United States Department of Labor
Employees' Compensation Appeals Board

T.R., Appellant **and** **DEPARTMENT OF JUSTICE, FEDERAL CORRECTIONAL COMPLEX, Coleman, FL, Employer**	)))))))))	**Docket No. 20-0588** **Issued: June 25, 2021**

Appearances:
Capp P. Taylor, for the appellant[1]
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 22, 2020 appellant, through counsel, filed a timely appeal from a December 4, 2019 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 to consider 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 six percent permanent impairment of the left upper extremity, for which he previously received schedule award compensation.

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 2, 2004 appellant, then a 42-year-old lieutenant, filed a traumatic injury claim (Form CA-1) alleging that on that date he was attempting to move a mattress when his left hand caught under one and pulled him, causing pain in his left shoulder. OWCP accepted the claim for left rotator cuff syndrome and subsequently expanded acceptance of the claim to include left shoulder impingement syndrome. On August 30, 2004 appellant underwent OWCP-approved left shoulder surgery.[4]

On September 22, 2016 appellant filed a claim for a schedule award (Form CA-7).

OWCP received an October 7, 2015 report from Dr. Samy F. Bishai, an orthopedic surgeon, who related appellant's history of injury to his left shoulder. Dr. Bishai diagnosed rotator cuff syndrome of the left shoulder joint, left shoulder impingement syndrome, severe supraspinatus tendinitis of the left shoulder, and status postoperative arthroscopic surgery for treatment of shoulder impingement syndrome and rotator cuff syndrome and tears. He referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] and explained that he utilized the stand-alone range of motion (ROM) methodology for calculating permanent impairment because appellant's loss of ROM of the left shoulder joint had become appellant's primary disability. Dr. Bishai concluded that appellant had 24 percent left upper extremity impairment due to loss of left shoulder ROM under the A.M.A., *Guides*.

OWCP's district medical adviser (DMA), Dr. Jovito Estaris, a specialist in occupational medicine, reviewed the claim on November 8, 2016. Regarding the October 7, 2015 report from Dr. Bishai, he noted that "inexplicably" his measurement of ROM was "markedly different" from other physicians. The DMA also noted that Dr. Bishai did not provide three sets of measurements, as recommended by the A.M.A., *Guides*, and he recommended that appellant be referred for a second opinion evaluation.

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[3] Docket No. 17-1961 (issued December 20, 2018).

[4] Appellant underwent arthroscopic labrum repair of the shoulder, arthroscopic supraspinatus rotator cuff debridement, arthroscopic subacromial decompression, and subacromial pain catheter placement.

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

On November 14, 2016 OWCP referred appellant for a second opinion examination with Dr. Richard C. Smith, a Board-certified orthopedic surgeon. In a December 8, 2016 report, Dr. Smith reviewed appellant's history of injury. He noted that the accepted condition was left rotator cuff syndrome and left shoulder impingement syndrome. Dr. Smith utilized the diagnosis-based impairment (DBI) methodology for rating permanent impairment pursuant to the A.M.A., *Guides*, Table 15-5.[6] He used the Shoulder Regional Grid from Table 15-5[7] and placed appellant's impairment in Class 1 due to some residual loss of function with normal motion. Dr. Smith applied the net adjustment formula for a grade modifier for functional history (GMFH), grade modifier for physical examination (GMPE), and grade modifier for clinical studies (GMCS) and concluded that appellant had five percent permanent impairment of the left upper extremity. He also explained that he did not disagree with Dr. Bishai's calculation, but the DBI methodology "better reflects the claimant's overall condition."

On March 7, 2017 OWCP requested further review of the record by Dr. Estaris, the DMA. In a May 3, 2017 supplemental report, the DMA noted that he had reviewed Dr. Smith's report. He noted that Dr. Smith's permanent impairment rating was made using the DBI methodology for rotator cuff syndrome with impingement of the left shoulder and he concurred that appellant had five percent left upper extremity permanent impairment, utilizing the DBI methodology.

On July 5, 2017 OWCP received an undated addendum from Dr. Estaris. He advised that neither Dr. Bishai, nor Dr. Smith followed the A.M.A., *Guides* for the ROM methodology because neither had provided three sets of ROM measurements. The DMA recommended another second opinion evaluation by a Board-certified orthopedic surgeon to provide an impairment rating using the ROM methodology in accordance with the A.M.A., *Guides*.

By decision dated July 19, 2017, OWCP granted appellant a schedule award for five percent impairment of the left upper extremity.

On September 1, 2017 appellant, through counsel, appealed to the Board. By decision dated December 20, 2018, the Board set aside the July 19, 2017 decision and remanded the case for further development. The Board noted that the July 19, 2017 decision referred to the DMA's May 3, 2017 report, but made no mention of his undated addendum received on July 5, 2017. Thus, the DMA's recommendation to further develop the medical evidence had not been followed.

On February 5, 2019 OWCP referred appellant for a second opinion examination with Dr. Patrick Horan, a Board-certified orthopedic surgeon. In a February 26, 2019 report, Dr. Horan noted the history of appellant's accepted left shoulder injury. He indicated that he rated appellant's permanent impairment under both the DBI and ROM methods. Dr. Horan first discussed the DBI methodology using a diagnosis of rotator cuff injury, partial thickness tear. Applying the A.M.A., *Guides*, Table 15-5,[8] he placed appellant's impairment in Class 1, applied the grade modifiers and concluded that the net adjustment resulted in five percent left shoulder permanent impairment

[6] A.M.A., *Guides* 402.

[7] *Id.*

[8] *Id*.

under the DBI methodology. Dr. Horan also utilized the ROM impairment rating methodology, he recorded three sets of ROM measurements for both the right and left shoulders. Regarding appellant's left shoulder, he found 115 degrees of forward flexion, 30 degrees of extension, 91 degrees of abduction, 50 degrees of adduction, 51 degrees of external rotation, and 75 degrees of internal rotation. Dr. Horan calculated nine percent permanent impairment of the left upper extremity due to loss of ROM. He indicated that, when the DBI and ROM ratings were different, the greater rating was used. Therefore, Dr. Horan concluded that appellant had nine percent left upper extremity permanent impairment.

OWCP routed the case record, including Dr. Horan's February 26, 2019 report, to Dr. Estaris, the DMA, for review. In a March 12, 2019 report, the DMA noted that, according to the DBI rating methodology, under the A.M.A., *Guides*, Table 15-5, Shoulder Regional Grid,[9] appellant had four percent permanent impairment of the left upper extremity.

The DMA also utilized the ROM methodology in Table 15-34[10] and found three percent impairment for 120 degrees of flexion, one percent impairment for 30 degrees of extension, three percent impairment for 90 degrees of abduction, zero percent impairment for 50 degrees of adduction, zero percent impairment for 80 degrees of internal rotation, and two percent impairment for 50 degrees of external rotation. He added these values to equal nine percent permanent impairment of the left upper extremity. The DMA noted that appellant also had a right shoulder permanent impairment of three percent due to loss of ROM and subtracted this rating to conclude that appellant had six percent permanent impairment of his left upper extremity under the ROM methodology, which was greater than the DBI rating. He noted that, since appellant was previously granted a schedule award for five percent permanent impairment of the left upper extremity, an additional award of one percent was warranted.

By decision dated March 18, 2019, OWCP granted appellant a schedule award for an additional one percent permanent impairment of the left upper extremity, for a total six percent permanent impairment of the left upper extremity, noting that he was previously paid for five percent permanent impairment of the left upper extremity.

On November 5, 2019 appellant, through counsel, requested reconsideration. He argued that the DMA improperly reduced the left shoulder impairment rating by the contralateral right shoulder impairment of three percent. Counsel asserted that, in reports dated May 9 and October 2, 2019, Dr. Robert R. Reppy, an osteopathic physician Board-certified in orthopedic surgery, found that appellant's right shoulder was not normal.

In a May 9, 2019 report, Dr. Reppy explained that the DMA reduced the percentage of impairment for appellant's left shoulder using the right shoulder as appellant's normal, uninjured base status. He advised that he saw signs of osteoarthritis in the glenoid joint of the right shoulder and the possibility of a rotator cuff lesion in the right shoulder as well, and opined that one could

[9] *Id*.

[10] *Supra* note 6 at 475.

not consider the right shoulder as "normal." Dr. Reppy indicated that he was ordering a magnetic resonance imaging (MRI) scan of appellant's right shoulder.

In an October 2, 2019 report, Dr. Reppy advised that appellant's MRI scan revealed osteoarthritis in the glenoid joint of the right shoulder, and the possibility of a rotator cuff lesion in the right shoulder. He argued that these conditions did not preexist the accepted 2004 employment injury, and thus should be added to the list of accepted conditions.

In a November 23, 2019 supplemental report, the DMA reviewed the reports from Dr. Reppy and appellant's MRI scan. He related that there was no documentation of any injury to appellant's right shoulder and advised that, pursuant to the A.M.A., *Guides*, page 461, section 15.7a, clinical measurements of motion, "If the opposite extremity is neither involved nor previously injured, it must be used to define normal for that individual any losses should be made in comparison to the opposite normal extremity." Additionally, the DMA noted that the June 14, 2019 MRI scan of the right shoulder showed a degenerative subchondral cyst and a posterior labral tear. He explained that labral tears were "either the result of injury or degenerative changes." As there was no documented injury to the right shoulder, the DMA opined, "in all probability, this labral tear is a degenerative change. Degenerative changes are the result of aging and not from injury." He opined that his six percent permanent impairment rating remained unchanged.

By decision dated December 4, 2019, OWCP denied modification of the March 18, 2019 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,[11] and its implementing federal regulations,[12] 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.[13] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[14]

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

[13] *Id.* at § 10.404(a).

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

The sixth edition requires identifying the impairment class for the class of diagnosis (CDX), which is then adjusted by GMFH, GMPE, and GMCS.[15] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16]

Regarding the application of the ROM or the 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.*" (Emphasis in the original.)[17]
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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…."[18]

ANALYSIS

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

Preliminarily, the Board notes that it is unnecessary for the Board to consider the evidence appellant submitted prior to the issuance of OWCP's July 19, 2017 merit decision because the Board considered that evidence in its December 20, 2018 decision. Findings made in prior Board decisions are *res judicata* absent any further review by OWCP under section 8128 of FECA.[19]

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[15] *Supra* note 6 at 383-492.

[16] *Id.* at § 411.

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

[18] *Id.*

[19] *A.G.*, Docket No. 18-0329 (issued July 26, 2018); *Clinton E. Anthony*, *Jr.*, 49 ECAB 476 (1998).

In a February 26, 2019 report, Dr. Horan provided three sets of ROM measurements and calculated nine percent permanent impairment of appellant's left shoulder due to loss of ROM. He also rated appellant's left shoulder permanent impairment using the DBI method and found that appellant had a lesser than five percent permanent impairment under the DBI rating methodology.

On March 12, 2019 Dr. Estaris the DMA, rated appellant's left shoulder permanent impairment utilizing both the DBI methodology under Table 15-5 and the ROM method under Table 15-34. According to the DBI rating method, he concluded that under Table 15-5 appellant had four percent permanent impairment of the left shoulder.

Dr. Estaris then rated appellant's left shoulder permanent impairment under the ROM methodology. He correctly noted that the A.M.A., *Guides* provide that if the opposite member is not involved or previously injured, any losses should be made in comparison to the opposite normal extremity. Using ROM measurements for both shoulders, the DMA found that appellant had nine percent impairment of the left shoulder and three percent impairment of the right shoulder. He subtracted the right shoulder rating from the left shoulder rating to conclude that appellant had six percent permanent impairment of his left upper extremity. As the ROM rating was higher than the DBI rating, the DMA found that appellant's permanent impairment was best represented by the ROM rating. He noted that appellant was previously awarded five percent for the left upper extremity impairment and advised that an additional one percent award was warranted.

Counsel thereafter submitted medical reports dated May 9 and October 2, 2019 from Dr. Reppy to support his argument that appellant's right shoulder was not normal, and therefore the DMA's opinion was invalid.

In the May 9, 2019 report, Dr. Reppy noted that the DMA reduced the percentage of appellant's left shoulder impairment by three percent, based on the right shoulder being appellant's normal, uninjured base status. He noted that he had found signs of osteoarthritis in the glenoid joint of the right shoulder and the possibility of a rotator cuff lesion in the right shoulder, and therefore appellant's right shoulder could not be considered "normal." In an October 2, 2019 report, Dr. Reppy noted that an MRI scan confirmed his findings of glenoid joint right shoulder osteoarthritis and the possibility of right shoulder rotator cuff lesion. He argued that these conditions did not preexist the employment injury and thus should not be added to the list of accepted conditions.

The Board notes that the A.M.A., *Guides* explain that in evaluating ROM measurements "If the opposite extremity is neither involved nor previously injured, it must be used to define normal for that individual; any losses should be made in comparison to the opposite normal extremity."[20] Dr. Reppy indicated that appellant's right shoulder was not "normal." He concluded that it must have been injured during the employment injury as his right shoulder conditions did not exist prior to the employment injury. Appellant has not, however, alleged that he injured his right shoulder during the employment injury, or at any other time. Dr. Reppy, therefore, failed to provide an accurate history of injury as identified by appellant on his Form CA-1 and the medical

[20] *Supra* note 5 at page 461.

reports of record.[21] He therefore did not provide a rationalized medical opinion explaining that appellant's right shoulder was involved in the accepted employment injury or previously injured, as required by the A.M.A., *Guides*. As such, his report is insufficient to meet appellant's burden of proof.[22]

The DMA, after reviewing Dr. Reppy's reports, properly explained that appellant's right shoulder must be used to define normal for the impairment rating of the left shoulder. He referred to the A.M.A., *Guides* and noted that there was no documentation of any injury to the right shoulder. The DMA also noted that the June 14, 2019 MRI scan of the right shoulder showed a degenerative subchondral cyst and a posterior labral tear. He explained that labral tears were "either the result of injury or degenerative changes." Because there was no documented injury to the right shoulder, the DMA advised that, "in all probability, this labral tear is a degenerative change. Degenerative changes are the result of aging and not from injury." The DMA advised that Dr. Reppy's findings with regard to the right shoulder did not change his opinion that the right shoulder impairment of three percent must be used to calculate the left shoulder impairment.

The Board therefore finds that there is no probative medical evidence of record that appellant has more than six percent permanent impairment of the left upper extremity, for which he previously received schedule award compensation.

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 his burden of proof to establish greater than six percent permanent impairment of the left upper extremity, for which he previously received schedule award compensation.

[21] *See D.M.*, Docket No. 20-0266 (issued January 8, 2021); *J.K.*, Docket No. 20-0590 (issued July 17, 2020).

[22] *See D.A.*, Docket No. 20-0951 (issued November 6, 2020); *G.M.*, Docket No. 15-1288 (issued September 18, 2015).

ORDER

IT IS HEREBY ORDERED THAT the December 4, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 25, 2021
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