United States Department of Labor
Employees' Compensation Appeals Board

L.D., Appellant	)	
and	)	**Docket No. 19-0495**
	)	**Issued: February 5, 2020**
U.S. POSTAL SERVICE, CLEVELAND PROCESSING & DISTRIBUTION CENTER, Cleveland, OH, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 8, 2019 appellant filed a timely appeal from a November 13, 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] Appellant timely requested oral argument before the Board. By order dated December 11, 2019, the Board exercised its discretion and denied the request as the matter could be adequately addressed based on a review of the case record. *Order Denying Request for Oral Argument*, Docket No. 19-0495 (issued December 11, 2019).

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that following the November 13, 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 12 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.[4] The facts and circumstances of the case as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On January 19, 2012 appellant, then a 48-year-old mail processing clerk, filed a traumatic injury claim (Form CA-1) alleging that on January 18, 2012 her right shoulder "popped" while in the performance of duty. OWCP accepted her traumatic injury claim for right shoulder sprain and right shoulder impingement syndrome.[5] It authorized payment of intermittent wage-loss compensation as of March 6, 2012. Appellant worked limited duty until October 2013, when she stopped work due to a left shoulder condition.[6]

On February 28, 2017 appellant underwent authorized left shoulder arthroscopy with debridement, arthroscopic acromioplasty, limited distal clavicle resection, limited open repair of the left rotator cuff, and proximal biceps tenodesis with application of sling.

On May 31, 2017 OWCP expanded acceptance of the claim to include right shoulder algoneurodystrophy, unspecified rotator cuff tear or rupture of left shoulder (not specified as traumatic), incomplete rotator cuff tear or rupture of left shoulder (not specified as traumatic), impingement syndrome of left shoulder, right shoulder and upper arm sprain, other affections of right shoulder region, not elsewhere classified, and old disruption of posterior cruciate ligament.

On June 8, 2018 appellant filed a claim for an additional schedule award (Form CA-7).

In a May 8, 2018 report, Dr. Robert R. Reppy, an osteopath and family medicine specialist, indicated that appellant reached maximum medical improvement (MMI) on May 4, 2018. He provided impairment ratings for accepted diagnoses of left rotator cuff tear, rupture of left shoulder, left impingement syndrome under the sixth edition of the American Medical Association,

[4] Docket No. 15-1311 (issued July 21, 2017).

[5] By decision dated May 23, 2014, OWCP granted appellant a schedule award for five percent permanent impairment of the right upper extremity. By decision dated March 19, 2015, an OWCP hearing representative affirmed the May 23, 2014 schedule award decision. Appellant appealed the March 19, 2015 decision to the Board. By decision dated July 21, 2017, the Board set aside the hearing representative's March 19, 2015 schedule award decision of the right upper extremity. The Board remanded the case for OWCP to utilize a consistent method for calculating the permanent impairment for the upper extremities. Following further development, by decision dated September 18, 2017, OWCP awarded appellant an additional 11 percent permanent impairment of the right upper extremity, for a total of 16 percent permanent impairment of the right upper extremity.

[6] Appellant ultimately retired on disability, effective August 8, 2014.

Guides to the Evaluation of Permanent Impairment (A.M.A., *Guides*).[7] Using the diagnosis-based impairment (DBI) method for the left upper extremity, Dr. Reppy found that appellant had seven percent permanent impairment for a grade E, class 1 full-thickness tear of the supraspinatus under the Shoulder Regional Grid, Table 15-5 page 403, and five percent permanent impairment for a grade E, class 1 impingement syndrome under Table 15-5, page 402. He set forth his calculations under the A.M.A., *Guides*. Under the range of motion (ROM) impairment rating method, following three repetitions and using the most restrictive measurements, Dr. Reppy found that appellant had 13 percent permanent impairment of the left upper extremity. The three measurements provided were: forward flexion, 91, 110, and 100 degrees; abduction, 85, 90, and 80 degrees; internal rotation, 80, 75, and 80 degrees; external rotation, 65, 70, and 73 degrees; adduction, 75, 70, and 77 degrees; and extension, 35, 30, and 25 degrees. This amounted to three percent impairment for 90 degrees flexion, six percent impairment for 80 degrees abduction, two percent impairment for 75 degrees internal rotation, zero percent impairment for 65 degrees external rotation, zero percent impairment for 70 degrees adduction, and two percent impairment for 25 degrees extension. For the right upper extremity, Dr. Reppy found that appellant had one percent permanent impairment for grade C, class 1 nonspecific shoulder pain under Table 15-5, page 401 under the DBI methodology. He also noted that the ROM methodology yielded 13 percent permanent impairment. Dr. Reppy concluded that, under the Combined Values Chart on page 604, that appellant had 23 percent total left upper extremity impairment.

On July 10, 2018 OWCP forwarded appellant's case record to an OWCP district medical adviser (DMA) to determine appellant's permanent impairment.

In a July 14, 2018 report, Dr. Herbert White, Jr., Board-certified in physical medicine and rehabilitation serving as a DMA, reviewed the medical evidence of file and indicated that appellant had reached MMI on May 8, 2018. He utilized Dr. Reppy's May 8, 2018 evaluation findings and set forth impairment ratings for the right and left upper extremity. For the left upper extremity, under the DBI methodology, the DMA found that appellant had 12 percent permanent impairment for the left shoulder distal clavicle resection, pursuant to Table 15-5, page 403, as opposed to Dr. Reppy's 7 percent permanent impairment rating for the full-thickness rotator cuff tear. Under Table 2.1, page 20 and page 389 of the A.M.A., *Guides*, he explained that as appellant had more than one diagnosis, this diagnosis yielded the highest impairment rating. Under Table 15-5, page 405, the DMA found class 1 class of diagnosis (CDX) distal clavicle resection was 10 percent impairment. Under Table 15-7, page 406, he found a grade modifier functional history (GMFH) was grade 2, under Table 15-8, page 408, a grade modifier physical evaluation (GMPE) was grade 1, and under Table 15-9, page 410, a grade modifier clinical studies (GMCS) was grade 4. Utilizing the net adjustment formula calculation, the DMA found a net adjustment of 4,[8] which resulted in a grade E or 12 percent permanent impairment for left shoulder distal clavicle resection.

Under the ROM methodology for the left upper extremity, the DMA indicated that he obtained an upper extremity permanent impairment rating of 7 percent as opposed to Dr. Reppy's upper extremity impairment rating of 13 percent. He indicated that Dr. Reppy properly recorded three separate ROM motion efforts, but that the maximum observed measurement should have

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

[8] (GMFH-CDX)(2-1) + (GMPE-CDX)(1-1) + (CMCS–CDX)(4-1) = 4.

been used to determine ROM impairment as opposed to the restrictive measurement Dr. Reppy had utilized. Using Dr. Reppy's ROM findings and rounding to the nearest number ending in 0, the DMA calculated under Table 15-34, page 475: 110 degrees flexion equaled three percent impairment; 40 (35) degrees extension equaled one percent impairment; 90 degrees abduction equaled three percent impairment; 80 degrees adduction equaled zero percent impairment; 80 degrees internal rotation equaled zero percent impairment; and 70 degrees external rotation equaled zero percent impairment, for a total upper extremity impairment of seven percent.[9] Under Table 15-35, page 477, and Table 15-7, page 406, he assigned a grade 1 ROM modifier, and a grade 2 functional history modifier. The DMA then used Table 16-17, page 545, to find a ROM modifier adjustment of .35 percent (5 percent times 7 percent), which yielded a total permanent impairment of 7.35 percent rounded down to 7 percent. He concluded that the DBI methodology of 12 percent impairment represented appellant's left upper extremity impairment as it produced the higher rating over the 7 percent ROM methodology.

By decision dated July 18, 2018, OWCP granted appellant a schedule award for 12 percent permanent impairment of the left upper extremity. The period of the award ran from May 8, 2018 to January 25, 2019. The weight of the medical evidence was accorded to the DMA.

On July 30, 2018 appellant requested a review of the written record by an OWCP hearing representative. She set forth arguments in a July 29, 2018 statement.

By decision dated November 13, 2018, an OWCP hearing representative affirmed OWCP's July 18, 2018 decision with regard to whether appellant has established permanent impairment of her left upper extremity.[10]

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 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

[9] The Board notes that Dr. Reppy recorded adduction of 75, 70, and 77 degrees. The DMA's notation of 80 degrees of adduction is harmless error as adduction greater than 40 degrees equals zero percent impairment under Table 15-34.

[10] The hearing representative remanded the case for a formal decision regarding permanent impairment of the right upper extremity and the possibility of an overpayment of compensation.

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

adoption.[13] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[14]

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.[15] After a CDX is determined (including identification of a default grade value), the impairment class is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[16] The net adjustment formula is (GMFH CDX) + (GMPE CDX) + (GMCS CDX).[17]

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 impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[18]

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."[19]

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

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

[14] 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).

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

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

[17] *Id.* at 411.12. *See supra* note 13 at 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).

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

[19] FECA Bulletin *id.*; *V.L., id.*; *A.G., id.*

should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[20]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than 12 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

OWCP received a May 8, 2018 report from Dr. Reppy who opined that, for the left upper extremity, appellant had seven percent permanent partial impairment for a grade E, class 1 full-thickness tear of the supraspinatus and five percent permanent partial impairment for a grade E, class 1 impingement syndrome under the DBI methodology. However, if a claimant has two significant diagnoses, the examiner should use the diagnosis with the highest causally related impairment rating for the impairment calculation.[21] Dr. Reppy also reported that appellant had 13 percent permanent impairment of the left upper extremity under the ROM methodology. While he provided three sets of ROM measurements, he used the most restrictive as opposed to the greatest measurement as provided in FECA Bulletin No. 17-06.[22] As a result, Dr. Reppy's impairment ratings did not comply with the A.M.A., *Guides* and are of limited probative value.[23]

The Board finds that Dr. White, OWCP's DMA, properly determined that appellant had no more than 12 percent permanent impairment of her left upper extremity. Utilizing the ROM methodology found in Table 15-34, page 475 of the A.M.A., *Guides*, the DMA used the greatest ROM measurement and found that appellant had seven percent upper extremity impairment. He calculated: 110 degrees flexion equaled three percent impairment; 40 (35) degrees extension equaled one percent impairment; 90 degrees abduction equaled three percent impairment; 80 degrees adduction equaled zero percent impairment; 80 degrees internal rotation equaled zero percent impairment; and 70 degrees external rotation equaled zero percent impairment. Under Table 15-35, page 477, and Table 15-7, page 406, the DMA assigned a grade 1 ROM modifier, and a grade 2 functional history modifier. Pursuant to the ROM modifier adjustment for the upper extremities under Table 15-36, page 477, a modifier adjustment of .35 (total ROM impairment times five percent) would result. The DMA therefore concluded that the ROM methodology would yield a total left upper extremity permanent impairment of 7.35 rounded down to 7 percent.[24]

The DMA properly noted that appellant had more than one diagnosis of the left upper extremity and found that the diagnosis of distal clavicle resection yielded the highest impairment rating. Under Table 15-5, page 405, a class 1 (CDX) distal clavicle resection has a default

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

[21] A.M.A., *Guides* 387.

[22] *Supra* note 19.

[23] *See S.R.*, Docket No. 18-1307 (issued March 27, 2019).

[24] The DMA provided the proper calculation but cited Table 16-17, page 545, instead of Table 15-36, page 477. This constitutes harmless error.

impairment value of 10 percent impairment. The DMA assigned, under Table 15-7, page 406, GMFH 2; under Table 15-8, page 408, GMPE 1; and under Table 15-9, page 410, GMCS 4. He properly calculated a net adjustment of 4 from the net adjustment formula,[25] which resulted in a grade E or 12 percent permanent impairment for left shoulder distal clavicle resection. The DMA explained that as the DBI rating resulted in the greater percentage of impairment than the ROM rating and, under the A.M.A., *Guides*, the method producing the highest rating should be used. He concluded that this resulted in 12 percent left upper extremity permanent impairment based upon the DBI rating method. The DMA's report constitutes the weight of the medical evidence.

The Board thus finds that appellant has not established more than 12 percent permanent impairment of her left upper extremity, for which she previously received a schedule award.[26]

On appeal appellant contends that Dr. Reppy's report found 23 percent permanent impairment of her left shoulder, therefore, she should be entitled to a greater impairment than that previously awarded. As explained 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 12 percent permanent impairment of the left 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 permanent impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish greater than 12 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

[25] (GMFH-CDX)(2-1) + (GMPE-CDX)(1-1) + (CMCS–CDX)(4-1) = 4.

[26] *See M.H.*, Docket No. 19-0290 (issued June 18, 2019).

ORDER

IT IS HEREBY ORDERED THAT the November 13, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 5, 2020
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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