United States Department of Labor
Employees' Compensation Appeals Board

D.P., Appellant	)	
and	)	**Docket No. 19-1514**
	)	**Issued: October 21, 2020**
DEPARTMENT OF THE NAVY, U.S. FLEET FORCES COMMAND, Kings Bay, GA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Deputy Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On July 9, 2019 appellant filed a timely appeal from a July 3, 2019 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 greater than 10 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On February 23, 2017 appellant, then a 62-year-old machinist, filed a traumatic injury claim (Form CA-1) alleging that on February 21, 2017 he sustained a left shoulder strain as a result of removing a rotor from an engine lathe while in the performance of duty. On the reverse side of the claim form, the employing establishment indicated that he stopped work on the date of injury and returned to work on the same day.[2] OWCP assigned the claim OWCP File No. xxxxxx662 and accepted an unspecified sprain of the left shoulder joint, initial encounter, impingement syndrome of the left shoulder, and unspecified rotator cuff tear or rupture of the left shoulder, not specified as traumatic. On September 22, 2017 appellant underwent authorized left shoulder arthroscopy with arthroscopic rotator cuff repair, superior labrum anterior and posterior repair, Bankart repair, subacromial decompression, major debridement, synovectomy, glenoid bone removal, and large joint injection performed by Dr. Kevin P. Murphy, an attending Board-certified orthopedic surgeon.

On April 18, 2018 appellant filed a claim for a schedule award (Form CA-7).[3]

In an April 9, 2018 medical report, Dr. Murphy noted that appellant presented following a September 22, 2017 left shoulder arthroscopy. He also noted that appellant's shoulder was doing well. Dr. Murphy provided normal presentation, strength, range of motion, and function on examination of the left shoulder and assessed pain and primary osteoarthritis in the left shoulder. He advised that appellant had reached maximum medical improvement (MMI) on the date of his examination. Dr. Murphy, in an April 9, 2018 work capacity evaluation (Form OWCP-5c), reiterated his MMI finding and indicated that appellant was capable of performing his usual work without restriction.

In an April 26, 2018 letter, OWCP requested that Dr. Murphy provide a medical report which included a statement that appellant's accepted conditions had reached MMI and an impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] It afforded him 30 days to submit the requested evidence. No response was received.

On September 13, 2018 OWCP referred appellant, together with a statement of accepted facts (SOAF), the medical record, and a set of questions, to Dr. Raymond F. Topp, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine the extent of his employment-related permanent impairment based on the sixth edition of the A.M.A., *Guides* and the date he reached MMI.

In a report dated October 9, 2018, Dr. Topp discussed findings on examination of appellant's left shoulder. He noted, among other findings, that left deltoid atrophy was present,

[2] The record indicates that appellant retired from the employing establishment on July 14, 2017.

[3] On June 3, 2008 OWCP had previously granted appellant a schedule award for 10 percent permanent impairment of each arm under a claim assigned OWCP File No. xxxxxx418, which was accepted for bilateral carpal tunnel syndrome.

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

2.5 centimeter (cm) as compared to the right shoulder. Dr. Topp found no tenderness or instability. He reported range of motion (ROM) measurements of 180 degrees of abduction, 180 degrees of forward flexion, full adduction, internal rotation was decreased to posterior superior iliac spine (PSIS), and external rotation of 40 degrees. Dr. Topp assessed left anterior shoulder pain.

Referring to Table 15-5 of the sixth edition of the A.M.A., *Guides*, Dr. Topp determined that appellant had a class 1, grade C impairment, for a primary diagnosis of rotator cuff tear. He derived a grade modifier for functional history (GMFH) of 2, grade modifier for physical examination (GMPE) of 2, and grade modifier for clinical studies (GMCS) of 2, with an additional grade modifier of 1 for a *Quick*DASH score of 35. Dr. Topp concluded that appellant's class 1, grade C impairment, resulted in five percent permanent impairment of the left upper extremity due to his rotator cuff tear diagnosis.

Dr. Topp again referred to Table 15-5 and determined that appellant had a class of diagnosis (CDX) of 1 for a superior labral tear from anterior to posterior (SLAP) and labral tear and GMFH, GMPE, and GMCS all of 2 with a *Quick*DASH score of 35, he had a grade C impairment, which yielded three percent left upper extremity permanent impairment. He added the five percent permanent impairment rating for a rotator cuff tear and three percent permanent impairment rating for SLAP and labral tears, to calculate a combined eight percent permanent impairment of the left upper extremity. Dr. Topp noted that he was unable to use the ROM method to rate impairment of appellant's left shoulder because he did not have a normal opposing extremity to make a comparison. He determined that appellant had reached MMI on September 22, 2018, one year following his September 22, 2017 authorized left shoulder rotator cuff surgery.

On January 8, 2019 OWCP referred the case record, including Dr. Topp's October 9, 2018 report, to Dr. Herbert White, Jr., Board-certified in physical medicine and rehabilitation and serving as the district medical adviser (DMA), for review. In a January 12, 2019 report, the DMA noted that he had reviewed the SOAF and the medical record, including Dr. Topp's October 9, 2018 report. Utilizing the diagnosis-based impairment (DBI) rating methodology in Table 15-5, page 403 of the sixth edition of the A.M.A., *Guides*, he identified a CDX of one for the diagnosis of full thickness rotator cuff tear, residual loss functional. The DMA assigned a GMFH of 2 under Table 15-7, page 406, a GMPE of 2 under Table 15-8, page 408, and a GMCS of 2 under Table 15-9, page 410. He applied the net adjustment formula, (GMFH-CDX)(2-1) + (GMPE-CDX)(2-1) + (GMCS-CDX)(2-1), to find +3 net adjustment, which moved the default grade C to grade E or seven percent permanent impairment of the left upper extremity due to a full-thickness rotator cuff tear.

The DMA noted that he was unable to rate impairment utilizing the ROM rating method with the information provided. He indicated that a recording of all ROMs was needed, noting that extension ROM was not provided and internal ROM was not provided in degrees by Dr. Topp. The DMA explained the discrepancies between his seven percent permanent impairment rating for

appellant's full-thickness rotator cuff tear and Dr. Topp's five percent impairment rating. He noted that Dr. Topp had not properly applied the grade modifiers as indicated above.[5]

On January 22, 2019 OWCP requested that Dr. Topp provide the information raised in the DMA's January 12, 2019 report.

Dr. Topp responded, in a February 4, 2019 addendum, that internal rotation was 20 degrees and extension was 10 degrees based on his examination.

In an amended February 11, 2019 report, the DMA reviewed the medical record including Dr. Topp's February 4, 2019 addendum. He utilized the ROM method in Table 15-34, page 475 of the A.M.A., *Guides* to find 0 percent impairment for 180 degrees of flexion, 2 percent impairment for 10 degrees of extension, 0 percent impairment for 180 degrees of abduction, 0 percent impairment for adduction within normal limits, 4 percent impairment for 20 degrees of internal rotation, and 2 percent impairment for 40 degrees of external rotation, totaling 8 percent left upper extremity permanent impairment due to a rotator cuff tear. The DMA noted that appellant had reached MMI on February 4, 2019, the date of Dr. Topp's addendum.

On February 14, 2019 OWCP requested that the DMA clarify his February 11, 2019 report. It requested that he determine whether appellant had greater than 10 percent permanent impairment of the left upper extremity for which he previously received a schedule award in June 2008.

The DMA responded, in a February 19, 2019 amended report, that appellant had no additional permanent impairment of the left arm. He reiterated his DBI impairment ratings of seven percent permanent impairment for a rotator cuff tear and five percent permanent impairment for a labral tear of the left upper extremity. The DMA also reiterated his ROM impairment ratings of eight percent left upper extremity permanent impairment. He assigned a grade modifier 1 for ROM under Table 15-35, page 477. Under Table 15-7, page 406, the DMA found a GMFH of 1 due to pain with normal activity. He applied the formula (GMFH = 2) - (grade modifier for ROM = 1), which yielded a modifier adjustment of 1. Next, using Table 15-36, page 477, the DMA adjusted the impairment rating using functional history total ROM by five percent (8 percent x 5 percent or .4 percent adjustment), 8 percent + .4 percent or 8.4 percent left upper extremity impairment. He rounded the number down to 8 percent. The DMA explained that as the ROM method resulted in a higher rating than the DBI method, the ROM calculation should be used.

[5] The DMA noted that Dr. Topp should have only rated impairment due to the rotator cuff tear diagnosis. He indicated that page 389 of the A.M.A., *Guides*, provides that if more than one diagnosis could be used, the most clinically accurate causally-related impairment rating should be used, which was generally the more specific diagnosis, and that typically, one diagnosis would adequately characterize the impairment and its impact on activities of daily living. The DMA noted that Table 2.1, page 20, #12 mandated that, if the A.M.A., *Guides* provided for more than one method to rate a particular impairment or condition, the method producing the higher rating "must be used." He maintained that the rotator cuff tear provided the greater impairment, seven percent permanent impairment of the left upper extremity. The DMA further maintained that Dr. Topp's statement that he was unable to use the ROM method because right shoulder motions were not normal was incorrect. He indicated that abnormal right shoulder motions only meant that motions of the right shoulder could not be considered normal so the left could not be compared to the right using the right as normal. The DMA recommended that Dr. Topp provide internal ROM and extension ROM in degrees. He determined that appellant had reached MMI on October 9, 2018, the date of Dr. Topp's impairment evaluation.

Regarding appellant's previous schedule award for 10 percent permanent impairment of the left upper extremity, he cited section 2.5c Apportionment on page 25 of the A.M.A., *Guides*, which provides that a total impairment rating (A) (an all-inclusive current rating) is derived irrespective of preexisting and resulting conditions and that in this case the impairment was eight percent. The DMA indicated that section 2.5c provides that a second "baseline rating" (B) is derived that accounts solely for preexisting conditions without associated or aggravated reinjury and that in this case the previous impairment was 10 percent. He concluded that the final rating was derived in which the preexisting conditions were discounted by subtracting the second from the first rating (A - B), resulting in an additional impairment of zero percent (8 percent - 10 percent = 2 percent).

By decision dated February 21, 2019, OWCP denied appellant's claim for a schedule award finding that Dr. Topp's October 9, 2018 report constituted the weight of the medical evidence.

In a letter received by OWCP on March 18, 2019, appellant requested reconsideration. He contended that the medical evaluation of his left shoulder injury had not included an evaluation of his carpal tunnel injury. Appellant noted that he had a nearly identical case involving his right shoulder for which he received an additional schedule award in a claim assigned OWCP File No. xxxxxx444.[6]

OWCP, by decision dated July 3, 2019, denied modification of its February 21, 2019 decision finding that the weight of the medical evidence rested with the February 19, 2019 report of the DMA who determined that appellant had no additional permanent impairment of the left upper extremity beyond the previously awarded 10 percent permanent impairment of the left upper extremity. It noted that the DMA considered appellant's preexisting condition in his impairment rating.

LEGAL PRECEDENT

The schedule award provisions of FECA,[7] and its implementing federal regulations,[8] 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

[6] OWCP granted appellant a schedule award for six percent permanent impairment of the right arm under OWCP File No. xxxxxx444, which was accepted for sprain of the right shoulder and upper arm, rotator cuff.

[7] *Supra* note 1 at § 8107.

[8] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10]

In addressing upper extremity impairments, the sixth edition requires identification of the CDX for the diagnosed condition, which is then adjusted by GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] OWCP's procedures provide that, after obtaining all necessary medical evidence, that file should be routed to a DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of the permanent impairment specified.[13]

Regarding the application of the 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."*] (Emphasis in the original.)[14]
>
> 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

[9] *Id*. at § 10.404(a).

[10] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); *see also* Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017).

[11] *L.T.*, Docket No. 18-1031 (issued March 5, 2019); A.M.A., *Guides* 383-492.

[12] A.M.A., *Guides* 411.

[13] *R.B.*, Docket No. 18-1308 (issued January 10, 2019); *P.R.*, Docket No. 18-0022 (issued April 9, 2018); *supra* note 10 at Chapter 2.808.6f (March 2017).

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

should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[15]

It is well established that benefits payable under 5 U.S.C. § 8107(c) are 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) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[16]

ANALYSIS

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

On June 3, 2008 OWCP previously granted appellant a schedule award for 10 percent left upper extremity permanent impairment based on his accepted condition of bilateral carpal tunnel syndrome. On April 18, 2018 appellant filed a claim for an increased schedule award and submitted medical evidence. Utilizing the DBI methodology found in Table 15-5, Dr. Topp, OWCP's referral physician, determined that appellant had eight percent permanent impairment of the left upper extremity due to a primary diagnosis of rotator cuff, SLAP, and labral tears. DMA Dr. White also utilized the DBI methodology in Table 15-5 and determined that appellant had seven percent permanent impairment of the left upper extremity due to full-thickness rotator tear, residual loss functional. Additionally, he used the ROM methodology found in Table 15-34 and determined that appellant had eight percent permanent impairment of the left upper extremity due to his rotator cuff tear. The DMA properly explained that appellant's current permanent impairment of the left upper extremity was based on the ROM methodology as it yielded a higher permanent impairment rating than the DBI methodology.[17] In a February 14, 2019 letter, OWCP requested that the DMA clarify whether appellant had greater than 10 percent permanent impairment of the left upper extremity for which he previously received a schedule award in June 2008. In a February 19, 2019 amended report, the DMA apportioned appellant's left upper extremity impairment between the accepted left shoulder condition in the instant claim assigned OWCP File No. xxxxxx662 and the accepted bilateral wrist condition in the claim assigned OWCP File No. xxxxxx418, and determined that there was no additional permanent impairment of the left upper extremity. OWCP, in a February 21, 2019 decision, denied appellant's claim for an increased schedule award. Appellant requested reconsideration and by decision dated July 3, 2019, OWCP denied modification of its prior decision. OWCP based its determination that he was not entitled to a schedule award greater than the 10 percent permanent impairment of the left upper extremity previously awarded on the opinion of its DMA who advised that, at present, he was only entitled to 8 percent left upper extremity permanent impairment.

[15] *Id.*

[16] 20 C.F.R. § 10.404(d); *see S.M.*, Docket No. 17-1826 (issued February 26, 2018); *T.S.*, Docket No. 16-1406 (issued August 9, 2017); *T.S.*, Docket No. 09-1308 (issued December 22, 2009).

[17] A.M.A., *Guides* 473.

Although the DMA sought to apportion appellant's impairment between the current accepted condition and the previously accepted condition, the Board notes that a claimant is not precluded from an additional schedule award solely because he or she received a greater award to the same scheduled member from another claim.[18] The Board has previously held that simply comparing the prior percentage of permanent impairment awarded to the current impairment for the same member is not always sufficient to deny an increased schedule award claim.[19] The issue is not whether the current permanent impairment rating is greater than the prior impairment ratings, but whether it duplicates in whole or in part the prior impairment rating.[20] Therefore, the Board finds that OWCP has not properly analyzed appellant's entitlement to schedule award benefits in the present claim for his accepted shoulder conditions.

Furthermore, OWCP's procedures provide that cases should be administratively combined when correct adjudication of the issues depends on frequent cross-referencing between files.[21] For example, if a new injury case is reported for an employee who previously filed an injury claim for a similar condition or the same part of the body, doubling is required.[22] Because they both involve schedule awards for accepted injuries to appellant's left upper extremity, for a full and fair adjudication, the claims in OWCP File Nos. xxxxxx662 and xxxxxx418 must be administratively combined.[23]

Accordingly, the Board will remand the case to OWCP to administratively combine the case records for OWCP File Nos. xxxxxx662 and xxxxxx418 and analyze appellant's entitlement to an additional schedule award for his accepted conditions. Following this and other such further development, as deemed necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.

CONCLUSION

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

[18] *See S.M., supra* note 16.

[19] *R.K.*, Docket No. 19-0247 (issued August 1, 2019); *M.K.*, Docket No. 18-1614 (issued March 25, 2019); *T.S.*, Docket No. 16-1406 (issued August 9, 2017).

[20] *Id.*

[21] *See supra* note 10 at Part 2 -- Claims, *File Maintenance and Management*, Chapter 2.400.8(c) (February 2000).

[22] *Id.*; *D.C.*, Docket No. 19-0100 (issued June 3, 2019); *N.M.*, Docket No. 18-0833 (issued April 18, 2019); *K.T.*, Docket No. 17-0432 (issued August 17, 2018).

[23] *See B.O.*, Docket No. 18-1100 (issued February 24, 2020).

ORDER

IT IS HEREBY ORDERED THAT the July 3, 2019 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: October 21, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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