral hearing, which was held before an OWCP hearing representative on December 17, 2015. At the hearing, she described continued limited motion in her right hand and shoulder. Appellant's husband presented information and quoted newspaper articles about RSD syndrome. Appellant submitted photographs illustrating her limited hand motion, including the inability to make a fist with her right hand. Following the hearing, she submitted physical therapy notes.

By decision dated March 2, 2016, OWCP's hearing representative affirmed OWCP's May 5, 2015 schedule award determination, finding that the additional evidence submitted did not establish that appellant sustained greater than 18 percent permanent impairment of the right upper extremity.

Appellant appealed to the Board on July 1, 2016. By decision dated April 11, 2017, the Board set aside the March 2, 2016 decision.[5] The Board found that OWCP had inconsistently applied Chapter 15 of the A.M.A., *Guides* regarding the proper use either the DBI or ROM methodology in assessing the extent of permanent impairment. The Board remanded the case for OWCP to issue a *de novo* decision after development of a consistent method for calculating permanent impairment of the upper extremities.

On June 16, 2017 OWCP requested that its medical adviser review Dr. Seidman's March 2, 2015 impairment rating of 18 percent permanent impairment of the right upper extremity and explain how the impairment calculation was determined under the reprinted 2009 sixth edition A.M.A., *Guides.* In pertinent part, it indicated that the medical adviser must reference all pertinent objective and subjective findings, identify the methodology used by the rating physician, and advise whether the applicable tables in the A.M.A., *Guides* identify a diagnosis that can alternatively be rated by ROM. If the A.M.A., *Guides* allows 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. If the rating physician provided an assessment using the ROM method and the A.M.A., *Guides* allows for use of ROM diagnosis in question, the medical adviser was to independently calculate the impairment using both the ROM and DBI methods and identify the higher rating. He noted that if it was clear to the evaluator evaluating loss of ROM that a restricted ROM had an organic basis, three (3) independent measurements should be documented/recorded and the greatest ROM should be used for the determination of impairment. If the medical evidence of record was not sufficient to render a rating based on ROM where allowed, the medical adviser was advised to note the medical evidence necessary to complete the ROM rating and render an impairment rating using the DBI method, if possible, given the available evidence. OWCP noted that appellant had previously

[5] *Supra* note 2.

been awarded 18 percent permanent impairment of the right upper extremity and requested that its medical adviser opine whether an additional impairment had been incurred.

On June 19, 2017 Dr. Nathan Hammel, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, reviewed the evidence of record. He noted that appellant had received 18 percent permanent partial impairment of the right upper extremity, but the calculation of additional impairment was not possible as the examination findings of March 2, 2015 were not provided. Dr. Hammel noted that, under the DBI method, she had 10 percent permanent impairment for class 1 distal clavical excision under Table 15-5, page 403 of A.M.A., *Guides*.

The medical adviser indicated that the most recent clinical examination of January 12, 2015 showed mild continued shoulder and wrist pain with moderate ROM loss in the right shoulder. The ROM in the digits limited to 90 PIP and MCP index through small finger. The PIP joint had 10 degree flexion contracture. The shoulder showed mild limitation in ROM with no crepitus. The wrist was limited to 40 degrees of extension with full motion in all other planes.

Utilizing the DBI method, the medical adviser indicated under Table 15-5, page 403, a distal clavicle excision, class 1 default C had 10 percent impairment. A grade 1 was provided for history modifier for mild continued symptoms and a grade 1 was provided for examination modifier for mild ROM loss. A clinical studies modifier was not applicable as it was used to select DBI. Applying the net adjustment formula, the medical adviser concluded that appellant had 10 percent upper extremity impairment under the DBI method.

Utilizing the ROM method, the medial adviser found a total impairment of seven percent for the hand/wrist. Under Table 15-32, wrist extension of 40 degrees was given three percent impairment with all other planes noted as normal. Under Table 15-31, 90 degrees flexion equaled six percent digit impairment; 10 flexion contracture equaled three percent digit impairment. Four fingers equated nine percent digit impairment, which, when converted under Table 15-11, equaled four percent total right hand impairment, consisting of one percent impairment for each of the index, long, ring and small fingers. No specific findings ROM were noted for the shoulder impairment or an analysis under ROM for shoulder.

The medical adviser combined the DBI (10 percent distal clavicle resection) and ROM (7 percent wrist/digit) impairment for a total 17 percent right upper extremity permanent impairment. He indicated that, March 2, 2015, the date of the award examination, was the date MMI was reached. The medical adviser stated that the 17 percent upper extremity impairment was not additive to the previously awarded 18 percent. He also stated that, based on his calculations above, the previous impairment calculation seemed reasonable.

By decision dated July 14, 2017, OWCP denied appellant's claim as the medical evidence did not support an increase in the impairment already compensated. It noted that the medical adviser had applied the DBI and ROM methodologies to the examination findings provided by the treating physician and had indicated that the calculation seemed reasonable.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. It, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[7] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*.[8]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.[9] In some instances, an OWCP medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an attending physician indicates that the MMI has been reached and described the permanent impairment of the affected member, but does not offer an impairment rating. In this instance, a detailed opinion by an OWCP medical adviser, who gives a percentage based on reported findings and the A.M.A., *Guides*, may constitute the weight of the medical evidence.[10]

OWCP procedures state that any previous impairment to the member under consideration is included in calculating the percentage of loss, except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.[11]

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).

[6] 5 U.S.C. § 8107.

[7] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[9] *Id*. at Chapter 2.808.6(f) (February 2013); *see also L.R.*, Docket No. 14-0674 (issued August 13, 2014); *D.H.*, Docket No. 12-1857 (issued February 26, 2013).

[10] *See* Federal (FECA) Procedure Manual, *id.* at Chapter 2.810.8(i) (September 2010).

[11] *Id.* at Chapter 2.808.8.b (February 2013).

"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 original).

The Bulletin further advises:

"If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.

"Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination."

ANALYSIS

On prior appeal, the Board remanded the case for OWCP to reevaluate the extent of appellant's permanent impairment of her right upper extremity after it determined a consistent method for rating upper extremity impairments under the A.M.A., *Guides*. On remand the medical adviser, Dr. Hammel, reviewed the evidence and found that she had 17 percent right upper extremity permanent impairment after combining DBI (10 percent distal clavicle resection) and ROM (7 percent wrist/digit) impairment. On July 14, 2017 OWCP denied an increased schedule award as the medical evidence of record did not support an increase in the permanent impairment previously awarded. The Board finds that this case is not in posture for decision.

In his March 2, 2015 report, Dr. Seidman opined that appellant had 18 percent right upper extremity impairment. He also indicated that she had attained MMI as of January 12, 2015. However, Dr. Seidman neither referenced a specific edition of the A.M.A., *Guides*, nor provided any calculations or examination findings explaining his 18 percent permanent impairment rating. As he did not provide an impairment calculation referring to specific elements of the A.M.A., *Guides*, his impairment rating is of diminished probative value.[12]

OWCP's medial adviser, Dr. Hammel, found that appellant had reached MMI as of March 2, 2015. He used Dr. Seidman's January 12, 2015 examination findings to calculate her impairment as there were no examination findings of March 2, 2015. For the DBI impairment,

[12] *See Shalanya Ellison*, 56 ECAB 150, 154 (2004) (an estimate of permanent impairment is irrelevant and of diminished probative value where it is not based on the A.M.A., *Guides*).

OWCP's medical adviser indicated that appellant had 10 percent right upper extremity impairment due to distal clavicle resection. There is no indication that Dr. Seidman obtained three ROM measurements and that the ROM had an organic basis. In its June 16, 2017 instructions, OWCP specifically informed its medical adviser that "if it was clear to the evaluator evaluating loss of ROM that a restricted ROM had an organic basis, three (3) independent measurements should be documented/recorded and the greatest ROM should be used for the determination of impairment." It further instructed that "If the medical evidence of record was not sufficient to render a rating based on ROM where allowed, the medical adviser was advised to note the medical evidence necessary to complete the ROM rating." The medical adviser failed to follow OWCP's instructions as he did not indicate what medical evidence was used to complete the ROM rating. Furthermore, the prior schedule award was for ROM deficits in the shoulder and wrist/digits. The medical adviser failed to include Dr. Seidman's ROM shoulder findings in his ROM impairment calculation. Due to the above-noted deficiencies, OWCP's medical adviser's impairment report is of diminished probative value.[13]

Pursuant to its procedures, OWCP shall further develop the claim to obtain the three independent ROM measurements required under FECA Bulletin 17-06 (issued My 8, 2017). Following this and other such development as it deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's claim for an increased right upper extremity schedule award.[14]

CONCLUSION

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

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

[14] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the July 14, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: March 12, 2018
Washington, DC

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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