United States Department of Labor
Employees' Compensation Appeals Board

J.D., widow of J.D., Appellant	)	
and	)	**Docket No. 22-0427**
	)	**Issued: January 5, 2023**
DEPARTMENT OF DEFENSE, DEFENSE COMMISSARY AGENCY, Camp Pendleton, CA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
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 January 28, 2022 appellant, through counsel, filed a timely appeal from a December 28, 2021 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq*.

ISSUE

The issue is whether appellant has met her burden of proof to establish that the employee had greater than 13 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

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

On March 15, 2003 the employee, then a 52-year-old meat cutter, filed a traumatic injury claim (Form CA-1) alleging that on that date he injured his left shoulder when lifting a piece of meat while in the performance of duty. OWCP accepted the claim for an aggravation of a left rotator cuff tear.[4]

On February 14, 2003 the employee underwent an arthroscopic subacromial decompression and coupling of the distal clavicle of the left shoulder. On May 27, 2003 he underwent a left shoulder mini open rotator cuff repair. On January 30, 2004 the employee underwent a left shoulder mini open rotator cuff repair and lysis of adhesions.

In a report dated September 24, 2004, Dr. Thomas Wenyeh Wang, a physician Board-certified in family medicine, diagnosed a left shoulder rotator cuff tear and re-tear, status post repairs. He provided range of motion (ROM) measurements for the left upper extremity.

On October 25, 2006 Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), applied the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[5] to Dr. Wang's clinical findings. He determined that the employee had 6 percent impairment of the left upper extremity due to loss of ROM of the left shoulder and 6 percent impairment of the left upper extremity due to left shoulder muscle weakness, for a total left upper extremity impairment rating of 13 percent.

By decision dated November 29, 2007, OWCP granted the employee a schedule award for 13 percent permanent impairment of the left upper extremity. The award was for 40.56 weeks and ran for the period November 25, 2007 to September 3, 2008.

[3] Docket No. 19-1168 (issued March 29, 2021).

[4] OWCP assigned the present claim OWCP File No. xxxxxx748. It had previously accepted, under OWCP File No. xxxxxx242, that the employee sprained his left shoulder rotator cuff on October 31, 2002. OWCP has also accepted, under OWCP File No. xxxxxx555, that appellant sprained/strained his left shoulder on December 18, 2002. It has administratively combined OWCP File Nos. xxxxxx242, xxxxxx555, and xxxxxx748, with the latter serving as the master file.

[5] A.M.A., *Guides* (5th ed. 2001).

On March 3, 2009 the employee underwent arthroscopic surgery with a mini open rotator cuff repair of the left shoulder.[6]

On June 10, 2015 OWCP expanded the acceptance of the claim to include aggravation of left shoulder arthritis.

OWCP referred the employee to Dr. Frederick W. Close, a Board-certified orthopedic surgeon, for a second opinion examination to determine his current work capacity and ability to participate in vocational rehabilitation.

In a report dated September 3, 2015, Dr. Close diagnosed traumatic arthritis and adhesive capsulitis of the left shoulder causally related to the accepted employment injury. He measured ROM for the shoulders one time and found that the employee had 10 percent permanent impairment of the left upper extremity due to loss of ROM. Dr. Close found that he was totally disabled from work.

The employee underwent a functional capacity evaluation (FCE) on November 19, 2015. The FCE provided one set of ROM measurements for the shoulders bilaterally.

In a report dated April 11, 2017, Dr. Wang reviewed the results from the November 19, 2015 FCE. He provided one set of ROM measurements for the bilateral shoulders and found that the employee had normal strength. Dr. Wang diagnosed left rotator cuff syndrome.

In an April 26, 2017 impairment rating report, Dr. Mesfin Seyoum, who specializes in family medicine, indicated that he had reviewed the evidence of record, but had not physically examined the employee. He diagnosed a rotator cuff tear and strain and adhesive capsulitis of the left shoulder. Utilizing Dr. Wang's physical findings, and referencing the sixth edition of the A.M.A., *Guides*, Dr. Seyoum identified the class of diagnosis (CDX) as a class 3 left shoulder arthroplasty according to Table 15-5 on page 405, which yielded a default impairment rating of 30 percent. He found a grade modifier for physical examination (GMPE) and a grade modifier for clinical studies (GMCS) of two and that a grade modifier for functional history (GMFH) was not applicable due to lack of information available to review. Dr. Seyoum utilized the net adjustment formula to find no change from the default value of 30 percent. He further found 15 percent permanent impairment due to loss of ROM of the shoulder according to Table 15-34 on page 475. Dr. Seyoum used ROM measurements from November 2015.

On June 16, 2017 the employee filed a claim for compensation (Form CA-7) for an increased schedule award.

On August 30, 2017 Dr. Morley Slutsky, Board-certified in occupational medicine and serving as a DMA, noted that Dr. Seyoum had based his impairment calculations due to loss of ROM of the employee's left shoulder on a November 2015 FCE. He opined that the measurements were invalid for purposes of rating impairment under the A.M.A., *Guides* as the evaluator had not obtained three ROM measurements per joint. Using the diagnosis-based impairment (DBI) method, Dr. Slutsky identified the CDX as a class 1 full-thickness rotator cuff tear with residual dysfunction according to Table 15-5 on page 403, which yielded a default value of five percent.

[6] On January 1, 2017 the employee elected to receive retirement benefits from the Office of Personnel Management in lieu of wage-loss compensation from OWCP.

He applied a GMFH of one and found that a GMPE was not applicable as Dr. Seyoum had not provided examination findings. Dr. Slutsky further noted that clinical studies were used to identify the correct diagnosis class and thus a GMCS was inapplicable. He found no adjustment from the default value of five percent for the left upper extremity after applying the net adjustment formula. Dr. Slutsky opined that the employee had reached maximum medical improvement (MMI) on April 11, 2017, the date of Dr. Wang's last examination. He noted that the employee had previously received an award for 13 percent left shoulder impairment and thus was not entitled to an increased schedule award.

By decision dated September 5, 2017, OWCP denied the employee's claim for an increased schedule award.

On September 11, 2017 the employee, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. A telephonic hearing was held on February 14, 2018.

By decision dated March 29, 2018, OWCP's hearing representative vacated the September 5, 2017 decision, finding that OWCP had not fully complied with FECA Bulletin No. 17-06. He remanded the case for OWCP to refer the employee for a second opinion examination on the issue of the extent of his left upper extremity impairment. OWCP's hearing representative noted that, if the A.M.A., *Guides* allowed for both the DBI and ROM methods to rate an impairment, both should be calculated and the greater used to determine the impairment percentage.

In a report dated February 21, 2018, Dr. Seyoum reviewed Dr. Slutsky's August 28, 2017 report. He noted that he had based his impairment rating on a November 2015 report from Dr. Wang as it was the most current evidence available for his review. Dr. Seyoum identified the CDX as a class 1 acromioplasty using Table 15-5 on page 403 of the A.M.A., *Guides,* which he found yielded an impairment rating range of 8 to 12 percent. He applied GMPE and GMCS of two and found that a GMFH was inapplicable. After using the net adjustment formula, Dr. Seyoum found 12 percent permanent impairment of the left shoulder using the DBI method. He noted that he would need to review three active ROM measurements for the shoulder to use the ROM method.

The employee passed away on April 22, 2018.

In a June 29, 2018 supplemental report, DMA Dr. Slutsky found no change from his prior impairment rating. He noted that Dr. Seyoum had rated the employee for an acromioplasty, which he advised was not a ratable diagnosis. Dr. Slutsky noted that he had based his impairment rating on Dr. Wang's findings in his April 11, 2017 report. He asserted, however, that Dr. Wang had failed to provide valid ROM measurements and thus rated the employee using the DBI method. Dr. Slutsky noted that the A.M.A., *Guides* found that an acromioplasty differed from status post distal clavicle excision. He reiterated that the employee had five percent permanent impairment of the left upper extremity. As the employee had previously received an award for 13 percent of the same joint, Dr. Slutsky found that he had no additional impairment.

By decision dated July 24, 2018, OWCP denied appellant's claim for an increased schedule award.

On July 30, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

A telephonic hearing was held on December 13, 2018.

By decision dated February 15, 2019, OWCP's hearing representative affirmed the July 24, 2018 decision.

Appellant appealed to the Board. By decision dated March 29, 2021, the Board set aside the February 15, 2019 decision.[7] The Board found that Dr. Slutsky had not explained why the ROM measurements obtained by Dr. Wang were invalid. The Board remanded the case for the DMA to clarify his findings.

On May 12, 2021 Dr. Slutsky noted that on February 21, 2018 Dr. Seyoum had advised that his April 26, 2017 impairment rating was based on Dr. Wang's November 10, 2015 report. He found that Dr. Wang and the FCE examiner had provided invalid ROM findings based on the criteria set forth in the A.M.A., *Guides*. Dr. Slutsky set forth the criteria required by the A.M.A., *Guides* for rating impairment using the ROM method in his report. He noted that Dr. Seyoum had rated appellant for a distal clavicle resection even though he had undergone a co-planning rather than a resection. Dr. Slutsky indicated that he would use the September 3, 2015 report from Dr. Close for his impairment rating. He noted that he had previously determined that the most accurate diagnosis was a full-thickness rotator cuff tear with residual dysfunction, which yielded an impairment rating between three and seven percent depending on grade modifiers. Dr. Slutsky found, however, that Dr. Close had diagnosed shoulder arthritis in his September 3, 2015 report. Dr. Slutsky consequently identified the CDX as class 1 arthritis, which yielded a default impairment of five under Table 15-5 on page 405 of the A.M.A., *Guides*. He applied a GMFH of one, a GMPE of two due to tenderness to palpation, and found a GMCS was not applicable as it was used to identify the appropriate diagnosis class. In applying the GMPE, Dr. Slutsky noted that Dr. Close had documented only one motion per joint, which was inconsistent with the criteria for a valid ROM impairment rating under the A.M.A., *Guides*. He found, after utilizing the net adjustment formula, that the employee had seven percent left upper extremity impairment using the DBI method. Dr. Slutsky noted that the employee had previously been awarded 13 percent for the same left shoulder joint, and thus was not entitled to an increased award.

By decision dated June 23, 2021, OWCP denied appellant's claim for an increased schedule award.

On June 29, 2021 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

A telephonic hearing was held on October 19, 2021.

By decision dated December 28, 2021, OWCP's hearing representative affirmed the June 23, 2021 decision.

[7] *Supra* note 3.

LEGAL PRECEDENT

The schedule award provisions of FECA,[8] and its implementing federal regulations,[9] 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 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.[10] 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.[11]

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: A Contemporary Model of Disablement*.[12] Under the sixth edition, the evaluator identifies the impairment CDX which is then adjusted by a GMFH, GMPE, and GMCS.[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[15]

The A.M.A., *Guides* also provides that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[16] 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.[17] Adjustments for functional history may be made if the evaluator

[8] *Supra* note 2.

[9] 20 C.F.R. § 10.404.

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

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

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

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

[14] *Id*. at 411.

[15] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[16] A.M.A., *Guides* 461.

[17] *Id*. at 473.

determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[18]

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

> "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).
>
> "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.)[19]

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."[20]

It is well established that benefits payable under 5 U.S.C. § 8107(c) are reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different part of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[21]

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.[22]

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[18] *Id*. at 474.

[19] FECA Bulletin No. 17-06 (issued May 8, 2017). *See also L.G.*, Docket No. 18-0519 (issued March 8, 2019); *D.F.*, Docket No. 17-1474 (issued January 23, 2018).

[20] *Id*.

[21] 20 C.F.R. § 10.404(d); *see T.S.*, Docket No. 16-1406 (issued August 9, 2017); *T.S.*, Docket No. 09-1308 (issued December 22, 2009).

[22] *See* Federal (FECA) Procedure Manual, *supra* note 11 at Chapter 2.808.6f (March 2017).

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish that the employee had greater than 13 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

On prior appeal, the Board remanded the case for Dr. Slutsky, the DMA, to explain his reasoning as to why Dr. Wang's ROM measurements were not valid. On remand, in a report dated May 12, 2021, Dr. Slutsky related that Dr. Wang and the administrator of the FCE had not provided valid ROM findings in accordance with the provisions of the A.M.A., *Guides*. He noted that he had previously found that the most accurate CDX for the employee was a full-thickness rotator cuff tear with residuals dysfunction, which yielded an impairment from three to seven percent. Dr. Slutsky applied the provisions of the A.M.A., *Guides* to Dr. Close's findings in his September 3, 2015 report. He noted that Dr. Close had diagnosed shoulder arthritis in his September 3, 2015 report, and consequently identified the CDX as class 1 arthritis, which yielded a default impairment of five percent according to Table 15-5 on page 405 of the A.M.A., *Guides*. Dr. Slutsky applied a GMFH of one, a GMPE of two due to tenderness to palpation, a found a GMCS was not applicable as it was used to identify the appropriate diagnosis class. He applied the net adjustment formula and concluded that the employee had seven percent left upper extremity impairment.[23] Dr. Slutsky further noted that Dr. Close had only documented one ROM measurement per joint, which did not meet the criteria for rating a ROM impairment under the A.M.A., *Guides*. He determined that appellant was not entitled to an additional schedule award as the employee previously received 13 percent for the same left shoulder joint.

As noted by Dr. Slutsky, neither Dr. Wang nor Dr. Close provided ROM measurements in accordance with the A.M.A., *Guides*. Section 15.7 on page 464 of the A.M.A., *Guides* provides that, for ROM, three motion measurements per joint movement must be obtained to meet the validity criteria. As Dr. Wang and Dr. Close failed to measure ROM three times, their measurements are not valid for impairment calculations.[24]

Using the DBI methodology for rating impairment, Dr. Slutsky indicated that using the CDX of a full-thickness tear of the rotator cuff yielded between a 3 and 7 percent impairment under Table 15-5 on page 403 due to a full-thickness tear. In his subsequent report, using the CDX of arthritis, or post-traumatic degenerative joint disease, he found an impairment of 7 percent after applying grade modifiers. The maximum allowed for the diagnosis of class 1 arthritis under Table 15-5 on page 405 is 9 percent. The employee previously received 13 percent permanent impairment of the left shoulder for weakness and loss of ROM. There is no medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, establishing that the employee has greater than 13 percent permanent impairment of the left upper extremity. Accordingly, appellant has not established entitlement to a schedule award greater than that previously awarded.

[23] Utilizing the net adjustment formula discussed above, (GMFH-CDX) + (GMPE-CDX) or (1-1) + (2-1) = 0, yielded a zero adjustment.

[24] A.M.A., *Guides* 464; *see also C.H.*, Docket No. 20-0529 (issued June 16, 2021).

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 that the employee had greater than 13 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the December 28, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 5, 2023
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