United States Department of Labor
Employees' Compensation Appeals Board

M.D., Appellant	)	
and	)	**Docket No. 20-0007**
	)	**Issued: May 13, 2020**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Washington, DC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On October 2, 2019 appellant filed a timely appeal from a June 28, 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.

ISSUE

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

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts and circumstances of the case as set forth in the Board's prior decisions are incorporated herein by reference. The relevant facts are as follows.

On January 29, 2015 appellant, then a 40-year-old internal revenue agent, filed an occupational disease claim (Form CA-2) alleging that he sustained a right rotator cuff injury due to factors of his federal employment. He explained that he repeatedly assembled documents for review and used a whole puncher to perforate case file documents. Appellant noted that he first became aware of his injury and first realized that it was caused by his federal employment on October 3, 2014. OWCP accepted his claim for sprain of the right shoulder and upper arm, acromioclavicular (AC) joint and disorder of the bursae and tendons in the right shoulder region, unspecified, complete right rotator cuff rupture, and right brachial neuritis or radiculitis, not otherwise specified. On July 7, 2015 appellant underwent OWCP-authorized right shoulder arthroscopy with subacromial decompression and distal clavicle resection by Dr. Steven H. Bernstein, an attending Board-certified orthopedic surgeon. OWCP paid appellant wage-loss compensation benefits on the periodic rolls. On June 18, 2016 appellant returned to full-time work with restrictions.

On June 28, 2016 appellant filed a claim for a schedule award (Form CA-7). He submitted a June 17, 2016 medical report from Dr. Bernstein who found 29 percent right upper extremity permanent impairment and 24 percent whole body impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] Dr. Bernstein utilized the diagnosis-based impairment (DBI) methodology to rate appellant's permanent impairment. He found that, under Table 15-5, page 402, she had five percent permanent impairment for a rotator cuff contusion with impingement and eight percent permanent impairment for an AC joint injury/disease. Utilizing the Combined Values Chart, page 604, Dr. Bernstein calculated 13 percent permanent impairment of the right upper extremity and 8 percent permanent impairment of the whole person. He advised that appellant had an additional four percent permanent impairment for pain, weakness, and loss of endurance and function. Dr. Bernstein found no additional impairment for atrophy. He concluded that appellant had a combined total of 29 percent right upper extremity permanent impairment.

In a July 21, 2016 report, Dr. Jovito Estaris, Board-certified in occupational medicine serving as an OWCP district medical adviser (DMA), noted appellant's diagnoses of impingement syndrome and AC joint disease, referenced Dr. Bernstein's range of motion (ROM) measurements, and determined that appellant had 10.5 percent permanent impairment of the right upper extremity which was rounded up to 11 percent based on the ROM rating method. He explained that his impairment rating was markedly lower than Dr. Bernstein's impairment because Dr. Bernstein had rated two diagnoses under the DBI method and combined the impairment ratings. The DMA noted that, page 387 of the A.M.A., *Guides*, directed that, if a patient had two significant diagnoses, the examiner should use the diagnosis with the highest causally related impairment for the impairment

[2] Docket No. 18-1073 (issued January 18, 2019); Docket No. 17-1424 (issued October 25, 2017).

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

calculation. He also noted that Dr. Bernstein's award of additional impairment rating for pain, weakness, and loss of endurance and function was not acceptable under the sixth edition of the A.M.A., *Guides*. The DMA determined that appellant reached maximum medical improvement (MMI) on June 17, 2016 the date of Dr. Bernstein's impairment evaluation.

In an August 4, 2016 letter, OWCP requested that appellant obtain a supplemental report from Dr. Bernstein regarding the extent of his permanent impairment based on the physician's review of Dr. Estaris' July 21, 2016 report.

Dr. Bernstein, in a letter dated August 19, 2016, noted that he had reviewed Dr. Estaris' report and disagreed with his use of the ROM methodology to calculate appellant's impairment rating. He asserted that this methodology was inappropriate and inadequate as it failed to capture the degree of appellant's pain, difficulty, and impairment. Dr. Bernstein reiterated his prior finding that appellant had 29 percent right arm permanent impairment.

On September 20, 2016 Dr. Estaris reviewed Dr. Bernstein's August 19, 2016 report. He again explained why his use of the ROM methodology to calculate appellant's impairment rating was more appropriate under the A.M.A., *Guides*. The DMA also reiterated why Dr. Bernstein's impairment rating was not acceptable under the A.M.A., *Guides*.

OWCP, by decision dated October 4, 2016, granted appellant a schedule award for 11 percent permanent impairment of the right upper extremity, based on the opinion of its DMA, Dr. Estaris. The award ran for 34.32 weeks for the period June 18, 2016 to February 13, 2017.[4]

Appellant requested reconsideration on November 4, 2016.

By decision dated February 2, 2017, OWCP denied modification of its October 4, 2016 decision. It found that the weight of the medical evidence continued to rest with the opinion of its DMA.

On June 15, 2017 appellant appealed to the Board. By decision dated October 25, 2017, the Board set aside the February 2, 2017 decision.[5] The Board found that OWCP had inconsistently applied Chapter 15 of the A.M.A., *Guides* regarding the proper use of either the DBI or ROM methodology in assessing the extent of permanent impairment. The Board remanded the case for OWCP to issue a *de novo* decision after development of a consistent method for calculating permanent impairment of the upper extremities.

On remand, in a December 11, 2017 letter, OWCP requested that appellant submit an additional report from Dr. Bernstein including a review of a newly prepared statement of accepted facts (SOAF) and an evaluation of his prior impairment rating based on the reprinted 2009 sixth edition A.M.A., *Guides*. It afforded him 30 days to submit the requested evidence.

In a response letter dated January 10, 2018, appellant asserted that Dr. Estaris' opinion could not carry the weight of the medical evidence. He claimed that he did not receive a copy of

[4] On November 30, 2016 appellant accepted a lump-sum payment of the schedule award.

[5] Docket No. 17-1424 (issued October 25, 2017).

the SOAF, which inaccurately stated that he had preexisting cervical radiculitis, AC joint arthrosis, and a cervical herniated disc. Appellant contended that Dr. Bernstein's 29 percent right arm impairment rating was sufficient to establish his entitlement to an increased schedule award.

On February 15, 2018 OWCP requested that its DMA review his July 21 and September 21, 2016 reports and Dr. Bernstein's June 17, 2016 impairment rating and explain how their right upper extremity impairment calculations were determined under the reprinted 2009 sixth edition of the A.M.A., *Guides*. It related that, if the A.M.A., *Guides* allowed a rating using both the DBI and ROM methods, the impairment should be independently calculated using both methods. OWCP advised that three independent ROM measurements must be obtained and the greatest ROM measurements should be used to determine the extent of impairment. If the medical evidence of record was insufficient to render a rating based on the ROM method, where allowed, the DMA was advised to note the medical evidence necessary to complete the ROM rating method and render an impairment rating using the DBI method, if possible, given the available evidence.

On February 19, 2018 Dr. Estaris explained that according to Table 15-5, appellant had 12 percent right upper extremity permanent impairment, utilizing the DBI methodology, for a diagnosis of right shoulder AC joint arthropathy with impingement syndrome status post distal clavicle resection. He noted that, while the ROM method was applicable in this case, there was only one set of ROM measurements for the right shoulder. The DMA indicated that three independent measurements of ROM of the involved joint was required to use the ROM method. He reviewed Dr. Bernstein's June 15, 2016 impairment evaluation and reiterated his prior rationale explaining why Dr. Bernstein's 29 percent right upper extremity permanent impairment rating was not proper under the A.M.A., *Guides*.

OWCP, by decision dated February 22, 2018, vacated its February 2, 2017 decision, finding that appellant had an additional 1 percent right upper extremity permanent impairment, totaling 12 percent permanent impairment, based on the opinion of its DMA.

By decision dated April 13, 2018, OWCP granted appellant an additional 1 percent permanent impairment of the right upper extremity, for a total of 12 percent permanent impairment. The additional schedule award ran for 3.12 weeks for the period February 14 to March 7, 2017.

Appellant appealed to the Board on May 1, 2018. By decision dated January 18, 2019, the Board set aside the April 13, 2018 decision.[6] The Board found that OWCP failed to follow its procedures outlined in FECA Bulletin No. 17-06 (May 8, 2017) as its DMA advised that the necessary evidence of three independent ROM findings were not of record to rate appellant's permanent impairment utilizing the ROM methodology. The Board remanded the case for OWCP to complete the proper procedures outlined in FECA Bulletin No. 17-06 to rate appellant's upper extremity permanent impairment.

Following remand, on April 17, 2019, OWCP referred appellant to Dr. Rafael A. Lopez Steuart, a Board-certified orthopedic surgeon, for a second opinion evaluation for the purpose of

[6] Docket No. 18-1073 (issued January 18, 2019).

ascertaining the extent of his permanent impairment in accordance with the A.M.A., *Guides* and FECA Bulletin No. 17-06.

On May 8, 2019 Dr. Lopez Steuart noted a history of the accepted employment injury and appellant's medical treatment. On physical examination of the right shoulder, he reported 90 degrees of forward flexion, 50 degrees of extension, 90 degrees of abduction, 40 degrees of adduction, 60 degrees of external rotation, and 80 degrees of internal rotation after warmup and measured three times with a goniometer. Appellant was unable to flex his elbow more than 30 degrees because of posterior scapular pain, but he was later observed to fully flex his elbow. The biceps on the right side measured 31 centimeters (cm) compared to 30 cm on the left side. Forearm circumference was 27 cm on the right compared to 25 cm on the left. The musculature of the right shoulder girdle had normal appearance without evidence of atrophy. There was no evidence of swelling, erythema, crepitation, spasm, atrophy, or deformity. Rotator cuff strength was 5/5. There was exquisite tenderness to light palpation in the periscapular muscles. Appellant was uncooperative in ranging his shoulder and elbow and exhibited signs consistent with symptom magnification and suboptimal effort. There was no evidence of instability with a negative anterior and posterior apprehension test. There was also negative suicus, AC joint shear, empty-can, drop-arm, and lift-off tests and sulcus sign. There was slight prominence of the distal clavicle on the right compared to the left. Surgical portals were noted. Findings on neurological examination revealed intact sensation, good motor strength, symmetric reflexes, and no long-tract signs. Dr. Lopez Steuart indicated that appellant sustained a right shoulder strain with preexisting degenerative changes of the right shoulder. He also underwent an arthroscopic decompression and distal clavicle resection and, therefore, impingement was no longer present. Dr. Lopez Steuart found no evidence of preexisting tendinosis of the supraspinatus and infraspinatus tendons. He opined that there was no exacerbation or aggravation of a preexisting condition and that appellant had sustained a simple shoulder strain. Dr. Lopez Steuart found that he reached MMI on May 8, 2019, the date of his impairment evaluation.

Dr. Lopez Steuart applied the DBI rating method, utilizing Table 15-5, page 403, to find that appellant's AC joint injury or disease of the right shoulder status post distal clavicle resection resulted in a Class 1, grade C impairment. He assigned a grade modifier 1 for functional history, physical examination, and clinical studies. Dr. Lopez Steuart concluded that appellant had 10 percent permanent impairment of the right upper extremity. He also utilized the ROM rating method, noted three ROM measurements for appellant's right shoulder, and calculated six percent permanent impairment of the right upper extremity due to loss of ROM. Dr. Lopez Steuart explained that 90 degrees of forward flexion and 90 degrees of abduction each resulted in three percent permanent impairment, totaling six percent permanent impairment. He noted that appellant was previously awarded 12 percent permanent impairment of the right upper extremity and, therefore, no additional impairment had been incurred.

OWCP subsequently routed the case record, including Dr. Lopez Steuart's May 8, 2019 report, to the prior DMA for review. In a June 7, 2019 report, Dr. Estaris indicated that, according to the DBI rating method, under Table 15-5, Shoulder Regional Grid, page 403, appellant had a Class 1 impairment with a default value of 10 percent for class of diagnosis (CDX), which was AC joint arthropathy with impingement syndrome status post distal clavicle resection. He assigned a grade modifier 1 for functional history (GMFH) due to right periscapular pain with limited duty under Table 15-7, page 406. The DMA assigned a grade modifier 1 for physical examination

(GMPE) due to mild limitation of ROM, stability, and no atrophy of the right shoulder under Table 15-8, page 408. He related that a grade modifier for clinical studies (GMCS) was not used as a magnetic resonance imaging (MRI) scan, which showed AC joint arthropathy was used to establish the diagnosis and proper placement in the regional grid. The DMA utilized the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (1 - 1) + (1 - 1) = 0, which resulted in a grade C or 10 percent permanent impairment of the right upper extremity. He also utilized the ROM rating method in Table 15-34 finding three percent impairment for 90 degrees of flexion, zero percent impairment for 50 degrees of extension, three percent impairment for 90 degrees of abduction, zero percent impairment for 40 degrees of adduction, zero percent impairment for 80 degrees of internal rotation, and zero percent impairment for 60 degrees of external rotation. The DMA added these values to equal six percent permanent impairment of the right upper extremity. He concluded that appellant had 10 percent permanent impairment of his right upper extremity given that he had a higher rating for permanent impairment under the DBI rating. The DMA noted that since appellant was previously awarded 12 percent permanent impairment of the right upper extremity and the current impairment rating was included in that award, no additional award was warranted. He further noted that appellant reached MMI on May 8, 2019, the date of Dr. Lopez Steuart's impairment evaluation.

OWCP, by decision dated June 28, 2019, found that appellant was entitled to no more than 12 percent permanent impairment of the right upper extremity for which he previously received schedule awards. It determined that the weight of the medical evidence rested with the June 7, 2019 report of its DMA.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and its implementing 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 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.[9] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[10] The Board has approved the

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id. See also, Ronald R. Kraynak*, 53 ECAB 130 (2001).

[10] *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 2.808.6a (March 2017).

use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[11]

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.[12] 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.[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14]

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)."[15]

FECA Bulletin further advises:

> "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.)[16]

The Bulletin also 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."[17]

[11] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

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

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

[14] *Id*. at 411.

[15] FECA Bulletin No. 17-06 (May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[16] *Id.*

[17] *Id.*

OWCP's 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]

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 schedule award compensation.

Preliminarily, the Board notes that it is unnecessary for the Board to consider the evidence that was previously considered in its October 25, 2017 and January 18, 2019 decisions. Findings made in prior Board decisions are *res judicata*, absent any further review by OWCP under section 8128 of FECA.[19]

Following the Board's January 18, 2019 remand decision, OWCP referred appellant's schedule award claim to Dr. Lopez Steuart, serving as an OWCP second opinion physician, for examination and to provide a permanent impairment of appellant's right upper extremity in accordance with the A.M.A., *Guides* and FECA Bulletin No. 17-06. In a May 8, 2019 report, Dr. Lopez Steuart reviewed appellant's history and conducted an examination. He indicated that he performed ROM testing three times after warm-up. Dr. Lopez Steuart reported a diagnosis of AC joint injury or disease of the right shoulder status post distal clavicle resection. Utilizing the DBI methodology, he found that appellant had a Class 1, grade C impairment for AC joint injury or disease of the right shoulder status post distal clavicle resection under Table 15-5, page 403. Dr. Lopez Steuart assigned a grade modifier 1 for functional history, physical examination, and clinical studies. He concluded that appellant had 10 percent permanent impairment of the right upper extremity. Dr. Lopez Steuart also opined that appellant had six percent permanent impairment of the right upper extremity under the ROM methodology.

Dr. Estaris, OWCP's DMA, also found that appellant had 10 percent right upper extremity permanent impairment under the DBI methodology. He concurred with Dr. Lopez Steuart's finding of a Class 1 impairment with a default value of 10 percent impairment for appellant's diagnosis of AC joint arthropathy with impingement syndrome status post distal clavicle resection and assigned grade modifiers of 1 for functional history and physical examination. However, unlike Dr. Lopez Steuart, the DMA explained that a grade modifier for clinical studies was not applicable as an MRI scan was used to establish the diagnosis. He then properly calculated a net adjustment of 0 from the net adjustment formula,[20] which resulted in a grade C or 10 percent permanent impairment for right shoulder AC joint arthropathy with impingement syndrome status post distal clavicle resection. The DMA also concurred with Dr. Lopez Steuart's six percent right

[18] *See supra* note 10 at Chapter 2.808.6(f) (February 2013). *See also J.T.*, Docket No. 17-1465 (issued September 25, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

[19] *J.T.*, Docket No. 18-1757 (issued April 19, 2019); *D.B.*, Docket No. 18-0409 (issued October 28, 2019).

[20] (GMFH - CDX)(1-1) + (GMPE - CDX)(1-1) = 0.

upper extremity permanent impairment finding based upon the ROM methodology. He explained that, pursuant to the A.M.A., *Guides*, because the DBI method yielded greater impairment, appellant had 10 percent permanent impairment of the right upper extremity. However, the DMA noted that since he was previously awarded 12 percent permanent impairment of the right upper extremity and the current impairment rating was included in that award, no additional impairment had been incurred.

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. Dr. Estaris accurately summarized the relevant medical evidence, provided detailed findings on examination, and reached conclusions about appellant's condition which comported with his findings.[21] In addition, the DMA properly utilized the DBI method and ROM method to rate appellant's right shoulder condition pursuant to FECA Bulletin No. 17-06. As the DMA's report is detailed, well rationalized, and based on a proper factual background, his opinion represents the weight of the medical evidence.[22] Thus, the Board finds that appellant has not met his burden of proof to establish greater right 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.

CONCLUSION

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 schedule award compensation.

[21] *M.S.*, Docket No. 19-1011 (issued October 29, 2019); *W.H.*, Docket No. 19-0102 (issued June 21, 2019); *J.M.*, Docket No. 18-1387 (issued February 1, 2019).

[22] *See M.S., id.*; *D.S.*, Docket No. 18-1816 (issued June 20, 2019).

ORDER

IT IS HEREBY ORDERED THAT the June 28, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 13, 2020
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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