United States Department of Labor
Employees' Compensation Appeals Board

K.R., Appellant	)	
and	)	**Docket No. 20-1675**
	)	**Issued: August 19, 2022**
U.S. POSTAL SERVICE, DENVER COLORADO PROCESSING & DISTRIBUTION CENTER, Denver, CO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On September 28, 2020 appellant filed a timely appeal from an August 12, 2020 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the August 12, 2020 decision, appellant submitted additional evidence to OWCP. 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 five percent permanent impairment of his right upper extremity and two percent permanent impairment of his left upper extremity for which he previously received schedule award compensation.

FACTUAL HISTORY

On August 24, 2018 appellant, then a 59-year-old tractor trailer operator, filed an occupational disease claim (Form CA-2) alleging that he developed right rotator cuff syndrome "tendinitis" due to factors of his federal employment, including the repetitive motions of his duties and tasks. He noted that he first became aware of his condition on July 23, 2018 and realized its relation to his federal employment on August 23, 2018. Appellant stopped work on August 23, 2018. On October 1, 2018 OWCP accepted his claim for right shoulder rotator cuff syndrome. It paid appellant wage-loss compensation on the supplemental rolls from February 25 through March 26, 2019.

A magnetic resonance imaging (MRI) scan of the right shoulder dated December 31, 2018 demonstrated supraspinatus, infraspinatus, subscapularis tendinosis with partial thickness tear of the subscapularis from the lesser tuberosity, anterior, inferior, posterior inferior and posterior superior quadrant labral tear, and degenerative cartilage changes in the posterior superior quadrant of the glenoid.

On February 25, 2019 Dr. Cary Motz, a Board-certified orthopedist, performed an OWCP-authorized right shoulder arthroscopy with arthroscopic subscapularis repair, extensive debridement of the glenohumeral joint, partial thickness subscapularis tear and subacromial space, and arthroscopic subacromial decompression.[3]

On March 15, 2019 OWCP expanded the acceptance of appellant's claim to include right shoulder rotator cuff/impingement syndrome and right shoulder partial thickness subscapularis tear.

Appellant underwent a functional capacity evaluation (FCE) on October 21, 2019, which demonstrated his ability to function in the very heavy physical demand category.

On December 11, 2019 Dr. Jay Reinsma, a Board-certified family practitioner, prepared a duty status report (Form CA-17), diagnosed rotator cuff tear status post repair, and returned appellant to full-duty work as of December 11, 2019.

On February 21, 2020 appellant filed a claim for compensation (Form CA-7) for a schedule award.

[3] An MRI scan of the right shoulder dated June 26, 2019 revealed postoperative changes of an acromioplasty, mild edematous change and degenerative changes about the acromioclavicular (AC) joint slight progressed, fluid in the subacromial and subdeltoid bursa, tendinosis of the rotator cuff but the cuff remains intact, stable osteoarthritic changes of the glenohumeral articulation, and joint effusion with synovitis change.

In support of his claim, appellant submitted a January 14, 2020 report from Dr. Amanda Cava, a family practitioner, who documented appellant's right shoulder treatment following his right shoulder arthroscopy. Dr. Cava's physical examination of appellant's right shoulder revealed no biceps popeye deformity, the incision was clean, dry and intact, there was no tenderness, and palpation revealed no crepitus. She noted forward flexion of 165 degrees with pain, extension of 50 degrees, abduction of 150 degrees with pain, adduction of 25 degrees with pain, internal rotation of 20 degrees with pain, and external rotation of 70 degrees with pain. Dr. Cava noted motor and sensation testing were intact. She examined appellant's left shoulder, which did not indicate a biceps popeye deformity, there was no tenderness, and the appearance was normal. Dr. Cava noted forward flexion of 165 degrees with pain, extension of 50 degrees, abduction of 165 degrees with pain, adduction of 35 degrees with pain, internal rotation of 35 degrees with pain, and external rotation of 70 degrees with pain. Motor and sensation testing were intact. Dr. Cava diagnosed unspecified rotator cuff tear or rupture of the right shoulder, anterior to posterior tear of the superior glenoid labrum of the left shoulder, and status post arthroscopy of the right shoulder.

Utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] Dr. Cava initially calculated impairment based on the diagnosis-based impairment (DBI) rating method to find that under Table 15-5 (Shoulder Regional Grid), page 402, the class of diagnosis (CDX) for appellant's partial thickness rotator cuff tear of the right shoulder resulted in a class 1 impairment with a default value of 3. She assigned a grade modifier for functional history (GMFH) of 1 due to mild symptoms, a grade modifier for physical examination (GMPE) of 1 for mild problems. Dr. Cava found that a grade modifier for clinical studies (GMCS) was not applicable. She applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1-1) + (1-1) + (2-1) = -4, which resulted in a grade A or one percent permanent impairment of the right upper extremity.

Using the DBI rating method to rate the left shoulder under Table 15-5 (Shoulder Regional Grid), page 402, Dr. Cava identified the CDX for the diagnosis of shoulder impingement as a class 1 impairment with a default value of 1. She assigned a GMFH of 1 for mild symptoms, a GMPE of 1 for mild findings, and a GMCS of 1. Dr. Cava applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1-1) + (1-1) + (2-1) = +1, which resulted in a grade D or two percent permanent impairment of the left upper extremity.

Dr. Cava calculated impairment for the stand-alone range of motion (ROM) method and opined that appellant had 11 percent permanent impairment of the right upper extremity under Table 15-34 of the A.M.A., *Guides*.[5] Using the ROM method to calculate impairment of the left upper extremity corresponded to eight percent permanent impairment of the left upper extremity. Dr. Cava documented only one motion per joint movement. She opined that appellant had reached maximum medical improvement (MMI) on January 14, 2020.

On July 7, 2020 OWCP further expanded the acceptance of appellant's claim to include anterior to posterior tear of the superior glenoid labrum lesion of the left shoulder.

[4] 5 U.S.C. § 8107.

[5] A.M.A., *Guides* 475, Table 15-34.

OWCP referred appellant's medical record, along with a statement of accepted facts (SOAF), for a schedule award impairment rating with Dr. Morley Slutsky, Board-certified in occupational medicine, serving as the district medical adviser (DMA). In a July 15, 2020 report, Dr. Slutsky reviewed the SOAF and medical record. He noted that he was not provided with a copy of the February 25, 2019 right shoulder surgery report that he stated was key to rating the right shoulder. Dr. Slutsky utilized the DBI method to find that, under Table 15-5 (Shoulder Regional Grid), page 402, the CDX for the diagnosis of partial thickness rotator cuff tear with residual dysfunction resulted in a class 1 impairment with a default value of 3. He assigned a GMFH of 1, in accordance with Table 15-7, page 406, as appellant had no evidence of functional limitations as noted by Dr. Cava's January 14, 2020 report. Dr. Slutsky assigned a GMPE of zero, in accordance with Table 15-8, page 408 as Dr. Cava documented only one motion per joint movement, which was inconsistent with the validity criteria in Section 15.7 page 464, for measuring ROM. Therefore, the ROM measurements were not valid for impairment calculations. Dr. Slutsky, therefore, disagreed with Dr. Cava's assignment of a GMFH of 1. He noted that, a GMCS should be excluded, in accordance with Table 15-9, page 410, as an MRI scan was used for placement of the diagnosis within a specific class in the DBI grid. Dr. Slutsky calculated that appellant had a net adjustment of -1, resulting in movement from the default class of C to B and corresponding to two percent permanent impairment of the right upper extremity.

With regard to the left upper extremity, Dr. Slutsky utilized the DBI method to find that, under Table 15-5 (Shoulder Regional Grid), page 404, the CDX for the diagnosis of left shoulder labral tear was a class 1 impairment with a default value of 3. He assigned a GMFH of 1 for mild symptoms, in accordance with Table 15-7, page 406. Dr. Slutsky assigned a GMPE of zero, in accordance with Table 15-8, page 408, as Dr. Cava documented only one motion per joint movement, which was inconsistent with the validity criteria in Section 15.7 page 464, for measuring ROM. He, therefore, disagreed with Dr. Cava's assignment of a GMPE of 1. Dr. Slutsky noted that a GMCS should be excluded in accordance with Table 15-9, page 410, as an MRI scan was used for placement of the diagnosis within a specific class in the DBI grid. He calculated that appellant had a net adjustment of -1, resulting in movement from the default class of C to B and corresponding to two percent permanent impairment of the left upper extremity. Dr. Slutsky opined that appellant had reached MMI on January 14, 2020.

On July 21, 2020 OWCP requested clarification from Dr. Slutsky regarding his impairment rating. It provided Dr. Slutsky with the February 25, 2019 right shoulder operative report and requested he reevaluate his upper extremity impairment calculations.

In a supplemental report dated August 1, 2020, Dr. Slutsky reviewed the February 25, 2019 right shoulder operative report. He utilized the DBI rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 402, the CDX for the diagnosis of partial thickness rotator cuff tear with residual dysfunction resulted in a class 1 impairment with a default value of 3. Dr. Slutsky assigned a GMFH of 1, in accordance with Table 15-7, page 406, as appellant had no evidence of functional limitations. He assigned a GMPE of zero, in accordance with Table 15-8, page 408 as Dr. Cava documented only one motion per joint movement, which was inconsistent with the validity criteria in Section 15.7 page 464, for measuring ROM. Dr. Slutsky found a GMCS of 4 in accordance with Table 15-9, page 410, based on the right shoulder MRI scan dated December 31, 2018. Applying the net adjustment formula, he calculated that appellant had a net adjustment of +2, resulting in movement from the default class of C to E, corresponding to five

percent permanent impairment of the right upper extremity. Dr. Slutsky disagreed with Dr. Cava's calculation of the net adjustment formula for the right shoulder and indicated that the GMFH of 1 and GMPE of 1 was zero and not -2 as assigned by Dr. Cava. He noted no change from his July 15, 2020 report to the impairment rating for the left upper extremity.

By decision dated August 12, 2020, OWCP granted appellant a schedule award for five percent permanent impairment of the right upper extremity and two percent permanent impairment of the left upper extremity. The award ran for 21.84 weeks from January 14 through June 14, 2020 and was based on the January 14, 2020 report of Dr. Cava and the August 1, 2020 report of Dr. Slutsky, the DMA.

LEGAL PRECEDENT

The schedule award provisions of FECA,[6] and its implementing federal regulations,[7] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[10]

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 respect 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).[11] Under Chapter 2.3, evaluators

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id*. at § 10.404(a).

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

[10] *See S.C.*, Docket No. 20-0769 (issued January 12, 2021); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[11] A.M.A., *Guides* 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 rating stands alone and is not combined with a DBI rating. *Id*. at 401-05, 475-78.

are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[12]

The A.M.A., *Guides* also provide that the 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.[13] If ROM is used as a standalone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[14] 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.[15]

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.[16] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used*." (Emphasis in the original.)[17]

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 [claims examiner]."[18]

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

[12] *Id*. at 23-28.

[13] *Id*. at 461.

[14] *Id*. at 473.

[15] *Id*. at 474.

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

[17] *Id*.

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

accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[19]

ANALYSIS

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

In her January 14, 2020 report, Dr. Cava calculated impairment utilizing the ROM method and opined that appellant had 11 percent permanent impairment of the right upper extremity under Table 15-34 of the A.M.A., *Guides*.[20] Using the ROM method to calculate impairment of the left upper extremity corresponded to eight percent permanent impairment of the left upper extremity. However, Dr. Cava documented only one motion per joint movement.

OWCP referred Dr. Cava's report to Dr. Slutsky, its DMA, who opined that appellant had two percent permanent impairment of the left upper extremity for left shoulder labral tear and five percent permanent impairment of the right upper extremity for partial thickness rotator cuff tear with residual dysfunction under the DBI methodology. Dr. Slutsky advised that Dr. Cava's report did not contain complete ROM measurements and documented only one motion per joint movement, which was inconsistent with the validity criteria in Section 15.7, page 464, for measuring ROM. Therefore, the ROM measurements were not valid for impairment calculations.

OWCP did not ask Dr. Cava to clarify whether appellant had a loss of ROM of the shoulders and, if so, to provide three measurements of appellant's right and left shoulder ROM. Because Dr. Cava documented only one motion per joint movement, the DMA declared her ROM measurements invalid and then rated appellant's permanent impairment on July 15 and August 1, 2020 under the DBI methodology.

Pursuant to FECA Bulletin No. 17-06, if the ROM method of rating permanent impairment is allowed, after review of the DBI rating, and the ROM findings are incomplete, the DMA should advise as to the medical evidence necessary to complete the ROM method of rating if the medical evidence of record is insufficient to rate appellant's impairment using ROM.[21]

The Board finds that OWCP did not follow the procedures outlined in FECA Bulletin No. 17-06 after the DMA advised that the measurements for the bilateral shoulders were incomplete to rate appellant's permanent impairment utilizing the ROM methodology.[22]

[19] *Supra* note 9 at Chapter 2.808.6f; *P.W.*, Docket No. 19-1493 (issued August 12, 2020).

[20] A.M.A., *Guides* 475, Table 15-34.

[21] *Supra* note 16; *R.L.*, Docket No. 19-1793 (issued August 7, 2020); *E.P.*, Docket No. 19-1708 (issued April 15, 2020).

[22] *R.L., id.*; *C.T.*, Docket No. 18-1716 (issued May 16, 2019).

On remand, OWCP shall obtain the necessary evidence as required under FECA Bulletin No. 17-06.[23] Following this and other such further development as deemed necessary, it shall issue a *de novo* decision.[24]

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the August 12, 2020 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision of the Board.

Issued: August 19, 2022
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[23] *J.S.*, Docket No. 19-0483 (issued October 10, 2019).

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