United States Department of Labor
Employees' Compensation Appeals Board

J.D., widow of J.D., Appellant	)	
and	)	**Docket No. 19-1168**
	)	**Issued: March 29, 2021**
DEPARTMENT OF DEFENSE, DEFENSE COMMISSARY AGENCY, Camp Pendleton, CA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On April 30, 2019 appellant, through counsel, filed a timely appeal from a February 15, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met her burden of proof to establish that the employee had more than 13 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On March 15, 2003 the employee, then a 52-year-old meat cutter, filed a traumatic injury claim (Form CA-1) alleging that on that date he injured his left shoulder lifting a piece of meat while in the performance of duty. OWCP assigned the claim OWCP File No. xxxxxx748 and accepted it for an aggravation of a left rotator cuff tear.[3]

On February 14, 2003 the employee underwent an arthroscopic subacromial decompression and coupling of the distal clavicle of the left shoulder. On May 27, 2003 he underwent a left shoulder mini open rotator cuff repair and on January 30, 2004 he underwent a left shoulder mini open rotator cuff repair and lysis of adhesions.

In a report dated September 24, 2004, Dr. Thomas Wenyeh Wang, a Board-certified family practitioner, diagnosed a left shoulder rotator cuff tear and retear, status post repairs. He provided range of motion (ROM) measurements for the left upper extremity.

On October 25, 2006 Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), applied the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] to Dr. Wang's clinical findings. He determined that the employee had 6 percent impairment of the left upper extremity due to loss of ROM of the left shoulder and 6 percent impairment due to left shoulder muscle weakness, for a total left upper extremity permanent impairment of 13 percent.

By decision dated November 29, 2007, OWCP granted the employee a schedule award for 13 percent permanent impairment of the left upper extremity.[5] The award was for 40.56 weeks and ran from the period November 25, 2007 to September 3, 2008.

[3] OWCP previously accepted under OWCP File No. xxxxxx242 that on October 31, 2002 the employee sprained his left rotator cuff. It also accepted under OWCP File No. xxxxxx555 that on December 18, 2002 he sprained/strained his left shoulder. OWCP has administratively combined OWCP File Nos. xxxxxx242, xxxxxx555 and xxxxxx748 with the later serving as the master file.

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

[5] By decision dated November 9, 2007, OWCP reduced the employee's wage-loss compensation, effective November 25, 2007, after finding that he had the capacity to earn wages in the selected position of computer support technician. By decision dated June 26, 2008, an OWCP hearing representative affirmed the November 9, 2007 decision, and by decision dated November 19, 2008, OWCP denied modification of the June 26, 2008 decision. OWCP subsequently accepted that the employee sustained a recurrence of disability and paid him wage-loss compensation for total disability on the periodic rolls beginning March 15, 2009.

On March 3, 2009 the employee underwent arthroscopic surgery with a mini open rotator cuff repair of the left shoulder.[6]

On June 10, 2015 OWCP expanded its acceptance of the claim to include aggravation of left shoulder arthritis.

The employee underwent a functional capacity evaluation (FCE) on November 19, 2015. The FCE provided ROM measurements for the shoulders bilaterally.

In a report dated April 11, 2017, Dr. Wang reviewed the results from the November 19, 2015 FCE. He reviewed ROM measurements for the bilateral shoulders and found that the employee had normal strength. Dr. Wang diagnosed left rotator cuff syndrome.

In an April 26, 2017 impairment rating report, Dr. Mesfin Seyoum, who specializes in family medicine, indicated that he had reviewed the evidence of record, but had not physically examined the employee. He diagnosed a rotator cuff tear and strain and adhesive capsulitis of the left shoulder. Utilizing the Dr. Wang's physical findings, and referencing the sixth edition of the A.M.A., *Guides*, Dr. Seyoum identified the class of diagnosis (CDX) as a class 3 left shoulder arthroplasty according to Table 15-5 on page 405, which yielded a default impairment rating of 30 percent. He applied a grade modifier for physical examination (GMPH) of two and a grade modifier for clinical studies (GMCS) of two, and found that a grade modifier for functional history (GMFH) was not applicable due to lack of information available to review. Dr. Seyoum utilized the net adjustment formula to find no change from the default value of 30 percent. He further found 15 percent permanent impairment due to loss of ROM of the shoulder according to Table 15-34 on page 475. Dr. Seyoum used ROM measurements from November 2015.

On June 16, 2017 the employee filed a claim for an increased schedule award (Form CA-7).

On August 30, 2017 Dr. Morley Slutsky, Board-certified in occupational medicine and serving as a DMA, noted that Dr. Seyoum had based his impairment calculations due to loss of ROM of the employee's left shoulder on a November 2015 FCE. He opined that the measurements were invalid for purposes of rating impairment under the 6th edition of the A.M.A., *Guides*[7] as the evaluator had not obtained three ROM measurements per joint. Using the diagnosis-based impairment (DBI) method, Dr. Slutsky identified the CDX as a class 1 full-thickness rotator cuff tear with residual dysfunction according to Table 15-5 on page 403, which yielded a default value of five percent. He applied a GMFH of one and found that a GMPH was not applicable as Dr. Seyoum had not provided examination findings. Dr. Slutsky further noted that clinical studies were used to identify the correct diagnosis class and thus a GMCS was inapplicable. He found no adjustment from the default value of five percent for the left upper extremity after applying the net adjustment formula. Dr. Slutsky opined that the employee had obtained maximum medical

[6] By decision dated December 22, 2016, OWCP reduced the employee's wage-loss compensation as he had the capacity to earn wages in the selected position of customer complaint clerk. On January 1, 2017 the employee elected to receive retirement benefits from the Office of Personnel Management in lieu of wage-loss compensation from OWCP. By decision dated August 14, 2017, an OWCP hearing representative affirmed the December 22, 2016 decision.

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

improvement (MMI) on April 11, 2017, the date of Dr. Wang's last examination. He noted that the employee had previously received a schedule award for 13 percent permanent impairment of the left shoulder and was thus not entitled to an increased schedule award.

By decision dated September 5, 2017, OWCP denied the employee's claim for an increased schedule award.

On September 11, 2017 the employee, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. A telephonic hearing was held on February 14, 2018.

By decision dated March 29, 2018, OWCP's hearing representative vacated the September 5, 2017 decision, finding that OWCP had not complied with FECA Bulletin No. 17-06. He remanded the case for OWCP to refer the employee for a second opinion examination on the issue of the extent of his left upper extremity impairment. OWCP's hearing representative noted that, if the A.M.A., *Guides* allowed for both the DBI and ROM methods to rate an impairment, both should be calculated and the greater used to determine the impairment percentage.

In a report dated February 21, 2018, Dr. Seyoum reviewed Dr. Slutsky's August 28, 2017 report. He noted that he had based his impairment rating on a November 2015 report from Dr. Wang as it was the most current evidence available for his review. Dr. Seyoum identified the CDX as a class 1 acromioplasty using Table 15-5 on page 403 of the A.M.A., *Guides*, which he found yielded a range of 8 to 12 percent. He applied GMPE and GMCS of two and found that a GMFH was inapplicable. After using the net adjustment formula, Dr. Seyoum found 12 percent permanent impairment of the left shoulder using the DBI method. He noted that he would need to review three active ROM measurements for the shoulder in order to use the ROM method.[8]

On June 29, 2018 Dr. Slutsky affirmed prior impairment rating. He noted that Dr. Seyoum had rated the employee for an acromioplasty, which he advised was not a ratable diagnosis. Dr. Slutsky advised that he was basing his impairment rating on Dr. Wang's findings in his April 11, 2017 report. He asserted that Dr. Wang had failed to provide valid ROM measurements and thus rated the employee using the DBI method. Dr. Slutsky noted that the A.M.A., *Guides* found that an acromioplasty differed from status post distal clavicle excision. He reiterated that the employee had five percent permanent impairment of the left upper extremity. As the employee had previously received an award for 13 percent of the same joint, Dr. Slutsky found that he had no additional impairment.

By decision dated July 24, 2018, OWCP denied appellant's claim for an increased schedule award.

On July 30, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

A telephonic hearing was held on December 13, 2018.

[8] The employee passed away on April 22, 2018.

By decision dated February 15, 2019, OWCP's hearing representative affirmed the July 24, 2018 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,[9] and its implementing federal regulations,[10] 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. FECA, however, 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.[11] 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.[12]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning Disability and Health (ICF).[13] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by GMFH, GMPE and GMCS.[14] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[16]

The A.M.A., *Guides* also provide that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[17] 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

[9] *Supra* note 2.

[10] 20 C.F.R. § 10.404.

[11] 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 Award and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also id*. at Chapter 3.700, Exhibit 1 (January 2010).

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

[13] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[14] *Id*. at 494-531.

[15] *Id*. at 411.

[16] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

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

measured and added.[18] 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.[19]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides, in 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).
>
> "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.)[20]

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."[21]

It is well established that benefits payable under 5 U.S.C. § 8107(c) are reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different part of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[22]

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

[18] *Id*. at 473.

[19] *Id.* at 474.

[20] FECA Bulletin No. 17-06 (issued May 8, 2017). *See also L.G*., Docket No. 18-0519 (issued March 8, 2019); *D.F*., Docket No. 17-1474 (issued January 23, 2018).

[21] *Id*.

[22] 20 C.F.R. § 10.404(d); *see T.S.*, Docket No. 16-1406 (issued August 9, 2017); *T.S.*, Docket No. 09-1308 (issued December 22, 2009).

accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[23]

ANALYSIS

The Board finds that the case is not in posture for decision.

OWCP previously awarded the employee a schedule award for 13 percent permanent impairment of the left upper extremity due to loss of ROM and muscle weakness of the left shoulder.

The employee subsequently requested an increased schedule award. In a report dated April 26, 2017, Dr. Seyoum reviewed the evidence of record, but did not physically examine the employee. He identified the CDX as a left shoulder arthroplasty, which he found yielded an impairment rating of 30 percent after the applicable grade modifiers. The employee, however, did not undergo a shoulder arthroplasty, and thus Dr. Seyoum's impairment rating using the DBI method is of diminished probative value.[24] Using ROM measurements from a 2015 report, Dr. Seyoum found that the employee had 15 percent permanent impairment due to loss of ROM of the left shoulder.

On August 30, 2017 Dr. Slutsky, the DMA, used the DBI method to assess the employee's impairment, noting that the ROM measurements used by Dr. Seyoum failed to meet the criteria of the sixth edition of the A.M.A., *Guides*. Referencing Table 15-5 on page 403, he identified the CDX as a class 1 full-thickness rotator cuff tear with residual dysfunction, which yielded a default impairment rating of five percent. Dr. Slutsky applied a GMFH of one and found that a GMPH and GMCS were not applicable. After applying the net adjustment formula, he concluded that the employee had five percent permanent impairment of the left upper extremity.[25]

On February 21, 2018 Dr. Seyoum identified the CDX as a class 1 acromioplasty, for a default value of 10 percent. However, an acromioplasty is not a listed diagnosis in Table 15-5 on page 403 of the sixth edition of the A.M.A., *Guides*. Table 15-5 on page 403 provides a rating for an acromioclavicular joint injury with a default value of 10 after a distal clavicle resection or complete disruption of the joint capsule, which Dr. Slutsky determined was not applicable for the employee. Dr. Seyoum's impairment rating, consequently, fails to conform to the protocols for rating permanent impairment under the A.M.A., *Guides*.[26]

By decision dated March 29, 2018, an OWCP hearing representative instructed OWCP to refer the employee for a second opinion examination and to obtain ROM measurements that

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

[24] *See C.S.*, Docket No. 19-0172 (issued April 24, 2019).

[25] Utilizing the net adjustment formula discussed above, (GMFH - CDX), or (1-1) = 0, yielded a zero adjustment.

[26] *See C.M.*, Docket No. 19-0125 (issued August 16, 2019); *D.F.*, *supra* note 17; *James Kennedy, Jr.*, 40 ECAB 620 (1989) (finding that 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).

conformed to the A.M.A., *Guides* in accordance with FECA Bulletin No. 17-06. However, prior to the scheduled second opinion examination, the employee passed away.

On June 29, 2018 Dr. Slutsky reviewed Dr. Seyoum's February 21, 2018 report and again opined that the employee had five percent permanent impairment due to his rotator cuff tear with residual dysfunction. He indicated that an acromioplasty was not a ratable diagnosis. Dr. Slutsky advised that he was using findings from Dr. Wang's April 11, 2017 impairment evaluation to rate the employee's impairment. He asserted that Dr. Wang's ROM measurements were not valid. Dr. Slutsky, however, failed to explain why the ROM measurements obtained by Dr. Wang were insufficient for rating permanent impairment using the ROM method. As noted, after obtaining all necessary medical evidence, the file should be routed to the 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.[27] The DMA failed to provide such rationale. Consequently, the Board will remand the case for the DMA for clarification of his opinion consistent with OWCP's procedures set forth in FECA Bulletin No. 17-06.[28]

CONCLUSION

The Board finds that this case is not in posture for decision.

[27] *See J.S.*, Docket No. 18-1635 (issued May 15, 2019).

[28] *See J.F.*, Docket No. 17-1726 (issued March 12, 2018).

ORDER

IT IS HEREBY ORDERED THAT the February 15, 2019 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: March 29, 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