United States Department of Labor
Employees' Compensation Appeals Board

V.H., Appellant	)	
and	)	**Docket No. 18-0848**
	)	**Issued: February 25, 2019**
SOCIAL SECURITY ADMINISTRATION, Gastonia, NC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 13, 2018 appellant filed a timely appeal from a January 23, 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 10 percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On August 30, 2016 appellant, then a 61-year-old technical expert, filed an occupational disease claim (Form CA-2) alleging a left shoulder injury due to factors of her federal employment.

[1] 5 U.S.C. § 8101 *et seq.*

She did not stop work.[2] On December 1, 2016 OWCP accepted the claim for incomplete rotator cuff tear or rupture of the left shoulder.

Appellant underwent a left shoulder arthroscopy, decompression, distal clavicle excision, and rotator cuff repair on February 24, 2017. She was released to return to work with restrictions on May 1, 2017.

On August 28, 2017 appellant filed a claim for a schedule award (Form CA-7).

In an August 28, 2017 report, Dr. Erik C. Johnson, a Board-certified orthopedic surgeon, noted that appellant was seen for a follow-up evaluation after undergoing a left shoulder arthroscopy, decompression, distal clavicle excision, and medium rotator cuff repair on February 24, 2017. He indicated that appellant had returned to work with no lifting, pushing, or pulling more than 10 pounds and no overhead work. On physical examination, Dr. Johnson noted active and passive range of motion (ROM), forward flexion of 160 degrees, external rotation with the arm at the side to 80 degrees, and internal rotation to 70 degrees. He explained that appellant had 15 percent permanent impairment of the left upper extremity, which incorporated her surgical findings as well as her current clinical examinations. Dr. Johnson noted that she was released to return to work.

A September 14, 2017 memorandum of telephone call revealed that appellant contacted OWCP to inquire if they had received her claim for a schedule award. OWCP explained that they had received the claim, but the medical evidence submitted was insufficient because the physician had not indicated which arm had sustained permanent impairment and it also had not provided citation to a specific edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*)[3]. Appellant requested that a letter be sent to the treating physician asking for the necessary information.

In a September 14, 2017 report, Dr. Johnson explained that appellant had reached maximum medical improvement on August 28, 2017. He diagnosed a rotator cuff tear of the left shoulder. Dr. Johnson indicated that he applied the sixth edition of the A.M.A., *Guides.* Utilizing the diagnosis-based impairment (DBI) method for rating permanent impairment of the upper extremity he determined that appellant fell into an impairment class of 2. Dr. Johnson selected a grade modifier for functional history (GMFH) of 1, a grade modifier for physical examination (GMPE) of 1, and a grade modifier for clinical study (GMCS) of 1. Using these calculations he found that appellant had 14 percent permanent impairment of the left upper extremity as a result of the left shoulder rotator cuff tear and subsequent left shoulder arthroscopy, decompression, distal clavicle excision, and medium rotator cuff repair of February 24, 2017.

In a September 18, 2017 report, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), noted that he had reviewed the medical records provided by OWCP. He noted that he reviewed the medical records and provided a DBI impairment rating of 10 percent permanent impairment citing to Table 15-5 for a diagnosis of status post left shoulder arthroscopic subacromial decompression, rotator cuff repair, and distal

[2] The record reflects that appellant has a separate claim for her right shoulder under OWCP File No. xxxxxx933.

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

clavicle excision.[4] Dr. Harris also noted that appellant had a documented loss of ROM of her left shoulder. Utilizing section 15.7, Range of Motion Impairment, Table 15-34. Utilizing the ROM methodology for rating upper extremity permanent impairment he determined that appellant had three percent left upper extremity permanent impairment.[5] Dr. Harris explained that the DBI rating resulted in the greater percentage of permanent impairment than the ROM rating and, under the A.M.A., *Guides*, the method producing the higher rating must be used. He noted that this resulted in 10 percent left upper extremity permanent impairment based upon the DBI rating method.

In a November 30, 2017 report, Dr. Johnson, noted his review of the impairment rating report of Dr. Harris and noted that he had last evaluated appellant on August 28, 2017. He repeated the findings from his September 14, 2017 report in which he found 14 percent permanent impairment of the left upper extremity utilizing the DBI rating method. Dr. Johnson concluded, in comparing his report to that of Dr. Harris that, "I think it is reasonable to split the difference at 12 [percent] of the left upper extremity."

By decision dated January 23, 2018, OWCP granted appellant a schedule award for 10 percent permanent impairment of the left upper extremity. The period of the award ran from August 28, 2017 to April 3, 2018. OWCP found that in reviewing the evidence, the DMA, Dr. Harris, determined that Dr. Johnson had incorrectly applied the A.M.A., *Guides* to the findings on physical examination. It found, therefore, that the weight of the medical evidence regarding the percentage of permanent impairment rested with Dr. Harris, serving as the DMA, as he had correctly applied the A.M.A., *Guides* to the examination findings.

LEGAL PRECEDENT

The schedule award provision 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. 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.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

[4] *Id*. at 403, Table 15-5.

[5] *Id*. at 475, Table 15-34.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404(a).

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

The sixth edition requires identifying the impairment class for the diagnosed condition class of diagnosis (CDX), which is then adjusted by GMFH, GMPE, and GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

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).
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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 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.)[11]
>
> 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."[12]

OWCP 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

The Board finds that the case is not in posture for decision.

OWCP accepted appellant's claim for incomplete rotator cuff tear or rupture of the left shoulder. On February 24, 2017 appellant underwent a left shoulder arthroscopy, decompression, distal clavicle excision, and rotator cuff repair, performed by Dr. Johnson.

[10] A.M.A., *Guides* 494-531.

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

[12] *Id*.

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 2.808.6(f) (February 2013).

Appellant filed a claim for a schedule award and provided an initial rating of permanent impairment from her surgeon, Dr. Johnson. Then, in an August 28, 2017 report, Dr. Johnson noted his physical examination and findings of appellant's left shoulder condition. Utilizing the DBI method for rating permanent impairment of the upper extremities he determined that appellant fell into an impairment class of 2. After adjusting the class 2 impairment by the applicable grade modifiers Dr. Johnson found that appellant had 14 percent permanent impairment of her left upper extremity. While he provided a rating of permanent impairment based upon the DBI methodology, he did not perform a rating utilizing the ROM method.[14]

In accordance with its procedures, OWCP referred the evidence of record to a DMA who provided an impairment rating on September 18, 2017. While Dr. Harris, the DMA, performed both a DBI and an ROM rating, the Board finds that his impairment rating report is conclusory in nature as he merely provided a numerical rating without providing specific detail or rationale as to how he had utilized the A.M.A., *Guides* in reaching his conclusions. For instance, in performing the DBI rating he did not discuss grade modifiers or other physical findings in calculating 10 percent permanent impairment. In providing an ROM rating, Dr. Harris did not explain the loss of ROM measurements, he relied upon or cite to the tables of the A.M.A., *Guides* he had used, only concluding that claimant "has [three] percent left upper extremity impairment for loss of shoulder flexion." Furthermore, the ROM measurements from the attending physician were incomplete pursuant to the A.M.A., *Guides*. The report of Dr. Harris is therefore insufficient as a basis for a schedule award because, as the DMA, he did not appropriately determine appellant's permanent impairment based on the appropriate standards.[15] Upon receipt of the DMA report, it was incumbent upon OWCP to request clarification or obtain a supplemental report from the DMA.[16] As that was not done, the Board finds the DMA's report is an insufficient basis for a schedule award.

Although Dr. Johnson provided a supplemental report on November 30, 2017, it did not provide a basis for a schedule award, as he merely suggested a compromise rating between his rating and the DMA rating.

The Board notes that proceedings under FECA are not adversarial in nature, and OWCP is not a disinterested arbiter. The claimant has the burden of proof to establish entitlement to compensation. However, OWCP shares responsibility in the development of the evidence to see that justice is done.[17] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[18] Herein, the Board finds that Dr. Harris failed to provide a sufficiently detailed report and he lacked the relevant medical evidence necessary to render an informed rating based upon loss of ROM.

[14] The Board notes that in conducting his physical examination Dr. Johnson noted loss of ROM, but did not provide three ROM measurements as required by the A.M.A., *Guides*.

[15] *Supra* note 13 at Chapter 2.808.6.f(2)(a) (March 2017).

[16] *Id*.; *See W.G.*, Docket No. 17-1090 (issued March 12, 2018).

[17] *T.R.*, Docket No. 17-1961 (issued December 20, 2018); *William J. Cantrell*, 34 ECAB 1223 (1983).

[18] *Id*.; *Richard F. Williams*, 55 ECAB 343, 346 (2004).

The Board further finds that OWCP failed to follow the procedures outlined in FECA Bulletin No. 17-06, which requires that OWCP should instruct an evaluating physician to obtain three independent measurements of ROM loss, if they have not been provided into the record.[19]

On remand the case should be referred to Dr. Johnson or other specialist for a physical examination to determine appellant's ROM in conformance with the A.M.A., *Guides* followed by a rating report calculating permanent impairment under both the ROM and DBI methods. Thereafter, the case record should be referred to Dr. Harris or other DMA for a supplemental opinion addressing whether appellant has permanent impairment in accordance with the sixth edition of the A.M.A., *Guides* and FECA Bulletin No. 17-06. Following this and such further development deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for a schedule award.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the January 23, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: February 25, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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

[19] *Id*.