United States Department of Labor
Employees' Compensation Appeals Board

W.M., Appellant	)	
and	)	**Docket No. 21-0728**
	)	**Issued: December 2, 2022**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Russell Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On April 16, 2021 appellant, through counsel, filed a timely appeal from an October 23, 2020 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 nine percent permanent impairment of the right upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On January 20, 2009 appellant, then a 57-year-old tractor trailer operator, filed a traumatic injury claim (Form CA-1) alleging that on that date he experienced shoulder pain when he slipped on ice and fell while in the performance of duty.[3] He did not stop work. OWCP accepted appellant's claim for right shoulder impingement syndrome. On April 21, 2009 appellant underwent OWCP-authorized right shoulder surgery and stopped work. OWCP paid him wage-loss compensation on the periodic rolls, effective September 27, 2009. On April 12, 2010 appellant returned to full-time limited duty.

On March 8, 2011 appellant filed a claim for compensation (Form CA-7) for a schedule award.

Appellant submitted a December 16, 2010 report by Dr. David Weiss, an osteopath Board-certified in physical medicine and rehabilitation, who reviewed appellant's history and noted appellant's accepted February 27, 2002 and January 20, 2009 work injuries. He provided physical examination findings and diagnosed chronic post-traumatic cervical strain and sprain, cervical radiculitis, status post right shoulder surgeries, and post-traumatic impingement syndrome to the right shoulder. Dr. Weiss referenced the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[4] and indicated that, utilizing the range of motion (ROM) methodology, under Table 15-34 (Shoulder Range of Motion), page 475, appellant had eight percent permanent impairment of the right upper extremity.[5] He also referenced Table 15-21 (Peripheral Nerve Impairment), page 436, and determined that appellant had one percent permanent impairment for class 1 sensory deficit at the right C5 nerve root, one percent permanent impairment for class 1 sensory deficit at the right C7 nerve root, and one percent permanent impairment for class 1 sensory deficit at the left C7 nerve root. Dr. Weiss concluded that appellant had a total of 10 percent permanent impairment of the right upper extremity and 1 percent permanent impairment of the left upper extremity.

[3] On February 27, 2002 appellant, then a 51-year-old tractor trailer operator, filed a Form CA-1 alleging that on that date he pulled a muscle in his neck when he tried to open a tractor trailer door while in the performance of duty. OWCP assigned OWCP File No. xxxxxx672. Appellant stopped work on February 27, 2002 and returned to full-time limited duty on March 15, 2002. OWCP accepted his claim for cervical strain. By decision dated May 20, 2014, it expanded the acceptance of appellant's claim under OWCP File No. xxxxxx672 to include cervical radiculopathy.

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

[5] Dr. Weiss determined that appellant had three percent permanent impairment due to 90 degrees flexion, three percent permanent impairment due to 90 degrees abduction, and one percent permanent impairment due to 35 degrees adduction.

In an August 8, 2011 report, OWCP's district medical adviser (DMA) concurred with Dr. Weiss' impairment rating report and found that appellant had 10 percent permanent impairment of the right upper extremity and 1 percent permanent impairment of the left upper extremity.

By decision dated October 25, 2011, OWCP granted appellant a schedule award for 10 percent permanent impairment of the right upper extremity and 1 percent permanent impairment of the left upper extremity. The award ran for a period of 34.32 weeks from December 16, 2010 through August 13, 2011.

On April 29, 2019 OWCP referred appellant's case, along with a new statement of accepted facts and a copy of the case record to Dr. Theodore P. Vlahos, an orthopedic surgeon, to provide an opinion regarding appellant's upper extremity impairment for schedule award purposes. In a July 15, 2019 report, Dr. Vlahos noted that appellant had two accepted claims for cervical strain, cervical radiculopathy, and right shoulder impingement syndrome. He reviewed appellant's medical records and recounted appellant's current complaints of neck pain in the posterior aspect of the neck, mostly on the right side, and intermittent numbness and tingling in the right and left arms. Dr. Vlahos reported that examination of appellant's cervical spine revealed tenderness on the right paracervicals over C3-4 and C5-6. Neurological testing in the upper extremities showed 5/5 manual muscle testing, equal sensation, and intact dermatomal distributions. Examination of appellant's bilateral shoulders showed tenderness at either acromioclavicular (AC) joint or proximal biceps and tenderness at the right supraspinatus tendon. Range of motion testing revealed flexion to 140 degrees on the right, external rotation at the side to 40 degrees bilaterally, external rotation in abduction to 90 degrees bilaterally, and internal rotation in abduction to 70 degrees on the right. Dr. Vlahos diagnosed cervical sprain and radiculopathy as injuries sustained on February 27, 2002. He also noted that the work-related injuries due to appellant's January 20, 2009 injury included right shoulder partial rotator cuff tear, superior labrum from anterior to posterior (SLAP) tear, AC joint derangement, and impingement.

Dr. Vlahos referenced Table 15-5 (Shoulder Regional Grid), pages 401-05, of the A.M.A., *Guides* and indicated that the applicable categories would be impingement syndrome, rotator cuff injury partial thickness tear, AC joint injury or disease, and labral lesions, including SLAP tear. He determined that, under the diagnosis-based impairment (DBI) rating method, appellant had a class of diagnosis (CDX) of class 1 for normal criteria for his right shoulder conditions. Dr. Vlahos explained that the ROM method was the appropriate method of rating appellant's right shoulder. He utilized Table 15-34, (Shoulder Range of Motion), page 475 and determined that appellant had three percent permanent impairment due to 140 degrees flexion, one percent permanent impairment due to 40 degrees extension, three percent permanent impairment due to 140 degrees abduction, and two percent permanent impairment due to 70 degrees internal rotation for a total of nine percent permanent impairment of the right upper extremity. Dr. Vlahos noted that a grade modifier for functional history (GMFH) of 1 for mild loss of ROM resulted in no increase in impairment rating. He reported that it was possible that, at the time of the previous impairment rating, appellant had a GMFH of moderate, which would increase appellant's impairment rating to 10 percent. Dr. Vlahos opined that, because appellant's current symptoms were mild, he believed that nine percent permanent impairment of the right upper extremity was more accurate. He further noted that the 9 percent permanent impairment of the right upper extremity was included

in the prior schedule award of 10 percent permanent impairment of the right upper extremity, so no additional impairment was warranted.

In addition, Dr. Vlahos referenced *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*) and explained that appellant had one percent permanent impairment for mild right C5 sensory impairment, one percent permanent impairment for mild right C6 sensory impairment, and one percent permanent impairment for mild right C7 sensory impairment for a total of three percent permanent impairment of the right upper extremity. Regarding appellant's left upper extremity permanent impairment, he explained that appellant had an additional six percent permanent impairment compared to his prior schedule award of one percent permanent impairment of the left upper extremity.[6]

By decision dated May 8, 2020, OWCP granted appellant an amended schedule award for nine percent permanent impairment of the right upper extremity based on Dr. Vlahos' July 15, 2019 report. The period of the award ran for 28.08 weeks from December 16, 2010 through June 30, 2011. OWCP noted that, because Dr. Vlahos' impairment rating was included in the prior schedule award of 10 percent permanent impairment of the right upper extremity, appellant was not entitled to an increased schedule award.[7]

On May 15, 2020 appellant through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review, which was held on August 13, 2020.

By decision dated October 23, 2020, OWCP's hearing representative affirmed the May 8, 2020 decision.

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 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 of loss of a member 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 and the Board has concurred in such

[6] On August 22, 2019 OWCP combined OWCP File Nos. xxxxxx738 and xxxxxx672, with the latter claim as the master file.

[7] On May 15, 2020 OWCP issued a notice advising appellant of its preliminary overpayment determination that he received an overpayment in the amount of $4,722.12, for which he was without fault, for the period December 16, 2010 through June 29, 2011 because he received schedule award compensation for 10 percent permanent impairment of the right upper extremity, but was only entitled to receive 9 percent permanent impairment of the right upper extremity. The overpayment issue is currently not before the Board.

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

adoption.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[11]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401. After the CDX is determined from the Shoulder Regional Grid (including identification of the default grade value), the net adjustment formula is applied using a GMFH, grade modifier for physical examination (GMPE), and a grade modifier for clinical studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[14]

The A.M.A., *Guides* also provide that the ROM impairment 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.[15] 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.[16] 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.[17]

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).

[10] *Id*. at § 10.404 (a); *see also T.T.*, Docket No. 18-1622 (issued May 14, 2019); *Jacqueline S. Harris*, 54 ECAB 139 (2002).

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

[12] A.M.A., *Guides* 405-12; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[13] *Id*. at 411.

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

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

[16] *Id*. at 473.

[17] *Id*. at 474.

"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*." (Emphasis in the original.)[18]

The Bulletin further advises:

"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."[19]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[20]

ANALYSIS

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

On April 29, 2019 OWCP referred appellant's case to Dr. Vlahos to provide an opinion regarding appellant's upper extremity impairment for schedule award purposes. In a July 15, 2019 report, Dr. Vlahos utilized Table 15-5 (Shoulder Range of Motion) of the A.M.A., *Guides* and determined that appellant had nine percent permanent impairment of the right upper extremity due to loss of ROM in his right shoulder. By decision dated May 8, 2020, OWCP granted appellant a schedule award for nine percent permanent impairment of the right upper extremity based on Dr. Vlahos' July 15, 2019 report.

As noted above, after obtaining all necessary medical evidence, the file should be routed to OWCP's DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[21] OWCP's procedures further provide that, after a second opinion is received, the case should be referred to the DMA for review.[22] In the instant case, however, OWCP

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

[19] *Id*.

[20] *See supra* note 11 at Chapter 2.808.6 (March 2017). *R.M.*, Docket No. 18-1313 (issued April 11, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010).

[21] *Supra* note 18.

[22] *Supra* note 11 at Chapter 2.808.6(e) (March 2017). *See also P.W.*, Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan*, 57 ECAB 349 (2006).

failed to route the case record, including Dr. Vlahos' July 15, 2019 second-opinion report, to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*.[23] Accordingly, the case must be remanded for referral to a DMA.[24]

On remand, OWCP shall further develop the medical evidence of record by obtaining an opinion from a DMA regarding the nature and extent of appellant's right upper extremity permanent impairment for his accepted January 20, 2009 employment injury. Following this and other such further development as deemed necessary, it shall issue a *de novo* decision regarding appellant's schedule award claim.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the October 23, 2020 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: December 2, 2022
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board

[23] *See L.S.*, Docket No. 19-0092 (issued June 12, 2019).

[24] *See Order Remanding Case, D.K.*, Docket No. 21-0885 (issued January 14, 2022); *L.R.*, Docket No. 20-0493 (issued September 20, 2021).