United States Department of Labor
Employees' Compensation Appeals Board

B.L., Appellant	)	
and	)	**Docket No. 22-0068**
	)	**Issued: October 12, 2022**
DEPARTMENT OF LABOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, New York, NY, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On October 20, 2021 appellant filed a timely appeal from a September 30, 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.[2]

ISSUES

The issues are: (1) whether appellant has established greater than 8 percent permanent impairment of the left upper extremity and 12 percent permanent impairment of the right upper

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the September 30, 2021 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*.

extremity for which she previously received a schedule award; and (2) whether appellant has met her burden of proof to establish any permanent impairment of her lower extremities, warranting a schedule award.

FACTUAL HISTORY

This case has previously been before the Board on a different issue.[3] The facts and circumstances as set forth in the Board's prior order are incorporated herein by reference. The relevant facts are as follows.

On May 15, 2018 appellant, then a 37-year-old claims examiner, filed a traumatic injury claim (Form CA-1) alleging that on May 11, 2018 she sustained bilateral shoulder and back strains when she attempted to open a heavy door while pushing her chair to a new cubicle. She stopped work on the date of injury. Appellant returned to work on June 27, 2018 stopped work again on June 29, 2018 and returned to work on September 4, 2018. By decision dated April 5, 2019, OWCP accepted the claim for bilateral shoulder joint, lumbar, and pelvic strains.

In a report dated November 25, 2020, Dr. Erie T. Agustin, a physician specializing in internal and family medicine, advised that appellant had reached maximum medical improvement (MMI). He noted that she sustained neck, bilateral shoulder, upper and lower back, and left knee injuries due to an April 6, 2018 motor vehicle accident, and a May 11, 2018 work injury.

On December 31, 2020 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On March 10, 2021 OWCP referred appellant, together with a statement of accepted facts (SOAF) and medical record, to Dr. David Benatar, a Board-certified orthopedic surgeon, for a second opinion permanent impairment evaluation, due to the accepted work-related conditions.

In a report dated March 26, 2021, Dr. Benatar reviewed the SOAF and appellant's medical record. He set forth her physical examination findings and opined that she had reached MMI on the date of the examination, March 26, 2021. Regarding the lower extremities, Dr. Benatar noted negative bilateral straight leg raising, no motor or sensory deficits, and intact sensory from L2 to S1. Regarding the upper extremities, he noted positive impingement testing on both sides, negative instability testing, and intact motor and sensory testing.

With regard to the right shoulder, range of motion (ROM) of the right upper extremity was recorded as 120 degrees flexion, 35 degrees extension, 110 degrees abduction, 15 degrees adduction, 65 degrees internal rotation, and 45 degrees external rotation. In rating appellant's right upper extremity under the ROM method, Dr. Benatar determined that loss of flexion represented 3 percent permanent impairment, loss of extension represented 1 percent permanent impairment, loss of abduction represented 3 percent permanent impairment, loss of adduction represented 1 percent permanent impairment, loss of internal rotation represented 3 percent permanent impairment, and loss of external rotations represented 2 percent impairment, for a total permanent impairment of 12 percent. Utilizing Table 15-35 on page 477 of the sixth edition of the American

[3] *Order Granting Remand*, Docket No. 19-0240 (issued March 22, 2019).

Medical Association *Guides to the Evaluation of Permanent Impairment* (A.M.A. *Guides*),[4] Dr. Benatar assigned a grade modifier 2 for the 12 percent ROM impairment rating and a grade modifier for functional history (GMFH) of 2 that resulted in no change in the overall rating. He found that, under Table 15-34, appellant had 12 percent right upper extremity permanent impairment for loss of ROM, noting that the greatest of three measurements was used to calculate permanent impairment. 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*.[5] Dr. Benatar noted that appellant had a class of diagnosis (CDX) of 1 with a default value of two percent for residual symptoms and consistent objective findings for a diagnosis of right shoulder labral lesions including superior labrum anterior and posterior (SLAP) tear. He assigned a GMFH of 2, a grade modifier for clinical studies (GMCS) of 1, and a grade modifier for physical examination (GMPE) of 2, which moved the default value two spaces to the right resulting in a class 1, grade E rating of five percent permanent impairment of the right upper extremity. Dr. Benatar opined that appellant had 12 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.

With regard to the left shoulder, Dr. Benatar determined that, under Table 15-34, appellant had eight percent permanent impairment, noting that the greatest of three measurements was used to calculate permanent impairment. Using the DBI method, he noted that she had a CDX of 1 with a default value of three percent for a diagnosis of left shoulder impingement with residual loss. Dr. Benatar assigned a grade modifier for GMFH of 2, a grade modifier for GMCS of 0, and a grade modifier for GMPE of 1, which resulted in a class 1, grade C or three percent permanent impairment of the right upper extremity. He opined that appellant had eight percent permanent impairment of the left upper extremity based on the ROM rating method, which was greater than the three percent permanent impairment rating based on the DBI rating method.

On April 13, 2021 OWCP referred the medical record, including Dr. Benatar's March 26, 2021 report, to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA). In a report dated April 16, 2021, Dr. Harris concurred with Dr. Benatar's bilateral upper extremity findings. For the lower extremities, he indicated that appellant did not have any neurologic deficit in either the left or right lower extremity consistent with lumbar radiculopathy. This was consistent with severity 0 under Table 16-11 and a Class 0 impairment based on Table 2 of *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) *(The Guides Newsletter).* Dr. Harris concluded that this resulted in zero percent permanent impairment for lumbar radiculopathy in either the left or right lower extremity based on the methodology described in *The Guides Newsletter*. He indicated that the A.M.A., *Guides* did not allow for an impairment rating under the ROM method. Dr. Harris opined that appellant reached MMI on March 26, 2021, the date of Dr. Benatar's examination.

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

[5] *Id*.

By decision dated July 6, 2021, OWCP granted appellant a schedule award for 8 percent permanent impairment of her left upper extremity and 12 percent permanent impairment of her right upper extremity. The award ran 62.4 weeks for the period March 27, 2021 to June 6, 2022.

On July 27, 2021 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review.

By decision dated September 30, 2021, OWCP's hearing representative affirmed the July 6, 2021 decision.

LEGAL PRECEDENT -- ISSUE 1

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 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 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.[11] After a CDX is determined (including identification of a default grade value), the impairment class is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13]

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.*; *see also B.B.*, Docket No. 20-1187 (issued November 18, 2021); *Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

[10] *B.B.*, *supra* note 8; *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] *B.B.*, *id.*; *M.D.*, *id.*; *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

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

[13] *Id.*

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:

> "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 OWCP's 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 -- ISSUE 1

The Board finds that appellant has not met her burden of proof to establish greater than 12 percent permanent impairment of her right upper extremity and 8 percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

In a March 26, 2021 report, Dr. Benatar reviewed the SOAF and set forth his examination findings. He opined that appellant reached MMI on March 26, 2021. For the accepted right

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

[15] *Id.*

[16] *Id.*

[17] *See supra* note 9 at Chapter 2.808.6(f) (February 2013). *See also D.S.*, Docket No. 20-0670 (issued November 2, 2021); *J.T.*, Docket No. 17-1465 (issued September 25, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

shoulder labral lesions including SLAP tear, Dr. Benatar found under Table 15-5 a Class 1 impairment and default of two percent upper extremity impairment. He assigned a GMFH of 2, GMPE of 2, and a GMCS of 1, under Table 15-7, Table 15-8, and Table 15-9, respectively. Dr. Benatar found that the net adjustment within the diagnostic class resulted in Grade E or five percent right upper extremity permanent impairment for the accepted right shoulder labral lesions including SLAP tear. He also utilized the ROM rating method to determine permanent impairment to the right shoulder. Utilizing Table 15-34, page 475, Dr. Benatar determined that 120 degrees flexion represented 3 percent permanent impairment, 35 degrees extension represented 1 percent permanent impairment, 110 degrees abduction represented 3 percent permanent impairment, 15 degrees adduction represented 1 percent permanent impairment, and the internal rotation represented 3 percent permanent impairment, and external rotations represented 2 percent impairment, resulting in a total of 12 percent permanent impairment of the right upper extremity. Utilizing Table 15-35 on page 477, he assigned a grade modifier of 2 for the 12 percent ROM impairment rating and a GMFH of 2 that resulted in no change.

For the accepted left shoulder impingement CDX, Dr. Benatar found, under Table 15-5, a Class 1 impairment with residual loss of function and default value of three percent left upper extremity impairment. He assigned a GMFH of 2, GMPE of 1, and a GMCS of 0, under Table 15-7, Table 15-8, and Table 15-9, respectively. Dr. Benatar found that the net adjustment within the diagnostic class was zero, which resulted in Grade C or three percent permanent impairment. He also utilized the ROM rating method to determine permanent impairment to the left shoulder. Utilizing Table 15-34, page 475, Dr. Benatar determined that had a total of eight percent permanent impairment of the left upper extremity. As using the ROM method resulted in greater impairment than the DBI rating method, Dr. Benatar concluded that appellant had a total of eight percent left upper extremity permanent impairment.

In accordance with its procedures,[18] OWCP properly referred the evidence of record to Dr. Harris, serving as the DMA, who reviewed the March 26, 2021 report and clinical findings of Dr. Benatar. In his April 16, 2021 report, Dr. Harris concluded that appellant's bilateral shoulder permanent impairments under the ROM rating method were greater than her bilateral shoulder impairments using the DBI rating method. He concurred with Dr. Benatar, that, pursuant to the sixth edition of the A.M.A., *Guides*, the ROM methodology established 12 percent permanent impairment of the right upper extremity and 8 percent impairment of the left upper extremity.

The Board finds that OWCP properly determined that appellant has not established greater than 12 percent permanent impairment of the right shoulder and 8 percent permanent impairment of the left upper extremity based on the clinical findings and reports of Dr. Benatar and Dr. Harris.[19] There is no probative medical evidence of record demonstrating greater impairment than that previously awarded.[20]

[18] *Id*.

[19] *See D.S.*, *id*.; *J.S.*, Docket No. 19-1567 (issued April 1, 2020); *J.M.*, Docket No. 18-1334 (issued March 7, 2019).

[20] *See D.S.*, *id*.; *D.F.*, Docket No. 17-1474 (issued January 26, 2018); *A.T.*, Docket No. 16-0738 (issued May 19, 2016).

Appellant may request a schedule award or increased schedule award based at any time on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased permanent impairment.

LEGAL PRECEDENT -- ISSUE 2

Neither FECA nor its implementing regulations provides for the payment of a schedule award for the permanent loss of use of the back/spine, or the body as a whole. However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[21] The sixth edition of the A.M.A., *Guides* provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated into OWCP's procedures.[22]

ANALYSIS -- ISSUE 2

The Board further finds that appellant has not met her burden of proof to establish any permanent impairment of her lower extremities, warranting a schedule award.

OWCP accepted appellant's claim for lumbar spine and pelvis and bilateral shoulder sprains. In a March 26, 2021 report, Dr. Benatar examined her and found no neurologic deficit of either lower extremity consistent with lumbar radiculopathy. Consistent with its procedures,[23] OWCP properly referred the matter to a DMA for an opinion regarding appellant's permanent impairment in accordance with the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter*.

On April 16, 2021 Dr. Harris, OWCP's DMA, reviewed Dr. Benatar's March 26, 2021 report and opined that appellant did not have any neurologic deficit in either lower extremity consistent with lumbar radiculopathy. He found that this was consistent with severity 0 under Table 16-11 and a Class 0 impairment based on Table 2 of *The Guides Newsletter*. Dr. Harris concluded that this resulted in zero percent permanent impairment for lumbar radiculopathy in either the left or right lower extremity based on the methodology described in *The Guides Newsletter*. He indicated that the A.M.A., *Guides* did not allow for a lower extremity impairment rating assessed under ROM.

The Board finds that appellant has not established entitlement to a schedule award due to her accepted lumbar condition under *The Guides Newsletter*. The record contains no medical

[21] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see B.B.*, *supra* note 8; *A.G.*, Docket No. 18-0815 (issued January 24, 2019); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[22] *Supra* note 9 at Chapter 3.700, Exhibit 4 (January 2010); *see B.B.*, *id.*; *E.G.*, Docket No. 19-1081 (issued September 24, 2020).

[23] *Supra* note 16.

evidence in accordance with *The Guides Newsletter* demonstrating permanent impairment of either lower extremity due to her accepted lumbar condition.[24]

CONCLUSION

The Board finds that appellant has not established greater than 8 percent permanent impairment of the left upper extremity and 12 percent permanent impairment of the right upper extremity for which she previously received a schedule award. The Board also finds that appellant has not met her burden of proof to establish any permanent impairment of her lower extremities, warranting a schedule award.

ORDER

IT IS HEREBY ORDERED THAT September 30, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 12, 2022
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

[24] *See B.B.*, *supra* note 8; *E.G.*, Docket No. 19-1081 (issued September 24, 2020); *T.K.*, Docket No. 19-1222 (issued December 2, 2019); *C.S.*, Docket No. 18-0920 (issued September 23, 2019).