United States Department of Labor
Employees' Compensation Appeals Board

R.R., Appellant	)	
and	)	**Docket No. 17-1947**
	)	**Issued: December 19, 2018**
DEPARTMENT OF THE AIR FORCE, AIR NATIONAL GUARD, Minot, ND, Employer	)	

Appearances:
Appellant, pro se
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 18, 2017 appellant filed a timely appeal from a July 28, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 23 percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the July 28, 2017 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this evidence for the first time on appeal. *Id.*

FACTUAL HISTORY

On December 15, 2005 appellant, then a 55-year-old safety and occupational health manager, filed a traumatic injury claim (Form CA-1) alleging that he sustained a right upper extremity injury that day as a result of falling on ice in a parking lot. By decision dated December 28, 2006, OWCP accepted the claim for right shoulder partial rotator cuff tear with impingement syndrome. It further authorized a right shoulder surgery which appellant underwent on February 13, 2007.

On April 30, 2008 appellant filed a claim for a schedule award (Form CA-7). OWCP initially denied his claim for a schedule award on July 29, 2008 because the medical evidence then of record was insufficient to establish permanent impairment of a scheduled member or function of the body. On August 25, 2008 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review. By decision dated October 24, 2008, an OWCP hearing representative remanded the case for further development. OWCP subsequently accepted the claim for right shoulder post-traumatic osteoarthritis and granted appellant a schedule award for 23 percent permanent impairment of his right upper extremity. The award ran for 71.76 weeks for the period February 20, 2009 to July 7, 2010.

In a May 5, 2016 report, Dr. E. Dexter Scott, a Board-certified orthopedic surgeon, noted that appellant had ongoing problems with his right shoulder. He reported that in 2008 he had opined that appellant had 25 percent permanent impairment of the right upper extremity and 15 percent whole person permanent disability or impairment. Dr. Scott found that, with the progressive osteoarthritis there had been an increase to the point where, in his opinion, appellant had 20 percent whole person permanent impairment and 35 percent impairment of the right upper extremity.

On June 1, 2016 appellant filed a claim for an increased schedule award (Form CA-7).

In a June 13, 2016 development letter, OWCP advised appellant of the deficiencies of his claim and afforded him 30 days to submit additional evidence and respond to its inquiries.

Appellant subsequently submitted a July 12, 2016 report from Dr. Scott who diagnosed post-traumatic osteoarthritis of the right shoulder glenohumeral and acromioclavicular joint with chronic right shoulder rotator cuff tear and degeneration and weakness. Dr. Scott opined that appellant had 22 percent permanent impairment of the right upper extremity due to lack of full strength on flexion, abduction, and external rotation and lack of full mobility. He found that appellant had pain and tenderness on overhead movements and lacked 30 percent flexion and abduction of range of motion (ROM) and lacked 30 to 40 percent strength on flexion, abduction, and internal and external rotation of the right shoulder. Dr. Scott concluded that this converted to four to five percent full body disability based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

The case record was referred to Dr. Michael M. Katz, a Board-certified orthopedic surgeon and an OWCP district medical adviser (DMA). On October 1, 2016 Dr. Katz reviewed the medical

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

evidence of record and recommended that Dr. Scott be contacted and asked to submit a supplemental report calculating appellant's impairment in a detailed fashion, specifically documenting recorded motion measurements.

In a November 18, 2016 supplemental report, Dr. Scott noted that appellant had moderate lack of ROM of his right shoulder by 35 percent compared to normal, loss of flexion of 25 degrees, loss of extension by 10 to 12 degrees, loss of abduction by 25 degrees, loss of adduction by 20 degrees, loss of internal rotation by 20 degrees, and loss of external rotation by 40 degrees compared to the left shoulder. He calculated that this totaled 23 percent right upper extremity permanent impairment and 13 percent whole person impairment, based on appellant's class 2 diagnosis under Table 15-34 of the A.M.A., *Guides*.

On December 1, 2016 Dr. Katz determined that appellant had reached maximum medical improvement (MMI) on October 28, 2016, the date of Dr. Scott's last examination. He also found that Dr. Scott correctly referenced Table 15-34 of the A.M.A., *Guides*, but noted that it was unclear as to how he calculated 23 percent permanent impairment of the right upper extremity solely on the motion observed. Dr. Katz explained that, while Dr. Scott referenced a loss of strength, weakness was not ratable in conjunction with motion loss per the methodology of the sixth edition of the A.M.A., *Guides* and, therefore, his impairment for weakness was not acceptable. He explained that, while Table 15-34 was based on measured motion present, not loss of motion, it was his opinion that it was possible to perform a conversion to the preferred format using Dr. Scott's measurements from his physical examination. Dr. Katz noted that rounding would be performed based on motion lost, rather than on motion remaining. He noted Dr. Scott's measurements for loss of motion and calculated that the grade modifier resulting from ROM was 2. Dr. Katz determined that appellant had 14 percent permanent impairment of the right upper extremity, which was less than the prior schedule award of 23 percent, so there was no net additional award now due for the right upper extremity.

In a December 14, 2016 letter, OWCP advised appellant that it had found a conflict in the medical opinion evidence between his attending physician, Dr. Scott, and its DMA, Dr. Katz, regarding the issue of permanent impairment. It referred him to Dr. Michael Righetti, a Board-certified orthopedic surgeon, for an independent medical examination to resolve the conflict.

In his February 3, 2017 report, Dr. Righetti found that appellant's ROM included flexion to 45 degrees, extension to 30 degrees, external rotation and internal rotation approximately a total of 30 degrees, with 0 degrees external rotation, 30 degrees internal rotation, abduction to 90 degrees, and adduction to 40 degrees. He explained that, according to Table 15-34, appellant had impairment due to lack of flexion of 9 percent, lack of extension 1 percent, lack of internal and external rotation 9 percent, and lack of abduction 3 percent, totaling 22 percent permanent impairment of the right upper extremity. Dr. Righetti noted that his observed ROMs were different than Dr. Katz' observed findings which he determined from Dr. Scott's statements. He concluded that appellant's ROM resulted in permanent impairment less than the 23 percent permanent impairment of the right upper extremity previously awarded and therefore no further award for impairment was appropriate.

The case record was referred to Dr. Morley Slutsky, a Board-certified occupational medicine specialist and an OWCP DMA. On February 25, 2017 Dr. Slutsky reviewed the medical evidence of record and found that Dr. Righetti rated appellant's right shoulder using ROM

measurements and documented only one motion per joint movement. He indicated that this was not consistent with the validity criteria in section 15.7, page 464, of the A.M.A., *Guides* for measuring ROM and, as such, the ROM measurements were invalid for impairment calculations. Dr. Slutsky requested that OWCP ask Dr. Righetti if he performed three measurements for each shoulder motion, what those measurements were, and to show that they met the criteria under the A.M.A., *Guides*. He explained that, if only one active ROM measurement was taken, then Dr. Righetti would have to recalculate the impairment using the diagnosis-based impairment (DBI) method as opposed to the ROM method.

In an April 2, 2017 addendum report, Dr. Righetti noted that appellant's ROM was tested three times and the mean of those ranges were dictated. Each measurement was not provided in the dictation and each measurement was within 10 degrees of adjacent measurements. Mean ROM of appellant's right shoulder was flexion to 45 degrees compared to 150 degrees on the contralateral side, extension to 30 degrees compared to 40 degrees on the contralateral side, external rotation to 0 degrees on the involved side and 40 degrees on the uninvolved side, internal rotation to 30 degrees on the involved side and 90 degrees on the uninvolved side, abduction to 90 degrees on the involved side and adduction to 40 degrees on the involved side, and abduction to 150 degrees on the uninvolved side and adduction to 40 degrees on the uninvolved side. Dr. Righetti explained that the DBI method was not utilized because appellant did not have full ROM which he understood was required for using the DBI method.

On May 24, 2017 Dr. Slutsky found that Dr. Righetti used the average ROM value for each shoulder motion for final impairment calculations and failed to list three measurements for each shoulder motion. He indicated that FECA Bulletin 17-06[4] required that the greatest ROM value from each of the three measurements per motion was to be used for final impairment calculations, in accordance with the A.M.A., *Guides*. Dr. Slutsky requested that OWCP ask Dr. Righetti to document the greatest ROM value from each of the three measurements for each other shoulder and recalculate his impairment rating.

In a June 8, 2017 report, Dr. Righetti provided the following figures as the greatest ROM measurements recorded: flexion 50 degrees, extension 40 degrees, internal rotation 35 degrees, external rotation 5 degrees, abduction 95 degrees, and adduction 40 degrees. He reiterated that, according to Table 15-34, appellant had 9 percent impairment for flexion, 1 percent impairment for extension, 2 percent impairment for internal rotation; 5 percent impairment for external rotation, 3 percent impairment for abduction, and 0 percent impairment for adduction, totaling 20 percent permanent impairment of the right upper extremity and 12 percent whole person impairment.

On July 6, 2017 Dr. Slutsky determined that appellant had 19 percent permanent impairment of the right upper extremity based upon Dr. Righetti's valid ROM measurements. He concurred with Dr. Righetti's calculations, but rounded the odd numbers up to 10 degrees to the nearest number ending in zero. Utilizing Table 15-34, page 475, Dr. Slutsky calculated that appellant had 9 percent impairment for 50 degrees flexion, 1 percent impairment for 40 degrees extension, 3 percent impairment for 100 degrees abduction, and 0 percent impairment for 40 degrees adduction, 4 percent impairment for 40 degrees internal rotation; and 2 percent impairment

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

for 10 degrees external rotation, totaling 19 percent permanent impairment of the right upper extremity. He determined that appellant's date of MMI was February 3, 2017, the date of Dr. Righetti's impairment examination. Dr. Slutsky concluded that appellant's impairment rating was less than the 23 percent permanent impairment of the right upper extremity previously awarded and no further schedule award was appropriate.

Appellant submitted a June 9, 2017 report from Dr. Scott who advised that appellant had long-standing rotator cuff tendinitis and a previous rotator cuff rupture and repair with post-traumatic osteoarthritis.

By decision dated July 28, 2017, OWCP denied appellant's claim for an additional schedule award because the medical evidence of record was insufficient to establish four percent permanent impairment greater than that previously awarded.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing regulations[6] provide for compensation to employees sustaining impairment from loss or loss of use of specified members 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 determination is a matter which rests in the sound 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. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[7] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[8]

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).[9] Under the sixth edition, the evaluator identifies the impairment 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). Evaluators are directed to provide

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *See Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000). *See also* 5 U.S.C. § 8107.

[8] *See D.T.*, Docket No. 12-503 (issued August 21, 2012); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[9] 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*.

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

reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[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 claims examiner (CE) 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).[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 appellant has not met his burden of proof to establish more than 23 percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

OWCP accepted that appellant sustained a right shoulder partial rotator cuff tear with impingement syndrome and right shoulder post-traumatic osteoarthritis at work on December 15, 2005. It also authorized a February 13, 2007 right shoulder surgery and granted appellant a schedule award for 23 percent permanent impairment of the right upper extremity. OWCP is appellant's burden to submit sufficient evidence to establish the extent of permanent impairment.[14]

[11] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[12] *Supra* note 4.

[13] *Id.*

[14] *See Annette M. Dent*, 44 ECAB 403 (1993).

On December 14, 2016 OWCP advised appellant that it had found a conflict in the medical opinion evidence between his attending physician, Dr. Scott who opined that appellant had 23 percent permanent impairment of the right upper extremity, and its DMA Dr. Katz, who opined that appellant had 14 percent permanent impairment of the right upper extremity. It referred him to Dr. Righetti for an independent medical examination to resolve the conflict. In his June 8, 2017 report, Dr. Righetti provided the following figures as the greatest ROM measurements recorded: flexion 50 degrees, extension 40 degrees, internal rotation 35 degrees, external rotation 5 degrees, abduction 95 degrees, and adduction 40 degrees. He opined that, according to Table 15-34, appellant had 9 percent impairment for flexion, 1 percent impairment for extension, 2 percent impairment for internal rotation; 5 percent impairment for external rotation, 3 percent impairment for abduction, and 0 percent impairment for adduction, totaling 20 percent permanent impairment of the right upper extremity.

In accordance with its procedures, OWCP properly referred the evidence of record to Dr. Slutsky, an OWCP medical adviser, who reviewed the clinical findings of Dr. Righetti on July 6, 2017 and determined that appellant had 19 percent permanent impairment of the right upper extremity based upon Dr. Righetti's valid ROM measurements under the sixth edition of the A.M.A., *Guides*. Dr. Slutsky found that appellant had reached MMI as of February 3, 2017, the date of Dr. Righetti's initial impairment examination. Dr. Righetti explained that the DBI method was not utilized because appellant did not have full ROM, which he understood was required for using the DBI method. OWCP's medical adviser concurred with Dr. Righetti's diagnosis and methodology, but disagreed with Dr. Righetti's 20 percent impairment rating because he failed to round the odd-numbered measurements up 10 degrees to the nearest number ending in zero. Utilizing Table 15-34, page 475, of the A.M.A., *Guides*, Dr. Slutsky rounded up Dr. Righetti's ROM measurements and calculated that appellant had 9 percent impairment for 50 degrees flexion, 1 percent impairment for 40 degrees extension, 3 percent impairment for 100 degrees abduction, and 0 percent impairment for 40 degrees adduction, 4 percent impairment for 40 degrees internal rotation; and 2 percent impairment for 10 degrees external rotation, totaling 19 percent permanent impairment of the right upper extremity. He concluded that appellant's impairment rating was less than the 23 percent previously awarded and, therefore, no further schedule award was appropriate.

OWCP's medical adviser discussed how he arrived at his conclusion by listing specific tables and pages in the A.M.A., *Guides*. Dr. Slutsky properly interpreted the sixth edition of the A.M.A., *Guides* to find that appellant had 19 percent permanent impairment of the right upper extremity. The Board finds that OWCP's medical adviser in this case properly applied the standards of the A.M.A., *Guides*. His opinion is the weight of medical evidence and supports that appellant does not have a greater right upper extremity impairment than the 23 percent previously awarded. Thus, the Board finds that OWCP properly relied upon the opinion of its medical adviser in denying appellant's claim for an additional schedule award.

The Board finds that there is no current medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has more than 23 percent permanent impairment of the right upper extremity. Accordingly, appellant has not established that he is entitled to a schedule award greater than that previously awarded.

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish more than 23 percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the July 28, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 19, 2018
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