United States Department of Labor
Employees' Compensation Appeals Board

V.L., Appellant	)	
	)	
and	)	**Docket No. 18-0790**
	)	**Issued: November 13, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Tampa, FL, 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 March 1, 2018 appellant filed a timely appeal from a September 28, 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 case.[2]

ISSUE

The issue is whether appellant has established more than 10 percent permanent impairment of her left upper extremity, for which she previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence after OWCP rendered its September 28, 2017 decision. However, section 501.2(c)(1) of the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this evidence for the first time on appeal. *Id.*

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances as presented in the prior Board decision are incorporated herein by reference. The relevant facts are as follows.

On April 4, 2006 appellant, then a 40-year-old mail carrier, filed a notice of recurrence (Form CA-2a) alleging a recurrence of her medical condition on September 28, 2006 due to her March 1, 1999 employment injury, which was accepted by OWCP under File No. xxxxxx171.[4] OWCP developed this 2006 claim as a new occupational disease claim, under OWCP File No. xxxxxx985.

Appellant underwent a left shoulder magnetic resonance imaging (MRI) scan on March 5, 2012 which demonstrated impingement and heterogeneous signals in the supraspinatus and infraspinatus tendons. She underwent a cervical MRI scan on August 1, 2012 which indicated mild diffuse asymmetrical disc bulges and posterocentral disc protrusions at C3-4 through C6-7 levels with straightening of the cervical lordosis, suggestive of paraspinal muscle spasm. Appellant underwent a nerve conduction velocity study on April 3, 2013 which was read as abnormal and indicative of a right C6 upper trunk entrapment. She also underwent a November 8, 2013 MRI scan of the left shoulder which demonstrated partial thickness tear of the supraspinatus tendon with underlying acromiohumeral impingement and degenerative changes of the acromioclavicular (AC) joint.

Appellant's attending physician, Dr. Samy F. Bishai, an orthopedic surgeon, completed a report on February 11, 2014 and opined that appellant had reached maximum medical improvement. He noted that her left shoulder was tender overlying the anterior, lateral, and posterior aspects of the shoulder joint. Dr. Bishai used the range of motion (ROM) method of rating permanent impairment and found 80 degrees of flexion, 20 degrees of extension, 80 degrees of abduction, 15 degrees of adduction, 50 degrees of external rotation, and 40 degrees of internal rotation. He found reduced sensation in the ulnar nerve distribution of the left hand with a positive Tinel's sign and a positive Phalen's test. Dr. Bishai diagnosed chronic cervical strain, cervical disc syndrome, internal derangement of the left shoulder, radiculopathy of the upper extremities bilaterally, carpal tunnel syndrome of the left hand, and left shoulder impingement syndrome. He opined that appellant's left shoulder should be evaluated for permanent impairment purposes based on her loss of ROM. Dr. Bishai referenced Table 15-34 of the A.M.A., *Guides*[5] and found that 80 degrees of flexion was 9 percent permanent impairment, that 20 degrees of extension was 2 percent permanent impairment, that 80 degrees of abduction was 6 percent permanent impairment, that 15 degrees of adduction was 1 percent permanent impairment, that 20 degrees of internal rotation was 4 percent permanent impairment, and that 50 degrees of external rotation was 2 percent permanent

[3] Docket No. 16-1558 (issued April 4, 2017).

[4] OWCP had accepted appellant's claim for cervical sprain and aggravation of left shoulder tendinitis on June 21, 2006.

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

impairment. He concluded that appellant had 24 percent permanent impairment of her left arm using the ROM method.

On April 1, 2014 appellant filed a schedule award claim (Form CA-7).

By decision dated April 8, 2014, OWCP accepted the additional conditions of sprain of the neck, calcifying tendinitis of the left shoulder, and aggravation of displacement of cervical disc without myelopathy.

Appellant underwent a cervical MRI scan on April 17, 2014 which demonstrated a disc bulge at C4-5 which indented the anterior thecal sac, disc herniation at C5-6, as well as disc bulge, and herniation at C6-7.

Dr. Harvey Bishow, a Board-certified orthopedic surgeon, examined appellant on May 19, 2014 and also used the ROM method of rating permanent impairment. He found 160 degrees of abduction, 130 degrees of flexion, 60 degrees of internal rotation, and normal external rotation. Dr. Bishow noted that appellant had requested a surgical evaluation of her left shoulder. He then provided an impairment rating based on both her loss of range of motion in the left shoulder as well as a rating using the diagnosis-based impairment (DBI) method of impairment rating for a partial rotator cuff tear. Dr. Bishow combined these impairment ratings to reach 13 percent permanent impairment of the left upper extremity.

OWCP's medical adviser, Dr. James A. Dyer, a Board-certified orthopedic surgeon, reviewed Dr. Bishow's report and determined that appellant was not entitled to a permanent impairment rating based on both DBI and ROM. He reviewed Dr. Bishow's range of motion examination findings and found that under Table 15-34 she had eight percent permanent impairment of her left upper extremity.

By decision dated June 26, 2014, OWCP granted appellant a schedule award for eight percent permanent impairment of her left upper extremity. Appellant disagreed with this decision and requested an oral hearing before an OWCP hearing representative. The hearing was held on July 3, 2014.

By decision dated April 30, 2015, OWCP's hearing representative set aside OWCP's June 26, 2014 schedule award decision and remanded the case for referral to a second opinion physician to determine which of appellant's left shoulder conditions were related to her employment and whether she had any permanent impairment of the left upper extremity warranting a schedule award.

OWCP developed a statement of accepted facts (SOAF) on May 11, 2015 which listed the accepted conditions as neck sprain, aggravation of left shoulder tendinitis, and aggravation of displacement of cervical disc without myelopathy. It included that appellant had three other claims: File No. xxxxxx171, under which OWCP accepted neck and left trapezius injuries; File No. xxxxxx076, under which OWCP accepted lumbar and cervical strains; and File No. xxxxxx535, under which OWCP accepted adhesive capsulitis of the right shoulder.

On May 18, 2015 OWCP referred appellant for a second opinion evaluation, with Dr. William Dinenberg, a Board-certified orthopedic surgeon, to determine the extent of her permanent impairment for schedule award purposes. Dr. Dinenberg completed a report on June 9, 2015. He reviewed her medical history and diagnostic studies. Dr. Dinenberg performed a physical examination and found left shoulder range of motion at 120 degrees of flexion, 50 degrees of extension, 20 degrees of internal rotation, 70 degrees of external rotation, 90 degrees of abduction, and 40 degrees of adduction. He noted that appellant had a positive impingement sign with normal muscle strength and no acromioclavicular (AC) joint pain to palpation. Dr. Dinenberg reported that she had positive Phalen's test, positive Tinel's sign, and positive carpal tunnel compression test at the left wrist. He found decreased sensation to light touch in the left small finger, ring finger, and thumb. Dr. Dinenberg diagnosed aggravation of left shoulder tendinitis, and sprain of the cervical spine with aggravation of cervical disc displacement without myelopathy. He utilized the ROM method and correlated appellant's left shoulder loss of ROM with the A.M.A., *Guides* and found that she had 3 percent permanent impairment due to 120 degrees of flexion, 4 percent permanent impairment due to 20 degrees of internal rotation, and 3 percent permanent impairment due to 90 degrees of abduction for a total permanent impairment rating of 10 percent of the left upper extremity.

OWCP's medical adviser, Dr. H.P. Hogshead, a Board-certified orthopedic surgeon, reviewed the medical evidence of record on July 24, 2015 and found that Dr. Dinenberg's report established appellant's permanent impairment for schedule award purposes at 10 percent of the left upper extremity due to loss of range of motion.

By decision dated July 28, 2015, OWCP granted appellant a schedule award for an additional 2 percent permanent impairment of her left upper extremity, for a total 10 percent permanent impairment.

On August 5, 2015 appellant disagreed with this decision and requested an oral hearing before an OWCP hearing representative which was held on March 15, 2016. Appellant's representative contended that Dr. Bishai's impairment rating was the most appropriate.

Appellant subsequently submitted an April 7, 2016 left shoulder MRI scan, which demonstrated rotator cuff tendinosis with a partial thickness tear of the supraspinatus tendon and a partial thickness tear of the infraspinatus tendon. This MRI scan also demonstrated mild chronic AC joint osteoarthrosis and mild bursitis.

Appellant submitted a report from Dr. Bishai completed on July 4, 2015. In his examination of her left shoulder, Dr. Bishai found loss of range of motion including forward elevation of 75 degrees, backward elevation of 15 degrees, abduction of 75 degrees, adduction of 15 degrees, external rotation of 40 degrees, and internal rotation of 20 degrees. He found electrodiagnostic evidence consistent with cervical radiculopathy affecting the upper extremities. Dr. Bishai diagnosed chronic cervical strain, cervical disc syndrome, internal derangement of the left shoulder, bilateral radiculopathy of the upper extremities, left carpal tunnel syndrome, and left shoulder impingement syndrome. He reviewed Dr. Dinenberg's report and disagreed with his findings of appellant's range of motion. Dr. Bishai noted, "I have seen [appellant] numerous times and I conducted this examination many times and the range of motion figures have remained very

close every time I do the examination, so my impairment rating is based on multiple visits and many range of motion examinations at different times." He opined that Dr. Dinenberg's examination was very brief and that he did not "do much" of a complete examination in every movement.

By decision dated May 26, 2016, OWCP's hearing representative found that appellant had not established more than 10 percent permanent impairment of her left upper extremity. She found that Dr. Dinenberg's impairment rating based on his range of motion figures was appropriate.

On June 9, 2016 appellant's representative requested reconsideration of the May 26, 2016 decision and alleged an unresolved conflict of medical opinion evidence between appellant's treating physician and OWCP's medical adviser.

In a decision dated June 16, 2016, OWCP declined to reopen appellant's claim for consideration of the merits as no additional factual or medical evidence was submitted in support of her request for reconsideration. Counsel appealed the May 26 and June 16, 2016 decisions to the Board. In its April 4, 2017 decision,[6] the Board set aside OWCP's May 26 and June 16, 2016 decisions and directed OWCP to issue a *de novo* decision on appellant's claim for an upper extremity schedule award following the procedures as set forth in *T.H.*,[7] for evaluating upper extremity cases in which evaluation was possible under either the ROM or diagnosis-based impairment (DBI) methodologies.

On July 7, 2017 OWCP declared a conflict in the medical opinion evidence and referred appellant for an impartial medical examination with Dr. Robert Elkins, a Board-certified orthopedic surgeon, to resolve a conflict of medical opinion regarding appellant's impairment rating for schedule award purposes.

In a report dated July 25, 2017, Dr. Elkins reviewed the SOAF and medical treatment history. He performed a physical examination and diagnosed chronic neck and left shoulder pain, chronic herniated discs at C5-6 and C6-7 with a negative neurologic examination, abnormal nerve conduction study with right C7 upper trunk entrapment, and partial thickness tear of the supraspinatus as demonstrated on MRI scan as well as mild adhesive capsulitis of the left shoulder. Dr. Elkins found few objective physical findings beyond the positive imaging and nerve conduction studies. He noted that appellant's shoulder range of motion was normal except for abduction at 140 degrees. Dr. Elkins found that appellant had a normal neurologic examination with equal reflexes, sensation, and motor strength. He responded to OWCP's questions regarding appellant's percentage of permanent impairment for schedule award purposes and provided his impairment rating based on appellant's neck, left shoulder torn rotator cuff, and radiculopathy. Dr. Elkins diagnosed sprain/strain of the shoulder in addition to the small rotator cuff tear and found appellant had a class 1 or five percent upper extremity impairment due to this condition with no modifiers for neurologic changes, sensory, motor, or functional changes. He noted that Dr. Bishai's impairment rating of 24 percent was based on loss of range of motion in her left

[6] *Supra* note 3.

[7] Docket No. 14-0943 (issued November 25, 2016).

shoulder, but that her range of motion had improved and were essentially unremarkable. Dr. Elkins found electrodiagnostic evidence of radiculopathy affecting her left upper extremity. He noted, "Converting her spinal impairment to a left upper extremity impairment, I agree with a 10 percent impairment rating to the left upper extremity for her combined rotator cuff and radiculopathy." Dr. Elkins found that appellant had no more than 10 percent permanent impairment of her left upper extremity.

In a decision dated September 28, 2017, OWCP found that, based on Dr. Elkins' report, appellant had no more than 10 percent permanent impairment of her left upper extremity for which she previously received schedule award compensation. It thus denied appellant's request for an additional schedule award.

LEGAL PRECEDENT

The schedule award provisions of FECA[8] and its implementing regulations[9] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of loss of use, of scheduled members or functions of the body. FECA, 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 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[10]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[12]

The A.M.A., *Guides* also provide that the 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

[8] *Supra* note 1 at § 8107.

[9] 20 C.F.R. § 10.404.

[10] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5 (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[11] A.M.A., *Guides* 411.

[12] *P.R.*, Docket No. 18-0022 (issued April 9, 2018); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6f (March 2017).

diagnosis-based sections are applicable.[13] 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.[14] 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.[15]

Regarding the application of ROM or DBI 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 impairment evaluation, the 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.*"[16] (Emphasis in the original.)
>
> 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.
>
> "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."[17]

[13] A.M.A., *Guides* 461.

[14] *Id.* at 473.

[15] *Id.* at 474.

[16] FECA Bulletin No. 17-06 (issued May 8, 2017); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

[17] *Id.*

ANALYSIS

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

As noted above, FECA Bulletin No. 17-06 provides that, if the rating physician provided an assessment using the ROM method and the A.M.A., *Guides* allows 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.[18]

The Board therefore finds that this case requires further development of the medical evidence. Since Drs. Bishai, Bishow, and Dinenberg provided a rating based upon appellant's loss of range of motion of her left upper extremity , which is allowed (by asterisk) pursuant to Table 15-5 of the A.M.A., *Guides*,[19] OWCP should have referred these reports as well as Dr. Elkins July 25, 2017 report utilizing the DBI methodology to an OWCP medical adviser for calculation appellant's impairment using both the ROM and DBI methods under the relevant standards of the sixth edition of the A.M.A., *Guides,* and identification of the higher rating for the claims examiner. If the medical evidence of record is insufficient for OWCP's medical adviser to render a rating using the ROM or DBI method, he should advise as to the medical evidence necessary to complete the rating.[20]

This case will therefore be remanded for application of the new OWCP procedures found in FECA Bulletin No. 17-06. After such further development of the medical evidence as necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[18] *Id.*

[19] A.M.A., *Guides* 401-02, Table 15-5.

[20] *Supra* note 16.

ORDER

IT IS HEREBY ORDERED THAT the September 28, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision of the Board.

Issued: November 13, 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