United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 19-1011**
	)	**Issued: October 29, 2019**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Redding, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 2, 2019 appellant filed a timely appeal from an October 5, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] 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] Under the Board's *Rules of Procedure*, an appeal must be filed within 180 days from the date of issuance of an OWCP decision. An appeal is considered filed upon receipt by the Clerk of the Appellate Boards. *See* 20 C.F.R. § 501.3(e)-(f). One hundred and eighty days from October 5, 2018, the date of OWCP's last decision, was April 3, 2019. Because using April 8, 2019, the date the appeal was received by the Clerk of the Appellate Boards would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is April 2, 2019, rendering the appeal timely filed. *See* 20 C.F.R. § 501.3(f)(1).

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that following the October 5, 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 her burden of proof to establish greater than 10 percent permanent impairment of the right upper extremity and greater than 3 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On November 16, 2015 appellant, then a 37-year-old mail processing clerk, filed an occupational disease claim (Form CA-2) alleging that she developed injuries to both shoulders as a result of her routine, everyday employment duties. She first became aware of her condition on September 3, 2015 and realized it resulted from factors of her federal employment on November 12, 2015. Appellant did not stop work. OWCP accepted her claim for bilateral rotator cuff strains and bilateral rotator cuff bursitis/tendinitis.

On January 4, 2017 appellant underwent OWCP-approved right shoulder arthroscopic surgery and stopped work. OWCP paid wage-loss compensation on the supplemental rolls, effective January 4, 2017. On December 4, 2017 appellant returned to full-time, modified-duty employment.

On January 16, 2018 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated January 18, 2018, OWCP advised appellant that no medical evidence was submitted to establish her schedule award claim. It requested that she provide a medical report from her attending physician, which included a statement that the accepted condition had reached maximum medical improvement (MMI) and an impairment rating utilizing the appropriate portions of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] OWCP afforded appellant 30 days to submit the necessary evidence.

Appellant submitted a series of reports dated October 5, 2017 to January 3, 2018 by Dr. Richard P. Musselman, a family practitioner. Dr. Musselman recounted appellant's complaints of bilateral shoulder pain and described her employment duties as a mail processing clerk. He provided examination findings and diagnosed right rotator cuff tear, bilateral shoulder rotator cuff strain, rotator cuff disorder, and bilateral shoulder pain.

OWCP referred appellant, along with a statement of accepted facts (SOAF) and a copy of the record, to Dr. Charles F. Xeller, a Board-certified orthopedic surgeon, serving as a second-opinion examiner, to provide an assessment of appellant's work-related bilateral shoulder conditions and any resulting permanent impairment.

In a May 14, 2018 report, Dr. Xeller indicated that he had reviewed the SOAF and noted appellant's accepted conditions for bilateral shoulder rotator cuff strains and bilateral shoulder bursitis. He recounted appellant's complaints of pain with fast movements in the right shoulder and with overhead movement in both shoulders. Upon examination of both shoulders, Dr. Xeller

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

observed slight impingement on the right and left and some pain with supraspinatus resistant motion, bilaterally. He evaluated appellant's shoulder range of motion (ROM) and noted three measurements for each motion. Dr. Xeller diagnosed status post right shoulder surgery and slight impingement on the left, but normal range of motion.

Referring to Table 15-5, Shoulder Regional Grid, A.M.A., *Guides*, Dr. Xeller assigned class 1, default three percent, for diagnosis-based impairment (DBI) for left tendinitis, residual loss of function. He assigned a grade modifier of 1 for history (GMFH) due to pain overhead and a grade modifier of 1 for physical examination (GMPE) due to positive impingement signs. Dr. Xeller reported that there was no grade modifier for clinical studies as imaging was not available. He applied the net adjustment formula, which resulted in no change, for a total of three percent left upper extremity impairment. Dr. Xeller pointed out that appellant had normal ROM testing on the left. For appellant's right shoulder, he reported that appellant was also class 1, default three percent for right tendinitis, residual loss. Dr. Xeller indicated that the grades on the right were the same as the left and calculated that appellant had three percent right upper extremity permanent impairment under the DBI method. He explained that, in the alternative, right upper extremity impairment could also be rated under the ROM method and calculated that appellant had nine percent right upper extremity permanent impairment under the ROM method. Dr. Xeller reported a date of MMI of May 11, 2018.

In a May 23, 2018 addendum report, Dr. Xeller indicated that according to Table 15-34, Shoulder Range of Motion, for appellant's right shoulder, she had three percent impairment for 150 degrees flexion, 0 percent impairment for 50 degrees extension, 3 percent impairment for 142 degrees abduction, 0 percent impairment for 50 degrees adduction, 4 percent impairment for 42 degrees internal rotation, and 0 percent impairment for 64 degrees external rotation for a total of 10 percent right upper extremity impairment under the ROM method. He assigned a GMFH of 1, which resulted in no net modifier and a final impairment rating of 10 percent right upper extremity permanent impairment.

In an August 27, 2018 report, Dr. Herbert White, an OWCP district medical adviser (DMA) and Board-certified in occupational and preventive medicine, reviewed appellant's history, including the SOAF and medical record, and noted that her claim was accepted for bilateral shoulder rotator cuff strain and bilateral shoulder bursitis. Utilizing the DBI method, he referenced Table 15-5, Shoulder Regional Grid, and assigned class 1, tier 2 for right tendinitis. Dr. White assigned GMFH of 1 due to pain/symptoms with strenuous activity, GMPE of 1 for mild motion deficits, and no grade modifier for clinical studies. After applying the net adjustment formula, which yielded no change, he determined that appellant had three percent right upper extremity impairment. Dr. White indicated for appellant's right shoulder that under the ROM methodology and Table 15-34, Shoulder Range of Motion, appellant had 3 percent impairment for flexion, 0 percent impairment for extension, 3 percent impairment for abduction, 0 percent impairment for adduction, 4 percent impairment for internal rotation, and 0 percent impairment for external rotation for a total of 10 percent right upper extremity impairment. He explained that, pursuant to the A.M.A., *Guides*, because the ROM method resulted in the greater impairment, appellant had 10 percent permanent impairment of the right upper extremity.

For appellant's left shoulder, Dr. White referenced Table 15-5 and assigned class 1, tier 2 for left tendinitis under the DBI method. He assigned GMFH of 1 due to pain/symptoms with strenuous activity, GMPE of 1 for mild tenderness, and no grade modifiers for clinical studies.

After applying the net adjustment formula, which resulted in no change, Dr. White determined that appellant had default value of three percent left upper extremity impairment. Under the ROM methodology, he indicated that appellant had zero percent impairment for normal range of motion according to Table 15-34, Shoulder Range of Motion. Thus, Dr. White concluded that appellant had three percent permanent impairment of the left upper extremity. He assigned an MMI date of December 6, 2017, the date that Dr. Musselman indicated that appellant reached MMI.

By decision dated October 5, 2018, OWCP granted appellant schedule award compensation for 10 percent permanent impairment of the right upper extremity and 3 percent permanent impairment of the left upper extremity. The award ran for 40.56 weeks from May 11, 2018 to February 18, 2019.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing regulations[6] 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. FECA, however, does not specify the manner in which the percentage of loss of a member 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 and the Board has concurred in such adoption.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[8]

In addressing impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated.[9] After a class of diagnosis (CDX) is determined (including identification of a default grade value), the impairment class 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).[11]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's DMA for an opinion concerning the nature and percentage of

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*. at 10.404(a); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[8] 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] *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

[10] A.M.A., *Guides* 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[11] *Id*. at 411.

impairment in accordance with the A.M.A., *Guides,* with the DMA providing rationale for the percentage of impairment specified.[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."[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 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 appellant has not met her burden of proof to establish greater than 10 percent permanent impairment of the right upper extremity and greater than 3 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

Dr. Xeller, the second opinion examiner, noted appellant's accepted conditions for bilateral shoulder rotator cuff strains and bilateral shoulder bursitis. Upon examination of appellant's shoulders, he observed slight impingement on the right and left and some pain with supraspinatus resistant motion, bilaterally. For appellant's right shoulder, Dr. Xeller provided three ROM measurements and noted the highest measurements to be 150 degrees flexion, 50 degrees extension, 142 degrees abduction, 50 degrees adduction, 42 degrees internal rotation, and 64 degrees external rotation. He indicated that ROM for appellant's left shoulder was normal. Based on the DBI method, Dr. Xeller found three percent permanent impairment of the right and left

[12] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017). *R.M.*, Docket No. 18-1313 (issued April 11, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010).

[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).

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

upper extremities. Applying the ROM method, he found 10 percent permanent impairment of the right upper extremity and normal range of motion of the left upper extremity -- no impairment.

In an August 27, 2018 report, Dr. White, the DMA, noted that he had reviewed appellant's history, including the SOAF and Dr. Xeller's May 11, 2018 second-opinion report. For appellant's right shoulder, he utilized Table 15-5, Shoulder Regional Grid, and assigned class 1, tier 2 for right tendinitis. Dr. White reported GMFH of 1 and GMPE of 1. After applying the net adjustment formula, which resulted in no change, he determined that appellant had three percent right upper extremity impairment under the DBI method. Dr. White indicated that the ROM method could also be utilized to determine permanent impairment of appellant's right shoulder. Utilizing Table 15-34, Shoulder Range of Motion, he reported that appellant had 3 percent impairment for flexion, 0 percent impairment for extension, 3 percent impairment for abduction, 0 percent impairment for adduction, 4 percent impairment for internal rotation, and 0 percent impairment for external rotation for a total of 10 percent right upper extremity impairment. Dr. White explained that, pursuant to the A.M.A., *Guides*, because the ROM method resulted in the greater impairment, appellant had 10 percent permanent impairment of the right upper extremity.

For appellant's left shoulder, Dr. White referenced Table 15-5 and assigned class 1, tier 2 for left tendinitis under the DBI method. He assigned GMFH of 1 and GMPE of 1. After applying the net adjustment formula, which resulted in no change, Dr. White determined that appellant had default value of three percent left upper extremity impairment. Under the ROM methodology, he indicated that appellant had zero percent impairment for normal range of motion according to Table 15-34, Shoulder Range of Motion. Dr. White concluded that, since the DBI method provided the higher rating, appellant had three percent permanent impairment of the left upper extremity.

The Board finds that the DMA properly discussed how he arrived at his conclusion by listing appropriate tables and pages in the A.M.A., *Guides* and established that appellant sustained 10 percent right upper extremity permanent impairment and 3 percent left upper extremity permanent impairment. Dr. White accurately summarized the relevant medical evidence, provided detailed findings on examination, and reached conclusions about appellant's condition which comported with his findings.[15] In addition, he properly utilized the DBI method and ROM method to rate appellant's bilateral shoulder condition pursuant to FECA Bulletin No. 17-06. As Dr. White's report is detailed, well rationalized, and based on a proper factual background, his opinion represents the weight of the medical evidence.[16] Thus, the Board finds that appellant has not met her burden of proof to establish that she is entitled to a greater bilateral upper extremity permanent impairment than 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.

[15] *J.M.*, Docket No. 18-1387 (issued February 1, 2019); *W.H.*, Docket No. 19-0102 (issued June 21, 2019).

[16] *See D.S.*, Docket No. 18-1816 (issued June 20, 2019).

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than 10 percent permanent impairment of the right upper extremity and more than 3 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the October 5, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 29, 2019
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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