United States Department of Labor
Employees' Compensation Appeals Board

R.Y., Appellant	)	
and	)	**Docket No. 23-0385**
	)	**Issued: November 28, 2023**
DEPARTMENT OF HOMELAND SECURITY, U.S. CUSTOMS AND BORDER PROTECTION, Chula Vista, CA, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 18, 2023 appellant filed a timely appeal from a July 26, 2022 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]

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that following the July 26, 2022 decision, appellant submitted additional evidence to OWCP. 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 new evidence for the first time on appeal. *Id*.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 12 percent permanent impairment of the right upper extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On May 3, 2019 appellant, then a 42-year-old border patrol agent, filed a traumatic injury claim (Form CA-1) alleging that on March 12, 2019 he experienced bilateral shoulder pain and swelling after performing physical training exercises while in the performance of duty. He did not immediately stop work. OWCP assigned that claim OWCP File No. xxxxxx371 and accepted it for right and left shoulder superior glenoid labrum lesions and sprain of the ligaments of the cervical spine. It subsequently expanded the acceptance of appellant's claim to include herniated disc at C6-7 level. OWCP authorized arthroscopic surgery of the right shoulder, which was performed on August 19, 2020. It paid appellant compensation on the supplemental rolls, effective May 19, 2019.[3]

A magnetic resonance imaging (MRI) scan of the right shoulder dated April 2, 2019 revealed moderate-to-severe supraspinatus and infraspinatus tendinosis with linear interstitial fissuring of both tendons possible punctate full-thickness perforations, complex tear of the superior labrum extending into the anchor, and marked lateral downsloping of the acromion narrowing the distal coracoacromial arch.

An electromyogram and nerve conduction velocity (EMG/NCV) study dated September 26, 2019 revealed acute cervical disc protrusion at C6-7 with resolving left C7 radiculopathy and left shoulder pain.

On August 19, 2020 Dr. Michael R. Lenihan, a Board-certified orthopedic surgeon, performed OWCP-authorized right shoulder arthroscopy and superior labrum anterior and posterior (SLAP) repair, extensive debridement of the glenohumeral joint, arthroscopic subacromial decompression, and manipulation of the right shoulder under anesthesia. He diagnosed right shoulder SLAP tear, subacromial impingement plus labral SLAP tears posteriorly and inferiorly, and partial undersurface rotator cuff tear.

On May 20, 2021 Dr. Lenihan noted appellant's history of injury and medical treatment. He indicated that appellant reached maximum medical improvement (MMI). Dr. Lenihan referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent*

[3] Appellant had previously filed a Form CA-1 for a traumatic injury sustained on March 12, 2010 to his neck and right shoulder when he was involved in a motor vehicle accident while in the performance of duty. OWCP assigned the claim OWCP File No. xxxxxx977. It accepted that claim for neck sprain, contusion of the right shoulder, sprain of the right shoulder and upper arm, contusion of the abdominal wall, contusion of the chest wall, and contusion of the face, scalp, and neck, except eyes. By decision dated September 1, 2011, OWCP granted appellant a schedule award for a total of 12 percent permanent impairment of the bilateral upper extremities. The period of the award ran for 37.44 weeks from September 9, 2010 through May 29, 2011. It has administratively combined these claims with OWCP File No. xxxxxx371 serving as the master file.

Impairment (A.M.A., *Guides*),[4] and utilized the diagnosis-based impairment (DBI) rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 402, the class of diagnosis (CDX) for appellant's right rotator cuff injury, partial-thickness SLAP tear, resulted in a Class 1 impairment with a default value of three. He assigned a grade modifier for functional history (GMFH) of 2, and a grade modifier for physical examination (GMPE) of 1. Dr. Lenihan assigned a grade modifier for clinical studies (GMCS) of 4 as appellant was found to have a SLAP tear along with symptomatic biceps tendon pathology. He utilized the net adjustment formula, he calculated a maximum adjustment of +2 for five percent permanent impairment for the right upper extremity under the DBI method of rating permanent impairment.

Dr. Lenihan also utilized the range of motion (ROM) method by providing three sets of measurements and referring to Table 15-34 (Shoulder Range of Motion), page 475. Regarding the right shoulder, he reported findings of flexion of 160/160/160 degrees, extension of 30/30/30 degrees, abduction of 150/150/150 degrees, adduction of 30/30/30 degrees, external rotation of 60/60/60 degrees, and internal rotation of 40/40/40 degrees. Dr. Lenihan referred to Table 15-34, page 475, and noted appellant had 3 percent impairment for loss of flexion, 1 percent impairment for loss of extension, 3 percent impairment for loss of abduction, 1 percent impairment for loss of adduction, 0 percent impairment for external rotation, and 4 percent impairment for loss of internal rotation for a combined 11 percent permanent impairment of the right upper extremity. He noted the GMFH was equal to the ROM class and therefore no additional adjustment was made. Dr. Lenihan further noted appellant had lateral epicondylitis due to compensatory overuse, Table 15-4 (Elbow Regional Grid), page 399, resulting in a CDX of 1 with a default value of 1. He assigned a GMFH of 1, and found that a GMPE was not applicable as it was the basis for choosing the regional grid. Dr. Lenihan further indicated that, with regard to a GMCS, the clinical studies were consistent with the diagnoses. He applied the net adjustment formula, which resulted in zero adjustment, or one percent permanent impairment of the right upper extremity. Dr. Lenihan calculated 11 percent upper extremity impairment for the right shoulder combined with 1 percent impairment for the elbow for 12 percent permanent impairment of the right upper extremity.

On August 9, 2021 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a development letter dated November 12, 2021, OWCP requested that appellant submit an impairment evaluation from his attending physician that addressed whether he had obtained MMI and to provide a permanent impairment rating in accordance with the sixth edition of the A.M.A., *Guides*. It afforded him 30 days to submit the necessary evidence.

On January 4, 2022 OWCP routed Dr. Lenihan's May 20, 2021 report, a statement of accepted facts (SOAF), and the case file to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for review and a determination of permanent impairment of appellant's upper extremity under the A.M.A., *Guides*. OWCP requested that the Dr. Katz, review Dr. Lenihan's May 20, 2021 report and indicate whether he agreed with his findings.

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

In a January 9, 2022 report, Dr. Katz addressed the findings in Dr. Lenihan's May 20, 2021 report. Utilizing the DBI method of the sixth edition of the A.M.A., *Guides*, he assigned a CDX of Class 1 impairment for partial-thickness rotator cuff tear, functional with normal motion, which resulted in a default value of three. Dr. Katz calculated that appellant had a net adjustment of +2, resulting in movement from the default class of C to D and corresponding to five percent permanent impairment of the right upper extremity. Regarding the ROM method, he referred to Table 15-34, page 475. Regarding the right shoulder, Dr. Katz reported findings of flexion of 160 degrees for 3 percent impairment, extension of 30 degrees for 1 percent impairment, abduction of 150 degrees for 3 percent impairment, adduction of 30 degrees for 1 percent impairment, external rotation of 60 degrees for zero impairment, and internal rotation of 40 degrees for 4 percent permanent impairment for a combined 12 percent permanent impairment based on the ROM method. He noted the grade modifier resulting from the ROM was 2 and the GMFH was 2 for no further adjustment. Dr. Katz determined that the stand-alone ROM method yielded a higher value than the DBI method and therefore the ROM impairment was used for impairment purposes pursuant to FECA Bulletin No. 17-06.[5]

Dr. Katz concurred with Dr. Lenihan's findings that appellant had one percent upper extremity impairment for lateral epicondylitis, pursuant to Table 15-4, page 399. He opined that the total impairment for the shoulder of 12 percent combined with one percent for the elbow was 13 percent permanent impairment for the right upper extremity. Dr. Katz noted that there was a discrepancy between Dr. Lenihan's right upper extremity impairment and his right upper extremity impairment based on the ROM method, as Dr. Lenihan incorrectly added the total ROM impairment for the right shoulder of 11 percent when it should have been 12 percent.

On April 27, 2022 OWCP referred appellant, along with the case record, and a SOAF to, Dr. Harmeeth S. Uppal, a Board-certified orthopedic surgeon, for a second opinion evaluation of his permanent impairment for schedule award purposes.

In a May 18, 2022 report, Dr. Uppal noted appellant's history of injury and medical treatment. He reviewed the SOAF and medical records. Dr. Uppal diagnosed right shoulder SLAP tear status post repair and arthrofibrosis of the right shoulder. He noted the right shoulder was tender to palpation over the anterior part of the shoulder lateral to the coracoid, strength was 5/5, O'Brien's test was mildly positive, impingement test was negative, and appellant was neurologically intact. Dr. Uppal noted ROM findings for the right shoulder performed three times yielded flexion of 165 degrees, abduction of 160 degrees, external rotation of 60 degrees, internal rotation of 40 degrees, adduction of 30 degrees, and extension of 35 degrees. He noted that appellant reached MMI.

Dr. Uppal referred to the sixth edition of the A.M.A., *Guides* in determining the CDX, appellant's partial-thickness rotator cuff SLAP tear in the right shoulder region. He opined that the CDX resulted in a Class 1 impairment with a default value of 5, according to Table 15-5, page 401-405. Dr. Uppal assigned a GMFH of 2 and a GMPE of 1. He assigned a GMCS of 4, secondary to studies that confirmed the diagnosis of a SLAP tear. Dr. Uppal utilized the net adjustment formula, which yielded +4; however, the maximum allowed within Class 1 was +2

[5] FECA Bulletin No. 17-06 (issued May 8, 2017).

which yielded grade E for 5 percent permanent impairment of the right shoulder under the DBI method.

Dr. Uppal noted the right shoulder could be alternatively assessed using the ROM method for impairment, Table 15-34, page 475 of the A.M.A., *Guides*. He reported findings of flexion of 165 degrees for 3 percent impairment, extension of 35 degrees for 1 percent impairment, abduction of 160 degrees for 3 percent impairment, adduction of 30 degrees for 1 percent impairment, external rotation of 60 degrees for zero impairment, and internal rotation of 40 degrees for 4 percent impairment for a combined 12 percent permanent impairment based on the ROM method. Dr. Uppal further noted that his ROM rating was higher than Dr. Lenihan's rating because of an addition error in his calculation.

By decision dated July 26, 2022, OWCP denied appellant's claim for an additional schedule award.

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 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 upper extremity impairments, the sixth edition requires identification of the impairment CDX condition, which is then adjusted by grade modifiers or GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12]

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[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id., see also 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 Part 2 -- Claims, *Schedule Awards,* Chapter 2.808.5a (March 2017).

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

[11] A.M.A., *Guides* 383-492.

[12] *Id.* at 411.

Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[13]

The A.M.A., *Guides* also provide 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.[14] 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.[15] 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.[16]

Regarding the application of ROM or DBI 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).
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> "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*."[17] (Emphasis in the original.)

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.[18]

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[13] *Id.* at 23-28.

[14] *Id.* at 461.

[15] *Id.* at 473.

[16] *Id.* at 474.

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

[18] *See supra* note 11 at Chapter 2.808.6f (March 2017). *See also P.W.*, Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan*, 57 ECAB 349 (2006).

ANALYSIS

The Board finds that this case is not in posture for a decision.

OWCP accepted appellant's claim for right and left shoulder superior glenoid labrum lesions, sprain of the ligaments of the cervical spine, and herniated disc at the C6-7 level. In support of his schedule award claim, appellant submitted a May 20, 2021 report from Dr. Lenihan finding that he had 12 percent permanent impairment of the right upper extremity.[19] On January 9, 2022 Dr. Katz, OWCP's DMA, reviewed Dr. Lenihan's May 20, 2021 report and disagreed with his findings, noting that Dr. Lenihan incorrectly added the ROM impairment figures for the right shoulder to yield 11 percent permanent impairment of the right upper extremity when the correct calculation actually yielded 12 percent permanent impairment.

On April 27, 2022 OWCP referred appellant to Dr. Uppal for a second opinion evaluation of his permanent impairment for schedule award purposes. In a May 18, 2022 report, Dr. Uppal reviewed the medical records and performed a physical examination. He provided an additional impairment rating based on his examination and application of the sixth edition of the A.M.A., *Guides*, finding that appellant had five percent permanent impairment of the right upper extremity using the DBI method for a right shoulder SLAP tear. Dr. Uppal alternately assessed appellant's right shoulder impairment using the ROM method and calculated 12 percent permanent impairment of the right upper extremity. The Board notes that, under OWCP File No. xxxxxx977, relating to a March 12, 2010 work injury accepted for several conditions including neck and right shoulder/upper arm sprains, and right shoulder contusion, OWCP granted appellant a schedule award on September 1, 2011 for 12 percent permanent impairment of the bilateral upper extremities.

As Dr. Uppal provided an impairment rating based on his May 18, 2022 examination using the sixth edition of the A.M.A., *Guides*, pursuant to its procedures, OWCP should have routed the case record, including the additional electrodiagnostic studies and the additional report of Dr. Uppal, to a DMA for an opinion concerning the nature and percentage of permanent impairment of the right upper extremity in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified, if any.[20] As this was not done, the case must be remanded for referral to a DMA.[21]

On remand, OWCP shall further develop the medical evidence of record by obtaining an opinion from a DMA regarding the nature and extent of appellant's permanent impairment, for his accepted condition. The DMA shall review appellant's previous schedule award to determine his

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[19] Dr. Lenihan noted the ROM method for the right shoulder yielded 11 percent permanent impairment and the right elbow epicondylitis yielded 1 percent impairment for a total 12 percent permanent impairment for the right upper extremity.

[20] *L.S.*, Docket No. 19-0092 (issued June 12, 2019); *N.I.*, Docket No. 16-1027 (issued January 11, 2017); *Tommy R. Martin*, 56 ECAB 273 (2005); *supra* note 9 at Chapter 2.808.6f (March 2017) (providing that if the claimant's physician provides an impairment report, the case should be referred to a DMA for review).

[21] *L.S., id.*; *R.H.*, Docket No. 17-1017 (issued December 4, 2018).

entitlement to an additional schedule award and explain whether his current permanent impairment duplicated the prior schedule award. Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's schedule award claim.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the July 26, 2022 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: November 28, 2023
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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