



while in the performance of duty that day. He reportedly felt a sharp pain in his right shoulder after throwing parcels. Appellant stopped work on August 12, 2016, and received continuation of pay beginning August 13, 2016. On the reverse side of the claim form, the employing establishment indicated that he was in the performance of duty when injured. On November 2, 2016 OWCP accepted appellant's claim for right shoulder joint sprain, right upper arm/shoulder strain of the muscles/fascia/tendons, and right shoulder impingement syndrome.<sup>2</sup> It paid him wage-loss compensation for temporary total disability beginning October 7, 2016, and placed him on the periodic compensation rolls effective October 16, 2016.

On January 25 and July 20, 2017 appellant underwent OWCP-authorized right shoulder surgeries. The latter procedure involved open subacromial decompression and rotator cuff tendon repair, which was performed by Dr. Robert Hill, a Board-certified orthopedic surgeon. OWCP continued to pay appellant wage-loss compensation for temporary total disability until appellant resumed work on August 26, 2017.

On January 11 and June 13, 2018 appellant filed a claim for a schedule award (Form CA-7).

OWCP received reports dated January 24 to July 18, 2018 by Dr. William V. Kane, Board-certified in physical medicine and rehabilitation. Dr. Kane noted that appellant was status post right shoulder surgery and noted an overall improvement of symptoms. He reviewed appellant's history and conducted an examination. Dr. Kane reported right shoulder examination findings of decreased range of motion (ROM) and pain with external rotation. Hawkins and drop arm tests were positive on the right. Dr. Kane diagnosed disorder of the right rotator cuff, right shoulder arthralgia, and right shoulder adhesive capsulitis.

In a May 23, 2018 report, Dr. Barry S. Garcia, a Board-certified internist, indicated that OWCP had requested a permanent impairment rating from him. Dr. Kane reviewed appellant's medical history. He recounted that appellant had four right shoulder surgeries, but still had devastating limitations on his right arm. Dr. Kane related appellant's complaints of decreased ROM and anterior right shoulder pain. He measured ROM of the right shoulder as 90 degrees external rotation, 90 degrees internal rotation, 60 degrees flexion, 20 degrees extension, 30 degrees abduction, and 25 degrees adduction. Dr. Kane diagnosed status post shoulder surgery, right rotator cuff disorder, right shoulder arthralgia, and right shoulder impingement syndrome. He noted that appellant had reached maximum medical improvement (MMI) on April 25, 2018. Dr. Kane explained that appellant had 22 percent whole person permanent impairment based on loss of range of motion (ROM).

In a development letter dated June 26, 2018, OWCP advised appellant that the medical evidence submitted was insufficient to establish his schedule award claim. It requested that he provide a medical report from his attending physician which included a statement that the accepted condition had reached MMI and an impairment rating utilizing the appropriate portions of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*

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<sup>2</sup> Under OWCP File No. xxxxxx296, OWCP previously accepted bilateral shoulder impingement, which arose on or about November 25, 2001. The case record associated with OWCP File No. xxxxxx296 is not currently before the Board.

(hereinafter A.M.A., *Guides*).<sup>3</sup> OWCP afforded appellant 30 days to submit the necessary evidence.

In an August 23, 2018 report, Dr. Todd Fellars, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), noted that he had reviewed appellant's history, including the medical record, and noted that appellant's claim was accepted for right shoulder sprain, right shoulder impingement syndrome, and sprain of the muscle and fascia and tendons of the right shoulder. He reported that appellant had previously been awarded 20 percent permanent impairment for the right upper extremity. Utilizing the diagnosis-based impairment (DBI) method, Dr. Fellars explained that, according to Table 15-5, *Shoulder Regional Grid*, the maximum impairment rating for a diagnosis of rotator cuff tear would be seven percent permanent impairment. He indicated that under the ROM methodology and Table 15-34, *Shoulder Range of Motion*, appellant had nine percent for flexion, two percent for extension, six percent for abduction, two percent for adduction, four percent for internal rotation, and two percent for external rotation for a total of 25 percent right upper extremity impairment. Dr. Fellars reported that since appellant had previously been awarded 20 percent permanent impairment for the right upper extremity, he would be entitled to an additional 5 percent right upper extremity permanent impairment for a total of 25 percent of the upper extremity. He explained that he disagreed with Dr. Garcia's impairment rating since Dr. Garcia had not documented or provided the methodology as to how he calculated 22 percent whole person impairment. Dr. Fellars noted that appellant had reached MMI on May 23, 2018.

By decision dated February 19, 2019, OWCP granted appellant a schedule award for five percent permanent impairment of the right upper extremity. The award ran for 15.6 weeks for the period May 23 to September 9, 2018.

### **LEGAL PRECEDENT**

The schedule award provisions of FECA,<sup>4</sup> and its implementing federal regulations,<sup>5</sup> 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.<sup>6</sup> The Board has approved the use by OWCP of the

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<sup>3</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009).

<sup>4</sup> *Supra* note 2.

<sup>5</sup> 20 C.F.R. § 10.404.

<sup>6</sup> For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides* (6<sup>th</sup> ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.<sup>7</sup>

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).<sup>8</sup> Under the sixth edition, the evaluator identifies the impairment class of diagnosis (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).<sup>9</sup> The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).<sup>10</sup> Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.<sup>11</sup>

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 diagnosis-based sections are applicable.<sup>12</sup> If ROM is used as a stand-alone impairment rating method, the total of ROM impairment for all units of function must be calculated. All values for the joint are measured and combined.<sup>13</sup> 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.<sup>14</sup>

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*

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<sup>7</sup> P.R., Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

<sup>8</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009), p.3, section 1.3, ICF: A Contemporary Model of Disablement.

<sup>9</sup> *Id.* at 494-531.

<sup>10</sup> *Id.* at 411.

<sup>11</sup> R.R., Docket No. 17-1947 (issued December 19, 2018); R.V., Docket No. 10-1827 (issued April 1, 2011).

<sup>12</sup> A.M.A., *Guides* 461.

<sup>13</sup> *Id.* at 473.

<sup>14</sup> *Id.* at 474.

*impairment rating for the diagnosis in question, the method producing the higher rating should be used.”*<sup>15</sup> (Emphasis in the original.)

### ANALYSIS

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

In a May 23, 2018 report, Dr. Garcia indicated that OWCP had requested a permanent impairment rating from him due to appellant’s accepted right shoulder condition. Dr. Kane reviewed appellant’s medical history and conducted an examination. He measured ROM of the right shoulder as 90 degrees external rotation, 90 degrees internal rotation, 60 degrees flexion, 20 degrees extension, 30 degrees abduction, and 25 degrees adduction. Dr. Kane noted that appellant had reached MMI on April 25, 2018.

In accordance with OWCP’s procedures, Dr. Fellars, the DMA, reviewed the evidence, including Dr. Garcia’s May 23, 2018 report. In an August 23, 2018 report, the DMA determined that under the DBI methodology, appellant had seven percent permanent impairment for right shoulder rotator cuff tear. He also calculated permanent impairment utilizing the ROM methodology under Table15-34 for loss of ROM and determined that appellant had 25 percent right upper extremity impairment. The DMA concluded that since appellant was previously awarded 20 percent right upper extremity impairment, he was only entitled to an additional 5 percent permanent impairment due to his August 2, 2016 employment injury.

The Board finds, however, that neither Dr. Garcia nor the DMA indicated whether the ROM measurements utilized were obtained after three independent ROM findings pursuant to OWCP procedures. As noted above, FECA Bulletin No. 17-06 provides detailed instructions for obtaining sufficient evidence to conduct a complete permanent impairment evaluation.<sup>16</sup> Herein, OWCP did not properly develop 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 in the record.<sup>17</sup> In evaluating permanent impairment under the ROM method, the DMA should have obtained the necessary ROM measurements in order to complete the rating. For this reason, the case must be remanded for OWCP to complete the proper procedures outlined in FECA Bulletin No. 17-06.<sup>18</sup>

The Board further finds that while OWCP reduced the current award based on the DMA’s recommendation, the record currently before the Board does not include evidence of OWCP having previously issued a schedule award with respect to appellant’s right upper extremity.<sup>19</sup> To

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<sup>15</sup> *V.L.*, Docket No. 18-0760 (issued November 13, 2018); FECA Bulletin No. 17-06 (May 8, 2018).

<sup>16</sup> *Supra* note 12.

<sup>17</sup> *C.P.*, Docket No. 19-0151 (issued May 22, 2019); *V.H.*, Docket No. 18-0848 (issued February 25, 2019); *T.R.*, Docket No. 17-1961 (issued December 20, 2018).

<sup>18</sup> *M.D.*, Docket No. 18-1073 (issued January 18, 2019).

<sup>19</sup> *See supra* note 2.

the extent appellant received a schedule award under his previously accepted occupational disease claim, File No. xxxxxx296, OWCP should, at a minimum, incorporate the prior schedule award and other relevant medical evidence into the current claim file.<sup>20</sup> Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision.

**CONCLUSION**

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

**ORDER**

**IT IS HEREBY ORDERED THAT** the February 19, 2019 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: September 10, 2019  
Washington, DC

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

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

Janice B. Askin, Judge  
Employees' Compensation Appeals Board

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<sup>20</sup> OWCP's regulations provide that benefits payable under section 8107(c) shall be reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) OWCP finds that the later impairment in whole or in part would duplicate the compensation payable for the preexisting impairment. 20 C.F.R. § 10.404(d).