United States Department of Labor
Employees' Compensation Appeals Board

L.J., Appellant	)	
and	)	**Docket No. 20-1044**
	)	**Issued: July 9, 2021**
U.S. POSTAL SERVICE, POST OFFICE, Vancouver, WA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 15, 2020 appellant filed a timely appeal from an October 29, 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 over the merits of this case.

ISSUE

The issue is whether appellant has established more than 12 percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On July 3, 2015 appellant, then a 55-year-old rural carrier, filed a traumatic injury claim (Form CA-1) alleging that on May 1, 2015 she sustained a right upper arm injury when she picked up an oversized and heavy package out of the back of the truck. OWCP accepted the claim for

[1] 5 U.S.C. § 8101 *et seq.*

right shoulder and upper arm sprains and subsequently expanded acceptance of the claim to include right rotator cuff muscle/tendon strain. It authorized right rotator cuff repair, right shoulder arthroscopic surgery, clavicle excision/reconstruction, and right arthroscopic biceps tenodesis surgery, which occurred on March 3, 2016 and repeat right rotator cuff repair surgery, which occurred on August 4, 2017.

In a May 21, 2019 report, Dr. Paul M. Puziss, a Board-certified orthopedic surgeon, diagnosed history of right rotator cuff repair, open distal clavicle resection, biceps tenodesis, limited arthroscopic glenohumeral debridement with acromioplasty, right rotator cuff arthroscopic revision and repair, currently healed mildly captured right shoulder and failed recent rotator cuff repair. Referring to Table 15-5, page 403 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[2] and the diagnosis-based impairment (DBI) method, he determined that appellant had a class of diagnosis (CDX) of 1, grade C impairment, for a primary diagnosis of rotator cuff tear with residual loss and functional with normal motion. Dr. Puziss derived a grade modifier for functional history (GMFH) of 2,[3] a grade modifier for physical examination (GMPE) of 1,[4] and a grade modifier for clinical studies (GMCS) of 2.[5] The net adjustment formula resulted in a plus 2 movement to the right, resulting in seven percent right upper extremity permanent impairment. Dr. Puziss also calculated appellant's permanent impairment using the range of motion (ROM) method, which was measured three times, pursuant to Table 15-34, page 475 to find three percent permanent impairment for 150 degrees of flexion, one percent impairment for 20 degrees of adduction, two percent impairment for 20 degrees external rotation and 70 degrees internal rotation, three percent impairment for 140 degrees, zero percent impairment for 50 degrees extension, no impairment for 70 degrees external rotation/abduction, two percent impairment for 70 degrees internal rotation, and three percent impairment for 160 degrees abduction, resulting in a total of eight percent impairment for her multiple rotator cuff repairs. Using Table 15-5, page 403 and diagnosis of distal clavicle resection, he determined appellant was a class 1 with 10 percent impairment according to Table 15-5, page 403. Dr. Puziss then combined the ROM and DBI impairment ratings, finding a total 18 percent right upper extremity permanent impairment.

On September 10, 2019 appellant filed a claim for a schedule award (Form CA-7).

On September 19, 2019 OWCP referred the case record to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA, for review. In a September 25, 2019 report, the DMA reviewed the medical record including the impairment rating by Dr. Puziss. Dr. Katz utilized the ROM method in Table 15-34, page 475 of the A.M.A., *Guides* to find three percent impairment for 150 degrees flexion, zero percent impairment for 50 degrees extension, three percent impairment for 160 degrees abduction, one percent impairment for 20 degrees adduction, zero percent impairment for 70 degrees internal rotation, and two percent impairment for 30 degrees external rotation, totaling nine percent right upper extremity permanent impairment due

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

[3] *Id.* at 406, Table 15-7.

[4] *Id.* at 408, Table 15-8.

[5] *Id.* at 410, Table 15-9.

to a 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, the diagnosis of distal clavicle resection yielded the highest impairment rating. Under Table 15-5, page 403, the DMA found CDX of 1 for the diagnosis of distal clavicle resection was with a default value of 10 percent impairment. Under Table 15-7, page 406, he found a GMFH of 2; under Table 15-8, page 408, he found a GMPE of 1; and under Table 15-9, page 410, he found a GMCS of 2. Utilizing the net adjustment formula calculation, the DMA found a net adjustment of 2,[6] which resulted in grade E or 12 percent permanent impairment for right shoulder distal clavicle resection. The DMA advised that the DBI method should be used as it provided the higher rating percentage of permanent impairment. He noted that ROM impairment for a given region cannot be combined with any other DBI impairment for the same region. Dr. Katz determined the date of maximum medical improvement (MMI) to be May 21, 2019, the date of Dr. Puziss' examination.

By decision dated October 29, 2019, OWCP granted appellant a schedule award for 12 percent permanent impairment of the right upper extremity. The award ran for 262.08 weeks from May 21, 2019 to February 7, 2020.

LEGAL PRECEDENT

The schedule award provisions of FECA,[7] and its implementing federal 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 loss of a member shall be determined. The method used in making such a determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[9] The Board has approved the 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.[10]

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[6] (GMFH - CDX)(2-1) + (GMPE - CDX)(1-1) + (CMCS - CDX)(2-1) = 2.

[7] *Supra* note 1 at § 8107.

[8] 20 C.F.R. § 10.404.

[9] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides* (6th ed. 2009); 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, Exhibit 1 (January 2010).

[10] *See T.J.*, Docket No. 19-1656 (issued September 18, 2020); *K.J.*, Docket No. 19-1492 (issued February 26, 2020); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

It is the claimant's burden of proof to establish permanent impairment of a scheduled member or function of the body as a result of an employment injury.[11] OWCP's procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred, describes the impairment in sufficient detail so that it can be visualized on review, and computes the percentage of impairment in accordance with the A.M.A., *Guides*.[12]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment CDX condition, which is then adjusted by GMFH, GMPE, and GMCS.[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14]

The A.M.A., *Guides* also provide that the ROM impairment methodology is to be used as a standalone 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 standalone 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 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 [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an*

[11] *See P.W.*, Docket No. 19-1493 (issued August 12, 2020); *T.H.*, Docket No. 19-1066 (issued January 29, 2020); *D.F.*, Docket No. 18-1337 (issued February 11, 2019); *Tammy L. Meehan,* 53 ECAB 229 (2001).

[12] *See* 5 U.S.C. § 8101(19); *J.K.*, Docket Nos. 19-1420 & 19-1422 (issued August 12, 2020); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

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

[14] *Id*. at 411.

[15] *Id*. at 461.

[16] *Id*. at 473.

[17] *Id.* at 474.

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

impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)[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 should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[20]

OWCP's 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 12 percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

In a permanent impairment evaluation dated May 21, 2019, Dr. Puziss advised that appellant had eight percent permanent impairment of the right upper extremity due to loss of ROM. He also advised that using the DBI method appellant had 10 percent permanent impairment due to distal clavicle resection. Dr. Puziss combined these impairments to find a total of 18 percent right upper extremity permanent impairment. If a claimant has two significant diagnoses, the examiner should use the diagnosis with the highest causally related impairment rating for the impairment calculation.[22] In addition, the A.M.A., *Guides* state that ROM measurements for a given region must standalone and not be combined with any DBI rating for the same region.[23] Dr. Puziss combined DBI and ROM methods for the same region instead of using the higher rated impairment rating as required by the A.M.A., *Guides.* As a result, Dr. Puziss' impairment rating did not comply with the A.M.A., *Guides* and his report is of limited probative value.[24]

The Board finds that Dr. Katz, OWCP's DMA, properly determined that appellant had no more than 12 percent permanent impairment of her right upper extremity. Utilizing the ROM methodology found in Table 15-34, page 475 of the A.M.A., *Guides*, the DMA found that appellant

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[19] *Id.*

[20] *Id.*; *see also H.H.*, Docket No. 19-1530 (issued June 26, 2020); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

[21] Federal (FECA) Procedure Manual, *supra* note 9 at Chapter 2.808.6(f); *P.W.*, Docket No. 19-1493 (issued August 12, 2020).

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

[23] *Id.*

[24] *See L.D.*, Docket No. 19-0495 (issued February5, 2020); *S.R.*, Docket No. 18-1307 (issued March 27, 2019).

had nine percent upper extremity permanent impairment. He calculated: 150 degrees flexion equaled three percent impairment; 50 degrees extension equaled zero percent impairment; 90 degrees abduction equaled three percent impairment; 20 degrees adduction equaled one percent impairment; 70 degrees internal rotation equaled zero percent impairment; and 30 degrees external rotation equaled two percent impairment. The Board notes, however, that pursuant to Table 15-34, page 475, 70 degrees of internal rotation equals two percent permanent impairment. Therefore, appellant's loss of ROM of the right shoulder totaled 11 percent permanent impairment.

The DMA properly noted that appellant had more than one diagnosis of the right upper extremity and found that the diagnosis of distal clavicle resection yielded the highest impairment rating. Under Table 15-5, page 405, a CDX 1 distal clavicle resection has a default impairment value of 10 percent impairment. The DMA assigned: under Table 15-7, page 406, GMFH of 2; under Table 15-8, page 408, GMPE of 1; and under Table 15-9, page 410, GMCS of 2. He properly calculated a net adjustment from the net adjustment formula,[25] which resulted in a grade E or 12 percent maximum permanent impairment for right 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 right 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 right upper extremity, for which she previously received a schedule award.[26]

CONCLUSION

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

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

[26] *See L.D.*, *supra* note 24; *M.H.*, Docket No. 19-0290 (issued June 18, 2019).

ORDER

IT IS HEREBY ORDERED THAT the October 29, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 9, 2021
Washington, DC

Alec J. Koromilas, 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