United States Department of Labor
Employees' Compensation Appeals Board

R.W., Appellant	)	
and	)	**Docket No. 19-0532**
	)	**Issued: October 1, 2019**
DEPARTMENT OF THE NAVY, NORFOLK NAVAL SHIPYARD, Portsmouth, VA, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On December 7, 2018 appellant filed a timely appeal from a November 21, 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 his burden of proof to establish more than 12 percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq*.

FACTUAL HISTORY

On April 6, 2016 appellant, then a 43-year-old rigger, injured his right lower shoulder when descending a ladder while in the performance of duty. OWCP accepted his traumatic injury claim for unspecified sprain of the right shoulder. Appellant stopped work on April 6, 2016.

A magnetic resonance imaging (MRI) scan of the right shoulder dated April 14, 2016, revealed supraspinatus tendon articular sided high-grade partial thickness tear, acromioclavicular (AC) joint arthrosis, subacromial spurring, and mild subacromial subdeltoid bursitis.

On May 10, 2016, Dr. Martin R. Coleman, a Board-certified orthopedic surgeon, performed an arthroscopic decompression of the right shoulder, resection of the distal clavicle, and cuff debridement. He diagnosed impingement of the right shoulder, degenerative arthritis of the AC joint, and partial cuff tear.

On September 19, 2016 he underwent a magnetic resonance arthrogram of the right shoulder which revealed widening of the AC joint and exhibited post-traumatic widening versus surgical intervention.

Appellant came under the treatment of Dr. Arthur Wardell, a Board-certified orthopedist, who on September 21 and October 7, 2016 noted marked tenderness over the AC joint, right trapezius, infraspinatus, and supraspinatus tendons and restricted range of motion (ROM). Dr. Wardell advised that appellant developed adhesive capsulitis as a result of his work injury on April 6 and May 10, 2016 surgery. He recommended arthroscopic debridement, manipulation to treat his arthrofibrotic contractures, formal open distal clavicle excision/revision, possible biceps tenotomy, and possible rotator cuff repair.

On February 24, 2017 OWCP referred appellant for a second opinion evaluation with Dr. James Schwartz, a Board-certified orthopedic surgeon. In a March 18, 2017 report, Dr. Schwartz reviewed the medical record and a statement of accepted facts. He diagnosed partial rotator cuff tear of the right shoulder related to the April 6, 2016 date of injury and preexisting right shoulder AC joint arthrosis. Dr. Schwartz noted significant subjective findings with limited objective findings. He opined that no surgery was indicated at that time and recommended that appellant be seen by an orthopedist specializing in shoulder surgery. Dr. Schwartz advised that appellant was unable to use his right upper extremity, but could work within his physical limitations. He recommended vocational rehabilitation and reemployment.

On May 11, 2017 Dr. Wardell referred appellant for a functional capacity evaluation (FCE).

On May 31, 2017 appellant underwent a right shoulder MRI scan which revealed suspected two surgical anchors in the greater tuberosity, no high-grade cuff tear, supraspinatus and infraspinatus tendinopathy with perhaps minimal low grade interstitial tears, evidence of subacromial decompression with mild AC joint degenerative changes, and Type 2 acromion with perhaps mild intra-articular biceps tendinopathy.

A June 12, 2017 FCE revealed that appellant was functioning at the sedentary to light physical capacity demand levels below chest height. The results of the evaluation suggested that

he gave reliable effort. Utilizing computerized goniometric measurements, the FCE results revealed shoulder abduction on the left of 165 and on the right of 63 degrees, adduction on the left of 45 degrees and on the right of zero degrees, flexion on the left of 155 degrees and on the right of 55 degrees, extension on the left of 41 degrees and on the right of 14 degrees, external rotation on the left of 62 degrees and on the right of 25 degrees, and internal rotation on the left of 59 degrees and on the right of 62 degrees.[2]

On July 10, 2017 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated July 11, 2017, OWCP advised appellant that the medical evidence received in support of his schedule award claim was the June 12, 2017 FCE report. It noted that this medical evidence was insufficient to support his claim because there was no impairment rating provided by a physician. OWCP requested that appellant arrange for submission of a detailed narrative medical report from his treating physician based upon a recent examination with a permanent impairment rating in accordance with the sixth edition of the A.M.A., *Guides*.[3] It related that, if the A.M.A., *Guides* allowed a rating using both the diagnosis-based impairment (DBI) and ROM methods, the impairment should be independently calculated using both methods. OWCP advised that the evaluator must obtain three independent ROM measurements and use the greatest of the measurements to determine the extent of impairment. It afforded appellant 30 days to submit the requested evidence.

In a report dated July 20, 2017, Dr. Wardell calculated that appellant had 23 percent impairment of the right upper extremity based on the ROM method. He noted his calculation was based upon measurements taken by computerized goniometry at the time of the FCE on June 12, 2017.

On July 25, 2017 Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), reviewed the medical record. He noted that Dr. Wardell recommended 23 percent impairment based on loss of ROM for the right shoulder and used measurements from an FCE performed on June 12, 2017. The DMA observed that each of the computerized goniometric measurements for right shoulder ROM were apparently measured once. He calculated impairment based on the DBI method and opined that appellant had 12 percent permanent impairment due to distal clavicle resection under Table 15-5, page 403. The DMA found that he could not provide an impairment rating due to ROM, as measurements from the FCE used by Dr. Wardell did not include three independent ROM measurements. He concluded that appellant reached maximum medical improvement on June 12, 2017.

By decision dated August 2, 2017, OWCP granted appellant a schedule award for 12 percent impairment of the right upper extremity. The period of the award ran from July 23, 2017 to April 11, 2018.

[2] The Board notes that the computerized goniometric measurements were based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

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

On September 6, 2018 appellant requested an additional schedule award.

In a report dated August 30, 2018, Dr. Wardell noted that appellant had an FCE on July 9, 2018 which included "computerized goniometric measurements" of the right shoulder. He indicated that the goniometric measurement was performed three times with no significant difference in any of the three measurements. Dr. Wardell calculated 9 percent impairment due to loss of flexion, 2 percent impairment for loss of extension, 6 percent impairment for loss of abduction, 2 percent impairment for loss of adduction, 4 percent impairment for loss of internal rotation, and 2 percent impairment for loss of external rotation, for a combined 25 percent permanent impairment of the right upper extremity.

On September 11, 2018 the DMA, reviewed the medical record including Dr. Wardell's August 30, 2018 report. He noted that Dr. Wardell recommended 25 percent impairment based on loss of ROM for the right shoulder and reported using measurements from an FCE performed on July 9, 2018. However, the DMA noted that the only FCE in the file was from June 12, 2017. Upon review of that FCE report, he found no documentation stating that right shoulder ROM was measured more than once. Additionally, the FCE noted that appellant put forth reliable effort, but was deemed unreliable for the right and left rapid exchange grip test, the right-sided five position grip test, the rapid exchange grip test, and the left shoulder flexion test. Also noted was that appellant put forth marginal effort for the right shoulder flexion test and right internal rotation test. The DMA opined that the ROM loss did not have an organic basis, and therefore, he could not be rated based on ROM. He noted that there was no evidence of adhesive capsulitis and there was variability in appellant's right shoulder flexion measured at 130 degrees on January 12, 2018 and 120 degrees on April 20, 2018. Dr. Garelick noted that appellant was not entitled to an additional schedule award.

OWCP, by letter dated September 19, 2018, requested that Dr. Wardell review the report of the DMA and provide a supplemental report regarding the extent of appellant's permanent impairment.

In an October 24, 2018 letter, Dr. Wardell reviewed the DMA's report and disagreed with his use of the DBI methodology to calculate appellant's impairment rating. He contended that ROM was the preferred methodology as appellant's loss of ROM was due to his injury and the distal clavicle resection. Dr. Wardell indicated that appellant developed arthrofibrosis as a result of the injury and the distal clavicle resection with acromioplasty. He referenced his August 30, 2018 letter.

On October 30, 2018 the DMA reviewed the medical record including Dr. Wardell's August 30 and October 24, 2018 reports. He reiterated the findings in his September 11, 2018 report. The DMA indicated that if OWCP continued to have concern about his opinion as to permanent impairment after this correspondence he recommended that appellant be referred to a second opinion physician.

By decision dated November 21, 2018, OWCP denied appellant's claim for an additional schedule award.

LEGAL PRECEDENT

The schedule award provisions of FECA[4] and its implementing 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 of loss of a member 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 and the Board has concurred in such adoption.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[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 the impairment class of diagnosis (CDX) condition, 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). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[10]

The A.M.A., *Guides* also provide that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other DBI sections are applicable.[11] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[12] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[13]

---

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id*. at 10.404(a); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

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

[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 494-531.

[10] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[11] A.M.A., *Guides* 461.

[12] *Id*. at 473.

[13] *Id*. at 474.

Regarding the application of ROM or 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 impairment rating for the diagnosis in question, the method producing the higher rating should be used*."[14] (Emphasis in the original.)

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 the medical adviser providing rationale for the percentage of impairment specified.[15]

ANALYSIS

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

OWCP accepted that appellant sustained an unspecified sprain of the right shoulder due to an April 6, 2016 employment injury. On August 2, 2017 it granted him a schedule award for 12 percent permanent impairment of the right upper extremity. Appellant subsequently requested an increased schedule award, which OWCP denied on November 21, 2018.

In a report dated August 30, 2018, Dr. Wardell, citing a July 9, 2018 FCE which included computerized goniometric measurements of the right shoulder, calculated a combined 25 percent permanent impairment of the right upper extremity. He indicated that the computerized goniometric measurements were performed three times with no significant difference in any of the three measurements.

On September 11, 2018, Dr. Garelick serving as a DMA, reviewed Dr. Wardell's August 30, 2018 report which recommended 25 percent impairment based on loss of ROM for the right shoulder and found no FCE dated July 9, 2018, rather one dated June 12, 2017, and no documentation equivocally stating that right shoulder ROM was measured more than one time pursuant to FECA Bulletin No. 17-06. He further noted that appellant's effort on physical examination was deemed unreliable on numerous portions of the FCE. Dr. Garelick opined that

[14] FECA Bulletin No. 17-06 (May 8, 2018); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[15] *See supra* note 7 at Chapter 2.808.6(f) (February 2013).

the ROM loss did not have an organic basis and noted that appellant was not entitled to an additional schedule award.

In an October 24, 2018 report, Dr. Wardell again found 25 percent permanent impairment of the right upper extremity using the ROM methodology. He disagreed with the use of the DBI methodology to calculate appellant's impairment rating and contended that ROM was the preferred methodology as appellant's loss of ROM was due to his injury and the distal clavicle resection. Dr. Wardell indicated that appellant developed arthrofibrosis as a result of the injury and the distal clavicle resection and acromioplasty.

In accordance with OWCP's procedures the DMA reviewed the medical record on October 30, 2018 and determined that a rating based upon loss of ROM was not applicable in this case as there was no documentation in the FCE used by Dr. Wardell equivocally stating that right shoulder ROM was measured more than once pursuant to FECA Bulletin No. 17-06. He opined that using the DBI rating method, appellant had 12 percent permanent impairment of the right upper extremity due to the diagnosis of distal clavicle resection under Table 15-5 on page 405. He further recommended that appellant be referred to a second opinion physician if further clarification was required.

The Board finds that OWCP has not properly developed the medical evidence pursuant to FECA Bulletin No. 17-06, which requires that it should instruct an evaluating physician to obtain three independent measurements of ROM loss, if they have not been provided into the record.[16] It was incumbent upon the DMA, when performing the ratings under both the ROM and DBI methods to obtain the necessary ROM measurements to complete the full rating if they were found not to exist in the medical record.[17]

If, as in this case, Dr. Wardell does not provide the requested information OWCP shall refer appellant for a second opinion examination to obtain the necessary ROM measurements as outlined in FECA Bulletin No. 17-06 and the A.M.A., *Guides*. Only after proper development of the medical record should the case record be rerouted to the DMA for a review of the attending physician's rating of permanent impairment. After such further development as is deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[16] *V.H.*, Docket No. 18-0848 (issued February 25, 2019); *T.R.*, Docket No. 17-1961 (issued December 20, 2018).

[17] *See M.D.*, Docket No. 18-1073 (issued January 18, 2019) (finding that a DMA should advise as to the medical evidence necessary to complete the ROM method of rating if the medical evidence of record is insufficient to rate appellant's impairment using loss of ROM).

ORDER

IT IS HEREBY ORDERED THAT the November 21, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: October 1, 2019
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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