United States Department of Labor
Employees' Compensation Appeals Board

L.B., Appellant	)	
and	)	**Docket No. 22-1031**
	)	**Issued: April 6, 2023**
DEPARTMENT OF THE ARMY, ARMY FIELD SUPPORT BATALLION, Fort Stewart, GA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On June 27, 2022 appellant filed a timely appeal from a February 1, 2022 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 his burden of proof to establish greater than 15 percent permanent impairment of the left upper extremity for which he previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On December 6, 2016 appellant, then a 62-year-old logistics management specialist, filed a traumatic injury claim (Form CA-1) alleging that on April 10, 2015 he sustained a left shoulder injury when he moved a bookshelf in his office to access a picture that had fallen, while in the performance of duty. He stopped work on November 22, 2016.

On November 22, 2016 Dr. Douglas R. Adams, a Board-certified orthopedic surgeon, performed left shoulder arthroscopic rotator cuff repair, SLAP (superior labrum anterior and posterior) lesion repair, open biceps tenodesis, and arthroscopic os acromiale excision.

By decision dated February 3, 2017, OWCP accepted appellant's claim for complete rotator cuff tear or rupture of the left shoulder. Appellant returned to light-duty work in 2017.

In an April 23, 2019 report, Dr. Jay B. Cook, a Board-certified orthopedic surgeon, noted that appellant's November 22, 2016 surgery had been complicated by adhesive capsulitis. A March 30, 2018 magnetic resonance imaging (MRI) scan of the left shoulder demonstrated a partial thickness rotator cuff tear. Dr. Cook opined that as the MRI scan demonstrated a partial left rotator cuff tear, and appellant had continued limited range of motion, weakness, and pain, that he had attained maximum medical improvement (MMI).

In a June 14, 2019 report, Dr. Aaron D. Roberts, an orthopedist, reviewed an MRI scan of the left shoulder which demonstrated partial thickness tearing of the surgical repair with some fibers intact, edema at the anchor insertion site, and edema in the undersurface of the supraspinatus. He opined that as appellant was not interested in further operative treatment, his left shoulder had "probably" attained MMI.

A July 18, 2019 functional capacity evaluation (FCE), signed by physical therapists Josh Bauer and Carrie Ripp, demonstrated appellant's capacity to perform light- to medium-duty work with restrictions. They obtained range of motion measurements for the left shoulder of 85 degrees flexion, 27 degrees extension, 71 degrees abduction, 38 degrees adduction, 20 degrees internal rotation, and 31 degrees external rotation. Mr. Bauer and Ms. Ripp observed 3/5 motor strength in shoulder abduction and 4/5 strength for all other maneuvers.

In an August 12, 2019 work slip, Dr. James W. Wilson, a Board-certified orthopedic surgeon, noted examining appellant that day. He concluded that the July 18, 2019 FCE demonstrated 13 percent permanent impairment of the left upper extremity.

On September 9, 2019 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a statement of accepted facts (SOAF) dated September 17, 2019, OWCP noted that it had expanded acceptance of appellant's claim to include adhesive capsulitis of the left shoulder.

On November 22, 2019 OWCP referred appellant, the medical record, a SOAF, and a series of questions to Dr. Raymond Topp, Jr., a Board-certified orthopedic surgeon, for a second opinion examination regarding the extent of any employment-related permanent impairment.

In a report dated December 18, 2019, Dr. Topp discussed appellant's complaints of pain at the superior aspect of the left shoulder, worse with abduction and extension of the left upper extremity. On examination he measured the ROM of the bilateral shoulders three times following a warmup, and averaged the measurements to result in flexion of 170 degrees on the right and 100 degrees on the left, abduction of 170 degrees on the right and 90 degrees on the left, adduction of 40 degrees on the right and 20 degrees on the left, extension of 40 on the right and 10 degrees on the left, external rotation of 80 degrees on the right and 40 degrees on the left, and internal rotation of 80 degrees on the right and 40 degrees on the left. Dr. Topp obtained x-rays of the left shoulder, which demonstrated a Type 1 acromion and mild glenohumeral degenerative joint disease without joint narrowing. He diagnosed left shoulder pain, adhesive capsulitis of the left shoulder, other specific arthropathies of the left shoulder, unspecified rotator cuff tear or rupture of the left shoulder, not specified as traumatic, and traumatic complete left rotator cuff tear. Dr. Topp opined that appellant had reached MMI in November 2017, one year following the November 22, 2016 surgical procedure.

Referencing Table 15-5 (Shoulder Regional Grid), page 403, of the sixth edition of American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[2] Dr. Topp identified the class of diagnosis (CDX) for rotator cuff tear and adhesive capsulitis with suboptimal surgical results, as range of motion on the affected left side equaled 31 to 60 percent of the unaffected right shoulder. He explained that the diagnosis-based impairment (DBI) method was not applicable to appellant's case as his impairment was caused by loss of motion. Additionally, the range of motion (ROM) method would result in a higher percentage of impairment. Again, referencing Table 15-5, Dr. Topp found three percent impairment for left shoulder flexion at 100 degrees, two percent impairment for extension at 10 degrees, three percent impairment for abduction at 90 degrees, one percent impairment for abduction at 20 degrees, four percent impairment for internal rotation at 40 degrees, and two percent impairment for external rotation at 40 degrees. He added the impairments according to Table 15-34, page 475 of the A.M.A., *Guides* to calculate a final 15 percent permanent impairment of the left upper extremity.

In a February 2, 2020 report, Dr. Morley Slutsky, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), noted that Dr. Topp did not properly report the ranges of left shoulder motion observed as he averaged the three trials instead of recording the best of the three measurements for each maneuver. He offered a DBI impairment calculation of a seven percent permanent impairment of the left upper extremity.

On April 2, 2020 OWCP requested that Dr. Topp submit a supplemental report noting the measurements of the best of the three trials for each range of motion maneuver.

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

In an April 14, 2020 report, Dr. Topp clarified that the ROM measurements provided in his December 18, 2019 impairment assessment were the highest of the three trials recorded for each range of motion.

In a May 17, 2020 report, Dr. Slutsky concurred with Dr. Topp's assessment of 15 percent permanent impairment of the left upper extremity utilizing the ROM assessment method.

By decision dated June 19, 2020, OWCP granted appellant a schedule award for 15 percent permanent impairment of the left upper extremity (left arm). The period of the award ran for 46.8 weeks from December 18, 2019 through November 9, 2020.

On September 14, 2020 appellant filed a Form CA-7 for an increased schedule award.

In a March 4, 2021 report, Dr. Wilson noted that appellant had retired from the employing establishment in 2019 due to left shoulder pain requiring medication. He recounted appellant's complaints of difficulty with activities of daily living. Dr. Wilson opined that according to section 15.7g, page 472, and Table 15-34 of the A.M.A., *Guides*, appellant had three percent impairment of the left upper extremity for shoulder flexion at 105 degrees, one percent impairment for extension at 35 degrees, zero percent impairment for adduction at 40 degrees, three percent impairment for abduction at 100 degrees, four percent impairment for external rotation at 40 degrees, and two percent impairment for internal rotation at 70 degrees. He added these percentages to total 13 percent permanent impairment of the left upper extremity. Dr. Wilson then found a grade modifier for functional history (GMFH) resulting in an increase to the ROM impairment of 5 percent, resulting in a final 14 percent permanent impairment of the left upper extremity.

In a May 9, 2021 report, Dr. Slutsky found that Dr. Wilson had not indicated that he had performed the required three trials for each range of left shoulder motion recorded. Therefore, the ranges of motion reported could not be relied upon for impairment calculations.

On August 25, 2021 OWCP referred appellant, the medical record, an updated SOAF, and a series of questions to Dr. John P. George, a Board-certified orthopedic surgeon, for a second opinion examination regarding the extent of any employment-related permanent impairment.

In an October 21, 2021 report, Dr. George reviewed the medical record and SOAF. On examination, he observed limitation on "most all of his range of motion" of the left shoulder. Dr. George noted that appellant had reached MMI approximately one year after the November 2016 surgical procedure. He opined that the ROM rating method was preferable to the DBI rating method in appellant's case as it would provide a higher percentage of impairment. Referencing Table 15-5 of the A.M.A., *Guides*, Dr. George identified the CDX as rotator cuff impingement with a Class 1 impairment. He measured the ROM of the shoulders three times following a warmup, and noted that the highest of the three measurements were flexion at 180 degrees on the right and 110 degrees on the left, extension at 50 degrees on the right and 30 degrees on the left, abduction of 170 degrees on the right and 95 degrees on the left, adduction of 50 degrees on the right and 20 degrees on the left, internal rotation of 80 degrees on the right and 30 degrees on the left, and external rotation of 60 degrees on the right and 30 degrees on the left. Dr. George

found three percent impairment for limited flexion, one percent for limited extension, three percent for limited abduction, one percent for limited adduction, four percent for limited internal rotation, and two percent for limited external rotation. He added these percentages to calculate a total 14 percent permanent impairment of the left upper extremity.

In a January 24, 2022 report, Dr. Taisha Williams, a Board-certified physiatrist serving as an OWCP DMA, concurred with Dr. George's impairment rating and method of calculation.

By decision dated February 1, 2022, OWCP denied appellant's claim for an increased schedule award, based on Dr. George's medical opinion as reviewed by Dr. Williams, the DMA.

LEGAL PRECEDENT

The schedule award provisions of FECA,[3] and its implementing federal regulations,[4] 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 way 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 sixth edition of the A.M.A., *Guides*, published in 2009.[5] 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.[6]

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): A Contemporary Model of Disablement*.[7] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by GMFH, grade modifier for physical examination (GMPE), and grade modifier for clinical studies (GMCS).[8] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9] Evaluators are directed to

[3] *Supra* note 1.

[4] 20 C.F.R. § 10.404.

[5] 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 2.808.5a (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

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

[7] A.M.A., *Guides* 3 (6th ed. 2009), section 1.3.

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

[9] *Id.* 411.

provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[10]

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.[11]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 15 percent permanent impairment of the left upper extremity for which he previously received a schedule award.

In a March 4, 2021 impairment evaluation, Dr. Wilson found that appellant had 14 percent permanent impairment of the left upper extremity due to loss of ROM of the shoulder pursuant to the sixth edition of the A.M.A., *Guides*. However, he did not indicate that the ROM measurements recorded were the highest of the three trials for each maneuver. Thus, Dr. Wilson's opinion is of diminished probative value as it does not conform to the A.M.A., *Guides*.[12]

On October 21, 2021 Dr. George, an OWCP referral physician, found that appellant had limited range of left shoulder motion. He measured ROM of the bilateral shoulders. Dr. George diagnosed rotator cuff impingement. He determined that appellant had 14 percent permanent impairment of the left upper extremity due to loss of shoulder ROM, finding that 110 degrees flexion yielded three percent impairment, 30 degrees extension yielded one percent impairment, 95 degrees abduction yielded three percent impairment, adduction at 20 degrees yielded one percent impairment, 30 degrees internal rotation yielded four percent impairment, and 30 degrees external rotation yielded two percent impairment. Dr. George added the impairments for a final 14 percent permanent impairment of the left upper extremity. On January 24, 2022 Dr. Williams, the OWCP DMA, concurred with Dr. George's impairment rating and methodology. The Board finds, therefore, that the evidence supports that appellant has no more than 15 percent permanent impairment of the left upper extremity.[13]

As appellant has not established greater than 15 percent permanent impairment of the left upper extremity, for which he previously received a schedule award, the Board finds that he has not met his burden of proof.

[10] *H.C.*, Docket No. 21-0761 (issued May 5, 2022); *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[11] *See supra* note 5 at Chapter 2.808.6f. *See also 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).

[12] *See L.Y.*, Docket No. 20-0398 (issued February 9, 2021).

[13] *See R.R., supra* note 10.

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 his burden of proof to establish greater than 15 percent permanent impairment of the left upper extremity for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the February 1, 2022 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 6, 2023
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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