United States Department of Labor
Employees' Compensation Appeals Board

C.A., Appellant	)	
and	)	**Docket No. 21-0971**
	)	**Issued: June 1, 2023**
U.S. POSTAL SERVICE, POST OFFICE, Hamburg, NY, Employer	)	

Appearances:
Marissa Hines, 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
JANICE B. ASKIN, Judge

JURISDICTION

On June 7, 2021 appellant, through counsel, filed a timely appeal from a December 16, 2020 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 his burden of proof to establish greater than 11 percent permanent impairment of his left upper extremity for which he previously received a schedule award.

FACTUAL HISTORY

On January 2, 2019 appellant, then a 38-year-old rural carrier, filed a traumatic injury claim (Form CA-1) alleging that on January 2, 2019 he injured his left shoulder when a tray of mail he was pulling from the rear ledge snagged on something causing his shoulder to "twang" and then "pop" as he pushed the mail tray into place while in the performance of duty. He stopped work on January 2, 2019. On February 26, 2019 OWCP accepted the claim for strain of the left shoulder and upper arm.

On May 22, 2019 appellant's attending physician, Dr. Joseph E. Buran, a Board-certified orthopedic surgeon, diagnosed multidirectional glenohumeral instability of the left shoulder and performed an OWCP-authorized left shoulder arthroscopy with labrum debridement, anterior and inferior capsular reconstruction, and grade 2 superior labrum anterior to posterior (SLAP) repair with extensive subacromial bursitis. He provided a postoperative report dated September 12, 2019 finding that appellant was 100 percent temporarily disabled. He continued to provide treatment notes dated October 24, 2019 through February 13, 2020 indicating that appellant remained disabled.

On December 20, 2019 OWCP referred appellant, a statement of accepted facts (SOAF), and series of questions for a second opinion evaluation with Dr. Peter T. Remec, an orthopedic surgeon. Dr. Remec completed a report on January 20, 2020 recounting appellant's history of injury and medical history. He provided his findings on physical examination including range of motion measurements. Dr. Remec opined that appellant had not reached maximum medical improvement (MMI) as additional medical recovery could be expected.

Appellant returned to full-time, regular duty on March 2, 2020.

On August 12, 2020 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In an August 12, 2020 development letter, OWCP informed appellant that no medical evidence was received in support of his schedule award claim. It requested that he submit a detailed report from his treating physician which provided an impairment evaluation pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] OWCP specifically requested an opinion as to whether appellant had reached MMI, a diagnosis upon which the impairment was based, a detailed description of objective findings and subjective complaints, and a detailed description of any permanent impairment under the applicable criteria and tables in the sixth edition of the A.M.A., *Guides*.

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

On September 24, 2020 Dr. Buran diagnosed superior glenoid labrum lesion of the left shoulder and other instability, left shoulder. He opined that appellant had reached MMI following his left arthroscopic debridement anterior capsular reconstruction with labral repair, and subacromial bursectomy. Dr. Buran reported that appellant exhibited 150 degrees of forward flexion, 110 degrees of abduction, 10 degrees of external rotation, and 10 degrees of internal rotation. He noted that he measured range of motion (ROM) three times with a goniometer. Dr. Buran found no pain, no significant atrophy, and no significant loss of strength. He did not apply the A.M.A., *Guides* to his findings on physical examination.

Thereafter, OWCP referred the medical record and a SOAF to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, serving as an OWCP district medical adviser (DMA) for review and application of the A.M.A., *Guides*.

In an October 26, 2020 report, Dr. Harris reviewed Dr. Remec's report including appellant's ROM findings made prior to MMI. He applied the A.M.A., *Guides* utilizing the DBI method and found that the appellant had five percent impairment of the left upper extremity. Dr. Harris determined that appellant had reached MMI on January 20, 2020, the date of his examination with Dr. Remec.

In an October 27, 2020 report, appellant's treating physician, Dr. Benjamin Levy, an orthopedic surgeon, recounted his history of injury and associated medical history. He opined that appellant's preoperative diagnostic studies demonstrated superior labral tear with no evidence of rotator cuff injury, and that appellant underwent an arthroscopic Bankart and SLAP lesion repair with debridement of labral issue and received pre-and postoperative diagnoses of multidirectional instability. Utilizing the sixth edition of the A.M.A., *Guides*, based on the diagnosis-based impairment (DBI) method, Dr. Levy indicated that, under Table 15-5, page 404, appellant's condition was consistent with a Class 1 multidirectional shoulder instability, with a default value of 11. He noted decreased ROM, but that there was no evidence of gross instability postoperatively. Dr. Levy further found: a grade modifier for functional history (GMFH) of 1 (mild) as defined on page 406, Table 15-7 of the A.M.A., *Guides*; a grade modifier for physical examination (GMPE) of 2 (moderate decrease in ROM from uninjured side) in accordance with page 408, Table 15-8; and a grade modifier for clinical studies (GMCS) of 2, moderate pathology as found on page 410, Table 15-9 of that A.M.A., *Guides*. He applied the net adjustment formula from page 411 of the A.M.A., *Guides* to reach a final rating of 13 percent permanent impairment of the left upper extremity.

Dr. Levy also provided appellant's loss of ROM of the left shoulder, finding that appellant exhibited 150 degrees of forward flexion, 110 degrees of abduction, 30 degrees of adduction, 80 degrees of external rotation, 20 degrees of internal rotation, and 50 degrees of extension by averaging three repetitions.

On November 18, 2020 OWCP again referred the medical evidence, including Dr. Levy's October 27, 2020 report, and a SOAF to Dr. Harris, serving as an OWCP DMA. In a November 24, 2020 report, Dr. Harris found appellant's diagnosis as status post left shoulder arthroscopic labrum debridement and labral repair with capsular reconstructions. He determined that appellant had five percent left upper extremity impairment for the DBI due to labral lesion, Class 1E, value of 5, Table 15-5, page 404 of the A.M.A., *Guides*. The DMA further determined

that appellant had permanent impairment due to loss of ROM including 3 percent for loss of shoulder flexion, 3 percent for loss of shoulder abduction, 1 percent for loss of shoulder adduction, and 4 percent for loss of shoulder internal rotation resulting in 11 percent left upper extremity impairment in accordance with Table 15-34, page 475 of the A.M.A., *Guides*, and, as such, the ROM impairment rating was appropriate.

By decision dated December 16, 2020, OWCP granted appellant a schedule award for 11 percent permanent impairment of his left upper extremity.

LEGAL PRECEDENT

The schedule award provisions of FECA,[4] and its implementing regulations,[5] 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 sixth edition of the A.M.A., *Guides*, published in 2009.[6] 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.[7]

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*.[8] Under the sixth edition, the evaluator identifies the CDX, which is then adjusted by the GMFH, GMPE, and GMCS.[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[11]

[4] *Supra* note 2.

[5] 20 C.F.R. § 10.404.

[6] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* (2009) is used. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also id*. at Chapter 3.700, Exhibit 1 (January 2010).

[7] *A.T.*, Docket No. 20-0370 (issued September 27, 2021); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[8] *See supra* note 3 at 3, section 1.3.

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

[10] *Id*. at 411.

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

The A.M.A., *Guides* also provides that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairment when other grids direct its use or when no other diagnosis-based sections are applicable.[12] 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.[13] 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.[14]

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

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[16]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 11 percent permanent impairment of his left upper extremity for which he has previously received a schedule award.

In support of his claim for a schedule award, appellant submitted an October 27, 2020 report wherein Dr. Levy diagnosed status post left shoulder arthroscopic Bankert and SLAP lesion repair with debridement of labral issue and multidirectional instability and found that he had 13 percent permanent impairment using the DBI method. The A.M.A., *Guides*, Table 15-5, pages 401 and 404 provide with regard to the DBI of multidirectional shoulder instability, that postoperative patients with persistent symptoms with no instability may be rated using the ROM method. It further notes that if ROM is normal, then the rating should be by nonspecific shoulder pain with a default grade of one percent permanent impairment of the A.M.A., *Guides*. Dr. Levy found that appellant's current diagnosis was consistent with multidirectional instability without evidence of gross instability, but did not consider that appellant should be rated with ROM as he

[12] *Supra* note 3 at 461.

[13] *Id*. at 473.

[14] *Id*. at 474.

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

[16] *Id*.

was postoperative. As a result, his impairment rating did not comply with the A.M.A., *Guides* and his report is of limited probative value.[17]

In a November 24, 2020 report, Dr. Harris, serving as a DMA, reviewed the medical evidence of record including the October 27, 2020 report from Dr. Levy and noted appellant's diagnoses as status post left shoulder arthroscopic labrum debridement and labral repair with capsular reconstructions. He determined that under the DBI methodology for a labral lesion, that appellant had five percent permanent impairment of the left upper extremity in accordance with, Table 15-5, page 404 of the A.M.A., *Guides*.

The DMA further calculated appellant's impairment using the ROM method of Table 15-34, page 475 of the A.M.A., *Guides* and Dr. Levy's findings to determine that appellant had three percent for loss of shoulder flexion, three percent for loss of shoulder abduction, one percent for loss of shoulder adduction, and 4 percent for loss of shoulder internal rotation resulting in 11 percent left upper extremity impairment such that the ROM impairment rating was appropriate.

The Board finds that Dr. Harris, serving as DMA, explained with sufficient rationale how he arrived at his conclusion that appellant sustained 11 percent permanent impairment of the left upper extremity under the A.M.A., *Guides*. As Dr. Levy did not provide an explanation for his DBI of multidirectional shoulder instability in contrast with Dr. Buran's postoperative diagnosis or the specific requirements of the A.M.A., *Guides* for this diagnosis, his report is of insufficient probative value to establish greater than 11 percent permanent impairment of the left upper extremity.

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 11 percent permanent impairment of the left upper extremity. Accordingly, appellant has not established entitlement to a schedule award greater than that previously awarded.

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 11 percent permanent impairment of his left upper extremity for which he has previously received a schedule award.

[17] *See L.J.*, Docket No. 20-1044 (issued July 9, 2021); *L.D.*, Docket No. 19-0495 (issued February 5, 2020); *S.R.*, Docket No. 18-1307 (issued March 27, 2019).

ORDER

IT IS HEREBY ORDERED THAT the December 16, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 1, 2023
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board