United States Department of Labor
Employees' Compensation Appeals Board

H.H., Appellant	)	
and	)	**Docket No. 19-1530**
	)	**Issued: June 26, 2020**
U.S. POSTAL SERVICE, HENRY W. WHEELER POST OFFICE, St. Louis, MO, 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:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 10, 2019 appellant, through counsel, filed a timely appeal from a June 17, 2019 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.

[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.*

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 12 percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On February 22, 2012 appellant, then a 54-year-old mail carrier, filed a traumatic injury claim (Form CA-1) alleging that on February 21, 2012 he stubbed his right great toe and jammed his right shoulder when closing a cargo door, while in the performance of duty. OWCP accepted the claim for right shoulder strain, a right shoulder contusion, and a resolved right great toe contusion. It subsequently expanded acceptance of the claim to include a right rotator cuff tear and right biceps tenodesis.[3] Appellant underwent OWCP-authorized right shoulder surgeries on August 6, 2012, February 13, 2013, and January 14, 2016.

By letter dated August 26, 2016, Dr. Fallon Maylack, a Board-certified orthopedic surgeon, advised that appellant had reached maximum medical improvement (MMI).

On September 26, 2016 appellant filed a claim for a schedule award (Form CA-7).

By letter dated September 30, 2016, OWCP informed appellant that it would not take action on his schedule award claim as it did not appear that he had reached MMI, noting that he had undergone a right rotator cuff repair on January 4, 2016 and was participating in physical therapy as recently as August 9, 2016. It advised that if his physician believed he was currently at MMI, he should submit a detailed medical report providing rationale for this opinion.

In an October 12, 2016 permanent impairment evaluation, Dr. Neil Allen, a Board-certified neurologist and internist, diagnosed right shoulder sprain, a right shoulder contusion, right rotator cuff sprain, and right bicipital tenosynovitis. He described appellant's February 21, 2012 employment injury and noted that he had undergone three right shoulder surgical procedures, including rotator cuff repairs. Dr. Allen determined that he had reached MMI.

On examination of the right shoulder, Dr. Allen observed guarding, tenderness to palpation, moderate crepitus, and 4/5 strength in the deltoid. He obtained three range of motion (ROM) measurements for the right shoulder with the highest as follows: 160 degrees of flexion, 50 degrees of extension, 125 degrees of abduction, 40 degrees of adduction, 40 degrees of internal rotation, and 80 degrees of external rotation. Dr. Allen noted that an x-ray taken on July 5, 2012 revealed moderate degenerative changes of the acromioclavicular joint and mild narrowing of the subacromial space, while a magnetic resonance imaging (MRI) scan taken on December 13, 2012 demonstrated large, full-thickness tears present in the supraspinatus, infraspinatus, and subscapularis tendons, a complete tear of the biceps tendon, and degeneration of the superior labrum.

[3] OWCP accepted that appellant sustained low back strain in an August 29, 2016 motor vehicle accident, assigned OWCP File No. xxxxxx703.

Referencing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] Dr. Allen calculated the extent of appellant's permanent impairment of the right upper extremity using the diagnosis-based impairment (DBI) methodology. Referring to the shoulder regional grid, Table 15-5,[5] Dr. Allen identified the diagnosis as a full-thickness rotator cuff tear with a class of diagnosis (CDX) of 1 and a default value of five percent. Referring to Table 15-7 and Table 15-8,[6] he applied a grade modifier for functional history (GMFH) of two, a grade modifier for physical examination (GMPE) of two, and the grade modifier for clinical studies (GMCS) of four. Applying the net adjustment formula changed appellant's default grade C diagnosis of five percent permanent impairment to a grade E diagnosis, resulting in a final right upper extremity permanent impairment of seven percent.

In a September 12, 2017 report, Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), reviewed the medical evidence of record and determined that appellant had reached MMI on October 12, 2016, the date of Dr. Allen's impairment rating. He found that the maximum award for a rotator cuff tear with residual loss using the DBI methodology under the A.M.A., *Guides* was seven percent of the right upper extremity.[7] Dr. Garelick concluded that the ROM methodology should be used because it provided the higher impairment rating. He utilized Dr. Allen's ROM measurements and found that, according to Table 15-34 on page 475 of the A.M.A., *Guides*, 160 degrees flexion yielded three percent permanent impairment, 40 degrees extension yielded one percent permanent impairment, 125 degrees abduction yielded three percent impairment, 40 degrees internal rotation constituted four percent permanent impairment, and 80 degrees external rotation and 40 degrees adduction yielded no impairment. Dr. Garelick added the impairments due to loss of ROM to find 11 percent permanent impairment. He applied a GMFH of two, to find a total right upper extremity impairment of 12 percent using Table 15-35 and Table 15-36 on page 477.

By decision dated August 30, 2018, OWCP granted appellant a schedule award for 12 percent permanent impairment of the right arm. The period of the award ran for 37.44 weeks from October 12, 2016 through July 1, 2017.

On September 17, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. The telephonic hearing was held on February 4, 2019.

By decision dated March 15, 2019, OWCP's hearing representative affirmed the August 30, 2018 decision. He found that the medical evidence of record established that appellant had no more than 12 percent permanent impairment of the right upper extremity.

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

[5] *Id.* at 403.

[6] *Id.* at 406 and 408, respectively.

[7] *Supra* note 5.

On March 28, 2019 appellant, through counsel, requested reconsideration.

On May 1, 2017 Dr. Maylack noted that he had treated appellant after an employment-related injury to his right shoulder and advised that he had undergone rotator cuff repair surgery on January 14, 2016 without complication. He related that on April 3, 2017 he had measured "good passive motion of the right shoulder with only loss of extremes of internal (90 degrees) and external rotation (110 degrees)." Dr. Maylack further indicated that appellant had excellent active ROM with biceps muscle weakness and weakness in resisted abduction and forward elevation. He opined that, based on his review of the sixth edition A.M.A., *Guides*, appellant had 20 percent permanent impairment of the right shoulder due to his injury and subsequent surgery.

In an April 17, 2019 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA, reviewed Dr. Maylack's May 1, 2017 report along with the medical evidence of record. He advised that Dr. Maylack's findings were insufficient to support a rating using the DBI methodology as he failed to reference any tables or otherwise explain how he calculated the impairment using the A.M.A., *Guides*. Dr. Katz further noted that his finding of 20 percent impairment exceeded any "plausible DBI key factor values of impairment under Table 15-5…." He found that Dr. Maylack had failed to measure ROM three times or provide a complete arc of motion, and that his opinion was thus insufficient to support a rating based on loss of ROM. Dr. Katz agreed with Dr. Garelick's prior finding that appellant had 12 percent permanent impairment using the ROM methodology.

By decision dated June 17, 2019, OWCP denied modification of the March 15, 2019 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[8] and its implementing regulations 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.[9] 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. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[10] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[11]

[8] *Supra* note 2.

[9] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[10] 20 C.F.R. § 10.404; *L.T.*, Docket No. 18-1031 (issued March 5, 2019); *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[11] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (March 2017).

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).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13]

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.[14] 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.[15] 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.[16]

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

> "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 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.*"[18] (Emphasis in the original.)

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."[19]

[12] A.M.A., *Guides* 383-492.

[13] *Id*. at 411.

[14] *Id*. at 461.

[15] *Id*. at 473.

[16] *Id*. at 474.

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

[18] *Id*.

[19] *Id.*; *see also V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

OWCP's 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.[20]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 12 percent permanent impairment of the right upper extremity, for which he previously received a schedule award.

In an October 12, 2016 permanent impairment evaluation, Dr. Allen diagnosed a right shoulder sprain, right shoulder contusion, right rotator cuff sprain, and right bicipital tenosynovitis. He provided ROM findings of the right upper extremity based on three measurements as follows: 160 degrees of flexion, 50 degrees of extension, 125 degrees of abduction, 40 degrees of adduction, 40 degrees of internal rotation, and 80 degrees of external rotation. Using the DBI methodology, Dr. Allen calculated a final right upper extremity impairment of seven percent due to appellant's full-thickness rotator cuff tear under Table 15-5 on page 403, the maximum allowed for that diagnosis.

In a September 12, 2017 report, Dr. Garelick, serving as DMA, reviewed the medical evidence of record and noted that under the DBI methodology for a rotator cuff tear with residual loss, the most that appellant could be awarded was seven percent permanent impairment of the right upper extremity. He found that his impairment should be calculated using the ROM method as it provided the higher impairment rating. Dr. Garelick determined that, according to Table 15-34 on page 475 of the A.M.A., *Guides*, 160 degrees flexion yielded three percent permanent impairment, 40 degrees extension yielded one percent permanent impairment, 125 degrees abduction yielded three percent impairment, 40 degrees internal rotation yielded four percent permanent impairment, and 80 degrees external rotation and 40 degrees adduction yielded no impairment. He added the impairment ratings to find 11 percent permanent impairment. Dr. Garelick applied a GMFH of two to the 11 percent impairment, which yielded a total right upper extremity impairment of 12 percent using Table 15-35 and Table 15-36 on page 477.

On May 1, 2017 Dr. Maylack found that appellant had good passive ROM of the right shoulder and measured internal rotation of 90 degrees and external rotation of 110 degrees. He further found excellent active ROM. Dr. Maylack advised that appellant had weakness in resisted abduction, forward elevation, and of the biceps muscle. He opined that he had 20 percent permanent impairment of the right shoulder. Dr. Maylack, however, failed to explain how he arrived at his impairment rating in accordance with the relevant standards of the A.M.A., *Guides*.[21] As he did not refer to tables or charts in the A.M.A., *Guides* in support of his determination, his

[20] *See supra* note 11 at Chapter 2.808.6(f) (March 2017).

[21] *B.B.*, Docket No. 18-0782 (issued January 11, 2019); *James R. Hill, Sr.*, 57 ECAB 583 (2006).

report lacks the probative value necessary to determine appellant's permanent impairment for schedule award purposes.[22]

In an April 17, 2019 report, Dr. Katz, serving as DMA, agreed with Dr. Garelick's finding that appellant had 12 percent permanent impairment using the ROM methodology. He noted that Dr. Garelick correctly observed that Dr. Allen had provided probative ROM measurements, and appropriately calculated an impairment rating using Table 15-34 of 12 percent right upper extremity impairment. Dr. Katz asserted that Dr. Maylack's May 1, 2017 letter could not be accepted as probative evidence as he failed to explain his calculations, obtain three ROM measurements, or provide complete ROM measurements. The Board finds that Drs. Garelick and Katz, serving as DMAs, properly discussed how they arrived at their shared conclusion that appellant sustained 12 percent right upper extremity permanent impairment under the A.M.A., *Guides*.[23] As the record contains no other probative, rationalized medical opinion which supports that he had greater impairment of the right upper extremity based upon the A.M.A., *Guides*, he has not met his burden of proof to establish greater than 12 percent permanent impairment of the right upper extremity for which he received schedule award compensation.[24]

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 his burden of proof to establish greater than 12 percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

[22] *B.B.*, *id.*

[23] *See O.F.*, Docket No. 19-0986 (issued February 12, 2020); *K.J.*, Docket No. 19-0901 (issued December 6, 2019).

[24] *See J.H.*, Docket No. 18-1207 (issued June 20, 2019).

ORDER

IT IS HEREBY ORDERED THAT the June 17, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 26, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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