

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 10 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On January 14, 2015 appellant, then a 54-year-old food safety inspector, filed a traumatic injury claim (Form CA-1) alleging that he sustained a left arm injury when a hog shed fell and hit him on the hook of his left arm. He did not initially stop work. By decision dated February 26, 2015, OWCP accepted the claim for left shoulder sprain, left hand sprain, left elbow sprain, and left ulnar neuropathy. It subsequently expanded acceptance of the claim to include left lateral epicondylitis, superior glenoid labrum lesion of the left shoulder, and impingement syndrome of the left shoulder. Appellant received intermittent wage-loss compensation on the supplemental rolls as of March 1, 2015 and on the periodic rolls as of June 26, 2016.

Appellant underwent OWCP approved surgery on September 2, 2015 for left tennis elbow release and on April 13, 2016 for left shoulder arthroscopy with repair of anterior labral detachment and subacromial decompression arthroscopically with acromioplasty and left elbow revision tennis elbow release with lateral epicondylectomy, performed by Dr. Steven J. Stokesbary, a Board-certified orthopedic surgeon.

On February 22, 2017 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated February 28, 2017, OWCP requested that appellant submit a permanent impairment evaluation from his attending physician in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).³ It afforded him 30 days to submit the requested impairment evaluation.

In support of his claim, appellant submitted Dr. Stokesbary's April 13, 2016 operative report and January 31, 2017 postoperative evaluation. Dr. Stokesbary determined that appellant had reached maximum medical improvement (MMI) following his April 13, 2016 left lateral epicondylectomy revision with left shoulder arthroscopy with superior labral anterior to posterior (SLAP) repair and subacromial decompression.

On October 13, 2017 OWCP referred appellant to Dr. Adam T. Kafka, Board-certified in physical medicine and rehabilitation, for a second opinion evaluation regarding permanent impairment of his left elbow and shoulder.

In a November 1, 2017 report, Dr. Kafka discussed appellant's medical history, provided physical examination findings, and determined that MMI was reached on January 31, 2017. On physical examination, he utilized the diagnosis-based impairment (DBI) methodology to determine the degree of permanent impairment. Dr. Kafka indicated that, in accordance with Table

³ A.M.A., *Guides* (6th ed. 2009).

15-5, Shoulder Regional Grid, of the sixth edition of the A.M.A., *Guides*,⁴ the impairment diagnosis was class 1 acromioclavicular (AC) joint disease with a default impairment value of 10 percent due to distal clavicle resection. He assigned a grade modifier for functional history (GMFH) of two based on appellant's *QuickDASH* score, a grade modifier of 1 for physical examination (GMPE) based on minimal palpatory findings and mild decrease in range of motion (ROM) from opposite sides, and a grade modifier of 4 for clinical studies (GMCS) as the magnetic resonance imaging showed a rotator cuff tear along with a labral lesion. Applying the net adjustment formula, Dr. Kafka subtracted 1, the numerical value of the class, from the numerical value of the grade modifiers resulting in a net adjustment of 4 $((2-1) + (1-1) + (4-1))$.⁵ Application of the net adjustment formula meant that movement was warranted from the class 1 default value grade C to grade E, for a combined rating of 12 percent permanent impairment of the left shoulder.⁶ Dr. Kafka also provided ROM findings based on three measurements and calculated five percent permanent impairment using the ROM methodology. He determined that the DBI methodology should be used as it provided the higher rating.

Dr. Kafka further provided an impairment rating pertaining to the left elbow. Utilizing the DBI methodology found at Table 15-4, Elbow Regional Grid, of the A.M.A., *Guides*, he assigned class 1 impairment for lateral epicondylitis status postsurgical release of extensor origins, amounting to a default impairment value of five percent.⁷ Dr. Kafka discussed the net adjustment formula and assignment of grade modifiers, determining that no adjustment was for a default value of five percent permanent impairment of the left elbow. He did not utilize the ROM methodology for the left elbow as physical examination revealed full ROM. Dr. Kafka reported that the A.M.A., *Guides* allowed for combination of two impairments of the same limb. He referenced Appendix A on page 604, explaining that 12 percent impairment was combined with 5 percent for a final 16 percent permanent impairment of the left upper extremity.⁸

OWCP routed Dr. Kafka's report and the case file to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for review and a determination as to whether appellant sustained a permanent impairment of the left shoulder and elbow.

In a May 24, 2018 report, Dr. Harris determined that appellant had four percent permanent impairment of the left upper extremity for loss of shoulder internal rotation under the ROM methodology.⁹ He opined that the DBI methodology should be used since it provided the higher left shoulder rating, amounting to five percent permanent impairment for arthroscopic surgery

⁴ *Id.* at 403.

⁵ *Id.* at 411.

⁶ *Id.* at 403, Table 15-5.

⁷ *Id.* at 399, Table 15-4.

⁸ *Id.* at 604.

⁹ *Id.* at 475, Table 15-34.

including labral repair.¹⁰ The DMA further found five percent permanent impairment of the left elbow for residual problems with lateral epicondylitis. He noted full ROM for the left elbow which amounted to zero percent impairment using the ROM methodology. The DMA concluded that appellant had a combined value of 10 percent permanent impairment of the left upper extremity and had reached MMI on November 1, 2017. He disagreed with Dr. Kafka's 16 percent impairment rating of the left upper extremity, explaining that the physician had provided impairment for having undergone excision of the distal clavicle which was not documented on the April 13, 2016 operative report.

By decision dated September 20, 2018, OWCP granted appellant a schedule award for 10 percent permanent impairment of the left arm (left shoulder and left elbow). The date of MMI was November 1, 2017 and the period of award ran from November 1, 2017 to June 7, 2018. OWCP found that in reviewing the evidence, the DMA determined that Dr. Kafka had incorrectly applied the A.M.A., *Guides* to the examination findings. It found, therefore, that the weight of the medical evidence regarding the percentage of permanent impairment rested with the DMA, as he had correctly applied the A.M.A., *Guides* to the examination findings to calculate 10 percent permanent impairment of the left elbow and shoulder.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.¹¹ 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.¹² As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).¹³

In addressing upper extremity impairments, the sixth edition requires identification of the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based

¹⁰ *Id.* at 405, Table 15-5.

¹¹ 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

¹² 20 C.F.R. § 10.404; *L.T.*, Docket No. 18-1031 (issued March 5, 2019); *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

¹³ *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (March 2017).

on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).¹⁴ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).¹⁵

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology versus the ROM methodology for rating of upper extremity impairments.¹⁶ Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

“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

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.”¹⁸

OWCP 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.¹⁹

ANALYSIS

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

On November 1, 2017 OWCP referred appellant to Dr. Kafka for a second opinion evaluation and opinion regarding the extent of his permanent impairment of the left elbow and shoulder. Dr. Kafka provided an impairment rating using both the ROM and DBI methodologies. He discussed his calculations, provided reasoning for his ratings, and provided proper citations to

¹⁴ A.M.A., *Guides* 383-492.

¹⁵ *Id.* at 411.

¹⁶ FECA Bulletin No. 17-06 (May 8, 2017).

¹⁷ A.M.A., *Guides* 477.

¹⁸ *Supra* note 16; *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

¹⁹ *See supra* note 13 at Chapter 2.808.6(f) (March 2017).

the A.M.A., *Guides*. Dr. Kafka determined that the DBI methodology produced the higher impairment rating for the left shoulder, warranting 12 percent permanent impairment for class 1 AC joint disease due to distal clavicle resection.²⁰ He further discussed his findings and calculated five percent permanent impairment of the left elbow for class 1 lateral epicondylitis status postsurgical release of extensor origins.²¹ Dr. Kafka explained his calculations and concluded that appellant was entitled to a combined 16 percent permanent impairment of the left upper extremity.

In accordance with its procedures, OWCP referred the evidence of record to Dr. Harris, serving as OWCP's DMA who provided an impairment rating on May 24, 2018. The DMA disagreed with Dr. Kafka regarding his left shoulder permanent impairment rating for AC joint disease due to distal clavicle resection.

While the DMA, performed both a DBI and a 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.²² For example, in performing the DBI rating he did not discuss grade modifiers or other physical findings in calculating five percent impairment of the left shoulder and five percent impairment of the left elbow. In providing an ROM rating, the DMA did not explain the loss of ROM measurements which he relied upon, only concluding that appellant had four percent left upper extremity impairment for loss of shoulder internal rotation. The report of the DMA 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.²³ Upon receipt of the DMA report, it was incumbent upon OWCP to request clarification or obtain a supplemental report from the DMA.²⁴ As that was not done, the Board finds the DMA's report is an insufficient basis for a schedule award.

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.²⁵ 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.²⁶

Consequently, the Board finds that further development of the medical evidence is required to determine the extent of appellant's permanent impairment for schedule award purposes. On remand, OWCP should request clarification from Dr. Kafka pertaining to his use of the AC joint

²⁰ *Supra* note 5.

²¹ *Supra* note 6.

²² *V.H.*, Docket No. 18-0848 (issued February 25, 2019).

²³ *Supra* note 13 at Chapter 2.808.6.f(2)(a) (March 2017).

²⁴ *Id.*; *see W.G.*, Docket No. 17-1090 (issued March 12, 2018).

²⁵ *T.R.*, Docket No. 17-1961 (issued December 20, 2018); *William J. Cantrell*, 34 ECAB 1223 (1983).

²⁶ *Id.*; *Richard F. Williams*, 55 ECAB 343, 346 (2004).

disease with distal clavicle resection diagnosis for the left shoulder.²⁷ Following this additional development, the case should be routed back to a DMA for evaluation of appellant's permanent impairment in accordance with the A.M.A., *Guides*. After such further development as deemed necessary, OWCP shall issue an appropriate merit decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the September 20, 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: June 12, 2019
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

²⁷ *R.R.*, Docket No. 16-0589 (issued February 3, 2017).