United States Department of Labor
Employees' Compensation Appeals Board

B.T., Appellant	)	
and	)	**Docket No. 19-1586**
	)	**Issued: May 4, 2020**
U.S. POSTAL OFFICE, MARTECH POST OFFICE, Atlanta, 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
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 2, 2019 appellant filed a timely appeal from a December 11, 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.

ISSUE

The issue is whether appellant has met her burden of proof to establish more than 6 percent permanent impairment of the right upper extremity and 12 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

OWCP accepted that on February 4, 2015 appellant, then a 53-year-old letter carrier, sustained bilateral shoulder strain and unspecified rotator cuff tear or rupture of the right and left

[1] 5 U.S.C. § 8101 *et seq.*

shoulders, not specified as traumatic, as a result of lifting a tray while in the performance of duty.[2] It paid wage-loss compensation for intermittent periods of disability. On October 14, 2016 appellant underwent authorized arthroscopy of the left shoulder with debridement, subacromial decompression, Mumford, and rotator cuff repair to treat her rotator cuff tear with acromioclavicular (AC) joint arthritis which was performed by Dr. W. Joseph Absi, an attending Board-certified orthopedic surgeon.

In a May 8, 2017 medical report, Dr. Absi found that appellant had eight percent permanent impairment of the left shoulder and five percent whole person impairment according to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] He determined that she reached maximum medical improvement (MMI) on May 8, 2017.

On June 6, 2017 appellant filed a claim for a schedule award (Form CA-7). She submitted a May 11, 2017 letter from Dr. Absi. Dr. Absi explained that his eight percent left shoulder permanent impairment rating was based on a diagnosis of left shoulder arthroscopy with rotator cuff repair. He provided objective findings that appellant lacked about 10 degrees to 15 degrees range of motion (ROM) and her strength was 4+/5. Dr. Absi provided subjective findings of stiffness and pain. He indicated that appellant had no permanent impairment of the right shoulder.

On June 13, 2017 OWCP forwarded appellant's case record, including Dr. Absi's May 11, 2017 report, to a district medical adviser (DMA) to determine the extent of her permanent impairment and date of MMI.

On June 23, 2017 appellant filed a Form CA-7 schedule award claim.

OWCP, in a development letter dated June 27, 2017, advised appellant of the type of evidence needed to establish her schedule award claim. It requested that she provide an impairment rating in accordance with the sixth edition of the A.M.A., *Guides*.[4] OWCP afforded appellant 30 days to submit the necessary evidence.

In a June 25, 2017 report, Dr. Herbert White, Jr., Board-certified in physical medicine and rehabilitation and serving as a DMA, noted appellant's accepted conditions and reviewed the medical record, including Dr. Absi's May 11, 2017 report. He reported that an April 21, 2017 functional capacity evaluation (FCE) revealed 135 degrees of flexion, 135 degrees of abduction, 90 degrees of internal rotation, and 85 degrees of external rotation for the left shoulder. Dr. White related that there was no evidence that the ROM measurements were obtained following A.M.A., *Guides* protocol. He indicated that an October 6, 2015 right shoulder magnetic resonance imaging scan revealed a rotator cuff tear. Dr. White found that appellant reached MMI on the date of his impairment evaluation. He utilized the diagnosis-based impairment (DBI) rating method under the sixth edition of the A.M.A., *Guides*, and determined that she had 11 percent permanent impairment of the left upper extremity. Dr. White noted that the A.M.A., *Guides* preference was

[2] Appellant voluntarily retired from the employing establishment effective December 31, 2019.

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

[4] *Id*. at (6th ed. 2009).

for use of the DBI methodology whenever possible. He further noted that he did not use the ROM impairment rating method because additional evidence was needed. Dr. White needed verification that three measurements were taken as required on page 464 of the A.M.A., *Guides*. He also needed a recording of all shoulder motions, noting that ROM measurements were not recorded for extension and adduction. Dr. White referenced Table 15-5, Shoulder Regional Grid, page 403, and identified the class of diagnosis (CDX) of AC joint injury or disease resulting in a distal clavicle resection as a class 1 impairment. He assigned a grade modifier for functional history (GMFH) of 2 under Table 15-7, page 406, due to pain/symptoms with normal activity. Under Table 15-8, page 408, Dr. White assigned a grade modifier for physical examination (GMPE) of 1 based on mild decreases in ROM and strength. He excluded a grade modifier for clinical studies (GMCS), page 410, as there were no clinical studies to review. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), page 411, Dr. White calculated that appellant had a net adjustment of (2-1) + (1-1) = 1, which moved the grade C default value of 10 percent impairment up one grade to D, resulting in 11 percent permanent impairment of the left upper extremity. He explained that there was a difference between his impairment rating and Dr. Absi's impairment rating because they used different editions of the A.M.A., *Guides*. Dr. White noted that he was unable to rate impairment of the right upper extremity with the information in the record because there was no physical evaluation or history for the right shoulder at MMI.

In an October 6, 2017 letter, OWCP requested that Dr. Absi review the DMA's report and determine whether he agreed with the DMA's impairment rating using the sixth edition of the A.M.A., *Guides*.

On November 6, 2017 Dr. Absi agreed with the DMA's 11 percent left arm permanent impairment rating.

OWCP, by decision dated November 20, 2017, granted appellant a schedule award for 11 percent permanent impairment of the left arm. The award ran 34.32 weeks from May 8, 2017 to January 3, 2018 and was based on the permanent impairment evaluations of Dr. Absi and the DMA.

OWCP thereafter received a November 21, 2017 report from Dr. Absi who reiterated that appellant reached MMI on May 8, 2017 and that she had eight percent permanent impairment of the left shoulder and five percent whole person impairment. Dr. Absi also found that she had 11 percent permanent impairment of the right shoulder and 5 percent whole person impairment. He noted that appellant underwent a right shoulder rotator cuff repair in 2013.[5] Dr. Absi reported objective findings that included about 10 degrees to 15 degrees of flexion and 4+/5 strength. He also reported subjective findings of stiffness and pain in both shoulders.

In a January 19, 2018 development letter, OWCP requested that Dr. Absi clarify his right shoulder impairment rating and provide three measurements if he used the ROM rating method to calculate appellant's permanent impairment.

[5] The record indicates that appellant underwent right shoulder rotator cuff repair decompression and biceps tenotomy on March 1, 2013.

In an April 13, 2018 report, Dr. Absi continued to find that appellant had eight percent permanent of the left upper extremity and five percent impairment of the whole person. He noted that the right shoulder was slightly worse than the left shoulder with 11 percent permanent impairment and 7 percent whole person impairment according to the fifth edition of the A.M.A., *Guides*. Dr. Absi provided an impression of bilateral improved pain status post arthroscopy. He restated that appellant had reached MMI.

On May 24, 2018 OWCP routed appellant's case record to the DMA to determine her right upper extremity permanent impairment rating and date of MMI.

In a May 30, 2018 report, DMA Dr. White again reviewed appellant's medical record, including Dr. Absi's November 21, 2017 and April 13, 2018 reports. He determined that she had six percent permanent impairment of the right upper extremity in accordance with the sixth edition of the A.M.A., *Guides*. Under Table 15-5, Shoulder Regional Grid page 403, Dr. White identified the diagnosis of full-thickness rotator cuff tear (distal clavicle resection) as a class 1 impairment. He assigned a grade modifier of 2 for GMFH under Table 15-7, page 406, due to pain/symptoms with normal activity. Dr. White assigned a grade modifier of 1 for GMPE under Table 15-8, page 508, based on mild decreases in ROM and strength. He excluded a grade modifier for GMCS, page 418, as it was used to determine diagnostic placement. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. White calculated that appellant had a net adjustment of (2-1) + (1-1) = 1, which moved the grade C value of five percent impairment one space to D, resulting in six percent permanent impairment of the right upper extremity.

Regarding impairment to the left upper extremity, DMA Dr. White again identified the diagnosis of AC joint injury or disease resulting in a distal clavicle resection as a class 1 impairment. He assigned a grade modifier 2 for GMFH under Table 15-7 due to pain/symptoms with normal activity. Under Table 15-8, Dr. White assigned a grade modifier of 1 for GMPE based on mild decreases in ROM and strength. He referenced Table 15-9, page 410, and assigned a grade modifier of 2 for GMCS. Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. White calculated that appellant had a net adjustment of (2-1) + (1-1) + (2-1) = 2, which moved the grade C default value of 10 percent impairment two spaces, resulting in a grade E value of 12 percent permanent impairment rating for the left upper extremity. He indicated that he was unable to rate her permanent impairment of the right and left upper extremities using the ROM method for the same reasons provided in his June 25, 2017 report. Dr. White recommended that appellant be sent back to Dr. Absi to provide all shoulder ROM measurements following A.M.A., *Guides* protocol.

On October 12, 2018 appellant file a Form CA-7 for an increased schedule award.

By development letters dated October 22 and November 2, 2018, OWCP again advised appellant of the type of evidence needed to establish her increased schedule award claim. It also again requested that she provide an impairment rating in accordance with the sixth edition of the A.M.A., *Guides*. OWCP afforded appellant 30 days to submit the necessary evidence.

On November 9, 2018 OWCP requested that DMA Dr. White clarify his May 30, 2018 report.

In an amended report dated November 16, 2018, Dr. White reiterated his prior calculations based on a diagnosis of full-thickness rotator cuff tear and concluded that appellant had six percent right upper extremity permanent impairment. He also utilized the ROM impairment rating method and determined that, under Table 15-34, page 475, she had zero percent permanent impairment of the right upper extremity. Dr. White noted the right shoulder ROM measurements provided in the April 21, 2017 FCE and reported that 170 degrees of flexion, 155 degrees of abduction, 95 degrees of internal rotation, and 90 degrees of external rotation each represented 0 percent impairment for a total of 0 percent permanent impairment of the right upper extremity. He concluded that appellant had six percent permanent impairment of the right upper extremity given that she had a higher rating for permanent impairment under the DBI rating. Regarding impairment to the left upper extremity, Dr. White reiterated his prior calculations based on a diagnosis of AC joint injury or disease resulting in distal clavicle resection and determined that appellant had 12 percent permanent impairment. He also utilized the ROM method to determine that, under Table 15-34, she had zero percent left upper extremity permanent impairment. Based on the left shoulder ROM measurements set forth in the April 21, 2017 FCE, Dr. White found that 135 degrees of flexion, 135 degrees of abduction, 90 degrees of internal rotation, and 85 degrees of external rotation each represented 0 percent impairment for a total of 0 percent permanent impairment of the left upper extremity. He concluded that appellant had 12 percent permanent impairment of the left upper extremity given that she had a higher rating for permanent impairment under the DBI rating. Dr. White noted that she had been previously awarded a schedule award for 11 percent permanent impairment of the left upper extremity. He deducted this impairment rating from his 12 percent permanent impairment rating and found that appellant had an additional 1 percent permanent impairment. Dr. White determined that she had reached MMI on May 30, 2018.

OWCP, by decision dated December 11, 2018, granted appellant a schedule award for 6 percent permanent impairment of the right upper extremity and an additional 1 percent permanent impairment of the left upper extremity for a total of 12 percent left upper extremity permanent impairment. The award ran for 21.84 weeks from May 30 to October 29, 2019 and was based on the DMA's November 16, 2018 permanent impairment evaluation.

LEGAL PRECEDENT

The schedule award provisions of FECA,[6] and its implementing federal 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. 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

[6] *Supra* note 1.

[7] 20 C.F.R. § 10.404.

specified edition of the A.M.A., *Guides*, published in 2009.[8] 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.[9]

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).[10] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[13]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the percentage of permanent impairment using the A.M.A., *Guides*.[14]

Regarding the application of ROM or DBI impairment 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)."
>
> "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*

[8] 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 2.808.6 (March 2017); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

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

[10] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

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

[12] *Id*. at 521.

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

[14] *Supra* note 8 at Chapter 2.808.6(f) (March 2017); *A.C.*, Docket No. 19-1333 (issued January 22, 2020).

impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original)."[15]

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."[16]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than 6 percent permanent impairment of the right upper extremity and 12 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

Dr. Absi, found in reports dated November 21, 2017 and April 13, 2018 and May 8 and 11, 2017 that, under the fifth edition of the A.M.A., *Guides*, appellant had 11 percent permanent impairment of the right shoulder which corresponded to 7 percent whole person impairment and 8 percent permanent impairment of the left shoulder which corresponded to 5 percent whole person impairment due to her bilateral improved pain status post arthroscopy. However, his reports are of limited probative value as he did not use the sixth edition of the A.M.A., *Guides*.[17] Moreover, Dr. Absi provided whole person impairment ratings, which are of no probative value as a whole person permanent impairment rating is not permitted under FECA.[18]

On May 30, 2018 Dr. White, a DMA, noted that he had reviewed Dr. Absi's November 21, 2017 and April 13, 2018 reports. He, however, disagreed regarding the extent of permanent impairment to appellant's right and left upper extremities. Dr. White found that she had six percent permanent impairment of the right upper extremity due to a full-thickness rotator cuff tear. He utilized the DBI method for rating appellant's permanent impairment. Under Table 15-5, Shoulder Regional Grid, page 403, Dr. White identified the diagnosis of full thickness rotator cuff tear (distal clavicle resection) as a class 1 impairment with a default rating of five percent. He applied a grade modifier of 2 for GMFH and a grade modifier of 1 for GMPE to the net adjustment formula, finding an adjustment of 1, which equaled six percent permanent impairment of the right upper extremity. Dr. White indicated that a grade modifier for GMCS was excluded because it was used to determine diagnostic placement.

[15] FECA Bulletin No. 17-06 (May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

[16] FECA Bulletin No. 17-06.

[17] *See L.L.*, Docket No. 19-0855 (issued September 24, 2019); *S.J.*, Docket No. 16-1162 (issued February 8, 2017) (a medical opinion not based on the appropriate edition of the A.M.A., *Guides* is of diminished probative value in determining the extent of permanent impairment).

[18] *E.R.*, Docket No. 18-1646 (issued May 17, 2019); *A.L.*, Docket No. 08-1730 (issued March 16, 2009); *Marilyn S. Freeland*, 57 ECAB 607 (2006).

For appellant's left shoulder, Dr. White determined that appellant had a grade E default value of 12 percent left upper extremity permanent impairment. He referenced Table 15-5 and assigned class 1 impairment for a diagnosis of AC joint injury or disease resulting in a distal clavicle resection under the DBI method. Dr. White applied a grade modifier of 2 for GMFH and GMCS and a grade modifier of 1 for GMPE of 1 to the net adjustment formula, finding an adjustment of 2 which warranted movement two spaces to a grade E default value of 12 percent left upper extremity permanent impairment.

In an amended November 16, 2018 report, Dr. White utilized the ROM methodology and determined that, under Table 15-34, page 475, appellant had zero percent permanent impairment of the right upper extremity. He found that 170 degrees of flexion, 155 degrees of abduction, 95 degrees of internal rotation, and 90 degrees of external rotation each represented 0 percent impairment for a total of 0 percent permanent impairment of the right upper extremity. Dr. White explained that, pursuant to the A.M.A., *Guides*, because the DBI method resulted in the greater impairment, appellant had six percent permanent impairment of the right upper extremity.

Regarding impairment to the left upper extremity, Dr. White utilized the ROM methodology and determined that, under Table 15-34, appellant had zero percent permanent impairment of the left upper extremity. He found that 135 degrees of flexion, 135 degrees of abduction, 90 degrees of internal rotation, and 85 degrees of external rotation each represented 0 percent impairment for a total of 0 percent permanent impairment of the left upper extremity. Dr. White concluded that appellant had 12 percent permanent impairment of the left upper extremity because the DBI method resulted in greater impairment. He noted that she had been previously awarded a schedule award for 11 percent permanent impairment of the left upper extremity. Dr. White deducted the 11 percent impairment rating from his 12 percent permanent impairment rating and found that appellant had an additional 1 percent permanent impairment.

The Board finds that the DMA properly discussed how he arrived at his conclusion by listing appropriate tables and pages in the A.M.A., *Guides* and established that appellant sustained 6 percent right upper extremity permanent impairment and 12 percent left upper extremity permanent impairment. Dr. White accurately summarized the relevant medical evidence, provided detailed findings on examination, and reached conclusions about her condition which comported with his findings.[19] In addition, he properly utilized the DBI method and ROM method to rate appellant's bilateral shoulder condition pursuant to FECA Bulletin No. 17-06. As Dr. White's reports are detailed, well rationalized, and based on a proper factual background, his opinion represents the weight of the medical evidence.[20] Thus, the Board finds that appellant has not met her burden of proof to establish greater bilateral upper extremity permanent impairment than that which was previously awarded.

[19] *M.S.*, Docket No. 19-1011 (issued October 29, 2019); *W.H.*, Docket No. 19-0102 (issued June 21, 2019) *J.M.*, Docket No. 18-1387 (issued February 1, 2019).

[20] *See M.S., id.*; *D.S.*, Docket No. 18-1816 (issued June 20, 2019).

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 impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than 6 percent permanent impairment of the right upper extremity and 12 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the December 11, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 4, 2020
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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