United States Department of Labor
Employees' Compensation Appeals Board

T.G., Appellant **and** **U.S. POSTAL SERVICE, KAUFMAN POST OFFICE, Kaufman, TX, Employer**	))))))))	**Docket No. 20-0660** **Issued: June 3, 2021**

Appearances:
Charles Westmoreland, for the appellant[1]
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 January 31, 2020 appellant, through his representative, filed a timely appeal from a November 25, 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.[3]

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[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 Boards 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.*

[3] The Board notes that, following the November 25, 2019 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 his burden of proof to establish greater than 14 percent permanent impairment of his left upper extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On August 19, 2014 appellant, then a 49-year-old distribution window clerk, filed a traumatic injury claim (Form CA-1) alleging that on August 5, 2014 he injured his left shoulder when he lifted a heavy parcel while in the performance of duty. OWCP initially accepted the claim for left sprain of the shoulder and upper arm and other affections of the left shoulder region not elsewhere classified.[4]

On November 12, 2014 appellant underwent OWCP-approved surgical procedures of mini open rotator cuff repair of the left shoulder with acromioplasty and arthroscopic distal clavicle excision of the left shoulder.

In a report dated May 5, 2015, Dr. John Teig Port, a Board-certified orthopedic surgeon, applied the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] to his examination findings. He opined that appellant had 17 percent left upper extremity permanent impairment.

On May 18, 2015 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated June 5, 2015, OWCP informed appellant that the medical evidence submitted was insufficient to support appellant's claim. It advised him of the type of medical evidence needed and afforded him 30 days to submit the necessary medical evidence.

In a report dated October 1, 2015, Dr. Jeff Zhao, an osteopathic physician Board-certified in orthopedic surgery, related that appellant sustained a work-related injury on August 5, 2014. Appellant underwent a left shoulder open rotator cuff procedure in November 2014, but was told that the tear was too large and only partially reparable. He complained of reduced left shoulder overhead function and pain, as well as right shoulder pain due to compensatory actions. Dr. Zhao diagnosed complete rotator cuff tear or rupture of the left shoulder, left shoulder impingement syndrome, and displacement of the internal fixation device of the left humerus. He recommended revision and repair surgery to include extraction of loose hardware in the subacromial space.

In a letter dated October 28, 2015, OWCP informed appellant that, as Dr. Zhao had recommended left shoulder revision repair surgery, appellant's condition had not yet reached

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[4] Under OWCP File No. xxxxxx561, appellant has a previously-accepted occupational disease claim (Form CA-2) for bilateral wrist conditions, involving upper extremity nerve damage, which arose on or about November 2, 2010. OWCP granted him a schedule award for three percent permanent impairment of the left upper extremity on June 14, 2013. Appellant's claims have not been administratively combined by OWCP. The case record associated with her accepted bilateral wrist and upper extremity nerve conditions is therefore not currently before the Board.

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

maximum medical improvement (MMI) and therefore no additional action could be taken on his schedule award claim at that time.

On November 20, 2015 appellant underwent OWCP-approved left shoulder arthroscopy with rotator cuff repair, subacromial decompression and partial acromioplasty with extensive labral debridement, tenotomy of the shoulder area, and removal of hardware.

On May 12, 2017 appellant filed a claim for a schedule award (Form CA-7).

In a March 2, 2017 report, Dr. Rory Allen, an osteopathic physician specializing in family medicine, applied the sixth edition of the A.M.A., *Guides*[6] to appellant's examination findings of the same date. He indicated that appellant had reached MMI as of February 21, 2017. Dr. Allen obtained three measurements of appellant's left shoulder's flexion, extension, abduction, adduction, internal rotation, and external rotation, resulting in the following rounded averages: 100, 40, 90, 30, 20, and 30. Utilizing the sixth edition of the A.M.A., *Guides*, he calculated that appellant had 16 percent impairment of his left upper extremity based on the range of motion (ROM) method for left rotator cuff injury. Referencing Table 15-5, page 403, of the A.M.A., *Guides*, Dr. Allen noted that appellant did not have ROM of his left shoulder, and therefore the ROM method would be used to rate appellant's impairment. He referred to Table 15-34 for shoulder ROM and found that appellant's measured total of 16 percent upper extremity impairment (3 percent for flexion, 1 percent for extension, 3 percent for abduction, 1 percent for adduction, 4 percent for internal rotation, and 2 percent for external rotation) resulted in a grade modifier of 2 for ROM per Table 15-35. Dr. Allen found that appellant's grade modifier for functional history (GMFH) was 2 due to pain and symptoms with normal activity, use of medication to control symptoms, and ability to perform modified self-care activities unassisted. Applying the net adjustment formula resulted in no adjustment, and thus he calculated 16 percent permanent impairment of appellant's left upper extremity based on the ROM methodology.

Regarding appellant's diagnosis of status post distal clavicle resection, Dr. Allen calculated that appellant had 12 percent impairment of the left upper extremity using the diagnosis-based impairment (DBI) method. He noted a class of diagnosis (CDX) of 1, grade C with a default of 10 percent upper extremity impairment according to Table 15-5. The GMFH was 2 due to pain and symptoms with normal activity, use of medication to control symptoms, and ability to perform modified self-care activities unassisted per Table 15-7. The grade modifier for physical examination (GMPE) was 2 due-to-moderate palpatory findings according to Table 15-8. Dr. Allen found a grade modifier for clinical studies (GMCS) of 1 per Table 15-9. Applying the net adjustment formula resulted in an adjustment of 2, raising the 10 percent default value to 12 percent permanent impairment of the left upper extremity.

Referring to Appendix A, Combined Values Chart, page 604, Dr. Allen added the 16 percent impairment calculated using the ROM method and the 12 percent impairment calculated using the DBI method to arrive at a total left upper extremity permanent impairment of 26 percent.

OWCP thereafter routed Dr. Allen's report, a statement of accepted facts (SOAF), and the case file to Dr. Jovito Estaris, a Board-certified occupational medicine physician serving as an OWCP district medical adviser (DMA). In a June 24, 2017 report, the DMA found that appellant

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

had 14 percent permanent impairment of the left upper extremity based on the ROM methodology of evaluating permanent impairment under the A.M.A., *Guides*. His calculation utilized the measurements of appellant's left shoulder ROM from Dr. Allen's report. However, the DMA found that appellant had a GMFH of 2 for pain on regular activity. Applying the net adjustment formula resulted in no adjustment, and thus the DMA found that appellant had 14 percent permanent impairment of the left upper extremity based on the ROM method. Applying the DBI rating method for a diagnosis of rotator cuff injury resulted in seven percent permanent impairment of the left upper extremity. The DMA concluded that the ROM rating was higher and therefore appellant had 14 percent permanent impairment of the left upper extremity. Citing page 387 of the A.M.A., *Guides*, the DMA explained that his rating differed from Dr. Allen's because Dr. Allen had improperly combined impairment ratings using the DBI and ROM methodologies.

In a letter dated October 10, 2017, Dr. Allen concurred with the DMA's upper extremity impairment rating of 14 percent.

OWCP requested a supplemental report from the DMA on November 24, 2017, asking that he stipulate whether the percentage provided included the prior three percent schedule award appellant had been granted for his left upper extremity, or if it should be considered an addition to the prior percentage awarded.

In a letter dated November 29, 2017, the DMA noted that if the prior award of 3 percent was for the left shoulder, the additional award would be 11 percent for the left upper extremity.

By decision dated December 22, 2017, OWCP granted appellant a schedule award for 14 percent permanent left shoulder impairment. The award ran for 43.68 weeks for the period December 10, 2017 through January 6, 2018. OWCP found that as appellant's prior award of three percent was for the left wrist, rather than the left shoulder, and no subtraction was necessary for a prior award.

OWCP, on April 27, 2018, expanded its acceptance of appellant's claim to include other reduction defects of the left upper limb, primary osteoarthritis of the left shoulder, and right shoulder sprain.

On November 9, 2018 appellant filed a claim for an additional schedule award (Form CA-7).

In a May 1, 2018 report, Dr. Allen applied the sixth edition of the A.M.A., *Guides* to his examination findings of the same date. He indicated that appellant had reached MMI as of that date. Dr. Allen obtained three measurements of appellant's left shoulder's flexion, extension, abduction, adduction, internal rotation, and external rotation, resulting in the following measurements: 99, 100, 100 for flexion; 46, 47, 47 for extension; 94, 95, 96 for abduction; 38, 37, 38 for adduction; 18, 19, 20 for internal rotation; and 28, 30, 30 for external rotation. Utilizing the sixth edition of the A.M.A., *Guides*, he determined that appellant had 14 percent upper extremity impairment under the ROM methodology. Regarding appellant's diagnosis of status post distal clavicle resection, Dr. Allen calculated that appellant had 12 percent impairment of the left upper extremity using the DBI method. He noted a CDX of 1, grade C with a default of 10 percent upper extremity impairment according to Table 15-5. The GMFH was 2 due to a *Quick*DASH score of 52 per Table 15-7. The GMPE was 2 due to moderate palpatory findings according to Table 15-8.

Dr. Allen found a GMCS of 1 per Table 15-9. Applying the net adjustment formula resulted in an adjustment of 2, raising the 10 percent default value to 12 percent permanent impairment of the left upper extremity. Dr. Allen added appellant's 14 percent impairment for a left rotator cuff full thickness tear calculated under the ROM method to the 12 percent impairment for status post distal clavicle resection calculated under the DBI method to arrive at a total left upper extremity impairment rating of 26 percent.

On November 26, 2018 OWCP routed Dr. Allen's May 1, 2018 report, a SOAF, and the case file to the DMA for review and a determination of appellant's permanent impairment. In a January 21, 2019 report, the DMA reviewed Dr. Allen's May 1, 2018 report and calculated that, under the DBI method for a left shoulder rotator cuff injury, appellant would have seven percent permanent impairment of the left upper extremity. Under the ROM method, the DMA referenced his ROM examination findings on May 1, 2018, finding the following upper extremity ROM impairments for flexion, extension, abduction, adduction, internal rotation, and external rotation: 3, 0, 3, 0, 4, and 2. Dr. Allen found that the ROM grade modifier was 2 and the GMFH was 2, so there was no net adjustment. Noting that the ROM method produced the higher rating, he concluded that appellant had 12 percent permanent impairment of the left upper extremity. The DMA explained that his rating differed from the 26 percent rating of Dr. Allen because Dr. Allen had again improperly combined an impairment rating under the DBI method for the distal clavicle with an impairment rating under the ROM method for the rotator cuff injury. He noted that page 387 of the A.M.A., *Guides* stated that "when rating rotator cuff injury/impingement or glenohumeral pathology/surgery, incidental resection arthroplasty of the [acromioclavicular (AC)] joint is not rated." After noting appellant's previous award for three percent permanent impairment of the left upper extremity for median and ulnar neuropathy, the DMA explained that the current impairment rating was separate, because it was for the left shoulder joint. He stated that appellant's current impairment rating of 12 percent was an additional impairment for the left upper extremity. The DMA added the 12 percent to the 3 percent for a total of 15 percent left upper extremity impairment. He indicated that appellant's date of MMI was May 1, 2018.

By decision dated June 20, 2019, OWCP denied appellant's claim for an additional schedule award based on impairment greater than that already paid. It noted that he had previously been paid a schedule award of 14 percent for the left upper extremity on December 22, 2017 and had previously been paid 3 percent for the left upper extremity in OWCP File No. xxxxxx561.

On August 2, 2019 appellant, through his representative, requested reconsideration of the June 20, 2019 decision. The representative argued that the report of the DMA indicated 12 percent additional impairment above the 14 percent and 3 percent previously awarded, for a total left shoulder impairment rating of 29 percent.

In a follow-up report dated July 17, 2019, Dr. Allen examined appellant for complaints of bilateral shoulder pain. On physical examination of the shoulders, he observed that appellant had reduced active ROM in the right shoulder and weakness with abduction, as well as positive impingement and Hawkins tests of the right shoulder. Dr. Allen diagnosed left shoulder osteoarthritis, left shoulder impingement syndrome, other reduction deficits of the left upper limb, and bilateral shoulder joint sprain. He recommended continuation of physical therapy. On August 15, 2019 Dr. Allen observed 4/5 muscle strength of the left shoulder on flexion, abduction, and internal and external rotation on physical examination, with otherwise full muscle strength of the left shoulder.

A magnetic resonance imaging scan of appellant's left shoulder taken on August 29, 2019 demonstrated postsurgical changes, partial tearing and thinning of the infraspinatus, full thickness tearing within the supraspinatus, and muscle atrophy of the *supra*- and infraspinatus muscles.

In a follow-up report dated September 16, 2019, Dr. Allen examined appellant's shoulders, observing a positive Hawkins test bilaterally and a positive empty can test on the left, along with continued reduced strength of the left shoulder. He diagnosed left shoulder osteoarthritis, left shoulder impingement syndrome, other reduction deficits of the left upper limb, and bilateral shoulder joint sprain.

In a report dated November 12, 2019, Dr. Zhao examined appellant for complaints of bilateral shoulder pain. On physical examination of the shoulders, he observed a questionably positive right O'Brien's test and mild tenderness to palpation over the right biceps groove. Dr. Zhao diagnosed right rotator cuff sprain, a superior glenoid labrum lesion of the right shoulder, impingement syndrome of the right shoulder, and a complete rotator cuff tear or rupture of the left shoulder.

By decision dated November 25, 2019, OWCP again denied appellant's claim for an additional schedule award for his accepted left upper extremity conditions. It noted that his current rating derived from Dr. Allen's May 1, 2018 report was 14 percent for the left upper extremity using the ROM method. OWCP found that, as appellant had already been paid a schedule award for 14 percent of the left upper extremity on December 22, 2017, no additional schedule award compensation was currently due.

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 of a member 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 has 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 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]

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[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] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also id.* Chapter 3.700.2 and Exhibit 1 (January 2010).

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

Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment for the CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS and the net adjustment formula is applied. 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[12] 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 permanent impairment specified.[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:

> "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*

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

[13] *M.S.*, Docket No. 19-0282 (issued August 2, 2019); *supra* note 10 at Chapter 2.808.6f (March 2017).

[14] A.M.A., *Guides* 461.

[15] *Id.* at 473.

[16] *Id.* at 474.

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

impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)[18]

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]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 14 percent permanent impairment of his left upper extremity, for which he previously received schedule award compensation.

To determine the permanent impairment of appellant's left upper extremity, the DMA reviewed Dr. Allen's May 1, 2018 clinical findings, diagnoses, and his calculations of 14 percent impairment for a left rotator cuff full thickness tear calculated under the ROM method along with the 12 percent impairment for status post distal clavicle resection calculated under the DBI method for a total left upper extremity impairment of 26 percent. In his January 21, 2019 report, he calculated that, under the DBI method for a left shoulder rotator cuff injury, appellant would have seven percent permanent impairment of the left upper extremity. Using the ROM method, the DMA referenced Dr. Allen's ROM examination findings of May 1, 2018. He found that the ROM grade modifier was 2 and the GMFH was 2, so there was no net adjustment. The DMA calculated 12 percent permanent impairment of the left upper extremity, noting that the ROM method produced the higher rating. He related that appellant had previously received three percent schedule award for the left upper extremity in 2013. The DMA explained that his rating differed from the 26 percent rating of Dr. Allen because Dr. Allen had improperly combined an impairment rating under the DBI method for the distal clavicle with an impairment rating under the ROM method for the rotator cuff injury. He related that page 387 of the A.M.A., *Guides* stated that "when rating rotator cuff injury/impingement or glenohumeral pathology/surgery, incidental resection arthroplasty of the AC joint is not rated." After noting appellant's previous award for three percent for the left upper extremity for median and ulnar neuropathy, the DMA explained that the current impairment rating was separate from that three percent rating, because it was for the left shoulder joint. He stated that appellant's current impairment rating of 12 percent was an additional impairment for the left upper extremity.

The Board finds that the DMA properly determined that appellant had not established greater than 14 percent permanent impairment of the left upper extremity. The DMA's statement that appellant's impairment rating of 12 percent under the ROM method, based on Dr. Allen's May 1, 2018 examination, was an "additional" impairment for the left upper extremity, did not indicate that appellant had an additional impairment of 12 percent above the 14 percent already

[18] *See* A.M.A., *Guides* 477.

[19] *Id*. at 474; *P.W.*, Docket No. 19-1493 (issued August 12, 2020); *A.R.*, Docket No. 19-1284 (issued January 14, 2020); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

paid as a schedule award for his left shoulder conditions. Rather, this statement was in reference to appellant's prior schedule award of three percent for the left upper extremity under OWCP File No. xxxxxx561. The DMA properly explained that the 12 percent ROM impairment rating based on the examination of May 1, 2018 was higher than the 7 percent DBI impairment rating.[20] Appellant previously received a schedule award for 14 percent permanent impairment of the left upper extremity on December 22, 2017. Both Dr. Allen and the DMA concurred with each other at that time as to the 14 percent permanent impairment rating. The DMA had previously explained in his report of June 24, 2017 that Dr. Allen improperly combined impairment ratings using the DBI method and the ROM method in his report of March 2, 2017 as he did again in his report of May 1, 2018. There is no medical evidence of record, properly applying the sixth edition of the A.M.A., *Guides*, establishing greater than 14 percent permanent impairment of the left upper extremity.

Therefore, the Board finds that appellant has not submitted probative medical evidence to establish more than 14 percent permanent impairment of his left upper extremity, due to his left shoulder conditions under this claim. As such, an additional schedule award is not warranted.

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 14 percent permanent impairment of his left upper extremity, for which he previously received schedule award compensation.

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[20] *See supra* note 18.

ORDER

IT IS HEREBY ORDERED THAT the November 25, 2019 decision of the Office of Workers' Compensation Programs is affirmed.[21]

Issued: June 3, 2021
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

[21] Upon return of the case record OWCP should consider administratively combining the present claim with OWCP File No. xxxxxx561.