United States Department of Labor
Employees' Compensation Appeals Board

P.H., Appellant	)	
and	)	**Docket No. 18-0987**
	)	**Issued: March 30, 2020**
U.S. POSTAL SERVICE, POST OFFICE, Westville, NJ, 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, Deputy Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On April 16, 2018 appellant, through counsel, filed a timely appeal from a December 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.

ISSUE

The issue is whether appellant has met his burden of proof to establish permanent impairment of a scheduled member or function of the body for schedule award purposes.

[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.*

FACTUAL HISTORY

On October 12, 2006 OWCP accepted that appellant, then a 51-year-old letter carrier, developed right lateral epicondylitis due to factors of his federal employment, including engaging in repetitive motions such as casing, holding, and pulling down mail. Appellant had stopped work on August 25, 2006 and returned to modified work on November 6, 2006. OWCP paid him wage-loss compensation on the supplemental rolls and he retired from federal service on March 1, 2014.

Appellant received treatment for his upper extremity problems from Dr. Bruce A. Monaghan, a Board-certified orthopedic surgeon. In numerous reports dated between 2006 and 2016, Dr. Monaghan diagnosed such conditions as right lateral epicondylitis and degenerative arthritis of the right thumb.[3] He regularly provided lifting restrictions for the right upper extremity.

In a January 4, 2016 report, Dr. Fredric D. Levin, a Board-certified orthopedic surgeon, reviewed appellant's medical history and reported physical examination findings.[4] Examination of the upper extremities revealed full range of motion (ROM) of the shoulders, elbows, wrists, and hands. Appellant had no atrophy or deformity of either upper extremity. He had negative Tinel's and Phalen's signs bilaterally, and sensory examination failed to reveal any perceived sensory deficit involving either upper extremity. Appellant exhibited marked tenderness at the metacarpophalangeal (MCP) joint of the right thumb with positive grind, shake, and pinch testing. Dr. Levin applied the diagnosis-based impairment (DBI) rating method, utilizing Table 15-2 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[5] to find that appellant's carpometacarpal (CMC) degenerative joint disease of the right thumb caused two percent permanent impairment of the right upper extremity. He also opined that, under Table 15-23, appellant's entrapment neuropathy of the right median nerve at the wrist caused four percent permanent impairment of that member. Dr. Levin combined these impairment rating values and concluded that the total permanent impairment of appellant's right upper extremity was six percent.[6]

Prior to reaching his conclusion regarding the extent of permanent impairment of appellant's right upper extremity, Dr. Levin also conducted an impairment calculation under the DBI rating method for appellant's accepted condition of right lateral epicondylitis. He indicated that, under Table 15-4, this condition fell under class 1 for the class of diagnosis (CDX), a designation which warranted a default value of one percent permanent impairment of the right

[3] A March 1, 2007 magnetic resonance imaging (MRI) scan of appellant's right elbow contained an impression of sprain of the radial collateral ligament, mild-to-moderate proximal common extensor tendinopathy, and small joint effusion most prominent within the lateral compartment.

[4] Dr. Levin noted that in this report appellant walked without a noticeable limp, but had difficulty with heel and toe walking secondary to pain.

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

[6] Dr. Levin found that appellant reached maximum medical improvement (MMI) on January 4, 2016, the date of his physical examination.

upper extremity.[7] Dr. Levin found that appellant had a grade modifier for functional history (GMFH) of 1, a grade modifier for physical examination (GMPE) of 0, and a grade modifier for clinical studies (GMCS) of 0. Application of the net adjustment formula resulted in movement two spaces to the left of the default value on Table 15-4 to the value of zero percent permanent impairment. Therefore, Dr. Levin concluded that appellant had zero percent permanent impairment of the right upper extremity due to the accepted condition of right lateral epicondylitis.

On November 16, 2016 appellant filed a claim for a schedule award (Form CA-7).

Appellant subsequently submitted a November 15, 2016 report from Dr. Monaghan who indicated that he had reviewed Dr. Levin's January 4, 2016 report and expressed his concurrence with Dr. Levin that appellant had six percent permanent impairment of the right upper extremity.

On December 14, 2016 OWCP referred appellant's case to Dr. Herbert White, Jr., a Board-certified occupational medicine physician serving as a district medical adviser (DMA), and requested that he review the medical evidence of record, including Dr. Levin's January 4, 2016 report, and provide an opinion as to the extent of appellant's permanent impairment.

On December 20, 2016 the DMA reviewed the medical evidence of record and concluded that appellant had zero percent permanent impairment of the right upper extremity. He indicated that, under Table 15-4, appellant's right epicondylitis fell under class 1 for the CDX with a default value of one percent permanent impairment of the right upper extremity.[8] The DMA determined that appellant had a GMFH of 1 (due to a *Quick*DASH score of 40), a GMPE of 0 (due to a "normal" examination), and a GMCS of 0 (due to no studies at the time of MMI). Application of the net adjustment formula resulted in movement two spaces to the left of the default value on Table 15-4 to the value of zero percent permanent impairment. The DMA therefore found that appellant had zero percent permanent impairment of the right upper extremity due to the accepted condition of right lateral epicondylitis.[9] He also indicated that he was unsure of how Dr. Levin obtained his rating of six percent permanent impairment of the right upper extremity, and he reiterated his conclusion that appellant had no permanent impairment of the right upper extremity.

By decision dated July 13, 2017, OWCP denied appellant's schedule award claim, finding that the weight of the medical evidence, as represented by the DMA's December 20, 2016 report, showed that appellant did not have permanent impairment of a scheduled member or function of the body, warranting a schedule award.

On July 19, 2017 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. Counsel later requested that OWCP's hearing representative conduct a review of the written record in lieu of an oral hearing. He argued

[7] This class 1 designation (with associated default value) is intended for conditions with a history of painful injury and residual symptoms without consistent objective findings. A.M.A., *Guides* 399, Table 15-4.

[8] The DMA found that appellant reached MMI on January 4, 2016, the date of Dr. Levin's physical examination.

[9] The DMA advised that he did not use the "surgical release grid" of Table 15-4 because appellant did not undergo right elbow surgery. He determined that appellant reached MMI on January 4, 2016, the date of Dr. Levin's physical examination.

that there was a conflict in the medical opinion evidence between Dr. Levin and the DMA regarding permanent impairment.

By decision dated December 15, 2017, OWCP's hearing representative affirmed the July 13, 2017 decision finding no conflict between the calculations of permanent impairment by Dr. Levin and the DMA with respect to appellant's accepted condition of right lateral epicondylitis.

LEGAL PRECEDENT

The schedule award provisions of FECA,[10] and its implementing regulations,[11] 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. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[12] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[13] The sixth edition requires identifying the class for the CDX, which is then adjusted by grade modifiers GMFH, GMPE, and GMCS.[14] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15]

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)."
>
> "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*

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] *Id.*

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

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

[15] *Id.* at 521.

impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)

* * *

"If the rating physician provided an assessment using the DBI 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."[16]

ANALYSIS

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

The Board has previously found that OWCP had inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation had been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[17] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[18] In *T.H.*, the Board concluded that OWCP physicians were at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and DMAs use both DBI and ROM methodologies interchangeably without a consistent basis. Furthermore, the Board observed that physicians interchangeably cited to language in the first printing or the second printing when justifying use of either the ROM or DBI methodology. The Board therefore found that OWCP should develop a consistent method for calculating permanent impairment for upper extremities, which could be applied uniformly.

As noted above, FECA Bulletin No. 17-06 provides that, if the rating physician provided an assessment using the DBI rating method, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.[19]

The Board finds that this case requires further development of the medical evidence. On December 20, 2016 the DMA indicated that he had reviewed the January 4, 2016 report of

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

[17] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

[18] *K.J.*, Docket No. 19-0901 (issued December 6, 2019); *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[19] *See supra* note 17.

Dr. Levin, an attending physician, and determined that appellant had zero percent permanent impairment of his right upper extremity as calculated under the DBI rating method. Since Dr. Levin provided a rating using the DBI rating method, and appellant's condition provided for application of the ROM rating method,[20] the DMA was required to independently calculate his impairment using both the DBI and ROM methods and identify the higher rating for the claims examiner.[21]

The Board notes that, the DMA did not conduct an impairment rating calculation under the ROM method and the case record does not contain recent ROM findings for properly conducting a right upper extremity permanent impairment rating under the ROM method. As noted above, FECA Bulletin No. 17-06 provides instructions for obtaining sufficient evidence to conduct a complete permanent impairment evaluation. However, such instructions were not carried out in this case and therefore further development of the medical evidence is required in accordance with FECA Bulletin No. 17-06.[22] Dr. Levin indicated in his January 4, 2016 report, that appellant had full ROM of his right elbow, but he did not provide specific ROM measurements for that elbow. The DMA, who reviewed Dr. Levin's report, did not conduct any evaluation under the ROM method.

Section 15.7 of the sixth edition of the A.M.A., *Guides* provides that ROM should be measured after a "warm up," in which the individual moves the joint through its maximum ROM at least three times. The ROM examination is then performed by recording the active measurements from three separate ROM efforts and all measurements should fall within 10 degrees of the mean of these three measurements. The maximum observed measurement is used to determine the ROM impairment.[23] There currently is no evidence in the case record that these requirements for evaluating permanent impairment due to ROM deficits have been met.

In order to conduct a full evaluation of appellant's right upper extremity permanent impairment, the Board finds that the case shall be remanded to OWCP in order for it to obtain the raw data from Dr. Levin's ROM testing for the right upper extremity. Once the data is obtained, it should be evaluated and considered under the relevant standards of the A.M.A., *Guides*, including referral to a DMA, as a possible basis for an impairment rating. If no such data is available, OWCP shall take appropriate action for further examination to obtain the necessary ROM measurements.

This case shall therefore be remanded for full application of OWCP's procedures found in FECA Bulletin No. 17-06 and the standards of the sixth edition of the A.M.A., *Guides*. After conducting this and other such further development of the medical evidence as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's schedule award claim.

[20] *See* A.M.A., *Guides* 399, Table 15-4.

[21] *See supra* note 17.

[22] *Id.*

[23] A.M.A., *Guides* 464.

CONCLUSION

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

ORDER

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

Issued: March 30, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board