United States Department of Labor
Employees' Compensation Appeals Board

D.T., Appellant	)	
and	)	**Docket No. 18-1773**
	)	**Issued: April 22, 2019**
DEPARTMENT OF HOMELAND SECURITY, FEDERAL AIR MARSHAL SERVICE, Denver, CO, 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 19, 2018 appellant filed a timely appeal from an April 3, 2018 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 to consider the merits of this case.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that following the April 3, 2018 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 additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 13 percent permanent impairment of the right upper extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On September 25, 2014 appellant, then a 42-year-old federal air marshal, filed a traumatic injury claim (Form CA-1) alleging that, on September 18, 2014, he injured his right shoulder, elbow, and wrist lifting weights for physical fitness training while in the performance of duty. On February 4, 2015 OWCP accepted his claim for lateral epicondylitis and lesion of the ulnar nerve in the right upper extremity.[3]

Appellant underwent a right shoulder magnetic resonance imaging (MRI) scan on February 1, 2016 which demonstrated a superior labrum anterior and posterior (SLAP) tear from the posterior superior labrum into the biceps labral anchor. On March 4, 2016 OWCP expanded acceptance of his claim to include C5-6 and C6-7 disc protrusion and C6-7 cervical radiculopathy. On May 6, 2016 it expanded acceptance of appellant's claim to include impingement syndrome of the right shoulder and bicipital tendinitis of the right shoulder.

On November 18, 2016 OWCP referred appellant, a statement of accepted facts (SOAF), and a list of questions to Dr. John D. Douthit, a Board-certified orthopedic surgeon, for a second opinion evaluation. In his December 12, 2016 report, Dr. Douthit diagnosed degenerative disease of the shoulder acromioclavicular (AC) joint and cervical spine as well as pain syndromes of the cervical spine, right shoulder, and right elbow related to work. He found limited range of motion (ROM) in the right shoulder resulting in 150 degrees of flexion, 130 degrees of abduction, 80 degrees of internal rotation, 30 degrees of adduction, and 40 degrees of extension. Dr. Douthit reported that appellant's right elbow ROM was -5 extension and 120 degrees of flexion with 80 degrees of pronation and supination. He found no dysesthesias and no weakness. Dr. Douthit opined that appellant was at maximum medical improvement (MMI) from these conditions. He applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[4] and found that appellant had three percent permanent impairment of the right elbow utilizing the ROM method.

On January 8, 2017 appellant filed a schedule award claim (Form CA-7).

On February 11, 2017 Dr. Morley Slutsky, Board-certified in occupational medicine, acting as an OWCP district medical adviser (DMA), reviewed Dr. Douthit's report and found two percent permanent impairment of the right upper extremity based on loss of ROM of the right

[3] OWCP File Nos. xxxxxx137 and xxxxxx078 have been administratively combined, with the latter serving as the master file. OWCP File No. xxxxxx078 was accepted for generalized anxiety disorder. Appellant has not appealed the most recent merit decision in OWCP File No. xxxxxx078, an April 5, 2018 loss of wage-earning capacity determination. The Board will therefore, not consider that decision in this appeal. *See* 20 C.F.R. § 501.3.

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

elbow. He determined that appellant had only mild extension loss of the right elbow resulting in two percent permanent impairment under the A.M.A., *Guides*.[5] He further noted that appellant had no clinical evidence of right lateral epicondylitis.

By decision dated June 9, 2017, OWCP granted appellant a schedule award for two percent permanent impairment of the right upper extremity.

On June 27, 2017 appellant requested an oral hearing with a representative OWCP's Branch of Hearings and Review. By decision dated October 31, 2017, OWCP's hearing representative set aside the June 9, 2017 decision and remanded the case for a supplement report from Dr. Douthit documenting appellant's physical findings in accordance with the A.M.A., *Guides*.

On November 3, 2017 OWCP requested a supplemental report from Dr. Douthit and authorized him to reexamine appellant for permanent impairment ratings related to his accepted employment injuries. In a December 11, 2017 supplemental report, Dr. Douthit noted that appellant reported right-sided neck, shoulder, and elbow pain. He provided appellant's ROM for the right shoulder based on three measurements and reached 150 degrees of flexion, 130 degrees of abduction, 80 degrees of both internal rotation and external rotation, 30 degrees of adduction, and 40 degrees of extension. Dr. Douthit found diffuse pain with palpation above the right shoulder as well as pain on abduction of the right shoulder consistent with impingement.

In regard to appellant's right elbow, Dr. Douthit took three ROM measurements and found 5 degrees of extension, 120 degrees of flexion, as well as 80 degrees of both pronation and supination. Appellant reported pain over the lateral epicondyle and pain with gripping. His grip strength on three measurements was 20 pounds on the right and 110 pounds on the left. Dr. Douthit found no dysesthesias of the ulnar or radial nerves. He diagnosed pain over the lateral elbow consistent with lateral epicondylitis.

Dr. Douthit reviewed the SOAF and medical history. He diagnosed lateral epicondylitis of the right elbow and impingement of the right shoulder. Dr. Douthit reported that the three ROM measurements of appellant's right shoulder and elbow were consistent and validated. He correlated his clinical findings with the diagnosis-based impairment (DBI) estimates of the A.M.A., *Guides* and determined that appellant had mild impingement syndrome of the right shoulder[6] with class 1, grade D or two percent permanent impairment. Dr. Douthit further found class 1, grade D or two percent permanent impairment of the right elbow due to lateral epicondylitis.[7] He concluded that appellant had four percent permanent impairment of his right upper extremity.

[5] *Id*. at 474, Table 15-33.

[6] *Id*. at 402, Table 15-5.

[7] *Id*. at 399, Table 15-4.

On March 21, 2018 the DMA, Dr. Slutsky, reviewed Dr. Douthit's December 11, 2017 report and noted that for upper extremity permanent impairments FECA Bulletin No. 17-06[8] required that OWCP should determine whether schedule awards are available for both DBI estimates and ROM losses, calculate both impairment ratings, and award the claimant a schedule award based on the higher of the two impairment calculation methods. He noted that for both of appellant's right upper extremity conditions, the A.M.A., *Guides* provides that the impairments could be based on either ROM or DBI estimates. The DMA determined that Dr. Douthit provided valid ROM measurements. Utilizing Table 15-34, page 475, he calculated that appellant had three percent impairment for 150 degrees of flexion, one percent impairment for 40 degrees of extension, three percent impairment for 130 degrees of abduction, and one percent impairment for 30 degrees of adduction, for a combined eight percent permanent impairment of the right upper extremity due to loss of ROM of the shoulder.[9] The DMA noted that there was no ratable impairment due to 80 degrees of internal and external rotation. He further utilized Table 15-33, page 474 and calculated the percent of impairment for 120 degrees of flexion, and two percent impairment for -5 degrees of extension for five percent permanent impairment of the right upper extremity due to the elbow loss of ROM.[10] The DMA determined that there was no ratable impairment for 80 degrees of both pronation and supination. He found that the ROM method exceeded the impairment rating under the DBI and determined that appellant had reached MMI on December 11, 2017, the date of Dr. Douthit's report. The DMA found appellant had a combined 13 percent right upper extremity permanent impairment, or an additional 11 percent right upper extremity permanent impairment.

By decision dated April 3, 2018, OWCP granted appellant a schedule award for an additional 11 percent permanent impairment of his right upper extremity.

LEGAL PRECEDENT

The schedule award provisions of FECA[11] and its implementing regulations[12] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions 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 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.[13] The Board has approved the use by OWCP of the A.M.A., *Guides*

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

[9] A.M.A., *Guides* 475, Table 15-34.

[10] *Id*. at 474, Table 15-33.

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[14]

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).[15] 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).[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[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 claims examiner (CE) should provide this information (*via* the updated instructions noted above) to the rating physician(s).
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> "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]
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> The Bulletin further advises:
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> "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

[14] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[15] 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.

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

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

[18] *Supra* note 8.

should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[19]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 13 percent permanent impairment of the right upper extremity, for which he previously received schedule award compensation.

OWCP accepted that appellant sustained lateral epicondylitis and lesion of the ulnar nerve in the right upper extremity; impingement syndrome of the right shoulder and bicipital tendinitis of the right shoulder; C5-6 and C6-7 disc protrusions; and C6-7 cervical radiculopathy due to his September 18, 2014 employment injury.

OWCP referred appellant for a second opinion evaluation with Dr. Douthit and in his September 18, 2014 report, he found that appellant had reached MMI due to his accepted conditions and had permanent impairment. In his December 11, 2017 supplemental report, Dr. Douthit found that appellant had four percent permanent impairment based on the DBI estimates of the A.M.A., *Guides*. He also provided ROM measurements after three tests for appellant's right shoulder and elbow.

In accordance with its procedures, OWCP properly referred the evidence of record to Dr. Slutsky, a DMA, who reviewed the clinical findings of Dr. Douthit on December 11, 2017 and determined that appellant had 13 percent permanent impairment of the right upper extremity based upon Dr. Douthit's valid ROM measurements under the sixth edition of the A.M.A., *Guides*. He found that appellant had reached MMI as of December 11, 2017, the date of Dr. Douthit's supplemental report. Utilizing Table 15-34, page 475, the DMA calculated appellant had three percent impairment for 150 degrees of flexion, one percent impairment for 40 degrees of extension, three percent impairment for 130 degrees of abduction, and one percent impairment for 30 degrees of adduction, totaling eight percent permanent impairment of the right upper extremity due to the shoulder[20] loss of ROM. He noted that there was no ratable impairment due to 80 degrees of internal and external rotation. The DMA further utilized Table 15-33, page 474 and calculated the percent of impairment for 120 degrees of flexion, and two percent impairment for -5 degrees of extension for five percent permanent impairment of the right upper extremity due to the elbow loss of ROM.[21] He concluded that appellant's right upper extremity impairment rating was 13 percent permanent impairment or an additional 11 percent right upper extremity permanent impairment.

The Board finds that the DMA discussed how he arrived at his conclusion by listing specific tables and pages in the A.M.A., *Guides* and he properly interpreted the sixth edition of the A.M.A., *Guides* to find that appellant had 13 percent permanent impairment of the right upper extremity. Therefore, his opinion is the given the weight of the medical evidence and supports

[19] *Supra* note 8.

[20] A.M.A., *Guides* 475, Table 15-34.

[21] *Id*. at 474, Table 15-33.

that appellant does not have a greater right upper extremity impairment than the 13 percent awarded.[22]

There is no current medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has greater than the 13 percent permanent impairment of the right upper extremity previously awarded. Accordingly, appellant has not met his burden of proof to establish that he is entitled to an additional schedule award.

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 greater than 13 percent permanent impairment of his right upper extremity, for which he previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the April 3, 2018 merit decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 22, 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

[22] *R.R., supra* note 17.