United States Department of Labor
Employees' Compensation Appeals Board

B.W., Appellant	)	
and	)	**Docket No. 19-0370**
	)	**Issued: October 10, 2019**
U.S. POSTAL SERVICE, ROCKFORD CARRIER ANNEX, Rockford, MI, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 10, 2018 appellant filed a timely appeal from a November 15, 2018 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 November 15, 2018 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*.

ISSUE

The issue is whether appellant has met her burden of proof to establish more than seven percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On January 17, 2017 appellant, then a 59-year-old sales, services and distribution associate, filed a traumatic injury claim (Form CA-1) alleging that she injured her left shoulder that morning when she slipped on ice in the employing establishment parking lot while in the performance of duty.[3] She stopped work following the incident and returned to full-time, modified-duty employment on January 19, 2017. OWCP accepted appellant's claim for left biceps tendon strain, left trapezius strain, and left rotator cuff tear.

On June 25, 2018 appellant filed a claim for a schedule award (Form CA-7).

Appellant submitted a June 12, 2018 impairment rating by Dr. Mark A. Seldes, a Board-certified family practitioner. Dr. Seldes reviewed appellant's medical records and related her complaints of continued daily left shoulder pain with significant limited range of motion. Upon examination of her left shoulder, he observed moderate tenderness to palpation over the anterior, lateral, and posterior aspects. Neer's and Hawkin's tests were positive. Dr. Seldes indicated that range of motion testing was completed after initial warm-up and performed three times. He explained that the findings were the same each time and reported 75 degrees flexion, 10 degrees extension, 65 degrees abduction, 10 degrees adduction, 30 degrees external rotation, and 0 degrees internal rotation. Dr. Seldes diagnosed internal derangement of the left shoulder joint, left shoulder impingement syndrome, and torn rotator cuff of the left shoulder joint. He noted a *Quick*DASH score of 73. Dr. Seldes opined that appellant had reached maximum medical improvement (MMI) as of June 12, 2018.

Referring to Table 15-5, Shoulder Regional Grid, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] Dr. Seldes selected a class 1 diagnosis-based impairment (DBI) for a rotator cuff tear. He explained that the maximum impairment rating under the DBI methodology is five percent permanent impairment. Dr. Seldes related that, as an alternative, a range of motion (ROM) impairment method may be assessed using section 15.7. Utilizing Table 15-34, Shoulder Range of Motion, he reported that appellant had nine percent permanent impairment for 75 degrees flexion, two percent permanent impairment for 10 degrees extension, six percent permanent impairment for 65 degrees abduction, one percent permanent impairment for 10 degrees adduction, two percent permanent impairment for 30 degrees external rotation, and four percent permanent impairment for 0 degrees internal rotation. Dr. Seldes calculated a combined 24 percent left upper extremity permanent impairment due to loss of ROM. He explained that, if more than one method was appropriate for rating the impairment, the method which produced the higher impairment

[3] Appellant lost her balance, but was able to avoid falling to the ground.

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

rating should be adopted. As the ROM method resulted in 24 percent permanent impairment and the DBI method resulted in a maximum of 5 percent permanent impairment, Dr. Seldes concluded that the higher impairment rating of 24 percent based on loss of ROM should be applied to appellant's case.

In a development letter dated August 15, 2018, OWCP advised appellant of the type of evidence needed to establish her schedule award claim, including a statement from her attending physician that the accepted condition had reached MMI and an impairment rating utilizing the appropriate portions of the A.M.A., *Guides*. It afforded her 30 days to submit the necessary evidence. OWCP subsequently received another copy of Dr. Seldes' June 12, 2018 impairment rating.

In an August 23, 2018 report, Dr. Kevin Kuhn, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), reviewed the medical evidence of record and noted the accepted conditions of strain of the left arm biceps tendon, left shoulder strain, and left shoulder rotator cuff tear. He opined that the ROM method, as used by Dr. Seldes in his June 12, 2018 impairment rating, was not applicable in this case because there was lack of evidence of three independent measurements and the greatest ROM measurement had not been identified. Dr. Kuhn noted June 12, 2018 as the date of MMI.

Dr. Kuhn indicated that according to the DBI method, under Table 15-5, Shoulder Regional Grid, appellant had sustained a class 1 impairment (default three percent) due to residual loss for partial-thickness rotator cuff tear. He reported a grade modifier for functional history (GMFH) of 3 (*Quick*DASH score of 73); a grade modifier for physical examination (GMPE) of 2 (moderate palpatory findings); and a grade modifier for clinical studies (GMCS) of 2 (moderate pathology). Applying the net adjustment formula, (3-1) + (2-1) + (2-1), resulted in a net modifier of plus 4, which raised the default three percent value to five percent permanent impairment of the left upper extremity permanent impairment. For the diagnosis of left shoulder strain, Dr. Kuhn noted that appellant had sustained a class 1 impairment (default value 1 percent). He reported GMFH 3 (*Quick*DASH score); GMPE 2 (moderate palpatory findings); and GMCS 2 (moderate pathology). Applying the net adjustment formula, (3-1) + (2-1) + (2-1), resulted in a net modifier of plus 4, which raised the default one percent value to two percent permanent impairment of the left upper extremity impairment. Dr. Kuhn combined the two DBI-based impairment ratings for a total of seven percent left upper extremity permanent impairment.

In a September 7, 2018 report, Dr. Seldes noted his disagreement with Dr. Kuhn's August 23, 2018 report that the ROM method was not applicable. He explained that in his June 12, 2018 report, he clearly explained that ROM testing had been completed after an initial warm-up and was performed three times as required by the A.M.A., *Guides*. Dr. Seldes further related that since both the DBI and ROM methods could be used to rate appellant's impairment or condition, the A.M.A., *Guides* provides that the method which produced the higher rating must be used. He concluded that appellant should be awarded the higher impairment rating of 24 percent based on loss of ROM.

In an October 2, 2018 report, Dr. Kuhn reviewed Dr. Seldes's September 7, 2018 supplemental report and provided an impairment rating utilizing the ROM method based on Dr. Seldes's measurements. Utilizing Table 15-34, Shoulder Range of Motion, he calculated that

appellant had 9 percent permanent impairment for 75 degrees with grade 1 modifier, 2 percent permanent impairment for 10 degrees extension with grade 0 modifier, 6 percent permanent impairment for 65 degrees abduction with grade 1 modifier, 2 percent permanent impairment for 10 degrees adduction with grade 0 modifier, 8 percent permanent impairment for 0 degrees internal rotation with grade 0 modifier, and 9 percent permanent impairment for 30 degrees external rotation with grade 0 modifier, for a total left upper extremity impairment of 36 percent. Dr. Kuhn further explained that since the ROM modifier and GMFH with the DBI method were both 3, there was no modification of appellant's impairment rating and the impairment rating remained unchanged at seven percent permanent left upper extremity impairment under the DBI method. He contended that Dr. Seldes failed to convert the total ROM deficit into a ROM modifier and recommended that Dr. Seldes refer to example 15-25 on pages 477 and 478 of the A.M.A., *Guides*. Dr. Kuhn determined that according to Table 15-5, Shoulder Regional Grid, appellant had a combined seven percent permanent impairment of the left upper extremity due to diagnoses of left shoulder rotator cuff tear and left shoulder strain.

By decision dated November 15, 2018, OWCP granted appellant a schedule award for seven percent permanent impairment of the left upper extremity, based on the DMA's October 2, 2018 report. The period of the award ran for 21.84 weeks from June 12 to November 11, 2018.

LEGAL PRECEDENT

The schedule award provisions of FECA,[5] and its implementing federal regulations,[6] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

In determining 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. With respect to the shoulder, reference is made to Table 15-5 (Shoulder Regional Grid).[9] After the class of diagnosis (CDX) is determined from the Shoulder Regional Grid (including identification of a default grade value), the impairment class is then adjusted by grade

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*. at § 10.404(a).

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[9] A.M.A., *Guides* 401-05.

modifiers of functional history, physical examination, and clinical studies.[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[11]

FECA Bulletin No. 17-06[12] provides guidance in applying ROM or DBI methodologies in rating permanent impairment of the upper extremities.[13] 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*."[14] (Emphasis in the original.)
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> The Bulletin further advises:
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> "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.
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> "If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence."[15]

[10] *Id*. at 383-492.

[11] *Id*. at 411.

[12] The FECA Bulletin No. 17-06 advises that, if the A.M.A., *Guides* allows 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 claims examiner. *See* FECA Bulletin No. 17-06 (issued May 8, 2017); *see also D.F.*, Docket No. 17-1474 (issued January 26, 2018).

[13] *J.M.*, Docket No. 18-1387 (issued February 1, 2019).

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

[15] *Id*.

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.

ANALYSIS

The Board finds that appellant has established that she has 24 percent permanent impairment of the left upper extremity.

OWCP accepted appellant's claim for left biceps tendon strain, left trapezius strain, and left rotator cuff tear as causally related to a January 17, 2017 employment injury. On November 15, 2018 it granted her a schedule award for seven percent permanent impairment of the left upper extremity based on the DMA's October 2, 2018 report. In his October 2, 2018 supplemental report, the DMA calculated 36 percent upper extremity permanent impairment under Table 15-34 based on Dr. Seldes' June 12, 2018 left shoulder ROM measurements.[16] Instead of providing a stand-alone rating based on appellant's left shoulder ROM deficits, he treated appellant's ROM deficit as a GMFH of 3, which he noted was equal to the previous grade modifier assigned (3) based on appellant's *Quick*DASH score. As such, the DMA concluded that there was no basis to modify his prior DBI rating of seven percent left upper extremity impairment due to appellant's shoulder strain and partial rotator cuff tear.

The Board finds, however, that the DMA erred in at least two respects. First, it was improper to combine impairments based on two separate diagnoses within the same shoulder regional grid.[17] Second, the DMA's October 2, 2018 impairment rating is inconsistent with FECA Bulletin No. 17-06, which provides in pertinent part that 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.[18] Because the DMA did not provide an impairment rating consistent with the A.M.A., *Guides* based upon ROM or DBI methodology, his opinion is of diminished probative value.[19]

In support of her schedule award claim, appellant submitted a June 12, 2018 impairment rating report by Dr. Seldes. Dr. Seldes reviewed appellant's history and conducted an examination of appellant's left shoulder. He indicated that ROM testing was completed after initial warm-up and performed three times. Dr. Seldes noted that appellant had reached MMI as of June 12, 2018. Referring to Table 15-5, Shoulder Regional Grid, of the A.M.A., *Guides*, he selected a class 1 DBI for a rotator cuff tear. He explained that the maximum impairment rating under the DBI methodology is five percent permanent impairment. Dr. Seldes related that, as an alternative, a

[16] A.M.A., *Guides* 475 (6th ed. 2009).

[17] Dr. Seldes provided a DBI rating based on a diagnosis of rotator cuff tear, whereas the DMA incorrectly rated appellant for both rotator cuff tear and shoulder strain.

[18] *Supra* note 12.

[19] *M.D.*, Docket No. 19-0510 (issued August 6, 2019); *G.S.*, Docket No. 13-1649 (issued December 24, 2013); *Mary L. Henninger*, 52 ECAB 408 (2001).

ROM impairment method may be assessed using Section 15.7. Utilizing Table 15-34, Shoulder Range of Motion, he reported that appellant had 9 percent permanent impairment for 75 degrees flexion, 2 percent permanent impairment for 10 degrees extension, 6 percent permanent impairment for 65 degrees abduction, 1 percent permanent impairment for 10 degrees adduction, 2 percent permanent impairment for 30 degrees external rotation, and 4 percent permanent impairment for 0 degrees internal rotation for a combined 24 percent left upper extremity permanent impairment due to loss of ROM.

The Board finds that Dr. Seldes properly utilized the A.M.A., *Guides* in determining that appellant had 24 percent permanent impairment of the left upper extremity. Dr. Seldes correctly referenced Table 15-5 and determined that, under the DBI methodology for a rotator cuff tear, the maximum impairment rating is 5 percent. He also correctly assessed that, as an alternative, a ROM impairment may be used. The Board notes that Dr. Seldes performed three ROM tests, explained his calculations for loss of ROM under Table 15-34, and properly determined that appellant had 24 percent left upper extremity impairment due to loss of ROM. Dr. Seldes explained that as the ROM method provided the higher impairment rating, appellant was entitled to a schedule award for 24 percent left upper extremity permanent impairment. The Board finds that he properly applied the standards of the A.M.A., *Guides* and his opinion is sufficiently well rationalized and based upon a proper factual and medical background. As he properly calculated that appellant had 24 percent left upper extremity impairment under the ROM method, the Board finds that appellant is entitled to an additional award of 17 percent.[20] Accordingly, the November 15, 2018 schedule award shall be modified to reflect entitlement to an additional 17 percent permanent impairment of the left upper extremity, for a total permanent impairment of 24 percent.

CONCLUSION

The Board finds that appellant has established that she has 24 percent permanent impairment of the left upper extremity. OWCP previously awarded 7 percent permanent impairment, and therefore, appellant is entitled to an additional schedule award for 17 percent permanent impairment for her left upper extremity.

[20] *See* Federal (FECA) Procedure Manual, *supra* note 8 at Chapter 2.808.5 (March 2017).

ORDER

IT IS HEREBY ORDERED THAT the November 15, 2018 decision of the Office of Workers' Compensation Programs is affirmed as modified.

Issued: October 10, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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