United States Department of Labor
Employees' Compensation Appeals Board

B.F., Appellant	)	
and	)	**Docket No. 19-0457**
	)	**Issued: August 16, 2019**
DEPARTMENT OF AGRICULTURE, FOOD SAFETY INSEPCTION SERVICE, Zeeland, MI, Employer	)	

Appearances:
Alan J. Shapiro, 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
JANICE B. ASKIN, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On December 27, 2018 appellant, through counsel, filed a timely appeal from a December 3, 2018 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 10 percent permanent impairment of the left upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On March 23, 2015 appellant, then a 57-year-old consumer safety inspector, filed a traumatic injury claim (Form CA-1) alleging that on March 22, 2015 he injured his left hip, left shoulder, neck, and head when he slipped and fell on ice inside a cooler while in the performance of duty. He stopped work on March 22, 2015 and returned to his regular employment on March 26, 2015. On May 3, 3015 appellant began working with restrictions. OWCP accepted the claim for left shoulder strain, a left rotator cuff sprain, cervical radiculopathy, neck strain, a left hip contusion, a left forearm ulnar nerve injury, and left shoulder bursitis.

An electromyogram (EMG) performed on September 3, 2015 revealed findings "most consistent with a left C7-8 cervical radiculopathy with some ongoing axon loss."

Appellant underwent two OWCP authorized surgeries. On October 26, 2015 he underwent an anterior cervical discectomy and fusion due to a C4-5 cervical disc herniation. On March 1, 2017 appellant underwent a subacromial decompression, bursectomy, and distal clavicle excision of the left shoulder.

In an impairment evaluation dated June 20, 2017, Dr. Peter E. Metropoulos, an osteopath Board-certified in occupation medicine and environmental medicine, discussed appellant's history of injury. On examination he found a decrease in grip strength of the hand bilaterally, symmetrically decreased motor strength, a loss of sensation in the C7 and C8 nerve roots, and possible thenar muscle atrophy on the left. Dr. Metropoulos further found pain in the shoulders bilaterally with reduced range of motion (ROM) on the left side. He diagnosed intermittent bilateral upper extremity paresthesia at the C7 and C8 dermatomal distribution, upper extremity weakness, cervical neck pain due to a disc herniation causing myelomalacia of the spinal cord, left shoulder pain following a subacromial decompression and acromioclavicular resection, low back pain, bilateral hip pain, and left elbow tenderness. Dr. Metropoulos opined that appellant had not yet reached maximum medical improvement (MMI) for his left shoulder condition. He noted that an EMG had revealed changes consistent with C7 and C8 left radiculopathy. Dr. Metropoulos determined that appellant had two percent permanent impairment of the left sacroiliac joint according to Table 16-4 on page 512 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] He further found two percent permanent impairment of the left lower extremity due to his left hip contusion, two percent permanent impairment of the left lower extremity due to sacroiliac pain, and two percent permanent impairment of the left upper extremity due to his left elbow contusion. Referencing *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (*The Guides Newsletter* July/August 2009), Dr. Metropoulos found nine percent permanent impairment

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

due to a motor deficit at both C7 and at C8 and three percent permanent impairment due to a sensory deficit at both C7 and C8. He combined the impairment ratings to find 23 percent permanent impairment of each upper extremity and four percent permanent impairment of the left lower extremity.

On August 2, 2017 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated August 10, 2017, OWCP notified appellant of the criteria for an impairment evaluation and requested that he submit a report from his attending physician addressing whether he had reached MMI and providing an impairment rating pursuant to the sixth edition of the A.M.A., *Guides*. It afforded him 30 days to submit the necessary evidence.

In a report dated August 15, 2017, Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), reviewed the June 20, 2017 impairment evaluation from Dr. Metropoulos and opined that appellant had four percent permanent impairment of each upper extremity due to pain and impaired sensation at C7 and C8 under *The Guides Newsletter*. He further found 12 percent permanent impairment of the left shoulder following a distal clavicle excision according to Table 15-5 on page 403 of the A.M.A., *Guides*. Dr. Harris noted that Dr. Metropoulos had not provided ROM measurements for the left shoulder and that he was thus unable to calculate the extent of any impairment due to reduced motion. He found two percent permanent impairment of the left elbow due to a strain, which he combined to find 17 percent permanent impairment of the left upper extremity. Regarding the lower extremities, Dr. Harris found two percent permanent impairment of the left hip. He concluded that appellant had 4 percent permanent impairment of the right upper extremity, 17 percent permanent impairment of the left upper extremity, and 2 percent permanent impairment of the left lower extremity.

In a letter dated October 10, 2017, OWCP requested that Dr. Metropoulos review the DMA's report and advise whether he concurred with his findings. It further asked that he provide ROM measurements for the left shoulder and an updated impairment rating.

In an addendum report dated November 6, 2017, Dr. Metropoulos indicated that he had not rated appellant's left shoulder impairment as he was not at MMI at the time of the prior examination. He disagreed with the DMA's finding that there was no objective evidence demonstrating cervical radiculopathy of the upper extremities, noting that he had found motor weakness, decreased hand strength, and likely muscle atrophy. Dr. Metropoulos further indicated that EMG testing performed September 3, 2015 had revealed left C7 and C8 radiculopathy and that a magnetic resonance imaging (MRI) study had documented spinal stenosis at multiple levels. He related, "To reiterate, the original report noted in the objective portion that there was evidence of motor weakness including but not limited to decreased strength in hand gripping along with likely muscle atrophy in the upper extremity and decreased motor strength to the shoulders with strength at grade 4+/5+." Citing Table 1 of *The Guides Newsletter*, Dr. Metropoulos opined that, after application of grade modifiers, appellant had nine percent permanent impairment of each upper extremity due to motor deficit at C7 and nine percent permanent impairment of each upper extremity due to motor deficit at C8. He further found three percent impairment of each upper extremity due to sensory deficit at both C7 and C8. Dr. Metropoulos combined his impairment determinations to find that appellant had 23 percent permanent impairment of the left upper

extremity and 21 percent permanent impairment of the right upper extremity. He further found four percent permanent impairment of the left lower extremity.

On November 18, 2017 Dr. Harris noted that Dr. Metropoulos had found that appellant had not reached MMI for his left shoulder condition. He disagreed with Dr. Metropoulos that he had documented weakness of the upper extremities originating in a spinal nerve root. Dr. Harris recommended a second opinion examination.

On December 4, 2017 OWCP referred appellant to Dr. Emmanuel Obianwu, a Board-certified orthopedic surgeon, for a second opinion examination.

In a report dated February 19, 2018, Dr. Obianwu discussed appellant's complaints of intermittent numbness radiating into his left upper extremity. He advised that electrodiagnostic studies showing C7 or C8 radiculopathy did not demonstrate impairment absent clinical correlation. Dr. Obianwu opined that appellant had obtained MMI. On examination, he measured left shoulder abduction of 170 degrees, adduction of 30 degrees, flexion of 160 degrees, extension of 40 degrees, external rotation of 60 degrees, and internal rotation of 70 degrees. Dr. Obianwu found no atrophy of the parascapular muscles or biceps, good strength of the left shoulder, and a negative Speed's test. He advised that appellant had no sensory deficits "of any significance in the upper extremities, certainly not any which conform to any dermatomal pattern. The deep tendon reflexes are equal bilaterally. No weakness of any groups of muscles is identified." Dr. Obianwu further found no evidence of lumbosacral neuritis. He diagnosed a left partial rotator cuff tear, rotator cuff tendinitis of the left shoulder, and a soft tissue injury of the left buttocks. Dr. Obianwu noted that appellant had undergone a resection of the left clavicle at the time of his March 1, 2017 surgery, but opined that it was unrelated to his employment. He opined that appellant had seven percent permanent impairment due to loss of ROM of the left shoulder using Table 15-34 on page 475 of the A.M.A., *Guides*. Dr. Obianwu further determined that appellant had seven percent left shoulder impairment using the diagnosis-based impairment (DBI) method. He identified the diagnosis as rotator cuff tear using Table 15-5 on page 402, the Shoulder Regional Grid. Dr. Obianwu applied grade modifiers and found seven percent permanent impairment of the left upper extremity due to appellant's shoulder injury. He related, "I do not see any impairment of parts of the upper extremity brought about by the pathology in the spine. The mere fact that an electrodiagnostic study reveals a radiculopathy does not immediately confer disability or impairment to the left upper extremity."

On March 10, 2018 Dr. Harris reviewed the evidence of record and applied the tables and provisions of the A.M.A., *Guides* to Dr. Obianwu's findings. He noted that Dr. Obianwu had found seven percent left upper extremity impairment due to reduced ROM of the left shoulder and no impairment of the upper extremity due to cervical radiculopathy. Dr. Harris opined that appellant had no impairment due to cervical radiculopathy pursuant to *The Guides Newsletter* as he did not have "any neurologic deficit in the upper extremity consistent with cervical radiculopathy…." For the left shoulder, he identified the diagnosis as residual rotator cuff difficulty following an excision of the distal clavicle using Table 15-5 on page 403 of the A.M.A., *Guides*, which yielded a default value of 10 percent. Dr. Harris further found three percent permanent impairment for loss of shoulder flexion, one percent impairment for loss of extension, one percent impairment due to loss of shoulder adduction, and two percent impairment for loss of internal rotation, for a total impairment due to reduced ROM of seven percent. He advised that

using the DBI method yielded the greater impairment, and thus found 10 percent permanent impairment of the left upper extremity.

By decision dated March 29, 2018, OWCP granted appellant a schedule award for 10 percent permanent impairment of the left upper extremity. The period of the award ran for 31.2 weeks from February 19 to September 25, 2018.

On April 5, 2018 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative.

A telephonic hearing was held on September 17, 2018. Counsel noted that Dr. Obianwu had not rated appellant's distal clavicle impairment as he found it was not employment related, even though it was part of his authorized surgery. He further argued that there was a conflict in medical opinion.

By decision dated December 3, 2018, OWCP's hearing representative affirmed the March 29, 2018 decision. She found that Dr. Obianwu's opinion represented the weight of the evidence and established that appellant had no radiculopathy or neuritis of the upper or lower extremities supporting a schedule award.

LEGAL PRECEDENT

The schedule award provision of FECA,[4] and its implementing federal regulation,[5] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or 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 a 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.[6] 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.[7]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning Disability

[4] *Supra* note 2.

[5] 20 C.F.R. § 10.404.

[6] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[7] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

and Health (ICF).[8] Under the sixth edition, the evaluator identifies the impairment class of diagnosis (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[11]

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 diagnosis-based sections are applicable.[12] 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.[13] 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.[14]

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.*"[15] (Emphasis in the original.)

[8] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[9] *Id*. at 494-531.

[10] *Id*. at 411.

[11] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

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

[13] *Id*. at 473.

[14] *Id*. at 474.

[15] FECA Bulletin No. 17-06 (May 8, 2018); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

Neither FECA nor its regulations provide for a schedule award for impairment to the back or to the body as a whole.[16] Furthermore, the back is specifically excluded from the definition of organ under FECA.[17] The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that FECA allows ratings for extremities and precludes ratings for the spine, *The Guides Newsletter,* Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*) offers an approach to rating spinal nerve impairments consistent with sixth edition methodology. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that *The Guides Newsletter* is to be applied.[18]

FECA provides that if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[19] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[20]

ANALYSIS

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

In a report dated June 20, 2017, appellant's attending physician, Dr. Metropoulos, diagnosed bilateral upper extremity paresthesia from the C7 and C8 dermatomal distribution, upper extremity weakness, cervical pain, left shoulder pain, low back pain, and left elbow tenderness. On examination he found reduced grip strength of the hands, a loss of motor strength, reduced sensation from the C7 and C8 nerve roots, and possible left atrophy at the thenar muscle. Dr. Metropoulos found that appellant had not yet achieved MMI for his left shoulder condition. For the cervical condition, he applied the provisions of *The Guides Newsletter* and found three percent permanent impairment at both C7 and C8 for loss of sensation of each upper extremity and nine percent permanent impairment at both C7 and at C8 due to a motor deficit. Dr. Metropoulos further found two percent permanent impairment of the left upper extremity due to an elbow contusion, two percent permanent impairment of the left lower extremity due to a left hip contusion, and two percent permanent impairment of the left lower extremity due to left sacroiliac pain.

In a supplemental report dated November 9, 2017, Dr. Metropoulos opined that a physical examination had demonstrated objective evidence of radiculopathy, including muscle weakness, decreased hand strength, and possible muscle atrophy. He also noted that an EMG study revealed C7 and C8 left radiculopathy. Dr. Metropoulos again rated appellant's cervical radiculopathy

[16] *See J.L.*, Docket No. 18-1380 (issued May 1, 2019). FECA itself specifically excludes the back from the definition of organ. 5 U.S.C. § 8101(19).

[17] 5 U.S.C. § 8101(19).

[18] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[19] 5 U.S.C. § 8123(a); *see A.G.*, Docket No. 18-0815 (issued January 24, 2019).

[20] *See A.G., id*.

using *The Guides Newsletter*. He combined his impairment determinations to find that appellant had 23 percent permanent impairment of the left upper extremity and 21 percent permanent impairment of the right upper extremity. Dr. Metropoulos further found four percent permanent impairment of the left lower extremity.

In a report dated February 19, 2018, Dr. Obianwu, an OWCP referral physician, found that appellant had reached MMI for all conditions. He found no evidence of cervical radiculopathy on examination, noting that EMG evidence of radiculopathy was insufficient to show impairment without clinical correlation. Dr. Obianwu indicated that an examination failed to demonstrate sensory deficits in any dermatomal pattern, muscle weakness, or a motor deficit. He further found on evidence of lumbosacral neuritis. Dr. Obianwu found that appellant had seven percent permanent impairment of the left shoulder due to reduced motion. He alternatively found seven percent of the left shoulder using the DBI method due to his rotator cuff tear.

On March 10, 2018 Dr. Harris concurred with Dr. Obianwu's finding of no impairment due to cervical radiculopathy and seven percent permanent impairment of the left upper extremity using the ROM method. He rated appellant's left upper extremity impairment using the DBI method and found 10 percent permanent impairment due to his distal clavicle excision.

As noted above, if there is a disagreement between an employee's physician and an OWCP referral physician, OWCP will appoint a referee physician or impartial medical specialist who shall make an examination.[21] The Board finds that there is an unresolved conflict in the medical evidence between Dr. Metropoulos and Dr. Obianwu regarding whether appellant has obtained MMI for his left shoulder condition,[22] whether he has a permanent impairment of the upper extremities due to cervical radiculopathy (left lower extremity), the extent of any upper extremity impairment, and whether he has a permanent impairment of the left lower extremity due to his accepted conditions. Therefore, the case must be remanded to OWCP for referral of appellant to an IME for resolution of the conflict in medical opinion evidence in accordance with 5 U.S.C. § 8123(a).[23] After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

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

[21] *G.W.*, Docket No. 19-0063 (issued June 21, 2019).

[22] If the independent medical examiner (IME) physician finds that appellant has reached MMI for the left shoulder accepted condition, an analysis of the extent and percentage of permanent impairment of the left upper extremity shall be performed in accordance with FECA Bulletin No. 17-06.

[23] *Id*.

ORDER

IT IS HEREBY ORDERED THAT the December 3, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: August 16, 2019
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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