United States Department of Labor
Employees' Compensation Appeals Board

E.H., Appellant	)	
	)	
and	)	**Docket No. 19-1569**
	)	**Issued: April 2, 2020**
U.S. POSTAL SERVICE, POST OFFICE, San Antonio, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Deputy Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 17, 2019 appellant filed a timely appeal from a June 7, 2019 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 record provided to the Board includes evidence received after OWCP issued its June 7, 2019 decision. 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 11 percent permanent impairment of the right upper extremity and 6 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On October 13, 2004 appellant, then a 41-year-old distribution clerk, filed an occupational disease claim (Form CA-2) alleging that factors of her federal employment since December 10, 2003, including repetitive upper extremity motion had caused or aggravated bilateral rotator cuff tears.[4] OWCP accepted that she sustained a complete left rotator cuff tear, left shoulder effusion, right rotator cuff sprain, and bilateral upper arm strains. It paid appellant wage-loss compensation and provided medical benefits.

On June 19, 2003 appellant underwent right shoulder arthroscopic subacromial decompression and mini-open rotator cuff repair of the supraspinatus tendon. She retired from the employing establishment effective July 28, 2004. Appellant filed a claim for a schedule award (Form CA-7) on February 5, 2007.

By decision dated March 28, 2007, OWCP granted appellant a schedule award for four percent permanent impairment of the left upper extremity and six percent permanent impairment of the right upper extremity due to limited motion, based on the criteria set forth in the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] The period of the award ran from October 13, 2006 to May 19, 2007.

On March 17, 2015 Dr. Richard Duey, a Board-certified orthopedic surgeon, performed an authorized revision of a subacromial decompression of the right shoulder, a revision rotator cuff repair of the right supraspinatus tendon, arthroscopic right biceps tenotomy, and arthroscopic excision of a one centimeter portion of the right distal clavicle.

On June 17, 2016 appellant filed a claim for an increased schedule award (Form CA-7) for bilateral upper extremity impairment. In support of her claim, she submitted a June 6, 2016 impairment rating from Dr. Salvador P. Baylan, a Board-certified physiatrist, who utilized the

[3] Docket No. 17-1931 (issued May 2, 2018).

[4] Under OWCP File No. xxxxxx265, OWCP accepted that appellant sustained bilateral rotator cuff tears. It administratively combined the present claim, File No. xxxxxx380, and File No. xxxxxx265, with the latter serving as the master file.

[5] A.M.A., *Guides* (5th ed. 2001).

sixth edition of the A.M.A., *Guides*[6] to calculate 18 percent permanent impairment of the right upper extremity and 19 percent permanent impairment of the left upper extremity due to limited motion of both shoulders.

In a September 26, 2016 report, Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), opined that the diagnosis-based impairment (DBI) rating method was preferable to the range of motion (ROM) method utilized by Dr. Baylan. The DMA found 4 percent permanent impairment of the left upper extremity due to shoulder impingement syndrome, and 11 percent permanent impairment of the right upper extremity due to distal clavicle resection.

By decision dated November 1, 2016, OWCP granted appellant schedule award compensation for an additional 5 percent permanent impairment of the right upper extremity for a total of 11 percent, with no additional permanent impairment of the left upper extremity beyond the 4 percent permanent impairment previously awarded.

On November 15, 2016 appellant requested a review of the written record by an OWCP hearing representative. By decision dated March 6, 2017, an OWCP hearing representative affirmed OWCP's November 1, 2016 schedule award determination. Appellant then appealed to the Board.[7]

By decision dated May 2, 2018, the Board set aside OWCP's March 6, 2017 decision and remanded the case to utilize the proper methodology for rating upper extremity permanent impairment.[8]

On remand appellant submitted additional medical evidence.

A September 19, 2017 MRI scan of the right shoulder demonstrated postsurgical changes, tendinosis and a partial thickness articular/intrasubstance tear of the superior aspect of the subscapularis tendon, subacromial subdeltoid bursitis, and mild osteoarthritis of the glenohumeral joint. A September 19, 2017 MRI scan of the left shoulder demonstrated a full-thickness complete tear of the supraspinatus tendon, tendinosis and partial-thickness tears of the subscapularis and infraspinatus tendons, mild acromioclavicular arthrosis and Type 3 acromion morphology contributing to narrowing of the supraspinatus outlet, small glenohumeral joint and bursal effusions, and mild degenerative changes of the superior labrum.

August 3, 2018 electromyography and nerve conduction velocity (EMG/NCV) studies of the bilateral upper extremities were negative for cervical radiculopathy.

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

[7] Appellant submitted additional evidence during the pendency of the prior appeal. A September 15, 2017 magnetic resonance imaging (MRI) scan of the left scapula showed postsurgical changes in the rotator cuff, and mild tendinosis of the proximal long head of the biceps tendon. A September 15, 2017 MRI scan of the right scapula showed a partial thickness supraspinatus tendon tear, mild grade 1 fatty atrophy of the supraspinatus and infraspinatus muscles, and postsurgical changes.

[8] *Supra* note 3.

On January 11, 2019 OWCP referred appellant for a second opinion evaluation to Dr. Thomas M. DeBerardino, a Board-certified orthopedic surgeon. In a report dated January 31, 2019, Dr. DeBerardino reviewed the medical record and a statement of accepted facts (SOAF). On examination he found positive impingement and crepitation tests in the right shoulder, with no sensory or motor deficit in either upper extremity. Dr. DeBerardino noted that active ROM measurements were obtained on three successive trials for each shoulder which included: left shoulder flexion at 120, 120, and 120 degrees; extension of 40, 50, and 40 degrees; abduction of 100, 100, and 100 degrees; adduction of 45, 45, and 45 degrees; internal rotation of 80 degrees on first trial; external rotation of 60 degrees on first trial. Right shoulder flexion was measured at 100, 100, and 100 degrees, extension of 45, 50, and 50 degrees, abduction of 25, 15, and 25 degrees, adduction of 30, 30, and 30 degrees, internal rotation of 50 degrees on first trial, and external rotation of 30 degrees on all trials. Dr. DeBerardino diagnosed a complete left rotator cuff tear, left shoulder effusion, right rotator cuff sprain, and cervical radiculopathy. He opined that appellant had attained maximum medical improvement (MMI). Dr. Bernardino found that according to *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*), appellant had no permanent impairment of either upper extremity due to spinal nerve root impairment as there were no objective findings of cervical radiculopathy.

Referring to Table 15-5, page 403 (Shoulder Regional Grid), Dr. DeBerardino noted a class 1 DBI class of diagnosis (CDX) of the right shoulder status post revision arthroscopic subacromial decompression, revision arthroscopic rotator cuff repair, arthroscopic biceps tenotomy, and arthroscopic excision of the distal clavicle. Utilizing the rotator cuff tear repair and CDX for clavicle resection, he found a grade modifier for functional history (GMFH) of one for pain with strenuous activity, a grade modifier for findings on physical examination (GMPE) of one for mildly limited motion, and a grade modifier for clinical studies (GMCS) of two for the September 19, 2017 MRI scan demonstrating a partial thickness rotator cuff tear. Applying the net adjustment formula, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (1-1) + (1-1) + (2-1) resulted in an adjustment of plus one, raising the default grade C upward to grade D, resulting in 11 percent permanent impairment of the right upper extremity. Dr. DeBerardino also provided an impairment rating for the right upper extremity utilizing the ROM method under Table 15-34, page 474 of the A.M.A., *Guides* (Shoulder Range of Motion). He found three percent impairment for limited flexion, three percent for limited abduction, one percent for limited adduction, two percent for limited internal rotation, and two percent for limited external rotation. Dr. DeBerardino added these impairments to equal 11 percent permanent impairment of the right upper extremity.

Regarding the left shoulder, Dr. DeBerardino found a class 1 CDX for a complete rotator cuff tear with effusion according to Table 15-5. He noted a GMFH of one for pain with strenuous activity, a GMPE of one for mild motion loss, and a GMCS of two for the September 19, 2017 MRI scan demonstrating a full-thickness rotator cuff tear. Dr. DeBerardino applied to net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or (1-1) + (1-1) + (2-1), resulting in a net adjustment of +1, raiding the default grade C to grade D, equaling six percent permanent impairment of the left upper extremity. He found that according to Table 15-34, appellant had three percent impairment for limited flexion and three percent impairment for limited abduction, equaling six percent permanent impairment of the left upper extremity. Dr. DeBerardino opined that the DBI rating method was preferable in appellant's case.

On February 14, 2019 OWCP referred Dr. DeBerardino's impairment rating and a SOAF to Dr. Herbert White, Jr., Board-certified in occupational medicine serving as a DMA. In a February 19, 2019 report, the DMA concurred with Dr. DeBerardino's impairment rating of 6 percent permanent impairment of the left upper extremity and 11 percent permanent impairment of the right upper extremity utilizing both the DBI and ROM methods. He agreed that the DBI method was appropriate for appellant's presentation. The DMA opined that appellant had attained MMI as of January 31, 2019, the date of Dr. DeBerardino's examination. He found appellant entitled to an additional two percent permanent impairment of the left upper extremity above the four percent previously awarded, for a total of six percent. The DMA noted that as she had previously received a schedule award for 11 percent permanent impairment of the right upper extremity, she was not entitled to an additional schedule award for the right arm.

By decision dated February 26, 2019, OWCP granted appellant a schedule award for two percent permanent impairment of the left upper extremity in addition to the four percent previously awarded, for a total six percent permanent impairment. It denied her claim for an increased schedule award for right upper extremity impairment as the medical evidence of record did not support greater than the 11 percent previously awarded. The period of the award ran from January 31 to March 15, 2019.

In a letter dated March 18, 2019[9] and received by OWCP on April 2, 2019, appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review. She contended that Dr. DeBerardino had not personally conducted the ROM trials and that he failed to consider all shoulder conditions in determining the DBI. Appellant submitted additional evidence.

In a March 17, 2015 addendum report, Dr. Duey noted that he had also performed a subcoracoid decompression during right shoulder arthroscopy that day.

A February 3, 2017 right shoulder MRI arthrogram demonstrated a partial thickness intrasubstance and articular retear of the supraspinatus tendon, mild fatty atrophy of the infraspinatus and supraspinatus muscles, and postsurgical changes.

In April 8 and 23, 2019 reports, a physician diagnosed compensatory bilateral periscapular scapular stabilizer pain. Appellant underwent a subacromial injection to the right shoulder on April 23, 2019 and to the left shoulder on May 14, 2019.

By decision dated June 7, 2019, a hearing representative affirmed the February 26, 2019 schedule award determination.

[9] The date of the postmark is illegible.

LEGAL PRECEDENT

The schedule award provisions of FECA[10] and its implementing regulations[11] 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. 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.[12] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[13]

In addressing upper extremity impairments, the sixth edition requires identification of the CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX). The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[14]

The A.M.A., *Guides* also provide that ROM impairment methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other DBI sections are applicable.[15] 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.[16] 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.[17]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating of upper extremity impairments.[18] Regarding the application of

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] *Id*. at § 10.404(a); *see also Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[13] 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).

[14] *See* A.M.A., *Guides* 387.

[15] *Id*. at 461.

[16] *Id*. at 473.

[17] *Id*. at 474.

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

ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "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*." (Emphasis in the original.)[19]
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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 should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[20]

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 impairment specified.[21]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than 11 percent permanent impairment of the right upper extremity and 6 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

Preliminarily, the Board notes that findings made in prior Board decisions are *res judicata* absent any further review by OWCP under section 8128 of FECA.[22] It is therefore unnecessary

[19] A.M.A., *Guides* 477.

[20] *Id.* at 474; *A.R.*, Docket No. 19-1284 (issued January 14, 2020); *M.S.*, Docket No. 19-1011 (issued October 29, 2019); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

[21] *See* Federal (FECA) Procedure Manual, *supra* note 13 at Chapter 2.808.6(f) (March 2017).

[22] *J.T.*, Docket No. 18-1757 (issued April 19, 2019); *S.S.*, Docket No. 17-1106 (issued June 5, 2018); *H.G.*, Docket No. 16-1191 (issued November 25, 2016).

for the Board to consider the evidence appellant submitted prior to the issuance of OWCP's March 6, 2017 decision because the Board considered that evidence in its May 2, 2018 decision.[23]

Dr. DeBerardino, the second opinion examiner, reviewed the medical record and SOAF, and diagnosed a complete left rotator cuff tear, left shoulder effusion, right rotator cuff sprain, and cervical radiculopathy. For appellant's left shoulder, he provided three ROM measurements and noted the highest measurements to be 120 degrees flexion, 50 degrees extension, 100 degrees abduction, 45 degrees adduction, 80 degrees internal rotation, and 60 degrees external rotation. Based on the DBI method, Dr. DeBerardino found six percent permanent impairment of the left upper extremity according to Table 15-5 due to a class 1 CDX for a complete rotator cuff tear with effusion, mild motion loss, and pain with strenuous activity. Regarding the left shoulder, Dr. DeBerardino found a class 1 CDX for a complete rotator cuff tear with effusion according to Table 15-5. He noted a GMFH of one for pain with strenuous activity, a GMPE of one for mild motion loss, and a GMCS of two for imaging studies demonstrating a full-thickness rotator cuff tear. Application of the net adjustment formula resulted in a net adjustment of +1, raiding the default grade C to grade D, equaling six percent permanent impairment of the left upper extremity. Dr. DeBerardino also found six percent permanent impairment of the left upper extremity utilizing the ROM method.

Regarding appellant's right shoulder, Dr. DeBerardino provided three ROM measurements and noted the highest measurements to be 100 degrees flexion, 50 degrees extension, 25 degrees abduction, 30 degrees adduction, 50 degrees internal rotation, and 30 degrees external rotation. Referencing Table 15-5, he found 11 percent permanent impairment of the right upper extremity due to a class 1 CDX for status post subacromial decompression, revision arthroscopic rotator cuff repair, biceps tenotomy, and arthroscopic resection of the distal clavicle. Dr. DeBerardino noted a CDX of 1 due to rotator cuff repair and arthroscopic excision of the distal clavicle. He found a GMFH of one for pain with strenuous activity, a GMPE of one for mildly limited motion, a GMCS of two for imaging scans demonstrating a partial thickness rotator cuff tear. Applying the net adjustment formula resulted in an adjustment of plus one, raising the default grade C upward to grade D, equaling 11 percent permanent impairment of the right upper extremity. Dr. DeBerardino also found 11 percent permanent impairment of the right upper extremity based on the ROM rating methodology.

To determine the permanent impairment of appellant's upper extremities, OWCP referred Dr. DeBerardino's report to a DMA, who concurred with Dr. DeBerardino's clinical findings and impairment rating. The DMA concluded that appellant had 11 percent permanent impairment of the right upper extremity and 6 percent permanent impairment of the left upper extremity based on the DBI method. He noted that, the percentages of impairment utilizing the DBI and ROM methods were equal in appellant's case.

The Board finds that Dr. DeBerardino properly discussed how he arrived at his permanent impairment rating by listing appropriate tables and pages in the A.M.A., *Guides* and established that appellant sustained 11 percent right upper extremity impairment and 6 percent left upper extremity impairment. Dr. DeBerardino accurately summarized the relevant medical evidence,

[23] *Supra* note 3.

provided detailed clinical findings on examination, and reached conclusions about appellant's condition which comported with his findings.[24] He properly utilized the DBI method and ROM method to rate appellant's bilateral shoulder condition pursuant to FECA Bulletin No. 17-06. In addition, the DMA concurred with Dr. DeBerardino's findings and methods of calculation. As Dr. DeBerardino's report is detailed, well rationalized, and based on a proper factual background, his opinion represents the weight of the medical evidence.[25] There is no other medical evidence of record establishing that appellant has a greater percentage of permanent impairment than previously awarded. Thus, the Board finds that appellant has not met her burden of proof to establish that she is entitled to an increased schedule award.

On appeal appellant contends that Dr. DeBerardino misapplied the A.M.A., *Guides* and failed to fully consider her imaging studies. As previously explained, Dr. DeBerardino's opinion, as reviewed by the DMA, is of sufficient probative quality to represent the weight of the medical evidence.

Appellant may request a schedule award or increased schedule award at any time based on evidence of new exposure, or medical evidence showing a 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 greater than 11 percent permanent impairment of the right upper extremity and 6 percent permanent impairment of the left upper extremity, for which she received schedule award compensation.

[24] *M.S.*, *supra* note 20; *J.M.*, Docket No. 18-1387 (issued February 1, 2019).

[25] *M.S.*, *supra* note 20.

ORDER

IT IS HEREBY ORDERED THAT the June 7, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 2, 2020
Washington, DC

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

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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