United States Department of Labor
Employees' Compensation Appeals Board

S.Y., Appellant	)	
and	)	**Docket No. 24-0443**
	)	**Issued: May 28, 2024**
DEPARTMENT OF HEALTH & HUMAN SERVICES, FOOD & DRUG ADMINISTRATION, Rockville, MD, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On March 21, 2024 appellant filed a timely appeal from November 17, 2023 and March 5, 2024 merit decisions 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]

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish greater than 12 percent permanent impairment of the left upper extremity for which he previously received

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that following the March 5, 2024 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*.

schedule award compensation; and (2) whether OWCP abused its discretion in denying appellant's request for authorization for platelet injections to the shoulder.

FACTUAL HISTORY

On April 26, 2017 appellant, then a 57-year-old international program and policy analyst, filed a traumatic injury claim (Form CA-1) alleging that on March 27, 2017 he tore the rotator cuff of his left shoulder participating in training exercises while in the performance of duty. He stopped work on April 12, 2017. OWCP accepted the claim for a complete rotator cuff tear or rupture of the left shoulder, not specified as traumatic.

A magnetic resonance imaging (MRI) scan of the left shoulder, obtained on April 13, 2017, revealed a full-thickness tear of the distal supraspinatus tendon superimposed on mild tendinopathy, findings consistent with a type 1 acromioclavicular (AC) joint injury versus mild osteoarthritis, and a small amount of complex fluid in the glenohumeral joint extending into the subacromial/subdeltoid bursa and through the rotator cuff tear that might represent synovitis.

On April 27, 2017 appellant underwent a left shoulder arthroscopic joint debridement with repair of a full-thickness rotator cuff tear.

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

OWCP referred appellant to Dr. Chester DiLallo, a Board-certified orthopedic surgeon, for a second opinion evaluation on the issue of permanent impairment. In an October 6, 2020 impairment evaluation, Dr. DiLallo provided range of motion (ROM) measurements for the left shoulder. Referencing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[3] (A.M.A., *Guides*), he found that the maximum left upper extremity impairment for a full-thickness rotator cuff tear using the diagnosis-based impairment (DBI) rating method set forth at Table 15-5 on page 403 was seven percent. Dr. DiLallo found that appellant had 28 percent permanent impairment using the ROM impairment rating method.

Dr. Alan J. Goodman, a Board-certified internist serving as a district medical adviser (DMA), reviewed Dr. DiLallo's report on November 9, 2020. Using the DBI method, he found five percent permanent impairment due to a full-thickness rotator cuff tear according to Table 15-5 on page 403 of the A.M.A., *Guides*. Dr. Goodman noted that Dr. DiLallo failed to specify which shoulder he obtained some ROM measurements for and that others were excluded because the three measurements varied more than a 10 percent mean.

By decision dated November 18, 2020, OWCP granted appellant a schedule award for five percent permanent impairment of the left upper extremity. The period of the award ran for 15.6 weeks from October 6, 2020 to January 23, 2021.

On June 28, 2021 OWCP expanded its acceptance of the claim to include a rotator cuff tear or ruptures of the right shoulder, not specified as traumatic.

[3] A.M.A., *Guides* (6th ed. 2008).

On July 12, 2021 appellant filed a Form CA-7 requesting an increased schedule award.

In an August 9, 2021 impairment evaluation, Dr. John C. Barry, a Board-certified orthopedic surgeon and OWCP referral physician, reviewed appellant's history of injury and provided ROM measurements of the left shoulder. He diagnosed a full-thickness rotator cuff tear of the left shoulder. Using the DBI method, Dr. Barry found four percent permanent impairment of the left shoulder due to rotator cuff tears under Table 15-5 on page 403. Using the ROM method, he found 8 percent permanent impairment of the left upper extremity.

On August 16, 2021 Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA, found eight percent impairment of the left upper extremity due to loss of ROM of the shoulder, according to Table 15-34 on page 475. He further found seven percent permanent impairment of the left upper extremity due to appellant's rotator cuff tear using the DBI method set forth at Table 15-5. In an addendum dated September 28, 2021, Dr. Harris advised that appellant had an additional three percent permanent impairment of the left upper extremity.

By decision dated October 13, 2021, OWCP granted appellant an additional three percent permanent impairment of the left upper extremity. The period of the award ran for 62.4 weeks from August 9, 2021 to October 19, 2022.

On August 31, 2023 Dr. Mark D. Klaiman, a Board-certified physiatrist, advised that he was treating appellant for pain in both shoulders from a March 27, 2017 work injury. He reviewed his history of a left rotator cuff repair in 2017 and right shoulder surgery in 2018, following which he had continued pain and limitations. Dr. Klaiman related that appellant had undergone physical therapy and corticosteroid injections. He indicated that a repeat MRI scan of the left shoulder demonstrated a recurrent partial tear of the supraspinatus and subacromial bursitis and that an MRI scan of the right shoulder demonstrated "significant joint effusion, glenohumeral arthritis, diffuse labral degeneration, and subscapularis tendinosis." Dr. Klaiman attributed appellant's symptoms to his accepted employment injury and advised that he "would benefit from a trial of bilateral shoulder PRP [platelet-rich plasma] injections. The right[-]sided procedure would be performed intra-articularly, and the left into the region of the distal supraspinatus tendon and subacromial bursa." He noted that physical therapy would likely be necessary after the injection. Dr. Klaiman related that "these procedures will help to promote improved shoulder mobility, reduce pain, and facilitate functional restoration."

On October 16, 2023 OWCP referred appellant to Dr. Randy Davis, a Board-certified orthopedic surgeon, for a second opinion examination.

In a report dated November 8, 2023, Dr. Davis reviewed appellant's history of injury and noted that Dr. Klaiman had recommended PRP injections. On examination he found restricted ROM of both shoulders. Dr. Davis diagnosed full-thickness rotator cuff tears of the bilateral shoulders. He found that the employment-related conditions had not resolved but recommended as further treatment only a home exercise program and anti-inflammatory medicine. Dr. Davis opined that there was insufficient "evidence-based medicine to support the use of PRP for the claimant's accepted condition" at the present time. He provided work restrictions.

By decision dated November 17, 2023, OWCP denied appellant's request for authorization for platelet injections of the shoulder. It found that Dr. Davis' opinion represented the weight of

the evidence and established that the treatment was not medically necessary as a result of the accepted employment injury.

On December 4, 2023 appellant filed a Form CA-7 for an increased schedule award.

In a development letter dated December 14, 2023, OWCP requested that appellant submit an impairment evaluation from his attending physician addressing whether he had reached maximum medical improvement (MMI) and providing an impairment rating in accordance with the sixth edition of the A.M.A., *Guides*. It afforded him 30 days to submit the requested information.

On January 18, 2024 OWCP referred appellant to Dr. Davis for a second opinion evaluation on the issue of the extent of permanent impairment.

In a report dated February 1, 2024, Dr. Davis measured ROM of the left shoulder, he found maximum ROM measurements of 125 degrees flexion, 40 degrees extension, 90 degrees abduction, 30 degrees adduction, 30 degrees external rotation, and 50 degrees internal rotation. He further found, after applying grade modifiers, four percent permanent impairment of the left upper extremity using Table 15-5 on page 403.

On February 28, 2024 Dr. Harris reviewed the evidence of record, including Dr. Davis' February 1, 2024 report. For the left upper extremity, using the DBI rating method, he found that appellant had seven percent permanent impairment due to his rotator cuff repair, the maximum allowed under Table 15-5 on page 403. Dr. Harris alternatively rated the impairment using the ROM impairment rating method. Using Table 15-34 on page 475, he found that, for the left shoulder, 125 degrees flexion yielded 3 percent impairment, 40 degrees extension yielded 1 percent impairment, 90 degrees abduction yielded 3 percent impairment, 30 degrees adduction yielded 1 percent impairment, 50 degrees internal rotation yielded 2 percent impairment, and 80 degrees external rotation yielded 2 percent impairment, for a total left upper extremity impairment of 12 percent. Dr. Harris opined that the ROM impairment rating method should be used as it resulted in the greater impairment. He concluded that appellant had 12 percent permanent impairment of the left upper extremity. Dr. Harris advised that he had reached MMI on February 1, 2024. He indicated that, considering appellant's prior schedule awards, he had a four percent increase in the left upper extremity impairment.

By decision dated March 5, 2024, OWCP granted appellant a schedule award for an additional four percent permanent impairment of the left upper extremity, for a total of 12 percent. The period of the award ran for 12.48 weeks from February 1 through April 28, 2024.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA,[4] and its implementing federal regulation,[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

[4] *Supra* note 1.

[5] 20 C.F.R. § 10.404.

not specify the way 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 specified 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 impairment class of diagnosis (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (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]

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.[12]

It is well established that benefits payable under 5 U.S.C. § 8107(c) are reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[13]

---

[6] 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 Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

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

[8] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3.

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

[10] *Id*. 411.

[11] *See J.S.*, Docket No. 23-0579 (issued January 30, 2024); *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[12] *See supra* note 6 at Chapter 2.808.6(f) (March 2017).

[13] 20 C.F.R. § 10.404(d); *see S.T.*, Docket No. 22-1342 (issued November 9, 2023); *B.C.*, Docket No. 21-0702 (issued March 25, 2022); *D.P.*, Docket No .19-1514 (issued October 21, 2020).

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met his burden of proof to establish greater than 12 percent permanent impairment of the left upper extremity for which he previously received schedule award compensation.

OWCP granted appellant a schedule award for 8 percent permanent impairment of the left upper extremity due to loss of shoulder ROM. On December 4, 2023 appellant requested an increased schedule award. OWCP referred him to Dr. Davis for a second opinion examination to determine the extent of permanent impairment.

In a February 1, 2024 impairment evaluation, Dr. Davis found that, using the DBI rating method, appellant had four percent permanent impairment of the left lower extremity due to a full-thickness rotator cuff tear using Table 15-5 on page 403. He provided three ROM measurements for the left shoulder, finding a maximum ROM of 125 degrees flexion, 40 degrees extension, 90 degrees abduction, 30 degrees adduction, 30 degrees external rotation, and 50 degrees internal rotation on the left.

On February 9, 2024 Dr. Harris, a DMA, reviewed Dr. Davis' February 1, 2024 report. He opined that, using the DBI rating method, appellant had seven percent permanent impairment due to his rotator cuff repair, the maximum amount allowed under Table 15-5 on page 403 of the A.M.A., *Guides*. Dr. Harris alternatively rated the impairment using the ROM impairment rating method. Referencing Table 15-34 on page 475, for the left shoulder, he found that 125 degrees flexion yielded 3 percent impairment, 40 degrees extension yielded 1 percent impairment, 90 degrees abduction yielded 3 percent impairment, 30 degrees adduction yielded 1 percent impairment, 50 degrees internal rotation yielded 2 percent impairment, and 80 degrees external rotation yielded 2 percent impairment, for a total left upper extremity impairment of 12 percent. As this was greater than the maximum award found using the DBI method, Dr. Harris recommended using the ROM method to rate appellant's impairment. He found 12 percent permanent impairment of the left upper extremity and that appellant had obtained MMI on February 1, 2024. Dr. Harris noted that he had previously received schedule awards for eight percent permanent impairment of the left upper extremity, and thus found that he was entitled to an award for an additional four percent permanent impairment of the left upper extremity. As noted, when the prior impairment is due to a previous work-related injury and a schedule award has been granted for such prior impairment, the percentage already paid is subtracted from the total percentage of impairment.[14] Thus, Dr. Harris properly found that appellant was entitled to a schedule award for an additional four percent permanent impairment of the left upper extremity.

There is no medical evidence in conformance with the sixth edition of the A.M.A., *Guides* establishing that appellant has greater than 12 percent permanent impairment of the left upper extremity. Thus, the Board finds that appellant has not established entitlement to additional schedule award compensation.[15]

[14] *Id*.

[15] *See A.R.*, Docket No. 21-0346 (issued August 17, 2022); *K.H.*, Docket No. 20-1198 (issued February 8, 2021).

Appellant may request a schedule award or increase 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.

LEGAL PRECEDENT -- ISSUE 2

Section 8103(a) of FECA[16] provides that the United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances, and supplies prescribed or recommended by a qualified physician, which OWCP considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening in the amount of monthly compensation.[17]

In interpreting section 8103 of FECA, the Board has recognized that OWCP has broad discretion in approving services provided, with the only limitation on OWCP's authority being that of reasonableness.[18] Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or actions taken which are contrary to both logic and probable deductions from established facts. It is not enough to merely show that the evidence could be construed to produce a contrary factual conclusion.[19]

ANALYSIS -- ISSUE 2

The Board finds that OWCP did not abuse its discretion in denying appellant's request for authorization for platelet injections to the shoulder.

In a report dated August 31, 2023, Dr. Klaiman discussed his treatment of appellant for bilateral shoulder pain following a work injury on March 27, 2017. He noted that he had undergone physical therapy and had corticosteroid injections. Dr. Klaiman advised that a repeat left shoulder MRI scan demonstrated joint effusion, glenohumeral arthritis, labral degeneration, and subscapularis tendinosis and that a repeat right shoulder MRI scan showed a recurrent partial tear of the supraspinatus and subacromial bursitis. He attributed appellant's symptoms to his accepted employment injury. Dr. Klaiman recommended bilateral PRP injections to his shoulders, noting that the injection would increase his range of motion of the shoulder, decrease pain, and improve function. He did not, however, explain how the conditions found on MRI scans resulted from the accepted employment injury and thus his opinion is insufficient to establish that the requested procedure should be authorized.[20]

On November 8, 2023 Dr. Davis, an OWCP referral physician, diagnosed full-thickness rotator cuff tears of the bilateral shoulders. He found that the conditions had not resolved but required only a home exercise program and anti-inflammatory medications. Dr. Davis reviewed

[16] *Supra* note 1.

[17] 5 U.S.C. § 8103; *see N.G.*, Docket No. 18-1340 (issued March 6, 2019).

[18] *See D.C.*, Docket No. 20-0854 (issued July 19, 2021); *C.L.*, Docket No. 17-0230 (issued April 24, 2018); *D.K.*, 59 ECAB 141 (2007).

[19] *See E.F.*, Docket No. 20-1680 (issued November 10, 2021); *J.L.*, Docket No. 18-0503 (issued October 16, 2018).

[20] *See A.E.*, Docket No. 23-0470 (issued September 5, 2023); *S.H.*, Docket No. 21-0987 (issued September 1, 2023).

Dr. Klaiman's recommendation for PRP injections but opined that that the evidence was currently insufficient to support the use of the injection.

As noted, the only limitation on OWCP's authority is approving or disapproving service under FECA is one of reasonableness.[21] OWCP developed the evidence by referring appellant to Dr. Davis, who found that he did not require PRP injections to treat his accepted employment injury. Thus, the Board finds that OWCP did not abuse its discretion in denying authorization for the requested procedure.[22]

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish greater than 12 percent permanent impairment of the left upper extremity for which he received schedule award compensation. The Board further finds that OWCP did not abuse its discretion in denying appellant's request for authorization for platelet injections to the shoulder.

[21] *See W.B.*, Docket No. 23-0935 (issued January 4, 2024); *B.I.*, Docket No. 18-0988 (issued March 13, 2020); *W.M.*, Docket No. 18-0957 (issued October 15, 2018); *Daniel J. Perea*, 42 ECAB 214 (1990).

[22] *See K.L.*, Docket No. 23-0978 (issued March 13, 2024); *D.S.*, Docket No. 18-0353 (issued February 18, 2020),

ORDER

IT IS HEREBY ORDERED THAT the November 17, 2023 and March 5, 2024 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: May 28, 2024
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board