# United States Department of Labor
# Employees' Compensation Appeals Board

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| **F.H., Appellant** | ) | |
| **and** | ) | **Docket No. 17-1924** |
| | ) | **Issued: January 25, 2019** |
| **U.S. POSTAL SERVICE, POST OFFICE, Southeastern, PA, Employer** | ) | |

*Appearances:*
*Thomas R. Uliase, 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 May 15, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

## ***ISSUE***

The issue is whether appellant has met his burden of proof to establish more than five percent permanent impairment of the left upper extremity, for which he previously received schedule award compensation.

## ***FACTUAL HISTORY***

On June 4, 2013 appellant, then a 50-year-old mail processing clerk, filed a traumatic injury claim (Form CA-1), alleging that he injured his left arm while putting an express mailbag into a hamper while in the performance of duty. OWCP accepted the claim for left rotator cuff sprain, adhesive capsulitis of the left shoulder, and a left shoulder labral tear. It subsequently expanded acceptance of the claim to include sprain of the shoulder and upper arm, rotator cuff on the left, and superior glenoid labrum lesion on the left. By letter dated September 8, 2014, counsel provided a June 24, 2014 report from Dr. Nicholas Diamond, an attending Board-certified physical medicine and rehabilitation physician, in support of appellant's claim for a schedule award.

In the June 24, 2014 report, Dr. Diamond noted the history of injury, provided physical examination findings, and made disability findings for four diagnosed conditions. His physical examination findings noted measurement of range of motion (ROM) times three for the left shoulder which revealed: forward elevation of 130/180 degrees with pain; abduction of 95/180 degrees with pain; cross over adduction of 60/75 degrees with pain; internal and external rotation of 60/90 degrees, and external rotation of 90/90 degrees. Dr. Diamond found the posterior reach was to the left greater trochanter with pain. He conducted manual muscle strength testing of the upper extremities which revealed the supraspinatus and deltoids were graded at 4/5 on the left side. Dr. Diamond also found a grade of 4/5 for the biceps and triceps on the left side. He noted that his sensory examination failed to reveal any perceived dermatomal abnormalities in either the right or left upper extremity. Dr. Diamond also explained that appellant had subjective findings of left shoulder pain and stiffness which was daily and constant, and noted that changes in weather exacerbated his left shoulder pain. He noted that appellant underwent restrictions in his activities of daily living.

Dr. Diamond referred to Table 15-34, Table 15-35, and Table 15-7 in his impairment rating calculations.[3] He determined that the ROM deficit for the left shoulder included: flexion of 130 degrees, which corresponded to three percent impairment rating; adduction of 95 degrees, which corresponded to three percent impairment rating; and internal rotation of 60 degrees, which corresponded to two percent impairment rating. Dr. Diamond noted that the total was eight percent impairment. He explained that the grade modifier for functional history and *Quick*DASH (disabilities of the arm, shoulder, and hand) was 54 percent or 2, and noted that the impairment increased by 5 percent and the final left upper extremity was 8 percent. Dr. Diamond found that maximum medical improvement (MMI) was reached on June 24, 2014.

In an October 3, 2014 report, Dr. Morley Slutsky, Board-certified in occupational medicine serving as an OWCP district medical adviser (DMA), reviewed the June 24, 2014 report from

[3] A.M.A., *Guides* 475, 477, and 406.

Dr. Diamond. Dr. Slutsky found only four percent left upper extremity impairment under the A.M.A., *Guides*. He disagreed with Dr. Diamond's left shoulder impairment using the ROM method. Dr. Slutsky explained that some of the ROM measurements were inconsistent with other providers' measurements at or near the date of MMI. Dr. Diamond indicated that he had used the best ROM measurements to reflect appellant's maximum effort, and instead relied on the "preferred" diagnosis-based impairment (DBI) methodology. He opined that the four percent left upper extremity impairment rating was based on residuals of a diagnosed labral tear under Table 15-34, Shoulder Range of Motion, A.M.A., *Guides* 475. Dr. Diamond found that appellant reached MMI on June 24, 2014, the date of Dr. Diamond's impairment examination.

On October 30, 2014 appellant filed a schedule award claim (Form CA-7).

By decision dated November 18, 2014, OWCP granted appellant a schedule award for four percent permanent impairment of the left upper extremity. The award covered a period of 12.48 weeks, for the period June 24 through September 19, 2014. OWCP based the award on the DMA's four percent impairment rating, noting that the DMA determined that appellant's attending physician had "incorrectly applied the [*Guides*]…."

On November 24, 2014 counsel requested a hearing, which was held before an OWCP hearing representative on March 26, 2015.

By decision dated May 8, 2015, OWCP's hearing representative vacated the November 18, 2014 decision and remanded the case for further medical development and consideration of additional conditions. She also instructed OWCP to refer appellant for an impartial examination to resolve the conflict identified between the attending physician, Dr. Diamond, and Dr. Slutsky, regarding appellant's left upper extremity permanent partial impairment.

OWCP developed the claim and on May 14, 2015 accepted the additional condition of left superior glenoid labrum lesion (labral tear). By letter dated May 27, 2015, it referred appellant for an impartial medical evaluation with Dr. Noubar A. Didizian, a Board-certified orthopedic surgeon.

In a July 21, 2015 report, Dr. Didizian noted appellant's history of injury and treatment and provided findings on physical examination. He utilized the DBI method under the A.M.A., *Guides* to calculate appellant's permanent impairment. Dr. Didizian explained that the DBI method was the preferred method because the ROM method had a bias. He explained that the patient could use different active ranges even though three attempts were made in the ROM testing. Dr. Didizian noted that the DBI method and use of the adjustment grids and grid modifiers took away the bias factor. He noted the accepted diagnosis and explained that the most tangible injury was the labral tear, and selected it as the prime diagnosis for the final calculations. Dr. Didizian referred to the Shoulder Regional Grid -- Upper extremity impairment -- Table 15-5,[4] under labral lesions. He referenced the appropriate tables and found a four percent impairment of the left upper extremity.

[4] A.M.A., *Guides* 404.

On July 21, 2015 Dr. Didizian's report was sent by OWCP for review to Dr. Arnold Berman, a Board-certified orthopedic surgeon and DMA.

In a September 9, 2015 report, Dr. Berman opined that appellant was entitled to a schedule award for five percent permanent impairment of the left upper extremity.

By decision dated September 9, 2015, OWCP granted appellant an additional award of one percent permanent of the left upper extremity. The award covered a period of 3.12 weeks, for the period July 21 to August 11, 2015.

On September 16, 2015 appellant, through counsel, requested reconsideration.

In a February 15, 2016 report, Dr. Diamond noted that he had reviewed the medical evidence to include the report of Dr. Didizian dated July 21, 2015 as well as the DMA memorandum dated June 4, 2013. He explained that the ROM findings of the left shoulder were very similar to the ROM findings that he had obtained on June 24, 2014. Dr. Diamond disagreed with Dr. Didizian that the DBI method using the diagnoses of labral tear was appropriate. He explained that appellant had also been diagnosed with adhesive capsulitis, which was a more debilitating diagnosis for him and he explained that due to the fact that they both obtained very similar ROMs to the left shoulder that would indicate reproducibility of physical examination findings and therefore, yield a higher accuracy. Dr. Diamond advised that he stood by his impairment rating of June 24, 2014 and opined that appellant had a final left upper extremity impairment of eight percent.

On March 30, 2016 OWCP's hearing representative set aside the September 9, 2015 decision and remanded the case for further medical development. She found that Dr. Diamond calculated eight percent permanent impairment of the left upper extremity based upon the ROM method, whereas the DMA, opined that the DBI method should be used for labral tear and instead calculated four percent left upper extremity impairment. In a July 7, 2016 report, Dr. Didizian explained that he calculated the permanent impairment for appellant and determined that appellant had four percent impairment. He noted that he had reviewed the February 15, 2016 report of Dr. Diamond and noted that he was contradicting his report on the basis that the ROM method was better than a DBI rating. Dr. Didizian also noted that Dr. Diamond indicated that adhesive capsulitis was the more debilitating diagnosis, rather than the labral tear. He opined that the "premise is wrong because adhesive capsulitis will resolve by itself without any particular treatment. Whereas, a labral tear is not going to resolve on its own and that is why surgery was done. At the time of the surgery both issues were addressed." Dr. Didizian noted that he had reviewed the report of Dr. Berman dated September 13, 2015 and he did not have any particular issues with that report. He reiterated that he stood by his own opinion and that "Dr. Diamond's opinion was wrong."

By decision dated July 19, 2016, OWCP denied an increased schedule award. It found that the medical evidence did not support an increased award.

On July 27, 2016 appellant, through counsel, requested an oral hearing.

In an August 15, 2016 decision, a hearing representative found that the case was not in posture for a hearing. She instructed OWCP to obtain a new impartial medical examiner (IME)

opinion on the issue of whether a DBI rating or ROM rating under the A.M.A., *Guides* should be utilized for purposes of rating appellant's left upper extremity. OWCP found that the prior referee had failed to provide an adequate clarification as requested and thus a new referee opinion was necessary to resolve the conflict

On August 16, 2016 OWCP referred appellant for an impartial medical examination in accordance with the instructions of OWCP's hearing representative to resolve the conflict as to the proper functional impairment rating under the A.M.A., *Guides.*

On August 16, 2016 OWCP referred appellant, together with a statement of accepted facts (SOAF), the medical record, and a list of questions, to Dr. Stanley Askin, a Board-certified orthopedic surgeon, for an impartial medical examination to determine appellant's left upper extremity permanent impairment. In a September 29, 2016 report, Dr. Askin noted appellant's history of injury and treatment and examined appellant. He noted that right shoulder ROM was offered to 180 degrees of forward flexion and abduction and 45 degrees each of internal and external rotation. Dr. Askin found that left shoulder motion was offered to 100 degrees of forward flexion and abduction (under his control), again in response to his request that he show only what he could do without hurting himself. He related that appellant was able to perform 20 degrees of internal rotation and 10 degrees of external rotation of the left shoulder. Dr. Askin responded to questions regarding impairment. He noted that appellant's ROM appeared to have been a moving target in that what he presently offered was less than was recorded earlier. Dr. Askin opined that there could be more than one explanation regarding such, such as whether appellant was being fully cooperative with respect to the examination or whether the accepted diagnoses were not an accurate representation of what has troubled him. He also explained that he was not in any manner disputing the SOAF, but merely offering a fully rationalized understanding of appellant's status.

Dr. Askin further noted that "[r]especting the fact that there has been variance regarding [appellant's] [ROM] over time (for example, Dr. Smith reported on [February 21, 2014] that the [ROM] was 130 degrees of active flexion and abduction and internal and external rotation of 60 degrees each), the DBI rating pursuant to Table 15-5 on page 404 of the sixth edition best conforms to that which had been accepted according to the [SOAF]." He summarily concluded that he was in agreement with the impairment rating conducted by Dr. Berman, which had modified the rating of Dr. Slutsky, was most consistent with the SOAF. By decision dated October 12, 2016, OWCP found that Dr. Askin had resolved the conflict of medical opinion and his opinion was therefore entitled to the special weight of the medical evidence. It noted that as appellant was previously paid a schedule award for five percent, the evidence of record did not support an increased schedule award. On October 18, 2016 appellant, through counsel, requested an oral hearing, which was held before an OWCP hearing representative on February 28, 2017.

By decision dated May 15, 2017, OWCP's hearing representative affirmed the prior schedule award decision.

## ***LEGAL PRECEDENT***

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has

vested the authority to implement the FECA program with the Director of OWCP.[5] 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.[6] FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[7]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment.*" The document included various changes to the original text, intended to serve as an *erratum*/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[8] 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.[9]

The sixth edition requires identifying the impairment for the class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[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)."

[5] *See* 20 C.F.R. §§ 1.1-1.4.

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

[7] 20 C.F.R. § 10.404; *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

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

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

[11] *Id*. at 521.

"Upon initial review of a referral for upper extremity evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, the DBI or ROM) and (2) whether the applicable tabled in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. If the [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."[12]

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."[13]

## ***ANALYSIS***

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

On August 16, 2016 OWCP referred appellant for an impartial medical examination in accordance with the instructions of OWCP's hearing representative to resolve the conflict between Dr. Diamond and the Dr. Berman, a DMA, regarding whether the ROM or DBI method was the more appropriate method to rate the extent of permanent impairment utilizing the A.M.A., *Guides*. The IME was tasked with utilizing a consistent method for calculating permanent impairment for the upper extremities to be applied uniformly, as described in FECA Bulletin No. 17-06.[14]

In his referee report dated September 29, 2016, Dr. Askin did not provide a responsive medical report. OWCP had instructed him to perform a physical examination, review the medical records and the SOAF, and provide an independent rating of appellant's left upper extremity pursuant to the A.M.A., *Guides*. The Board finds that he failed to fulfill his responsibilities as a referee physician as he merely acknowledged his agreement with the impairment opinion expressed by Dr. Berman, a DMA. Dr. Askin's report failed to cite table or charts in the A.M.A., *Guides* as he did not perform his own calculations. It is well established that when a physician's report provides an estimate of impairment, but does not address how the rating was made under the A.M.A., *Guides*, it lacks probative value.[15]

The Board has held that, when OWCP obtains an opinion from an IME for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in

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

[13] *Id*.

[14] *Id*.

[15] *See Paul R. Evans, Jr.*, 44 ECAB 646 (1993); *John Constantin*, 39 ECAB 1090 (1988) (a medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

his original report.[16] If the impartial specialist is unable to clarify or elaborate on the original report or if the supplemental report is also vague, speculative, or lacking in rationale, OWCP must submit the case record and a detailed SOAF to another impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[17] As OWCP did not follow its own procedures, the case shall be remanded for that purpose. After such other development as may be deemed necessary, OWCP shall issue *a de novo* decision on appellant's claim for an increased upper extremity schedule award.[18]

## ***CONCLUSION***

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

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the May 15, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: January 25, 2019
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

[16] *Talmadge Miller*, 47 ECAB 673 (1996); *Harold Travis*, 30 ECAB 1071, 1078 (1979); *see also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810(11)(c)(1)-(2) (September 2010).

[17] *Id.*

[18] *See supra* note 12.