

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

J.O., Appellant

and

**U.S. POSTAL SERVICE, FRESNO-CLINTER
STATION, Fresno, CA, Employer**

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**Docket No. 19-1337
Issued: February 2, 2021**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 3, 2019 appellant filed a timely appeal from a December 19, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.²

¹ 5 U.S.C. § 8101 *et seq.*

² Appellant submitted a timely request for oral argument before the Board. 20 C.F.R. § 501.5(b). Pursuant to the Board's *Rules of Procedure*, oral argument may be held in the discretion of the Board. 20 C.F.R. § 501.5(a). In support of appellant's oral argument request, he asserted that oral argument should be granted because he disagrees with OWCP's December 19, 2018 decision and asserts that he has greater than six percent permanent impairment of his right upper extremity. The Board, in exercising its discretion, denies appellant's request for oral argument because the arguments on appeal can adequately be addressed in a decision based on a review of the case record. Oral argument in this appeal would further delay issuance of a Board decision and not serve a useful purpose. As such, the oral argument request is denied and this decision is based on the case record as submitted to the Board.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than six percent permanent impairment of the right upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On December 26, 2012 appellant, then a 57-year-old mail carrier, filed a traumatic injury claim (Form CA-1) alleging that on that same date he strained his shoulder and upper arm when two dogs jumped on him and he swung his mailbag to keep them at bay while in the performance of duty. OWCP accepted the claim for a right shoulder and upper arm sprain, right bicipital tenosynovitis, and disorder of bursae and tendons in the right shoulder.

An April 10, 2013 operative report by Dr. Danilo Mamintim, a Board-certified surgeon, indicated that appellant underwent authorized mini open right shoulder rotator cuff tear repair, right shoulder arthroscopic subacromial decompression, and right shoulder synovectomy.

On January 19, 2018 appellant filed a claim for compensation (Form CA-7) for a schedule award.

A January 24, 2018 letter from Dr. Martin Wenthe, a Board-certified family physician, indicated that appellant sustained an employment-related right shoulder injury three years ago. He recommended that appellant be evaluated by his treating physician or an orthopedic surgeon regarding any permanent impairment he sustained.

In a development letter dated February 12, 2018, OWCP advised appellant that additional medical evidence was necessary to establish his schedule award claim. It requested that he submit a report from his treating physician which provided a permanent impairment rating pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).³

In a letter dated March 12, 2018, appellant requested an evaluation with a second opinion specialist, as his treating physician did not perform permanent impairment evaluations.

On August 15, 2018 OWCP referred appellant for a second opinion evaluation with Dr. Mark Bernhard, an osteopath Board-certified in family medicine, to determine the extent of his permanent impairment, if any, due to the accepted conditions.

An October 24, 2018 second opinion evaluation report by Dr. Bernhard reviewed appellant's SOAF, history of injury, and medical records. Appellant presented with complaints of shoulder pain when lifting and moving objects and the inability to sleep at night. He indicated that he had difficulty with activities of daily living, and stated that his pain was exacerbated by movement. Appellant also noted that, on occasion, he experienced numbness in his thumb and index and middle fingers and achiness and stiffness in his shoulder and neck. Dr. Bernhard related

³ A.M.A., *Guides* (6th ed. 2009).

that on physical examination of appellant's right shoulder, he obtained three measurements in each plane of motion, which revealed guarding in all planes of motion. He recorded appellant's range of motion (ROM) findings of flexion 60 degrees, extension 28 degrees, abduction 45 degrees, adduction 25 degrees, internal rotation 45 degrees, and external rotation 45 degrees. A motor examination revealed weakness and 4 out of 5 muscle strength in all planes of motion. Dr. Bernhard diagnosed right shoulder rotator cuff tear, bicipital tenosynovitis, status post open rotator cuff tear repair, subacromial decompression, coracoclavicular excision, distal clavicle excision, and synovectomy of the right shoulder.

Dr. Bernhard indicated that appellant reached his maximum medical improvement (MMI) on October 24, 2018, supported by physical examination findings. He explained that appellant's ROM of the right shoulder was more limited than what was listed in his postsurgical and post-therapy medical records. Dr. Bernhard also noted that appellant appeared to be steady and stable without any evidence of accompanying new injury pathology or other abnormalities, and he was reasonably functional to the limit of that loss of strength and motion.

Dr. Bernhard first evaluated the permanent impairment of appellant's right upper extremity utilizing the ROM rating method using table 15-34 on page 475 of the A.M.A., *Guides*. He indicated that appellant's 60-degree flexion equaled nine percent impairment, and he rounded appellant's 28-degree extension to 30 degrees and indicated that it equaled one percent impairment. Dr. Bernhard rounded appellant's 45-degree abduction to 50 and indicated that it equaled six percent impairment, and he rounded appellant's 25-degree adduction to 30 degrees and indicated that it equaled one percent impairment. He rounded appellant's 45-degree internal rotation to 50 and indicated that it equaled two percent impairment, and he rounded appellant's 45-degree external rotation to 50 and indicated that it equaled two percent impairment. Dr. Bernhard added up the percentages and calculated a total of 21 percent permanent impairment of the right upper extremity.

Dr. Bernhard then evaluated the permanent impairment of appellant's right upper extremity utilizing the diagnosis-based impairment (DBI) rating method. Using Table 15-5 on page 403 of the A.M.A., *Guides*, he identified the class of diagnosis (CDX) as rotator cuff injury, full-thickness tear as class 1 grade C because it was in the mid-range default with residual loss of function, which equaled five percent impairment. Dr. Bernhard explained that a grade modifier for functional history (GMFH) is obtained based on the need for pain medication and the ability to perform self-care activities, and that although appellant's *QuickDASH* score was 77 based on Table 15-7 on page 406, which would indicate a grade 3 modifier, he assigned a grade modifier 2 because it was more accurate. He indicated that as his physical examination of appellant revealed minimal palpatory findings, no significant instability, a relationship of symptoms with activity, and ROM plus or minus reproducible symptoms with stability testing, he assigned a grade modifier of physical examination (GMPE) of 1 using Table 15-8 on page 408. Dr. Bernhard explained that therefore the net adjustment formula of (GMFH-CDX) plus (GMPE-CDX) or $(2-1) + (1-1)$ resulted in the net adjustment of 1, which moved the grade C value of five percent impairment up to grade D, resulting in six percent permanent impairment of the right upper extremity. He also indicated that he did not find an organic basis for including the ROM method and therefore recommended the DBI method.

In a December 14, 2018 medical report, Dr. Jovito Estaris, Board-certified in occupational medicine serving as a district medical adviser (DMA), reviewed appellant's SOAF and the medical evidence of record, including the second opinion evaluation report from Dr. Bernhard. He indicated that the ROM method was not applicable, as Dr. Bernhard stated that there was no organic basis for using it as a method to evaluate appellant's upper extremity impairment. Dr. Estaris utilized the DBI rating method and utilized Table 15-15 on page 403 to assign appellant's diagnosis of rotator cuff injury, full-thickness tear as class 1, grade C, equaling a default value of five percent impairment due to appellant's residual loss with motion deficits. Using Table 15-7 on page 406, Dr. Estaris assigned a GMFH of 2 due to appellant's pain with regular activity. Using Table 15-8 on page 408, he assigned a GMPE of 1 due to appellant's physical examination revealing no tenderness, minimal palpatory findings, and negative shoulder tests. Dr. Estaris stated that he did not use a grade modifier of clinical studies (GMCS) because a magnetic resonance imaging (MRI) scan of appellant's right shoulder that displayed a rotator cuff tear was used in determining his diagnosis and proper placement in the regional grid. He used the net adjustment formula of (GMFH-CMX) + (GMPE-CDX) or (2-1) + (1-1) to calculate a net adjustment of 1. Dr. Estaris indicated that the net adjustment moved appellant's grade to D, resulting in a total of six percent permanent impairment. He additionally listed appellant's date of MMI as October 24, 2018.

By decision dated December 19, 2018, OWCP granted appellant a schedule award for six percent permanent impairment of the right upper extremity. The period of the award ran for 18.72 weeks from October 24, 2018 to March 4, 2019.

LEGAL PRECEDENT

The schedule award provisions of FECA,⁴ and its implementing federal regulations,⁵ set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of a scheduled member or function 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

⁴ *Supra* note 1.

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 2.808.5(a) (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).

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 and Health (ICF).⁸ Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by GMFH, GMPE, and 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

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the percentage of permanent impairment using the A.M.A., *Guides*.¹²

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 impairment rating for the diagnosis in question, the method producing the higher rating should be used.*” (Emphasis in the original).¹³

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

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 521.

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

¹² *Supra* note 6 at Chapter 2.808.6(f) (March 2017); *A.C.*, Docket No. 19-1333 (issued January 22, 2020).

¹³ FECA Bulletin No. 17-06 (May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.”¹⁴

ANALYSIS

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

Upon development of the claim, OWCP referred appellant to Dr. Bernhard for a second opinion examination and opinion regarding the permanent impairment of appellant’s right upper extremity. Dr. Bernhard obtained three measurements of appellant’s right shoulder, which were all consistent. He also related that while appellant’s ROM had decreased postsurgery and post-physical therapy, his ROM appeared to be steady and stable without any evidence of new injury or other pathology. Dr. Bernhard concluded that appellant was therefore reasonably functional to that loss of strength and motion. He recorded appellant’s ROM findings and concluded that his ROM impairment totaled 21 percent. Without further explanation, however, Dr. Bernhard concluded that he did not find an organic basis for the ROM rating method and would recommend that appellant’s impairment be rated under the DBI method.

When using the DBI method to calculate appellant’s percentage of permanent impairment, Dr. Bernhard explained that a GMFH is obtained based on the need for pain medication and the ability to perform self-care activities. He indicated that although based on Table 15-7 on page 406 appellant’s *QuickDASH* score was 77, which would indicate a grade 3 modifier, he assigned a grade modifier 2 because it was more accurate.

The Board finds that the Dr. Bernhard’s second opinion examination report requires clarification. Dr. Bernhard offered no explanation as to why there was not an organic basis for appellant’s ROM findings, given that he also related that his current evaluation resulted in consistent findings, and appellant had no evidence of new injury or other pathology. Furthermore, in assessing appellant’s impairment under the DBI method, Dr. Bernhard failed to provide a reason explaining why a grade modifier of 2 was more accurate despite a *QuickDASH* score indicating otherwise. As stated above, evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.¹⁵

It is well established that proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter.¹⁶ While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence and to see that

¹⁴ FECA Bulletin No. 17-06 *id.*

¹⁵ *Supra* note 11.

¹⁶ *D.L.*, Docket No. 19-0987 (issued October 23, 2019); *T.O.*, Docket No. 18-0659 (issued August 8, 2019).

justice is done.¹⁷ Once OWCP undertook development of the evidence it had a duty to secure an appropriate report addressing the relevant issues.¹⁸

The Board will therefore set aside OWCP's December 19, 2018 decision and remand the case to OWCP to seek clarification from its second opinion examiner Dr. Bernhard regarding his opinion that appellant's ROM findings were not organic in nature, and his reasoning for assigning appellant a GMFH of 2 despite calculating a *QuickDASH* score of 77. After such further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an increased schedule award.

CONCLUSION

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

¹⁷ *D.L., id.*; *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *Jimmy A. Hammons*, 51 ECAB 219 (1999).

¹⁸ *D.L., id.*; *Peter C. Belkind*, 56 ECAB 580 (2005); *Ayanle A. Hashi*, 56 ECAB 234 (2004).

ORDER

IT IS HEREBY ORDERED THAT the December 19, 2018 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: February 2, 2021
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board