United States Department of Labor
Employees' Compensation Appeals Board

T.B., Appellant	)	
and	)	**Docket No. 21-0563**
	)	**Issued: December 30, 2021**
DEPARTMENT OF ENERGY, BONNEVILLE POWER ADMINISTRATION, Custer, WA, 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
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On February 28, 2021 appellant filed a timely appeal from a January 28, 2021 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 January 28, 2021 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 his burden of proof to establish greater than 12 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On January 9, 2017 appellant, then a 49-year-old electrician, filed a traumatic injury claim (Form CA-1) alleging that on that date he injured his left shoulder when he slipped and fell when exiting his truck while in the performance of duty. OWCP accepted the claim for sprain of left shoulder joint and strain of other muscles, fascia and tendons at shoulder and upper arm level, left arm. Appellant stopped work on the date of injury and returned to full duty on January 10, 2017.

In an August 21, 2020 report, Dr. Eric S. Smith, a Board-certified occupational medicine specialist, indicated that appellant's chronic left shoulder condition has reached a point of medical stability. He opined that he would evaluate appellant for permanent impairment of the left shoulder under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), after OWCP sent appellant "an award letter."[3]

On November 18, 2020 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a December 4, 2020 report, Dr. Smith noted appellant's physical examination findings, including a goniometric evaluation of range of motion (ROM) with three measurements for both the right and left upper extremities. Inspection of the shoulders revealed no edema, swelling, rubor or cyanosis with equal shoulder height, normal sensation and normal motor strength testing and symmetrical reflexes. With regard to the left shoulder, Dr. Smith measured: flexion of 131, 134, and 132 degrees; extension of 44, 43 and 46 degrees; abduction of 87, 86, and 87 degrees; adduction of 68, 67 and 65 degrees; external rotation of 32, 32, and 31 degrees; and internal rotation of 21, 24, and 22 degrees. He noted that appellant demonstrated full effort and that the rest of the examination was unremarkable. Referencing the A.M.A., *Guides*, Dr. Smith indicated that all the diagnostic-based impairments (DBI) under Table 15-5 referred to normal ROM, however, appellant had abnormal ROM. Therefore, he found the ROM impairment methodology more appropriate. Under Table 15-34, page 475, Dr. Smith found that appellant's left shoulder had grade modifier (GM) 1. Appellant's loss of flexion was a 1 percent impairment, loss of extension was a 1 percent impairment, loss of abduction was a 3 percent impairment, loss of adduction was a 0 percent impairment, loss of internal rotation was a 4 percent impairment, and loss of external rotation was a 2 percent impairment, for a total of 13 percent permanent impairment of the left upper extremity. He also noted that an activities of daily living questionnaire, which appellant signed on December 3, 2020, indicated some difficulty with lifting activities. Dr. Smith concluded that appellant's left shoulder injury had reached maximum medical improvement.

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

On January 11, 2021 OWCP prepared a statement of accepted facts (SOAF) that listed appellant's accepted conditions. Appellant's case record was thereafter referred to Dr. Morley Slutsky, Board-certified in occupational medicine, serving as OWCP's District Medical Adviser (DMA), for review.

In a January 21, 2020 report, Dr. Slutsky reviewed the SOAF and Dr. Smith's December 4, 2020 medical report. He opined that appellant reached MMI on December 4, 2020, the date of Dr. Smith's impairment evaluation. Utilizing the DBI method, Dr. Slutsky found that the most impairing diagnosis under Table 15-5 was left shoulder sprain, with one percent default permanent impairment value. He assigned grade modifier functional history (GMFH) 1 under Table 15-7; grade modifier physical examination (GMPE) 1 under Table 15-8; and grade modifier clinical studies (GMCS) 0, noting that appellant was still symptomatic with normal diagnostic testing. After using the net adjustment formula, Dr. Slutsky found a negative 1 which moved the final grade to B or 1 percent upper extremity impairment. Under the ROM method, he indicated that he agreed with all the impairments Dr. Smith assigned for left shoulder ROM under Table 15-34 with the exception of extension, noting that 50 degrees of extension equaled 0 percent impairment, not the 1 percent impairment Dr. Smith assigned. Using Table 15-34, the DMA noted: 130 degrees flexion for 3 percent impairment; 50 degrees extension for 0 percent impairment, 90 degrees abduction for 3 percent impairment, 70 degrees adduction for 0 percent impairment, 20 degrees internal rotation for 4 percent impairment, and 30 degrees external rotation for 2 percent impairment, equaled 12 percent left lower extremity impairment. Under Table 15-35, he found that shoulder grade modifier ROM 2, for a ROM equal to 12 percent. Under Table 15-7, the DMA found GMFH 1 as appellant still had symptoms. Under Table 15-36, he found a net modifier -1 for the difference of ROM GMFH (1) and ROM GM (2). The DMA concluded that the ROM impairment remained the same and equaled 12 percent left upper extremity impairment. Thus, he opined that appellant had final 12 percent left upper extremity impairment under the ROM methodology, which yielded the highest impairment value.

By decision dated January 28, 2021, OWCP awarded appellant 12 percent permanent impairment of his left upper extremity. The award ran 37.44 weeks (fraction of a day) from December 4, 2020 through June 23, 2021. OWCP accorded the weight of the medical evidence regarding the percentage of impairment to the DMA, finding that he correctly applied the A.M.A., *Guides* to the examination findings.

LEGAL PRECEDENT

The schedule award provisions of FECA,[4] and its implementing federal regulations,[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 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.

[4] *Supra* note 1.

[5] 20 C.F.R. § 10.404.

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 DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning Disability and Health (ICF).[8] Under the sixth edition, the evaluator identifies class of diagnosis (CDX), which is then adjusted by a GMFH, GMPE, and 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]

FECA Bulletin No. 17-06 provides guidance in applying ROM or DBI methodologies in rating permanent impairment of the upper extremities. 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*

[6] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used. 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, Exhibit 1 (January 2010).

[7] *M.W.*, Docket No. 20-0252 (issued May 24, 2021); *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, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

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

[10] *Id.* at 411.

[11] *M.W.*, *supra* note 7; *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

impairment rating for the diagnosis in question, the method producing the higher rating should be used. (Emphasis in the original.)"[12]

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.[13]

ANALYSIS -- ISSUE 1

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

OWCP received a report from Dr. Smith, who opined that appellant had reached MMI and found that appellant had 13 percent permanent impairment of the left upper extremity based on ROM methodology.

In accordance with its procedures, OWCP properly routed the case record to the DMA, who, using Dr. Smith's evaluation findings, provided permanent impairment ratings using both the DBI and ROM methodologies. The DMA found that appellant had 1 percent permanent left upper extremity impairment under the DBI method and 12 percent permanent left upper extremity impairment under the ROM method. He also opined that the ROM methodology represented the greater left upper extremity permanent impairment rating.

The Board has reviewed the DMA's ROM impairment rating under Table 15-34, page 475 of the A.M.A, *Guides*, based on the findings of Dr. Smith, and finds that appellant has 12 percent total left upper extremity permanent impairment based upon the ROM methodology. As noted, if the evaluator evaluating loss of ROM determines that there is an organic basis for a restricted ROM, then the greatest of three ROM measurements should be used for the determination of the impairment. The greatest of the three ROM measurements of appellant's left shoulder from Dr. Smith reflects flexion of 134 degrees, extension of 46 degrees, abduction of 87 degrees, adduction of 68 degrees, external rotation of 32 degrees, and internal rotation of 24 degrees. These values based on the greatest measurement differ from both the values assigned by Dr. Smith and the DMA.[14] Pursuant to Table 15-34, flexion of 134 degrees equals 3 percent impairment; extension of 46 degrees rounded up to 50 degrees equals 0 percent impairment,[15] abduction of 87

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

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

[14] The DMA erroneously reported flexion of 130 degrees, extension of 50 degrees, abduction of 90 degrees, adduction of 70 degrees, external rotation of 30 degrees, and internal rotation of 20 degrees.

[15] For extension of the shoulder Table 15-34 provides that 30 to 40 degrees equals 1 percent upper extremity impairment and more than or equal to 50 degrees equals 0 percent upper extremity impairment. There is no category provided for the range of 41 degrees to 49 degrees. Appellant's 46 degree extension rounds up to 50 degrees and thus is equal to 0 percent upper extremity impairment.

degrees rounded up to 90 degrees equals 3 percent impairment,[16] adduction of 68 degrees equals 0 percent impairment; external rotation of 32 degrees equals 2 percent impairment, and internal rotation of 24 degrees equals 4 percent impairment, for a total 12 percent left upper extremity permanent impairment. Under Table 15-35, page 477, the DMA properly found GM was 2.[17] Under Table 15-36, page 477, he also properly found GMFH was 1. Under Table 15-36, the GMFH is -1, which equals no change in total ROM impairment, or 12 percent permanent impairment.

The Board finds that the DMA properly indicated that appellant's impairment finding under the ROM methodology represented the greater left upper extremity permanent impairment.[18]

There is no other current medical evidence in conformance with the sixth edition of the A.M.A., *Guides* establishing greater than the 12 percent permanent impairment of the left upper extremity for which he previously received a schedule award. Accordingly, appellant has met not his burden of proof.

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 12 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

[16] There is no category provided under Table 15-34 for abduction 87 degrees. Eighty-seven degrees rounds up to 90 degrees which provides three percent upper extremity impairment.

[17] Under Table 15-35, the range of motion grade modifier 2 for the shoulder is from 12 percent to 23 percent upper extremity impairment for total motion impairment.

[18] *See E.R.*, Docket No. 19-1574 (issued March 24, 2020).

ORDER

IT IS HEREBY ORDERED THAT the January 28, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 30, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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