United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 18-1509**
	)	**Issued: May 2, 2019**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PROTECTION, Calexico, CA, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 1, 2018 appellant filed a timely appeal from an April 20, 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 over the merits of this case.[2]

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 11 percent permanent impairment of his right upper extremity, for which he previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the April 20, 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.*

FACTUAL HISTORY

On February 16, 2015 appellant, then a 54-year-old custom and border patrol officer, filed a traumatic injury claim (Form CA-1) alleging that he sustained right shoulder and thumb injuries when he pushed a subject while in the performance of duty. He stopped work that day.[3] On April 3, 2015 OWCP accepted the claim for closed fracture of the right metacarpal bone, sprain of the right shoulder, rotator cuff and upper arm, and other affections of the right shoulder.

On October 15, 2015 appellant underwent an OWCP-authorized right shoulder arthroscopy with superior labrum anterior and posterior repair and a sub acromial bursectomy, which was performed by Dr. Veerinder Anand, a Board-certified orthopedic surgeon.[4]

On May 30, 2017 appellant filed a claim for a schedule award (Form CA-7).

In a May 15, 2017 permanent impairment evaluation, Dr. Anand discussed appellant's employment injury and noted examination findings from August 30, 2016. He indicated that appellant had reached maximum medical improvement (MMI) on August 30, 2016. Using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] and the August 30, 2016 examination findings, Dr. Anand opined that appellant had 17 percent total right upper extremity permanent impairment. For the right wrist, he found a diagnosis-based impairment (DBI) rating for the de Quervain's tenosynovitis without surgery equaled two percent permanent impairment of the right upper extremity. For the right shoulder, Dr. Anand opined that appellant's right shoulder impingement syndrome, status post arthroscopic surgery resulted in five percent permanent impairment. He opined, however, that a DBI rating for the shoulder did not adequately reflect appellant's functional limitations. Under the range of motion (ROM) method, Dr. Anand opined that appellant had 15 percent permanent impairment of the right shoulder. He cited to tables within the A.M.A., *Guides* and provided his impairment calculations.

In a June 13, 2017 letter, OWCP requested that Dr. Anand provide a detailed narrative medical report based on a recent examination, which included three independent ROM measurements for the right shoulder and wrist.

In a July 25, 2017 impairment evaluation report, Dr. Anand provided updated examination findings and three ROM measurements for the right shoulder and right wrist. He opined that appellant had reached MMI and had 17 percent total right upper extremity permanent impairment. Dr. Anand indicated his opinion had not changed and that appellant could be rated under the DBI methodology for the right wrist for the diagnosis of de Quervain's tenosynovitis. He further noted that while he offered a right shoulder rating based on DBI methodology, it remained his opinion that the ROM methodology more accurately reflected appellant's status.

[3] Under OWCP File No. xxxxxx960, appellant sustained a May 5, 2012 right shoulder injury while in the performance of duty. The case was never formally adjudicated.

[4] Appellant retired from the employing establishment on February 29, 2016.

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

Using the DBI methodology for the right wrist, Dr. Anand found, under Table 15-3 of the A.M.A., *Guides,* the wrist regional grid, that appellant's right de Quervain's tenosynovitis without surgery was class 1. He applied grade modifiers of 2 for functional history and physical examination and grade modifier of 1 for clinical studies, which yielded a net adjustment of 2 from the default value of 1, which resulted in class 1, grade E or two percent upper extremity impairment. Under the DBI methodology for the right shoulder, Dr. Anand diagnosed class one right shoulder impingement syndrome, a status post arthroscopic surgery, under Table 15-5 of the A.M.A., *Guides*, and the shoulder regional grid, which yielded a default impairment of three percent. He applied grade modifiers of 2 for functional history, physical examination, and clinical studies, which yielded a net adjustment of 2 for a five percent permanent impairment.

Under the ROM methodology, Dr. Anand noted that appellant's ROM for the right shoulder was moderately decreased when compared to the opposite side. He explained that section 15.7 of the A.M.A., *Guides* allowed impairment for wrist, elbow, and shoulder joints of 12 to 23 percent upper extremity impairment when there was a moderate decrease of ROM from normal. Dr. Anand indicated that appellant's ROM was moderately decreased when compared to the opposite and again found 15 percent upper extremity permanent impairment. He combined the two impairments (2 percent for wrist and 15 percent for shoulder) and obtained a total right upper extremity permanent impairment rating of 17 percent.

In an October 29, 2017 report, Dr. Herbert White, Jr., an OWCP district medical adviser (DMA) and Board-certified internist, reviewed the medical evidence. He opined that appellant had reached MMI on July 25, 2017. Dr. White also opined that appellant had 5 percent permanent impairment based on DBI for right labral lesion and 6 percent permanent impairment of the wrist based on ROM, for a total 11 percent right upper extremity permanent impairment. Using the DBI methodology, for the right shoulder, the DMA identified class 1 labral lesion under Table 15-5, page 404, which yielded a default impairment of three percent. Under Table 15-17, Table 15-8, and Table 15-9 found grade modifiers of one for functional history, 2 for physical examination, and 2 for clinical studies. Applying the net adjustment formula, the DMA calculated a net adjustment of 2, which resulted in a grade E or 5 percent permanent impairment rating. Using the ROM methodology for the shoulder, he calculated one percent upper extremity permanent impairment. Under Table 15-34, page 475, the DMA compared the right and left sides and found a total impairment of one percent.[6] Under Table 15.35, page 477, and Table 16-7, page 406, he found grade one modifiers for range of motion and functional history, respectively. The DMA calculated that there was no functional history net modifier as the grade modifier functional history (1) minus grade modifier range of motion (1). Thus, he found a total upper extremity permanent impairment of one percent for the shoulder. The DMA indicated that Dr. Anand had not compared the motions with the unaffected left shoulder as indicated on page 451 of the A.M.A., *Guides*. He

[6] Under Table 15-34, page 475 of A.M.A, *Guides* Dr. White reported that flexion of 90 degrees (3 percent impairment) on right minus 170 degrees (3 percent impairment) on left equaled zero impairment. Extension 50 degrees (0 percent impairment) on right minus 50 degrees (0 percent impairment) on left equaled zero impairment. Abduction 90 degrees (3 percent impairment) on right minus 120 degrees (3 percent impairment) equaled zero impairment. Adduction 50 degrees (0 percent impairment) on right minus 50 degrees (0 percent impairment) equaled 1 percent impairment. Internal rotation 80 degrees (0 percent impairment) on right minus 80 degrees (0 percent impairment) on left equaled zero impairment. External rotation 80 degrees (0 percent impairment) on right minus 80 degrees (0 percent impairment) on left equaled zero impairment.

noted, however, that the higher rating was produced under the DBI method and concluded that appellant had five percent permanent impairment of the right shoulder.

For the right wrist, Dr. White concurred with Dr. Anand's DBI rating of two percent impairment for the diagnosis of de Quervains. He noted that Dr. Anand had not rated the right wrist with the ROM method. Using the ROM methodology for the right wrist, utilizing Table 15-32, page 473 of A.M.A., *Guides*, Dr. White found that flexion 40 degrees equaled three percent impairment, extension 40 degrees equaled three percent impairment, radial deviation 25 degrees equaled zero percent impairment, and ulnar deviation 20 degrees equaled zero percent impairment. Under Table 15-35, he assigned a grade 1 range of motion grade modifier and, under Table 15-7, he assigned a grade 2 functional history grade modifier to find a functional history net modifier of 1. Under Table 15-36, page 477, a modifier adjustment of .3 (total ROM impairment times 5 percent) was found, which yielded a total permanent impairment of 6.3 percent rounded down to 6 percent. The DMA used the Combined Values Chart and found that 5 percent DBI impairment for labral lesion and 6 percent ROM impairment for wrist resulted in combined value of 11 percent total permanent impairment.

In a December 8, 2017 letter to Dr. Anand, OWCP provided a copy of the DMA's October 29, 2017 impairment report and afforded him 30 days to identify specific findings with which he disagreed along with the basis of his disagreement.

On January 10, 2018 OWCP received a December 14, 2017 report from Dr. Anand. While Dr. Anand indicated that he agreed with the 11 percent total right upper extremity permanent impairment rating, he disagreed with the 1 percent right upper extremity impairment under the ROM method for the right shoulder. He noted his calculations, but agreed that the DBI method should be used as it yielded the highest impairment rating for the shoulder at five percent.

By decision dated April 20, 2018, OWCP granted appellant a schedule award for 11 percent right upper extremity permanent impairment. The period of the award ran for 34.32 weeks from July 25, 2017 to March 22, 2018.

LEGAL PRECEDENT

The schedule award provisions of FECA,[7] and its implementing federal regulations,[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

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

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 DMA providing rationale for the percentage of permanent 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 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).
>
> "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*

[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.

[14] *Id.* at 473.

[15] *Id.* at 474.

impairment rating for the diagnosis in question, the method producing the higher rating should be used."[16] (Emphasis in the original.)

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[17]

ANALYSIS

The Board finds that appellant has established 13 percent permanent impairment of his right upper extremity.

Appellant provided May 15 and July 25, 2017 reports from Dr. Anand, who opined that appellant had 17 percent total right upper extremity permanent impairment under the A.M.A., *Guides* based on a DBI methodology for the wrist and ROM methodology for the shoulder. However, his May 15, 2017 report is of diminished probative value as Dr. Anand did not provide three ROM measurements as required by the A.M.A., *Guides*.[18]

On October 29, 2017 the DMA utilized the findings provided by Dr. Anand in his July 25, 2017 report and opined that appellant had 11 percent permanent impairment of the right upper extremity. He found that appellant had reached MMI on July 25, 2017. With regards to the right shoulder, the DMA concurred with Dr. Anand that appellant had five percent permanent impairment based on DBI, as the DBI methodology yielded the highest result.

Under the ROM methodology for the shoulder, Dr. Anand opined that appellant had 15 percent permanent impairment. The DMA, however, properly noted that Dr. Anand had not compared the motions with the unaffected left shoulder as required on page 461 of the A.M.A., *Guides*.[19] He calculated one percent permanent impairment of the upper extremity. In his December 14, 2017 report, Dr. Anand disagreed with the DMA's calculation and provided his own calculations.

With regard to the right wrist, both Dr. Anand and the DMA opined, under the DBI methodology, that appellant had two percent right upper extremity permanent impairment. Under Table 15-3, page 395, of the A.M.A., *Guides*, appellant's right de Quervain's tenosynovitis without surgery was class 1. Dr. Anand applied grade modifiers of 2 for functional history and physical examination and grade modifier of 1 for clinical studies, which yield a net adjustment of 2 from the default value of 1, which resulted in class 1, grade E or 2 percent upper extremity permanent impairment. While the DMA concurred with Dr. Anand's DBI rating of two percent impairment

[16] FECA Bulletin No. 17-06 (May 8, 2017); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

[17] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (March 2017).

[18] A.M.A., *Guides* 464.

[19] *See K.P.*, Docket No. 13-2079 (issued February 18, 2014).

for the diagnosis of deQuervains, he noted that Dr. Anand had not rated the right wrist under the ROM method.

Using the ROM methodology for the right wrist, the DMA found six percent permanent impairment. The Board finds however that Dr. White improperly calculated under Table 15-32, page 473 that 20 degrees ulnar deviation equaled zero percent impairment, as it in fact equals two percent impairment.[20] However, under Table 15-32, page 473, flexion 40 degrees equaled three percent impairment; extension 40 degrees equaled three percent impairment; radial deviation 25 degrees equaled zero percent impairment; and ulnar deviation 20 degrees equaled two percent impairment, for a combined value of upper extremity permanent impairment of eight percent. Thus this changes the total percentage of six percent to eight percent impairment under Table 15-32, page 473. The DMA assigned, under Table 15-35, a grade 1 range of motion grade modifier and a grade 2 functional history grade modifier, under Table 15-7, which yielded a functional history net modifier of 1. Under Table 15-36, page 477, a modifier adjustment of .4 results, (total ROM impairment (8) times 5 percent), which yields a total impairment of 8.4 percent, which rounds down to 8 percent. The eight percent permanent impairment based on loss of range of motion is higher than two percent DBI assigned impairment.

Under the Combined Values Chart on page 604 of the A.M.A., *Guides*, 5 percent permanent impairment for labral lesion and 8 percent permanent impairment for wrist results in a combined value of 13 percent permanent impairment. As appellant received a schedule award for 11 percent permanent impairment of his right upper extremity, the Board finds that he shall be compensated for an additional 2 percent permanent impairment of his right upper extremity.[21]

On appeal appellant contends that, due to his current symptoms, he should be entitled to a greater impairment than that awarded. As discussed above, there is no probative medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has more than 13 percent permanent impairment of the right upper extremity.

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 established 13 percent permanent impairment of his right upper extremity.

[20] *See supra* note 6.

[21] *See J.C.*, Docket No. 15-0534 (issued May 12, 2016).

ORDER

IT IS HEREBY ORDERED THAT the April 20, 2018 decision of the Office of Workers' Compensation Programs is affirmed as modified.

Issued: May 2, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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