United States Department of Labor
Employees' Compensation Appeals Board

D.S., Appellant	)	
and	)	**Docket No. 20-1469**
	)	**Issued: June 29, 2021**
DEPARTMENT OF THE NAVY, MILITARY SEALIFT COMMAND, Norfolk, VA, Employer	)	

Appearances:
Capp P. Taylor, 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 August 1, 2020 appellant, through his representative, filed a timely appeal from a July 9, 2020 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 to consider 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 more than 10 percent permanent impairment of the right upper extremity for which he previously received a schedule award.

FACTUAL HISTORY

On April 26, 2016 appellant, then a 58-year-old able seaman, filed a traumatic injury claim (Form CA-1) alleging that on April 22, 2016 he sustained blunt trauma to his right arm and right knee when he fell approximately two feet off a short ladder while dogging a watertight door in the performance of duty. He stopped work on the date of injury and returned to full-time regular-duty work with no restrictions on April 23, 2016. OWCP accepted appellant's claim for right shoulder labral tear.

On November 28, 2017 Dr. Kevin M. Kaplan, an attending Board-certified orthopedic surgeon, performed authorized right shoulder arthroscopy with extensive debridement of labrum, chondroplasty of the humeral head and glenoid, synovectomy, and arthroscopic biceps tenodesis. OWCP paid appellant wage-loss compensation for intermittent periods of disability from September 18, 2016 through March 31, 2018.[3]

In an April 30, 2018 medical report, Dr. Kaplan noted findings on examination of appellant's right shoulder. He reported full, active range of motion (ROM), five out of five strength resisted abduction and resisted internal/external rotation, and intact sensation. Dr. Kaplan provided impressions of improved right shoulder pain and right superior glenoid labrum lesion. He related that appellant was five months status post right shoulder arthroscopy with glenohumeral joint debridement and biceps tenodesis. Appellant was doing well and would be allowed to advance himself to tolerance. Dr. Kaplan advised that appellant had reached maximum medical improvement (MMI), and that he had zero percent permanent impairment according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

A March 21, 2019 report by Dr. Mark A. Seldes, a Board-certified family practitioner, noted appellant's history of injury on April 22, 2018 and related that, since that date, he had been unable to work. He provided examination findings, including decreased ROM of the right shoulder. Dr. Seldes opined that appellant reached MMI on the date of his evaluation. Utilizing the diagnosis-based impairment (DBI) rating method found at Table 15-5 on page 402 of the sixth edition of the A.M.A., *Guides*, Dr. Seldes noted that appellant had a class of diagnosis (CDX) of 1 with a default value of five percent for residual symptoms and consistent objective findings for a diagnosis of right shoulder superior labrum anterior and posterior (SLAP) tear. He assigned a grade modifier for functional history (GMFH) of 2 for pain and symptoms with normal activities and use of medication to control symptoms. Dr. Seldes also assigned a grade modifier for physical examination (GMPE) of 2 for moderate palpatory findings consistently documented and supported

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[3] Appellant retired from the employing establishment, effective March 31, 2018.

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

by observed abnormalities. He indicated that a grade modifier for clinical studies (GMCS) was not applicable because it was used to make the diagnosis. Dr. Seldes applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (2 - 1) + (2 -1) = 2, which moved the default value two spaces to the right resulting in a class 1, grade E or five percent permanent impairment of the right upper extremity. He noted that, since appellant did not have normal ROM of his right shoulder joint, the A.M.A., *Guides* allowed him to alternatively assess his impairment under Table 15-31 on page 475 as a stand-alone ROM impairment. Dr. Seldes found that, under Table 15-31, appellant had 25 percent right upper extremity permanent impairment, noting that the greatest of three measurements was used to calculate permanent impairment. He determined that 65 degrees of flexion represented 9 percent permanent impairment, 15 degrees of extension, 0 degrees of adduction, and 40 degrees of external rotation each represented 2 percent permanent impairment, 60 degrees of abduction represented 6 percent permanent impairment, and 10 degrees of internal rotation represented 4 percent permanent impairment, for a total permanent impairment of 25 percent. Dr. Seldes opined that appellant had 25 percent permanent impairment of the right upper extremity based on the ROM rating method, which was greater than the 5 percent permanent impairment based on the DBI rating method.

On June 19, 2019 appellant filed a claim for a schedule award (Form CA-7).

On August 27, 2019 OWCP referred the medical evidence and SOAF to Dr. Jovito Estaris, Board-certified in occupational and preventive medicine, serving as an OWCP district medical adviser (DMA), to review the findings in the March 21, 2019 report by Dr. Seldes. In a September 6, 2019 report, the DMA recommended that appellant undergo a second opinion evaluation with a Board-certified orthopedic surgeon because there were inconsistencies between the findings of Dr. Kaplan and Dr. Seldes regarding whether appellant had reached MMI and sustained right shoulder ROM loss.

OWCP subsequently referred appellant, along with a statement of accepted facts and the medical record, to Dr. Fady El-Bahri, a Board-certified orthopedic surgeon, for a second opinion examination.

In an October 29, 2019 report, Dr. El-Bahri noted that on physical examination of the right shoulder there was tenderness over biceps and supraspinatus tendons on palpation, a positive Neer impingement test, and a moderate crepitation test. ROM measurements included 100 degrees of flexion, 15 degrees of extension, 100 degrees of abduction, 10 degrees of adduction, 45 degrees of internal rotation, and 7 degrees of external rotation. Dr. El-Bahri diagnosed right shoulder labral tear and impingement syndrome. Utilizing the DBI rating method found at Table 15-5 on page 404 of the sixth edition of the A.M.A., *Guides*, he determined that appellant had a CDX of 1 for a labral tear. Dr. El-Bahri assigned a grade modifier 1 for GMFH for pain and symptoms while performing strenuous activities although appellant could perform activities of daily living independently based on Table 15-7 on page 406. He assigned a grade modifier 1 for GMPE for mildly restricted ROM under Table 15-8 on page 408. Dr. El-Bahri assigned a grade modifier 2 for GMCS as a magnetic resonance arthrogram (MRA) confirmed a labral tear based on Table 15-9 on page 410. He applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1- 1) + (1 - 1) + (2 - 1) = +1, which moved the default value one space to the right resulting in a class 1, grade D or four percent permanent impairment of the right upper extremity. Dr. El-Bahri also utilized the ROM rating method and provided three sets of measurements. He found that, under Table 15-34 on page 475, 100 degrees of flexion yielded 3 percent permanent

impairment, 15 degrees of extension yielded 2 percent permanent impairment, 100 degrees of abduction yielded 3 percent permanent impairment, 10 degrees of adduction yielded 1 percent permanent impairment, 45 degrees of internal rotation yielded 2 percent permanent impairment, and 70 degrees of external rotation yielded 0 percent permanent impairment, totaling 11 percent permanent impairment. Referring to Table 15-34 on page 477, Dr. El-Bahri assigned a grade modifier 1 for the 11 percent ROM impairment rating. He assigned a grade modifier 1 for GMFH under Table 15-7 on page 406. Dr. El-Bahri found that no modification of the 11 percent impairment rating was required in accordance with Table 15-36 on page 477. He concluded that appellant had 11 percent right upper extremity permanent impairment based on the ROM rating method as it was greater than the 4 percent permanent impairment rating under the DBI rating method. Dr. El-Bahri determined that appellant reached MMI on the date of his impairment evaluation.

On December 26, 2019 the DMA, Dr. Estaris, reviewed the medical record, including Dr. El-Bahri's October 29, 2019 findings. Utilizing the DBI rating method, under Table 15-5 on page 404, he determined that a CDX of labral tear with biceps tendinitis with residual symptoms and motion deficient represented a class 1 impairment with a default value of three percent. The DMA assigned a grade modifier of 1 for GMFH due to pain over the right shoulder on increase activity, under Table 15-7 on page 406. He assigned a grade modifier of 2 for GMPE due to tender right shoulder with ROM deficits and weakness, under Table 15-8 on page 408. The DMA assigned a grade modifier of 4 for GMCS as an MRA of the right shoulder showed labral lesion and biceps tendinitis, under Table 15-9 on page 410. He applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1 - 1) + (2 - 1) + (4 - 1) = 4, which moved the default value two spaces to the right resulting in a class 1, grade E, five percent permanent impairment of the right upper extremity. Additionally, the DMA utilized the ROM rating method to determine permanent impairment to the right shoulder and found that, under Table 15-34 on page 475, 100 degrees of flexion and 100 degrees of abduction each yielded three percent permanent impairment, "20 degrees (15 rounded)" of extension and 10 degrees of adduction each yielded 1 percent permanent impairment, 70 degrees of external rotation yielded 0 percent permanent impairment, and "50 degrees (45 rounded)" of internal rotation yielded 2 percent permanent impairment, resulting in 10 percent permanent impairment of the right upper extremity. Utilizing Table 15-35 and Table 15-36 on page 477, the DMA assigned a grade modifier 1 for the 10 percent ROM impairment rating and a grade modifier 1 for functional history that resulted in no change. He concluded that appellant had 10 percent right upper extremity permanent impairment based on the ROM method as it yielded greater permanent impairment than the DBI rating method. The DMA advised that he reached MMI on October 29, 2019, the date of Dr. El-Bahri's impairment evaluation. Further, he noted that the main discrepancy between his and Dr. El-Bahri's use of the ROM rating method was the assignment of an impairment rating for loss of extension. The DMA indicated that Dr. El-Bahri found two percent permanent impairment rating while Table 15-34 on page 475 indicated that two percent impairment rating was for 10 degrees of extension to 10 degrees of flexion. The DMA noted that the measurement for extension was "15 degrees which is rounded to 20 degrees," and was closer to the one percent impairment rating for loss of extension. The DMA related that his calculation reduced the total ROM impairment rating to 10 percent permanent impairment of the right upper extremity. He also noted that the main discrepancy between his and Dr. El-Bahri's use of the DBI rating method was the assignment of a grade modifier for GMCS. The DMA related that labral lesions with biceps tendon pathology, under Table 15-9 on page 410, represented a grade modifier of 4 for GMCS, which

moved the default value two places to the right, resulting in a class 1, grade E or five percent permanent impairment of the right upper extremity.

OWCP, by decision dated January 2, 2020, granted appellant a schedule award for 10 percent permanent impairment of the right arm. The period of the award ran for 31.2 weeks from October 29, 2019 through June 3, 2020 and was based on the December 26, 2019 impairment rating of OWCP's DMA.

On June 16, 2020 appellant requested reconsideration. In support of his request, he submitted an additional report dated January 29, 2020 from Dr. Seldes who reiterated his prior diagnoses of severe glenoid labrum lesion in the right shoulder and left shoulder impingement syndrome, consequential injury. Dr. Seldes also noted that appellant appeared to have adhesive capsulitis in the right shoulder. He expressed his concern that he would soon develop frozen shoulder. Dr. Seldes reviewed Dr. El-Bahri's October 29, 2019 findings. He indicated that Dr. El-Bahri's ROM measurements were inconsistent with his own ROM measurements, which he performed over three times. Dr. Seldes related that appellant reported to him that Dr. El-Bahri only performed a ROM measurement one time. Therefore, he concluded that, since there were inconsistencies in Dr. El-Bahri's examination of appellant, which were relied upon by OWCP's DMA, appellant must undergo a referee examination.

On July 3, 2020 the DMA reviewed Dr. Seldes' January 29, 2020 report. He noted that, although Dr. Seldes provided ROM measurements for both shoulders, he did not provide an impairment rating. The DMA reiterated his prior opinion that appellant had 10 percent permanent impairment of the right upper extremity.

By decision dated July 9, 2020, OWCP denied modification of its January 2, 2020 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing regulations[6] 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.[7] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[8] The Board has approved the use

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

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

[8] *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).

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.[9]

In determining 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. With regard to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401. After the CDX is determined from the Shoulder Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10]

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).
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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 impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)
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> "If the rating physician provided an assessment using the DBI 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.
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> "If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence."[11]

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

[10] *See* A.M.A., *Guides* (6th ed.) 405-12. Table 15-5 also provides that, if motion loss is present for a claimant with certain diagnosed conditions, permanent impairment may alternatively be assessed using Section 15.7 (ROM impairment). Such a ROM assessment stands alone and is not combined with a DBI rating. *Id.* at 401-05, 475-78.

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

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 the medical adviser providing rationale for the percentage of impairment specified.[12]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than 10 percent permanent impairment of the right upper extremity for which he previously received a schedule award.

In his December 26, 2019 report, the DMA properly calculated appellant's right upper extremity impairment in accordance with the sixth edition of the A.M.A., *Guides*. Utilizing the DBI rating method, under Table 15-5, page 404, he found that appellant's diagnosis of labral tear with biceps tendinitis with residual symptoms and motion deficient represented a CDX of 1 impairment, thereby warranting a default value of three percent permanent impairment. The DMA applied a GMFH of 1 under Table 15-7, page 406, a GMPE of 2 under Table 15-8, page 408, and a GMCS of 4 under Table 15-9, page 410. He applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1 - 1) + (2 - 1) + (4 - 1) = 4, which moved the default value two spaces to the right resulting in a class 1, grade E or five percent permanent impairment of the right upper extremity. He also utilized the ROM rating method to determine permanent impairment to the right shoulder. Utilizing Table 15-34, page 475, he determined that 100 degrees of flexion and 100 degrees of abduction each yielded 3 percent permanent impairment, 20 degrees (15 degrees rounded up) of extension and 10 degrees of adduction each yielded 1 percent permanent impairment, 70 degrees of external rotation yielded 0 percent permanent impairment, and "50 degrees (45 rounded)" of internal rotation yielded 2percent permanent impairment, resulting in 10 percent permanent impairment of the right upper extremity. Utilizing Table 15-35 and Table 15-36 on page 477, the DMA assigned a grade modifier 1 for the 10 percent ROM impairment rating and a GMFH of 1 that resulted in no change. He concluded that appellant had 10 percent right upper extremity permanent impairment under the ROM method as it resulted in greater impairment than the DBI rating method. The Board finds that the DMA correctly concluded that the total permanent impairment of appellant's right upper extremity was 10 percent.

The case record contains reports of Dr. Seldes, an attending physician, and Dr. El-Bahri, an OWCP referral physician, but the Board finds that their impairment rating analyses are of little probative value because neither physician adequately explained how his calculations were conducted in accordance with the standards of the sixth edition of the A.M.A., *Guides*.[13] The DMA properly identified the deficiencies in both physicians' impairment rating analyses. Regarding Dr. Seldes' March 21, 2019 report in which he opined that appellant had 25 percent permanent impairment of the right upper extremity based on the ROM rating method, the DMA explained that his findings were inconsistent with the findings of Dr. Kaplan, an attending

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[12] *See supra* note 7 at Chapter 2.808.6(f) (March 2017); *see D.J.,* Docket No. 19-0352 (issued July 24, 2020).

[13] *See J.H.,* Docket No. 19-0395 (issued August 10, 2020); *N.A.,* Docket No. 19-0248 (issued May 17, 2019); *James Kennedy, Jr.,* 40 ECAB 620, 626 (1989) (an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).

physician, who opined that appellant had zero percent permanent impairment of the right upper extremity, as to whether appellant had reached MMI and sustained right shoulder ROM loss. He, thus, recommended a second opinion impairment evaluation. The DMA subsequently reviewed Dr. Seldes' January 29, 2020 report and correctly noted that the physician did not offer an impairment rating.

Regarding Dr. El-Bahri's October 29, 2019 report, the DMA explained that Dr. El-Bahri improperly found that appellant had two percent permanent impairment of the right upper extremity for 15 degrees of extension under the ROM rating method as 2 percent impairment rating under Table 15-34, page 475, applied to 10 degrees of extension to 10 degrees of flexion. He rounded up the 15 degrees of extension to 20 degrees of extension, which he determined was closer to one percent impairment rating for loss of extension. The DMA advised that the one percent impairment rating for loss of extension reduced the total ROM impairment rating to 10 percent permanent impairment of the right upper extremity. Regarding the determination of right upper extremity permanent impairment under the DBI rating method, he explained that Dr. El-Bahri improperly assigned a grade modifier 2 for GMCS. The DMA noted that labral lesions with biceps tendon pathology, under Table 15-9 on page 410, warranted a GMCS of 4, which moved the default value two places to the right, resulting in a class 1, grade E or five percent permanent impairment of the right upper extremity.

The Board finds that the DMA properly applied the A.M.A., *Guides* to find that appellant had no more than 10 percent permanent impairment of the right upper extremity for which he previously received schedule award compensation. Dr. Estaris' report is detailed, well rationalized, and based on a proper factual background and, thus, his opinion represents the weight of the medical evidence.[14] As such, the Board finds that appellant has not met his burden of proof to establish greater right upper extremity permanent impairment than what was 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 more than 10 percent permanent impairment of the right upper extremity for which he previously received a schedule award.

[14] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the July 9, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 29, 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