United States Department of Labor
Employees' Compensation Appeals Board

J.A., Appellant	)	
	)	**Docket No. 21-1201**
and	)	**Issued: November 3, 2022**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Waterloo, IA, 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
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On August 3, 2021 appellant filed a timely appeal from a March 1, 2021 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.

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 22 percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq*.

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On April 29, 1999 appellant then, a 25-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that she sustained a displaced right shoulder blade as a result of the repetitive casing mail while in the performance of duty. OWCP accepted the claim for bursitis and tendinitis of the right shoulder and aggravation of the long thoracic nerve. On September 9, 1999 appellant underwent authorized pectoral muscle transfer surgery.

On August 16, 2001 appellant filed a claim for compensation (Form CA-7) for a schedule award.

OWCP, in an April 5, 2002 decision, granted appellant a schedule award for 10 percent permanent impairment of her right upper extremity. The period of the award ran for 31.20 weeks from September 14, 2001 to April 20, 2002.

By decision dated April 9, 2004, OWCP granted appellant a schedule award for an additional five percent permanent impairment of her left upper extremity, for a total of 15 percent left upper extremity permanent impairment. The period of the award ran for 15.6 weeks from April 21 to August 8, 2002 and was based on the February 26, 2004 report of the IME, Dr. Peter D. Wirtz, a Board-certified orthopedic surgeon.

On July 29, 2019 appellant filed a claim (Form CA-7) for an increased schedule award.

OWCP, by development letter dated August 5, 2019, requested that appellant submit medical evidence from her treating physician including a detailed description of any increased permanent impairment of her right upper extremity, and a final rating of the permanent impairment pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] OWCP afforded appellant 30 days to respond.[4]

In a progress note dated September 16, 2019, Dr. Arnold E. Delbridge, a Board-certified orthopedic surgeon, related that appellant's right shoulder condition had worsened. He discussed findings of physical examination of the right shoulder, including loss of range of motion (ROM), noting that appellant had 70 degrees of forward flexion, 50 degrees of abduction, 20 degrees loss of external rotation, and normal internal rotation and normal adduction. Dr. Delbridge provided

[2] Docket No. 03-1515 (issued October 21, 2003).

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

[4] On August 5, 2019 OWCP issued a corrected decision in which it granted appellant a schedule award for an additional five percent permanent impairment of her right upper extremity, totaling 15 percent permanent impairment of the right upper extremity rather than the left upper extremity as previously indicated in its April 9, 2004 decision.

an assessment of winged scapula of the right side, and recommended a permanent impairment evaluation.

On December 23, 2019 Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), reviewed the medical record, including Dr. Delbridge's September 16, 2019 progress note. He recommended a second opinion examination in accordance with the sixth edition of the A.M.A., *Guides*.[5]

On February 21, 2020 OWCP referred appellant, a statement of accepted facts, and a series of questions, to Dr. Farid Manshadi, a Board-certified orthopedic surgeon, for a second opinion examination to determine nature and the extent of any additional employment-related permanent impairment.

In a May 26, 2020 report, Dr. Manshadi noted appellant's history of injury and medical treatment, and discussed his findings on physical examination. He found evidence of winging of the right scapula medially. Muscle atrophy was noted along the right anterior and posterior right shoulder joint area. There was tenderness over the right upper and over the right levator scapula. Right shoulder ROM was both actively and passively limited. Three sets of ROM measurements reflected: 76 degrees, 80 degrees, and 78 degrees of forward flexion; 24 degrees, 27 degrees, and 26 degrees of extension; 50 degrees, 47 degrees, and 40 degrees of abduction; 17 degrees, 19 degrees, and 20 degrees of adduction; 48 degrees, 46 degrees, and 45 degrees of external rotation; and 49 degrees, 47 degrees, and 46 degrees of internal rotation. Sensation to light touch and pinprick was intact in the right upper extremity and was comparable to the left upper extremity. Manual muscle testing revealed forward flexion and abduction of 3-/5, extension was 4/5, and external and internal rotation was 4/5. Dr. Manshadi utilized the diagnosis-based impairment (DBI) rating method of the sixth edition of the A.M.A., *Guides* and referred to Table 15-21, page 437. He identified a class of diagnosis (CDX) of long thoracic nerve injury and assigned a CDX 1 or 13 percent right upper extremity permanent impairment. Dr. Manshadi noted, however, that it appeared that appellant's right shoulder ROM had significantly declined over the years. Further, she had evidence of adhesive capsulitis with increased pain, which was not an unusual presentation after close to 19 years, as a result of her original long thoracic nerve injury. Dr. Manshadi utilized the ROM rating method under Table 15-34, Table 15-35, and Table 15-36 as appellant's adhesive capsulitis fell under ankylosis. He then found 25 percent permanent impairment due to loss of flexion and extension, 9 percent permanent impairment due to ankylosis due to loss of abduction and adduction, and 6 percent permanent impairment due to loss of external and internal rotation. Dr. Manshadi noted that both active and passive ROMs were similar. He determined that appellant had a total of 36 percent permanent impairment of the right upper extremity, which represented a grade 3 modifier. Utilizing Table 15-36, Dr. Manshadi found that both the grade modifier for functional history (GMFH) and grade modifier for physical examination (GMPE) were equal and thus there was no change in the percentage of impairment. He thus concluded that appellant had a total of 36 percent permanent impairment of the right upper extremity. Dr. Manshadi noted that she reached MMI on May 20, 2020, the date of his impairment evaluation.

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

On August 7, 2020 DMA Katz reviewed the medical record, noted the deficiencies in Dr. Manshadi's May 26, 2020 report, and provided his own impairment calculations to find 22 percent permanent impairment of the right upper extremity under the ROM method of the sixth edition of the A.M.A., *Guides*. Utilizing the DBI method of the sixth edition of the A.M.A., *Guides*, he referred to Table 15-21, page 437, and identified a CDX of severe long thoracic nerve deficit as class 1 which represented a default value of grade C or nine percent impairment. The DMA assigned a GMFH of 3 and a GMPE of 2. He applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (3 - 1) + (2 - 1) = 3 (2 was the maximum), which shifted two spaces to the right of the default value of grade C to a default value of grade E or 11 percent right upper extremity permanent impairment.

The DMA also used the ROM method to rate permanent impairment to appellant's right upper extremity. Utilizing Table 15-34, page 475, he found that 80 degrees of flexion yielded 9 percent impairment, 30 degrees of extension yielded 1 percent impairment, 50 degrees of abduction yielded 6 percent impairment, 20 degrees of adduction yielded 1 percent impairment, and 50 degrees of internal and external rotation each yielded 2 percent impairment, totaling 21 percent impairment of the right upper extremity. The DMA assigned a GMPE of 2 under Table 15-35, page 477, and a GMFH of 3 under Table 15-7, page 406. He applied the net adjustment formula and found a net adjustment of 1. This figure was +5 higher than the ROM class derived from Table 15-35, which required multiplying the 21 percent impairment rating times 5 percent to equal 1.05 percent for a total right upper extremity permanent impairment of 22 percent. The DMA indicated that the 22 percent ROM impairment rating was higher than the 11 percent DBI impairment rating he had calculated for the right upper extremity. He noted that appellant reached MMI on May 20, 2020, the date of Dr. Manshadi's impairment evaluation.

By decision dated August 25, 2020, OWCP granted appellant a schedule award for an additional seven percent permanent impairment of the right upper extremity, for a total 22 percent right upper extremity permanent impairment. The period of the award ran for 21.84 weeks from May 20 to October 19, 2020 and was based on the report of its DMA, Dr. Katz.

On September 13, 2020 appellant requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated November 27, 2020, OWCP's hearing representative found the case not in posture for decision and vacated the August 25, 2020 decision. The hearing representative remanded the case for additional development on the issue of increased permanent impairment and directed that Dr. Manshadi review and comment on DMA Katz' August 7, 2020 report.

On December 16, 2020 OWCP requested that Dr. Manshadi review and comment on DMA Katz' August 7, 2020 findings.

In a December 31, 2020 letter, Dr. Manshadi disagreed with the DMA's impairment rating and noted that he stood by his 36 percent right upper extremity impairment rating. He maintained that based on his review of the medical record and his examination findings, appellant had ankylosis. Dr. Manshadi further maintained that his ROM values were passively and actively measured and thus Table 15-34 was the appropriate table to use to rate right upper extremity

impairment. Additionally, he noted that appellant had a long history of thoracic nerve injury on the right side which had complicated the right shoulder joint to the point that it became ankylotic, basically reducing the right shoulder ROM from the adhesions. Lastly, Dr. Manshadi noted that the DMA did not examine appellant. He agreed, however, that his 36 percent impairment rating should be subtracted from the previous schedule award of 15 percent permanent impairment of the right upper extremity. As such, Dr. Manshadi concluded that appellant had an additional 21 percent permanent impairment of the right upper extremity.

On January 14, 2021 OWCP requested that the DMA, Dr. Katz, review and comment on Dr. Manshadi's December 31, 2020 findings.

In a January 16, 2021 response, the DMA noted his review of Dr. Manshadi's May 26 and December 31, 2020 findings and maintained that his use of the ROM method was correct and that his opinion regarding appellant's right upper extremity permanent impairment remained unchanged. He noted that the arc of motion of the right shoulder as described by Dr. Manshadi did not meet the definition of ankylosis. The DMA indicated that while the right shoulder lacked flexibility it was not ankylosed at that time based on the documentation provided by Dr. Manshadi. He further indicated that other examiners, including Dr. Delbridge who noted in his September 16, 2019 report that appellant had no more than 70 degrees of forward flexion, about 50 degrees of abduction on the right side, normal internal rotation, 20 degrees of external rotation, and normal adduction, which supported his position that appellant's right shoulder was not ankylosed. Therefore, upon further review of the records, the DMA stood by his earlier recommendation.

By decision dated March 1, 2021, OWCP denied appellant's claim for an increased schedule award. It accorded the weight of the medical evidence to Dr. Katz, the DMA, who determined that appellant had no greater permanent impairment than the 22 percent previously awarded for the right upper extremity.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing 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 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.[8] As of May 1, 2009, schedule awards are determined in

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.*; *see also, Ronald R. Kraynak*, 53 ECAB 130 (2001).

accordance with the sixth edition of the A.M.A., *Guides* (2009).[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 addressing impairment of 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.[11] After a CDX is determined (including identification of a default grade value), the impairment class is then adjusted by a GMFH, GMPE, and/or grade modifier for clinical studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13]

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)."[14]

FECA Bulletin further advises:

> "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.)[15]

The Bulletin also advises:

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[9] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.* Chapter 2.808.5.a (March 2017).

[10] *M.D.*, Docket No. 20-0007 (issued May 13, 2020); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[11] *M.D., id.*; *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

[12] A.M.A., *Guides* 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[13] *Id.* at 411.

[14] FECA Bulletin No. 17-06 (issued May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[15] *Id.*

> "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."[16]

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.[17]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than 22 percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation.

Initially, OWCP granted appellant a schedule award for 10 percent permanent impairment of her right upper extremity. It subsequently granted appellant a schedule award for an additional 5 percent permanent impairment of the right upper extremity, for a total of 15 percent right upper extremity permanent impairment. OWCP found that the special weight of the medical evidence rested with the IME, Dr. Wirtz.

On July 29, 2019 appellant filed a Form CA-7 claim for an increased schedule award.

OWCP referred appellant for a second opinion evaluation with Dr. Manshadi on May 26, 2020. Dr. Manshadi provided findings on examination of appellant's right shoulder and found that she had reached MMI. He determined that, under the DBI method for rating impairment appellant had 13 percent permanent impairment for a CDX of long thoracic nerve injury in accordance with Table 15-21, page 437. Dr. Manshadi also utilized the ROM rating method to determine the extent of her right upper extremity permanent impairment. He provided three ROM measurements of appellant's right shoulder and noted that she had adhesive capsulitis which fell under ankylosis. Dr. Manshadi determined that, under Table 15-34, Table 15-35, and Table 15-36, appellant had 36 percent permanent impairment of the right upper extremity. He noted that both active and passive measurements were similar. Dr. Manshadi determined that appellant's 36 percent ROM impairment represented a grade 3 modifier. Utilizing Table 15-36, he found that both GMFH and GMPE were equal and thus there was no change in impairment. Dr. Manshadi, therefore, concluded that appellant had a total of 36 percent permanent impairment of the right upper extremity based on the ROM method.

[16] *Id*.

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

In accordance with its procedures,[18] OWCP properly referred the evidence of record to Dr. Katz, serving as the DMA. By report dated August 7, 2020, DMA Katz noted his disagreement with Dr. Manshadi's impairment analysis. He utilized the DBI method and determined that a CDX of severe long thoracic nerve deficit was class 1 with a default value of grade C or nine percent impairment under Table 15-21, page 437. The DMA assigned a GMFH of 3 and a GMPE of 2. He applied the net adjustment formula and concluded that appellant had 11 percent permanent impairment of the right upper extremity due to severe long thoracic nerve deficit. The DMA also used the ROM method to rate appellant's right upper extremity permanent impairment. He referenced Table 15-34, page 475 and found that she had 21 percent impairment of the right upper extremity. The DMA assigned a GMPE of 2 under Table 15-35, page 477 and a GMFH of 3 under Table 15-7, page 406. He then applied the net adjustment formula and found a net adjustment of 1, which was +5 higher than the ROM class derived from Table 15-35. The DMA multiplied the 21 percent impairment rating by 5 percent to arrive at 1.05 percent for a total right upper extremity permanent impairment of 22 percent, which was greater than her right shoulder impairment using the DBI rating method.

By decision dated August 25, 2020, OWCP granted appellant a schedule award for an additional seven percent permanent impairment of the right upper extremity, resulting in a total of 22 percent right upper extremity permanent impairment. However, following a preliminary review, OWCP's hearing representative, by decision dated November 27, 2020, found the case not in posture for decision and vacated the August 25, 2020 decision. The case was remanded for Dr. Manshadi to review and comment on DMA Katz' August 7, 2020 report.

In a December 31, 2020 letter, Dr. Manshadi disagreed with the DMA's impairment rating and related that his 36 percent ROM impairment rating for appellant's right upper extremity remained unchanged. He continued to find that appellant had ankylosis and that his ROM values were both passively and actively measured, thus requiring the use of Table 15-34 right upper extremity permanent impairment. Additionally, Dr. Manshadi contended that the DMA failed to examine appellant.

Upon OWCP's request, the DMA, Dr. Katz, reviewed Dr. Manshadi's December 31, 2020 findings and in a January 16, 2021 report, he related that his 22 percent ROM right upper extremity impairment rating remained unchanged. He explained that the condition of appellant's right shoulder as described and documented by Dr. Manshadi did not meet the definition of ankylosis and was not ankylosed at the time of Dr. Manshadi's examination. Further, the DMA maintained that his ROM impairment rating was supported by the September 16, 2019 ROM findings of Dr. Delbridge, appellant's treating physician.

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

[18] *Supra* note 9.

appellant's conditions which comported with his findings.[19] 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.[20]

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 22 percent permanent impairment of the right upper extremity previously awarded. Accordingly, appellant has not met her burden of proof to establish that she is entitled to an increased schedule award.[21]

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 permanent impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish greater than 22 percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation.

[19] *J.M.*, Docket No. 20-0602 (issued October 8, 2021); *G.J.*, Docket Nos. 19-1651 and 20-0199 (issued June 22, 2020; *M.D.*, Docket No. 20-0007 (issued May 13, 2020).

[20] *J.M., id.*; *G.J., id.*

[21] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the March 1, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 3, 2022
Washington, DC

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

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board