United States Department of Labor
Employees' Compensation Appeals Board

T.R., Appellant	)	
and	)	**Docket No. 22-0673**
	)	**Issued: November 19, 2024**
DEPARTMENT OF JUSTICE, FEDERAL CORRECTIONAL COMPLEX, Coleman, FL, Employer	)	

Appearances:
Capp P. Taylor, Esq., for the appellant[1]
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 March 1, 2022 appellant, through counsel, filed a timely appeal from a February 8, 2022 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 decisions 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 it 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 compensation (Form CA-7) for a schedule award.

OWCP received an October 7, 2015 report from Dr. Samy F. Bishai, an orthopedic surgeon, who 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. Dr. Bishai 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 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. He concluded that appellant had 24 percent left upper extremity permanent impairment due to loss of left shoulder ROM.

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

[3] Docket No. 20-0588 (issued June 25, 2021); 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 and noted that the accepted conditions were left rotator cuff syndrome and left shoulder impingement syndrome. He utilized the diagnosis-based impairment (DBI) methodology for rating permanent impairment using the A.M.A., *Guides*, Table 15-5, pages 401-405, Shoulder Regional Grid, and assigned a Class 1 for a diagnosis of impingement syndrome due to some residual loss of function with normal motion. Dr. Smith applied the net adjustment formula using a grade modifier for functional history (GMFH), a grade modifier for physical examination (GMPE), and a grade modifier for clinical studies (GMCS), and opined that appellant had five percent permanent impairment of the left upper extremity. He noted that he did not disagree with Dr. Bishai's calculation using the ROM method; however, he opined that the DBI method "better reflects the claimant's overall condition."

On March 7, 2017 OWCP requested further review of the record by the DMA.

In a May 3, 2017 supplemental report, Dr. Estaris noted that he concurred with Dr. Smith that appellant had five percent left upper extremity permanent impairment, utilizing the DBI methodology. He also noted that Dr. Smith provided ROM measurements of appellant's left shoulder which were "markedly different" from the measurements provided by Dr. Bishai.

On July 5, 2017 OWCP received an undated addendum from Dr. Estaris. Dr. Estaris, the DMA, noted that neither Dr. Bishai, nor Dr. Smith followed the A.M.A., *Guides* for the ROM methodology because neither provided three sets of ROM measurements. He recommended another second opinion evaluation by a Board-certified orthopedic surgeon to provide a permanent 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 20, 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.[6] The Board noted that OWCP's decision referred to the May 3,2017 DMA report from Dr. Estaris, but made no mention of the undated addendum from the DMA. The Board found that 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 appellant's accepted left shoulder injury and rated appellant's permanent impairment under both the DBI and ROM methodologies. He noted a diagnosis of a rotator cuff injury, partial thickness tear, and placed appellant's impairment in Class 1, according to the A.M.A., *Guides*, Table 15-5, pages 401-05, Shoulder Regional Grid. Dr. Horan applied the grade modifiers and the net adjustment formula and opined that appellant

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

had five percent permanent impairment of the left upper extremity, according to the DBI methodology. He also utilized the ROM methodology and recorded three sets of ROM measurements for each shoulder. Regarding appellant's left shoulder, Dr. Horan found 115 degrees of forward flexion, 30 degrees of extension, 91 degrees of abduction, 50 degrees of adduction, 51 degrees of external rotation, and 70 degrees of internal rotation. He added each percentage of loss of ROM and found that appellant had nine percent permanent impairment of the left upper extremity due to loss of ROM. Dr. Horan explained that when the DBI and ROM ratings were different, the greater rating must be used and concluded that appellant had nine percent left upper extremity impairment.

OWCP routed the case record, including Dr. Horan's February 26, 2019 report, to the DMA, Dr. Estaris, for review.

In a March 12, 2019 report, Dr. Estaris opined that appellant had four percent permanent impairment of the left upper extremity, according to the A.M.A., *Guides*, Table 15-5, Shoulder Regional Grid. The DMA also utilized the ROM method, rounded the measurements, 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 and calculated nine percent permanent impairment of the left upper extremity. The DMA further noted that appellant had a right shoulder permanent impairment of three percent due to loss of ROM and subtracted this to conclude that appellant had six percent permanent impairment of the left upper extremity, which was greater than the DBI rating. He noted that appellant was previously granted a schedule award for five percent permanent impairment of the left upper extremity and advised that 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, noting that appellant previously had received a schedule award for five percent left upper extremity impairment.

On November 5, 2019 appellant, through counsel, requested reconsideration. He argued that the DMA improperly reduced the left shoulder impairment rating by subtracting the contralateral right shoulder impairment of three percent.

Appellant submitted additional evidence. In a May 9, 2019 report, Dr. Robert R. Reppy, an osteopathic physician Board-certified in orthopedic surgery, 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 noted signs of osteoarthritis in the glenoid joint of the right shoulder and the possibility of a rotator cuff lesion in the right shoulder and opined that the right shoulder could not be considered as normal. Dr. Reppy also noted that he had ordered a magnetic resonance imaging (MRI) scan of appellant's right shoulder.

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

In a November 23, 2019 supplemental report, Dr. Estaris, the DMA, reviewed the May 9 and October 2, 2019 reports from Dr. Reppy and the MRI scan. Dr. Estaris noted that there was no documentation of any injury to appellant's right shoulder and advised that, according to the A.M.A., *Guides*, page 461, section l5.7a, 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 appellant's right shoulder showed a degenerative subchondral cyst and a posterior labral tear. He explained that labral tears could be "either the result of injury or degenerative changes." Dr. Estaris noted that there was no documented injury to the right shoulder and opined that, "in all probability, this labral tear is a degenerative change. Degenerative changes are the result of aging and not from injury." The DMA concluded that his six percent permanent impairment rating based on the ROM method remained unchanged.

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

On January 22, 2020 appellant, through counsel, filed a timely appeal from the December 4, 2019 merit decision. By decision dated June 25, 2021, the Board affirmed the December 4, 2019 decision.[7] The Board found that appellant had 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.

On November 11, 2021 appellant, through counsel, requested reconsideration. He repeated his argument that the right shoulder could not be used for comparison because it was not normal.

OWCP received an August 23, 2021 statement, wherein appellant related that he never experienced problems with either of his shoulders prior to his March 2, 2004 employment injury. He explained that after his left shoulder injury, he experienced problems with his right shoulder due to limitation in the use of his left shoulder.

In a September 2, 2021 report, Dr. Reppy noted that the DMA reduced the percentage of impairment of the left shoulder by comparison to the right shoulder as appellant's "normal" uninjured base status. He referred to page 461 of the A.M.A., *Guides* and noted that "if the opposite extremity was neither involved nor previously injured, it must be used to define normal for that individual and any losses should be made in comparison to the opposite normal extremity." Dr. Reppy explained that work-related injuries included those that were consequential to the original injury, not just those directly caused by it. He opined that the right shoulder was injured consequentially and therefore could not be used to define "normal." Dr. Reppy noted that the June 14, 2019 MRI scan showed a posterior labral tear, as well as signs of osteoarthritis in the glenoid joint of the right shoulder, which was a "wear and tear" phenomenon, consistent with having to use the right shoulder more because of the left shoulder injury. He opined, "I am willing to state definitively right here, that it is my expert medical opinion within all reasonable degree of medical probability, that the condition of the right shoulder is the result of over compensation

[7] Docket No. 20-0588 (issued June 25, 2021).

consequential to the injury of the accepted left shoulder condition, and as such cannot be used to define a normal range of motion for the left shoulder."

By decision dated February 8, 2022, OWCP denied modification.

LEGAL PRECEDENT

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of any employment injury.[8] The schedule award provisions of FECA,[9] and its implementing federal regulations,[10] 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.[11] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[12]

The sixth edition requires identifying the impairment class for the class of diagnosis (CDX), which is then adjusted by the GMFH, GMPE, and GMCS.[13] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[14] 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).
>
> "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] *J.B.*, Docket No. 17-1907 (issued March 8, 2018).

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] *Id.* at § 10.404(a).

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

[13] *Supra* note 5 at 383-492.

[14] *Id.* at 411.

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.

"If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* do not allow for the use of ROM for the diagnosis in question, the DMA should independently calculate impairment using the DBI method and clearly explain in the report, citing applicable tables in Chapter 15 of the [A.M.A.,] *Guides*, that ROM is not permitted as an alternative rating method for the diagnosis in question.

"If the rating physician provided an assessment using the DBI 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]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[17]

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 the December 4, 2019 OWCP merit decision because the Board considered that evidence in its June 25, 2021 decision. Findings made in prior Board decisions are *res judicata* absent any further review by OWCP under section 8128 of FECA.[18]

Following the Board's June 25, 2021 decision, appellant submitted a September 2, 2021 report, wherein Dr. Reppy noted that the DMA reduced the percentage of impairment of the left

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

[16] *Id.*

[17] *See supra* note 12, Chapter 2.808.6f (March 2017).

[18] *A.G.*, Docket No. 18-0329 (issued July 26, 2018); *Clinton E. Anthony, Jr.*, 49 ECAB 476, 479 (1998).

shoulder by comparison to the right shoulder as appellant's "normal" uninjured base status. He referred to page 461 of the A.M.A., Guides and noted that "if the opposite extremity was neither involved nor previously injured, it must be used to define normal for that individual and any losses should be made in comparison to the opposite normal extremity." Dr. Reppy explained that work-related injuries included those that were consequential to the original injury, not just those directly caused by it. He opined that the right shoulder was injured consequentially and therefore could not be used to define "normal." Dr. Reppy noted that the June 14, 2019 MRI scan showed a posterior labral tear, as well as signs of osteoarthritis in the glenoid joint of the right shoulder, which was a "wear and tear" phenomenon, consistent with having to use the right shoulder more because of the left shoulder injury. He opined that the condition of the right shoulder cannot be used to define a normal range of motion for the left shoulder. Dr. Reppy, however, essentially reiterated arguments previously raised and considered by OWCP and the Board. Moreover, he did not provide a rating of additional permanent impairment of the left upper extremity in accordance with the A.M.A., *Guides*.

As the medical evidence of record is insufficient to establish greater than the six percent permanent impairment of the left upper extremity previously awarded, the Board finds that appellant has not met his burden of proof.[19]

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 permanent 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.

[19] *Id.*; *see J.A.*, Docket No. 17-1846 (issued March 27, 2018).

ORDER

IT IS HEREBY ORDERED THAT the February 8, 2022 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 19, 2024
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