United States Department of Labor
Employees' Compensation Appeals Board

S.H., Appellant	)	
and	)	**Docket No. 18-1297**
	)	**Issued: January 3, 2019**
SOCIAL SECURITY ADMINISTRATION, Richmond, CA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
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 June 19, 2018 appellant, through counsel, filed a timely appeal from a May 3, 2018 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.[3]

[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.*

[3] The Board notes that following the May 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 evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met her burden of proof to establish more than 10 percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On May 14, 2010 appellant, then a 48-year-old claims authorizer, filed an occupational disease claim (Form CA-2) alleging that she sustained a right shoulder and arm strain causally related to factors of her federal employment. OWCP accepted the claim, assigned File No. xxxxxx521, for rotator cuff syndrome and impingement syndrome of the right shoulder, and dysthymic disorder.

OWCP had previously accepted that appellant sustained a traumatic right shoulder strain (Form CA-1) on May 4, 2009 under File No. xxxxxx115. It also accepted her January 26, 2012 occupational disease claim for left shoulder sprain, a partial infraspinatus tear, tendinitis, and cervicalgia under File No. xxxxxx606. OWCP administratively combined OWCP File Nos. xxxxxx521, xxxxxx115, and xxxxxx606, with OWCP File No. xxxxxx521 serving as the master file.

On April 30, 2012 appellant underwent a right shoulder acromioplasty with a distal clavicle excision and labral repair. On February 24, 2014 she underwent a synovectomy, bursectomy, ligament release, biceps tendon release, acromioplasty, debridement of the rotator cuff, and removal of the anchor from the labrum. OWCP paid appellant wage-loss compensation for intermittent periods of temporary total disability.

In a February 18, 2015 impairment evaluation, Dr. Michael E. Hebrard, a Board-certified physiatrist, diagnosed status postsurgical decompression of the right shoulder, bilateral adhesive capsulitis of the shoulders, and cervicobrachial syndrome. He measured range of motion of the shoulders and found positive crepitus on examination with moderate-to-severe right shoulder atrophy. Using Table 15-34 on page 477 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] Dr. Hebrard found 26 permanent impairment of the right upper extremity and 14 percent permanent impairment of the left upper extremity due to a loss of shoulder motion.

Dr. Ellen Pichey, an OWCP district medical adviser (DMA), who is Board-certified in family medicine, reviewed the medical evidence and opined that appellant had 18 percent permanent impairment of the right upper extremity and 14 percent permanent impairment of the left upper extremity due to reduced shoulder range of motion pursuant to Table 15-34.

Appellant, on April 28, 2017, filed a claim for a schedule award (Form CA-7).

On June 7, 2016 OWCP referred appellant to Dr. Mohinder S. Nijjar, a Board-certified orthopedic surgeon, for a second opinion examination regarding the extent of any permanent impairment due to the accepted employment injury. It asked that he address the extent of permanent impairment of the bilateral upper extremities. The statement of accepted facts,

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

however, described only appellant's right upper extremity condition and requested that Dr. Nijjar calculate her right upper extremity impairment.

In a July 26, 2017 impairment evaluation, Dr. Nijjar discussed appellant's employment injury and continued complaints of right shoulder pain and weakness. On examination, he measured normal range of motion of the shoulder with some tenderness over the acromioclavicular (AC) joint, anterior acromion process, and biceps tendon. Dr. Nijjar diagnosed right shoulder impingement syndrome and a partial rotator cuff tear, degenerative arthritis of the AC joint after surgery, and a superior labral lesion from anterior to posterior (SLAP) lesion status postsurgical debridement and subacromial decompression of the right shoulder. Using the diagnosis-based impairment (DBI) methodology for rating permanent impairment, he identified the diagnosis using Table 15-5 on page 403, the shoulder regional grid, as AC joint disease after a distal clavicle resection or AC separation, which yielded a default impairment of 10 percent. Dr. Nijjar applied grade modifiers of one for functional history and physical examination, and found that a grade modifier for clinical studies was not applicable, which yielded no change from the default value. He also identified a class one labral lesion, including SLAP tears, as a diagnosis using Table 15-5 on page 404, which yielded a default value of three percent. Dr. Nijjar applied grade modifiers of two for functional history and one for physical examination findings, which yielded four percent upper extremity permanent impairment. He concluded that appellant had a combined 14 percent permanent impairment of the right upper extremity.

On October 12, 2017 Dr. David H. Garelick, a Board-certified orthopedic surgeon and DMA, applied the A.M.A., *Guides* and FECA Bulletin No. 17-06[5] to Dr. Nijjar's findings. He noted that rating appellant's impairment using the range of motion (ROM) methodology was not possible as Dr. Nijjar had not obtained three measurements and had identified the range of motion as normal. Dr. Garelick concurred with Dr. Nijjar's finding of 10 percent right upper extremity impairment due to the distal clavicle resection using Table 15-5 on page 403, using the DBI methodology. He found that appellant could not receive an impairment rating for both the labral lesion and the distal clavicle resection as the A.M.A., *Guides* indicated that shoulder impairments often occurred together and instructed that the evaluator to select the most significant diagnosis. Dr. Garelick used the impairment rating for the distal clavicle resection and determined that appellant had 10 percent permanent impairment of the right upper extremity. He opined that appellant had reached maximum medical improvement on July 26, 2017.

By decision dated November 7, 2017, OWCP granted appellant a schedule award for 10 percent permanent impairment of the right arm. The period of the award ran for 31.2 weeks from October 15, 2017 to a fraction of a day on May 21, 2018.[6]

On November 14, 2017 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

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

[6] OWCP adjusted the beginning date of the schedule award to October 15, 2017 as appellant received wage-loss compensation for total disability through October 14, 2017.

During the telephonic hearing, held on April 2, 2018, counsel questioned why OWCP did not provide a rating for the left upper extremity. He further asserted that OWCP should consider the ROM impairment rating from Dr. Hebrard.

By decision dated May 3, 2018, OWCP's hearing representative affirmed the November 7, 2017 decision. He noted that OWCP should consider expanding the acceptance of appellant's claim to include a right shoulder labral tear based on Dr. Nijjar's opinion. The hearing representative also found that OWCP should develop the issue of whether she had a permanent impairment of the left upper extremity.

On appeal counsel asserts that Dr. Hebrard had provided complete range of motion findings sufficient for measuring permanent impairment utilizing the ROM methodology.

LEGAL PRECEDENT

The schedule award provisions of FECA,[7] and its implementing federal regulation,[8] 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.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10]

In addressing upper extremity impairments, the sixth edition requires identification of 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). The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[11] OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[12]

The A.M.A., *Guides* also provide that the ROM impairment method 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.[13] 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

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[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id.* at § 10.404(a).

[10] 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).

[11] A.M.A., *Guides* 411.

[12] *See P.R.*, Docket No. 18-0022 (issued April 9, 2018); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6f (March 2017).

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

measured and added.[14] 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.[15]

Regarding the application of ROM or DBI 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).
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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.*"[16] (Emphasis in the original.)

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than 10 percent permanent impairment of her right upper extremity, for which she previously received a schedule award.

Dr. Hebrard, on February 18, 2015, provided range of motion measurements for appellant's shoulders and determined that she had significant atrophy of the right shoulder. He found 26 percent permanent impairment of the right upper extremity and 14 percent permanent impairment of the left upper extremity due to a loss of range of motion of the shoulders according to Table 15-34 on page 477 of the A.M.A., *Guides*. Dr. Pichey, a DMA, concurred with Dr. Hebrard's finding in a November 2015 report.

On April 28, 2017 appellant filed a claim for a schedule award (Form CA-7). OWCP referred her to Dr. Nijjar for an impairment evaluation to determine the extent of permanent impairment of both upper extremities. It asked him, however, to calculate only the extent of permanent impairment of the right upper extremity.

Dr. Nijjar, in a July 26, 2017 impairment evaluation, found that appellant had normal range of motion of the shoulders with some tenderness. Using the shoulder regional grid set forth at Table 15-5 on page 403 of the A.M.A., *Guides*, he identified the diagnosis as class one AC joint disease after a distal clavicle resection, which yielded a default impairment value of 10 percent. Dr. Nijjar applied grade modifiers of one for both functional history and physical examination,

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[14] *Id*. at 473.

[15] *Id*. at 474.

[16] *Supra* note 3; *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

and noted that a grade modifier for clinical studies was not applicable, and thus found no change from the default value after application of the net adjustment formula.[17]

Dr. Nijjar further found that appellant had a class 1 labral lesion using Table 15-5 on page 404, which he found constituted 4 percent permanent impairment of the right upper extremity after the application of grade modifiers, for a total right upper extremity impairment of 14 percent.

Dr. Garelick, a DMA, reviewed the evidence on October 12, 2017 and explained that Dr. Nijjar should not have rated appellant for both AC joint disease and a labral lesion as the A.M.A., *Guides* provides, "In the shoulder, it is not uncommon for rotator cuff tears, a superior labral lesion from anterior to posterior (SLAP) lesion or other labral lesions, and biceps tendon pathology to all be present simultaneously. The evaluator is expected to choose the most significant diagnosis and to rate only that diagnosis using the DBI method that has been described."[18] Dr. Garelick used the impairment rating for the distal clavicle resection as the most significant diagnosis. He concurred with Dr. Nijjar's finding that appellant had 10 percent permanent impairment of the right upper extremity due to her AC joint disease after a distal clavicle resection, noting that it yielded the greater award. Dr. Garelick further determined that a diagnosis for ROM was not applicable in this case as Dr. Nijjar found normal range of motion measurements. There is no current medical evidence of record conforming to the A.M.A., *Guides*, which supports a greater impairment.[19]

On appeal counsel asserts that Dr. Hebrard provided complete range of motion findings. Dr. Hebrard's report, however, was completed more than two years before the report from Dr. Nijjar. The Board has held that stale medical evidence cannot form the basis for current evaluation of residual symptomology or disability determination.[20]

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 her burden of proof to establish more than 10 percent permanent impairment of her right upper extremity, for which she received a schedule award.

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[17] Utilizing the net adjustment formula discussed above, (GMFH-CDX) + (GMPE-CDX), or (1-1) + (1-1) = 0, yielded a zero adjustment.

[18] A.M.A. *Guides* 390.

[19] *See K.P.*, Docket No. 18-0777 (issued November 13, 2018).

[20] *See K.S.*, Docket No. 15-1082 (issued April 18, 2017).

ORDER

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

Issued: January 3, 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