

**United States Department of Labor
Employees' Compensation Appeals Board**

_____)
J.M., Appellant)

and)

DEPARTMENT OF THE NAVY, NAVAL)
SUPPLY SYSTEMS COMMAND, Gulfport, MS,)
Employer)

_____)

Docket No. 20-0602
Issued: October 8, 2021

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 January 24, 2020 appellant filed a timely appeal from a January 8, 2020 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.²

¹ 5 U.S.C. § 8101 *et seq.*

² The Board notes that, following the January 8, 2020 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 10 percent permanent of his right upper extremity for which he previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board.³ The facts and circumstances as set forth in the Board's prior decisions are incorporated herein by reference. The relevant facts are set forth below.

On July 8, 2008 appellant, then a 49-year-old materials handler, sustained employment-related sprains of the right elbow and forearm and right lateral epicondylitis when he injured his arm unloading pallets. He had right arm surgery on February 16, 2009 and returned to modified duty on March 2, 2009. Appellant was removed from Federal Employment for cause in April 2009. By decision dated September 29, 2009, OWCP denied his claim for disability. It noted that appellant returned to modified duty after the February 13, 2009 surgery and was then terminated for cause and not due to his inability to perform his modified-duty assignment. OWCP initially accepted the claim for sprain of the right elbow and forearm and lateral epicondylitis. It later expanded acceptance of the claim to include entrapment/lesion of ulnar nerve right elbow, and articular cartilage disorder of the right upper arm elbow.

Appellant filed a claim for compensation (Form CA-7) for a schedule award. By decision dated November 15, 2010, the Board affirmed September 29, 2009 and January 4, 2010 OWCP merit decisions that denied his claim for a schedule award.⁴

On December 8, 2011 appellant began pain management with Dr. Brian Tsang, a Board-certified anesthesiologist. Dr. Tsang and members of his staff continue pain management.

By decision dated April 3, 2013, OWCP granted appellant a schedule award for seven percent permanent impairment of the right arm.⁵

On January 7, 2015 Dr. Henry Leis, a treating Board-certified orthopedic surgeon, performed authorized right lateral epicondylectomy.

By decision dated October 24, 2016, the Board found that appellant had not met his burden of proof to establish more than seven percent impairment of the right arm for which he previously

³ *Order Remanding Case*, Docket No. 19-0601 (issued October 22, 2019); Docket No. 17-1603 (issued April 10, 2018); Docket No. 16-0669 (issued October 24, 2016); Docket No. 13-1275 (issued March 14, 2014); Docket No. 12-1906 (issued February 14, 2013); Docket No. 12-1699 (issued February 14, 2013); Docket No. 10-823 (issued November 15, 2010).

⁴ Docket No. 10-823 (issued November 15, 2010).

⁵ Appellant appealed the April 3, 2013 decision to the Board. The Board affirmed OWCP's decision on March 14, 2014. Docket No. 13-1275 (issued March 14, 2014).

received a schedule award. The Board further found that OWCP properly denied his request for reconsideration of the merits of the schedule award and properly denied his request for a hearing.⁶

By decision dated April 10, 2018, the Board found that appellant failed to establish that carpal tunnel syndrome was caused by the July 8, 2008 injury, and that OWCP properly refused to reopen his claim for further review of the merits on this issue. The Board further found that the case was not in posture for decision regarding the degree of impairment of his right upper extremity.⁷

In an April 10, 2018 decision, the Board set aside an OWCP January 18, 2017 schedule award decision regarding appellant's upper extremity impairment. The Board noted that a consistent interpretation had not been followed regarding the proper use of the diagnosis-based impairment (DBI) or the range of motion (ROM) methodology when assessing the extent of permanent impairment for schedule award purposes. The Board instructed OWCP to utilize a consistent method for calculating appellant's right upper extremity permanent impairment as provided in FECA Bulletin No.17-06,⁸ to be followed by a *de novo* decision on his claim for an upper extremity schedule award.⁹

Subsequent to the Board's April 10, 2018 decision, OWCP referred appellant to Dr. Joseph McGowin, III, a Board-certified orthopedic surgeon, for a second-opinion and impairment evaluation. A July 11, 2018 report from Dr. McGowin was submitted to OWCP. However, a review of this report indicated that page 4 was missing. The report forwarded to OWCP did not contain physical examination findings other than to indicate elbow ROM, and it only generally included a statement that appellant had eight percent impairment for diagnoses of lateral epicondylitis and ulnar neuropathy. Dr. McGowin concluded that appellant had nine percent permanent impairment based on the ROM method.

Dr. McGowin's report was forwarded to an OWCP district medical adviser (DMA), Dr. Amanda D. Trimpey, Board-certified in preventive medicine. In an August 1, 2018 report, Dr. Trimpey noted that Dr. McGowin's report did not include calculation, examination findings, and methodology used in reaching his DBI conclusion. Nonetheless, she found that appellant had six percent permanent impairment under the DBI method for a diagnosis of lateral epicondylitis and nine percent impairment under the ROM method.

By decision dated August 8, 2018, OWCP granted appellant a schedule award for an additional two percent permanent impairment of the right arm, for a total of nine percent.

⁶ Docket No. 16-0669 (issued October 24, 2016).

⁷ Docket No. 17-1603 (issued April 10, 2018).

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

⁹ *Supra* note 7.

On January 24, 2019 appellant appealed to the Board. By order dated October 22, 2019, the Board remanded the case to OWCP to obtain a complete copy of Dr. McGowin's July 11, 2018 report.¹⁰

Dr. Leis continued to treat appellant. On January 25, 2019 he noted appellant's complaint of increased right elbow pain, described physical examination findings, and diagnosed right cubital tunnel syndrome, right elbow pain, and right lateral epicondylitis. Dr. Leis recommended additional surgery.

On February 25, 2019 appellant began treatment with Dr. Benjamin Gray Guevara, a Board-certified orthopedic surgeon. Dr. Guevara provided upper extremity examination findings and noted that a right elbow x-ray demonstrated arthritic changes. He diagnosed right elbow arthritis and right ulnar neuritis, and recommended electromyography and nerve conduction velocity (EMG/NCV) testing. In an April 18, 2019 treatment note, Dr. Guevara indicated that appellant could not tolerate the EMG/NCV testing and reviewed a prior study that demonstrated moderate right carpal tunnel syndrome, but no cubital tunnel syndrome.¹¹ He continued to submit reports describing appellant's right arm condition. On September 26, 2019 Dr. Guevara noted appellant's complaint of constant right elbow pain and reported that he had a functional capacity evaluation which showed that appellant could work at a medium grade. He provided examination findings and reiterated his diagnoses. On October 15, 2019 Dr. Guevara indicated that appellant was at maximum medical improvement (MMI).

On October 25, 2019 OWCP obtained a complete copy of Dr. McGowin's July 11, 2018 report. On physical examination Dr. McGowin noted that cervical ROM was normal with minimal discomfort and no point tenderness. Right elbow ROM demonstrated 90 degrees of pronation times 3, 90 degrees of pronation times 3, 90 degrees of flexion times 3, and extension at -10, -8, and -10 in 3 measurements. Dr. McGowin found no intrinsic atrophy or crepitus in either hand or forearm, and tenderness at the lateral epicondyle of the right elbow. Bilateral upper extremity strength test was 5/5 and equal although grip and wrist extension on the right caused mild-to-moderate pain at the lateral elbow. Shoulder strength testing was normal bilaterally. Pinch testing on the left was 20, 22, and 24, and 20, 22, and 22 on the right, with average of 22 on the left and 22 on the right. Grip testing on the left was 104, 96, and 83, and 42, 54, and 67 on the right, with average of 84 on the left and 54 on the right. Right elbow x-ray showed moderate ulnohumeral and radiocapitellar arthritis. Dr. McGowin indicated that appellant had reached MMI on August 6, 2015. He advised that, in accordance with Table 15-4, Elbow Regional Grid, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),¹² appellant had a class 1 impairment for a class of diagnosis (CDX) of right lateral epicondylitis. Dr. McGowin found a grade modifier for functional history (GMFH) of 3, a grade modifier for physical examination (GMPE) of 1, and a grade modifier for clinical studies (GMCS) of 2. After applying the net adjustment formula, he concluded that appellant had a class 1 impairment of seven percent for this diagnosis. Dr. McGowin then utilized Table 15-21

¹⁰ Docket No. 19-0601 (issued October 22, 2019).

¹¹ A June 7, 2016 upper extremity EMG/NCV study demonstrated bilateral carpal tunnel syndrome only.

¹² A.M.A., *Guides* (6th ed. 2009).

for the ulnar neuritis, finding a sensory severity of 1 and a motor severity of 0. He found grade modifiers under Table 15-23, noting GMCS of 1, GMPE of 1, and GMFH of 2, which yielded a class 1 permanent impairment of one percent. Dr. McGowin then combined the impairments for lateral epicondylitis and ulnar neuropathy, finding a total eight percent right upper extremity impairment under the DBI method. In an addendum, he also noted that appellant had a total of nine percent permanent impairment under the ROM method.

OWCP forwarded the medical record, including Dr. McGowin's July 11, 2018 report, and a statement of accepted facts (SOAF) to its DMA on November 15, 2019. It asked that the DMA indicate a date of MMI and a right arm impairment in accordance with the A.M.A., *Guides* under both the DBI and ROM methods. In a December 8, 2019 report, Dr. Morley Slutsky, Board-certified in occupational medicine and serving as DMA, indicated that he disagreed with Dr. McGowin's impairment rating. The DMA noted that appellant's most impairing diagnosis was epicondylitis, status postsurgery, and that MMI was July 11, 2018, the date of Dr. McGowin's evaluation. He noted that the A.M.A., *Guides* allowed for an impairment rating using the ROM method for the diagnosis of lateral epicondylitis, and that Dr. McGowin provided valid ROM measurements. Using ROM methodology, the DMA found that appellant's loss of elbow flexion of 8 percent and extension of 2 percent yielded 10 percent right arm impairment, and found that under the DBI method, under Table 15-4, he had 6 percent upper extremity impairment for a diagnosis of lateral epicondylitis. Dr. Slutsky found no impairment under Table 15-23, noting there was no evidence on EMG/NCV testing of ulnar nerve axonal involvement at the elbow.

By decision dated January 8, 2020, OWCP granted appellant a schedule award for an additional 1 percent permanent impairment of the right arm, for a total of 10 percent. The award was for 3.12 weeks, to run from August 24 to September 14, 2018. OWCP noted that the impairment rating was based on the opinions of Dr. McGowin and its DMA. It attached copies of their reports.

LEGAL PRECEDENT

The schedule award provisions of FECA¹³ and its implementing federal regulations,¹⁴ 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 2009.¹⁵ The Board has approved the use by OWCP

¹³ *Supra* note 1.

¹⁴ 20 C.F.R. § 10.404.

¹⁵ 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).

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.¹⁶

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.¹⁷ 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*.¹⁸

In addressing upper extremity impairments, the sixth edition requires identification of the impairment CDX, which is then adjusted by GMFH, GMPE, and GMCS.¹⁹ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).²⁰

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.²¹ 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.²² 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.²³

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.²⁴ 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.,]

¹⁶ See *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).

¹⁷ See *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).

¹⁸ See 5 U.S.C. § 8101(19); *J.K.*, Docket Nos. 19-1420 and 19-1422 (issued August 12, 2020); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

¹⁹ A.M.A., *Guides*, *supra* note 15 at 383-492.

²⁰ *Id.* at 411.

²¹ *Id.* at 461.

²² *Id.* at 473.

²³ *Id.* at 474.

²⁴ FECA Bulletin No. 17-06 (issued May 8, 2017).

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).²⁵

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.”²⁶

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.²⁷

ANALYSIS

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

Preliminarily, the Board notes that findings made in prior Board decisions are *res judicata* absent further review by OWCP under section 8128 of FECA.²⁸ The Board, therefore, will not review the evidence addressed in its prior appeals.

Dr. Leis, Dr. Tsang, and Dr. Guevara did not provide impairment evaluations. OWCP properly referred appellant to Dr. McGowin for a second-opinion evaluation and impairment analysis.

After a Board remand on October 22, 2019 for OWCP to obtain a complete copy of Dr. McGowin’s July 11, 2018 report, OWCP obtained a complete copy. In his July 11, 2018 report, Dr. McGowin provided three ROM measurements of appellant’s right elbow and found that appellant had reached MMI. He determined that, under the DBI method for rating impairment, for the diagnosis of right lateral epicondylitis, appellant had seven percent right arm impairment. After applying the NAF, Dr. McGowin concluded that, under Table 15-4, appellant had a right elbow impairment of four percent. He also found that appellant had nine percent impairment based on ROM methodology. Dr. McGowin further determined that, under Table 15-21, Peripheral Nerve Impairment, for a diagnosis of ulnar neuritis, appellant had a sensory severity of 1 and a

²⁵ *Id.*

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

²⁷ *Supra* note at 15 at Chapter 2.808.6(f); *P.W.*, Docket No. 19-1493 (issued August 12, 2020).

²⁸ *K.K.*, Docket No. 20-1394 (issued July 26, 2021); *Clinton E. Anthony, Jr.*, 49 ECAB 476 (1998).

motor severity of 0, and that under Table 15-23, he had a GMCS of 1, a GMPE of 1, and a GMFH of 2, which yielded a class 1 impairment of 1 percent for ulnar nerve impairment. He then combined the DBI impairment with the peripheral nerve impairment, finding a total eight percent right upper extremity impairment.

In accordance with its procedures,²⁹ OWCP properly referred the evidence of record to Dr. Slutsky, serving as the DMA. By report dated December 8, 2019, the DMA noted his disagreement with Dr. McGowin's impairment analysis. He noted that appellant's most impairing diagnosis was epicondylitis, status postsurgery, and that MMI was July 11, 2018, the date of Dr. McGowin's evaluation. The DMA advised that the A.M.A., *Guides* allows for an impairment rating using the ROM method for the diagnosis of lateral epicondylitis, and that Dr. McGowin provided valid ROM measurements. Using ROM methodology, he found that appellant's loss of elbow flexion of 8 percent and extension of 2 percent yielded a 10 percent right arm impairment, whereas under the DBI method, under Table 15-4 he had six percent upper extremity impairment for a diagnosis of lateral epicondylitis. Dr. Slutsky found no impairment under Table 15-23, noting there was no evidence on EMG/NCV testing of ulnar nerve axonal involvement at the elbow. As noted, a June 7, 2016 upper extremity EMG/NCV study demonstrated bilateral carpal tunnel syndrome only.

The Board finds that the DMA discussed how he arrived at his conclusion by listing specific tables and pages in the A.M.A., *Guides*. The DMA accurately summarized the relevant medical evidence, provided detailed findings on examination, and reached conclusions about appellant's conditions which comported with his findings.³⁰ He 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 opinion is also detailed, well rationalized, and based on a proper factual background, the Board finds that it constitutes the weight of the medical evidence.³¹

There is no current medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that appellant has greater than the 10 percent permanent impairment of the right upper extremity previously awarded. Accordingly, appellant has not met his burden of proof to establish that he is entitled to an increased schedule award.³²

On appeal appellant asserts that he is entitled to 312 weeks' compensation. That amount, however, is for 100 percent loss of use of an arm.³³ Appellant has established only 10 percent permanent impairment, not 100 percent. The Board notes that, for 10 percent impairment, the proper award is 31.2 weeks.³⁴ On April 3, 2013 appellant was awarded 21.84 weeks' compensation, on August 18, 2018 6.24 weeks' compensation, and on January 8, 2020 an

²⁹ *Supra* note 27.

³⁰ *M.D.*, Docket No. 20-0007 (issued May 13, 2020).

³¹ *G.J.*, Docket Nos. 19-1651 and 20-0199 (issued June 22, 2020).

³² *Id.*

³³ 5 U.S.C. § 8107(c)(1).

³⁴ *Id.*; *see also supra* note 15 at Chapter 2.808, Exhibit 1.

additional 3.12 weeks' compensation, for total compensation of 31.2 weeks. As explained above, he has not established entitlement to a greater award.

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 10 percent permanent impairment of his right upper extremity for which he previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the January 8, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 8, 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