United States Department of Labor
Employees' Compensation Appeals Board

C.H., Appellant	)	
	)	
and	)	**Docket No. 20-0529**
	)	**Issued: June 16, 2021**
DEPARTMENT OF THE NAVY, NAVAL STATION NORFOLK, Norfolk, VA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 9, 2020 appellant filed a timely appeal from a July 16, 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.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the July 16, 2019 decision, appellant submitted additional evidence to OWCP. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 9 percent permanent impairment of his right upper extremity and 22 percent permanent impairment of his left lower extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On April 27, 2016 appellant, then a 58-year-old industrial specialist, filed an occupational disease claim (Form CA-1) alleging that on April 26, 2016 he sustained injury, including a left ankle fracture, when he fell from a ship ladder while in the performance of duty. He stopped work on the date of the claimed injury. On April 26, 2016 appellant underwent left ankle internal fixation surgery of an open pilon fracture and, on April 28, 2016 he underwent left ankle irrigation debridement surgery with vacuum-assisted wound closure. OWCP initially accepted his claim for open fracture of the left ankle. On June 21, 2016 the surgical hardware was removed from appellant's left lower extremity. OWCP authorized these procedures and paid wage-loss compensation on the supplemental rolls for disability from work commencing June 13, 2016 and on the periodic rolls for disability from work commencing June 26, 2016.

On July 21, 2016 OWCP expanded the acceptance of appellant's claim to include displaced open pilon fracture of the left tibia (type I or II), displaced transverse fracture (closed) of the left fibula shaft, complete rotator cuff tear/rupture of the right shoulder, superior glenoid labrum lesion of the right shoulder, and unspecified injury of the right shoulder/upper arm. On September 6, 2016 appellant underwent OWCP-authorized right shoulder surgery, including rotator cuff repair, superior capsular reconstruction, glenohumeral joint debridement, and subacromial decompression with acromioplasty. On September 29, 2016 he returned to limited-duty work and on May 16, 2017 he filed a claim for a schedule award (Form CA-7).

Appellant subsequently submitted a May 1, 2017 report from Dr. Patrick O'Connell, a Board-certified orthopedic surgeon, who reported the following range of motion (ROM) findings for appellant's right shoulder: flexion of 150 degrees, extension of 30 degrees, abduction of 120 degrees, adduction of 20 degrees, internal rotation of 40 degrees, and external rotation of 60 degrees. Dr. O'Connell found that, utilizing Table 15-34 on page 475 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] appellant had 12 percent permanent impairment of his right upper extremity. In a form report dated May 1, 2017, he reported the following ROM findings for appellant's right shoulder: flexion of 143 degrees; extension of 49 degrees; abduction of 128 degrees; adduction of 42 degrees; internal rotation of 60 degrees; and external rotation of 49 degrees. For the left shoulder, Dr. O'Connell reported the following findings: flexion of 157 degrees; extension of 70 degrees; abduction of 155 degrees; adduction of 40 degrees; internal rotation of 86 degrees; and external rotation of 65 degrees. He found that, utilizing Table 15-34, appellant had 12 percent permanent impairment of his right upper extremity.

[3] (6th ed. 2009).

On July 26, 2017 OWCP referred appellant's case to Dr. Herbert White, Jr., a Board-certified occupational medicine specialist serving as an OWCP district medical adviser (DMA). It requested that he review the medical evidence of record, including Dr. O'Connell's reports, and provide an opinion regarding appellant's permanent impairment. On July 30, 2017 Dr. White asserted that it was necessary to obtain additional clarification regarding Dr. O'Connell's right upper extremity permanent impairment rating.

In an August 8, 2017 development letter, OWCP requested that appellant obtain a report from Dr. O'Connell, which contained a detailed assessment of appellant's permanent impairment utilizing the diagnosis-based impairment (DBI) rating method as well as, if appropriate, the ROM rating method. It requested that the report should provide a date of maximum medical improvement (MMI) and indicate whether three measurements were obtained for each motion of appellant's right upper extremity. OWCP afforded appellant 30 days to obtain and submit the requested report.

In response, appellant submitted an August 24, 2017 report to OWCP in which Dr. O'Connell advised that his May 1, 2017 impairment rating was based on three measurements for each motion of appellant's right upper extremity. Dr. O'Connell opined that appellant reached MMI with respect to his right upper extremity on May 1, 2017.

On December 18, 2017 OWCP referred appellant, together with a statement of accepted facts (SOAF) and list of specific questions, for a second opinion examination with Dr. James Schwartz, a Board-certified orthopedic surgeon. It requested that Dr. Schwartz provide an opinion on appellant's permanent impairment under the sixth edition of the A.M.A., *Guides.*

In a January 27, 2018 report, Dr. Schwartz discussed appellant's factual and medical history, and noted physical examination findings, including mild antalgic gait of the left lower extremity and good dorsal pedal pulses, equal bilaterally. Appellant's right rotator cuff strength was 4+/5 at 90 degrees and 3+/5 at 45 degrees and the biceps strength was 5/5 bilaterally. For the right shoulder, Dr. Schwartz reported the following ROM findings: flexion of 135 degrees; extension of 65 degrees; abduction of 130 degrees; adduction of 20 degrees; internal rotation of 40 degrees; and external rotation of 55 degrees. For the left shoulder, he reported the following ROM findings: flexion of 170 degrees; extension of 70 degrees; abduction of 175 degrees; adduction of 45 degrees; internal rotation of 75 degrees; and external rotation of 90 degrees. Dr. Schwartz diagnosed repaired right shoulder rotator cuff tear and left pilon fracture distal tibia (post open reduction internal fixation) related to April 26, 2016 employment injury. He then referred to the sixth edition of A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 16-2 (Foot and Ankle Regional Grid), page 503, the class of diagnosis (CDX) for appellant's left tibia fracture (intra-articular) resulted in a class 2 impairment with a default value of 22 percent. Dr. Schwartz assigned a grade modifier for functional history (GMFH) of 2 based on the moderate deficits from appellant's condition (*Quick*DASH score of 52). He found that a grade modifier for physical examination (GMPE) and a grade modifier for clinical studies (GMCS) were not applicable as the physical examination and clinical studies were used to establish the diagnosis and proper placement in the regional grid. Dr. Schwartz utilized the net adjustment formula, (GMFH - CDX) = (2 - 2) = 0, which resulted in a grade C or 22 percent permanent impairment of the left lower extremity.

With regard to appellant's right upper extremity, Dr. Schwartz indicated that he would not utilize the tables for calculating appellant's permanent impairment under the DBI rating method, but rather would apply the ROM rating method "which gives him a higher rating which is more appropriate." He referenced Table 15-34 (Shoulder Motion Impairments), page 475, to find three percent permanent impairment for right shoulder flexion of 135 degrees, three percent for abduction of 130 degrees, one percent for adduction of 20 degrees, four percent for internal rotation of 40 degrees, and two percent for external rotation of 55 degrees. Dr. Schwartz combined these values to equal 13 percent permanent impairment of the right upper extremity. He found that, utilizing Table 15-36, page 477, appellant had a functional history grade adjustment of 2. This figure was +1 higher than the ROM class (derived from Table 15-35, page 477), which required multiplying the above-noted 13 percent figure times 5 percent to equal (after rounding up) a total right upper extremity permanent impairment of 14 percent. Dr. Schwartz concluded that appellant had 14 percent permanent impairment of his right upper extremity and 22 percent permanent impairment of his left lower extremity.[4]

On February 8, 2018 OWCP again referred appellant's case to Dr. White in his capacity as a DMA. It requested that he review the medical evidence of record, including Dr. Schwartz' January 27, 2018 report, and provide an opinion regarding appellant's permanent impairment.

In a February 18, 2018 report, Dr. White discussed appellant's factual and medical history, including his left ankle and right shoulder surgeries, and calculated an impairment rating based on Dr. Schwartz' January 27, 2018 physical examination findings. He referred to the sixth edition of the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 16-2, the CDX for appellant's left tibia fracture resulted in a class 2 impairment (based on moderate malalignment) with a default value of 22 percent. Dr. White assigned a GMFH of 2 based on abnormal gait and a GMPE of 2. He found that a GMCS was not applicable as the clinical studies were used to establish the diagnosis and proper placement in the regional grid. Dr. White utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) = (2 - 2 = 0) + (2 - 2 = 0) = 0, which resulted in a grade C or 22 percent permanent impairment of the left lower extremity. With respect to appellant's right upper extremity, Dr. White utilized the DBI rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 403, the CDX for appellant's full-thickness rotator cuff tear resulted in a class 1 impairment with a default value of five. He assigned a GMFH of 2 based on the *Quick*DASH score of 52, a GMPE of 1 due to mild ROM deficits, and a GMCS of 4 due to biceps tendon and labral tears. Dr. White utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (2 - 1) + (1 - 1) + (4 - 1) = +4, which resulted in a grade E or seven percent permanent impairment of the right upper extremity under the DBI rating method.

Dr. White then applied the ROM rating method and referenced Table 15-34 to find one percent permanent impairment for right shoulder extension of 65 degrees, three percent for abduction of 130 degrees, one percent for adduction of 20 degrees, and four percent for internal rotation of 40 degrees. He combined these values to equal nine percent permanent impairment of the right upper extremity. Dr. White found that, utilizing Table 15-36, page 477, appellant had a functional history grade adjustment of 2 due to his *Quick*DASH score of 52. He indicated that this figure was +1 higher than the ROM class (derived from Table 15-35, page 477), which required

[4] Dr. Schwartz found that appellant reached MMI on January 27, 2018, the date of his examination.

multiplying the above-noted nine percent figure times five percent to equal (after rounding down) a total right upper extremity permanent impairment of nine percent. Dr. White opined that one of the reasons his right upper extremity rating was different from Dr. Schwartz' 14 percent rating was that Dr. Schwartz did not compare the motions of the affected right shoulder to those of the unaffected left shoulder.[5] He asserted that, if this were done in appellant's case, then the ROM findings for flexion would be considered normal and a three percent impairment rating would not have been applied for that motion. Dr. White maintained that another reason that his impairment rating was different from Dr. Schwartz' 14 percent rating was that Dr. Schwartz erroneously rated appellant's right shoulder external rotation of 55 degrees as a two percent impairment. He indicated that Dr. Schwartz failed to round the 55 degrees of external rotation motion up to 60 degrees, a figure which equaled zero percent impairment.[6] Dr. White found that the nine percent impairment rating under the ROM rating method represented appellant's right upper extremity permanent impairment because it yielded a greater value than the DBI rating method. He concluded that appellant had 9 percent permanent impairment of his right upper extremity and 22 percent permanent impairment of his left lower extremity.[7]

By decision dated July 26, 2018, OWCP granted appellant a schedule award for 9 percent permanent impairment of his right upper extremity and 22 percent permanent impairment of his left lower extremity. The award ran for 91.44 weeks from March 31 to December 31, 2018 and was based on the February 27, 2018 report of Dr. White.

On November 30, 2018 appellant requested reconsideration of the July 26, 2018 decision. By decision dated January 9, 2019, OWCP denied his request for reconsideration of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

On July 5, 2019 appellant, through his then-counsel, requested reconsideration of the January 9, 2019 decision.

Appellant submitted April 11 and May 15, 2019 reports from Dr. Dirk Proffer, a Board-certified orthopedic surgeon, who discussed appellant's left ankle condition, but did not assess permanent impairment. He also submitted April 18 and 19, 2019 reports from Emily Bosch, a physician assistant.

By decision dated July 16, 2019, OWCP denied modification of the January 9, 2019 decision.

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[5] Dr. White advised that the sixth edition of the A.M.A., *Guides* provides on page 461, "If the opposite extremity is neither involved nor previously injured, it must be used to define normal for that individual; any losses should be made in comparison to the opposite normal extremity."

[6] Dr. White advised that the sixth edition of the A.M.A., *Guides* provides on page 464, "Measurements should be rounded up or down to the nearest number ending in 0 (*e.g.*, 20 degrees instead of 24 degrees and 30 degrees instead of 25 degrees)."

[7] Dr. White found that appellant reached MMI on January 27, 2018, the date of Dr. Schwartz' examination.

LEGAL PRECEDENT

The schedule award provision of FECA,[8] and its implementing federal regulation,[9] 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.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[11]

Regarding the application of ROM or DBI impairment methods 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* [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.)"
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> "If the rating physician provided an assessment using the DBI 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.
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> "If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an

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[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id. See also T.T.,* Docket No. 18-1622 (issued May 14, 2019).

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

impairment rating using the DBI method, if possible, given the available evidence."[12]

ANALYSIS

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

The Board notes that OWCP relied on the February 18, 2018 report of Dr. White, the DMA, to determine that appellant had not shown that he had greater than 9 percent permanent impairment of his right upper extremity and 22 percent permanent impairment of his left lower extremity, for which he previously received schedule award compensation.

In his February 18, 2018 report, Dr. White calculated an impairment rating based on the January 27, 2018 physical examination findings of Dr. Schwartz, OWCP's referral physician. He referred to the sixth edition of the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 16-2, appellant had 22 percent permanent impairment of the left lower extremity.[13] With respect to appellant's right upper extremity, Dr. White first applied the DBI rating method and utilized Table 15-5 to calculate a seven percent permanent impairment under this method.[14] He then referenced Table 15-34 to apply the ROM rating method and found one percent permanent impairment for right shoulder extension of 65 degrees, three percent for abduction of 130 degrees, one percent for adduction of 20 degrees, and four percent for internal rotation of 40 degrees.[15] Dr. White combined these values to equal nine percent permanent impairment of the right upper extremity. He found that, utilizing Table 15-36, page 477, appellant had a functional history grade adjustment of 2 due to his *Quick*DASH score of 52. Dr. White indicated that this figure was +1 higher than the ROM class (derived from Table 15-35, page 477), which required multiplying the above-noted nine percent figure times five percent to equal (after rounding down) a total right upper extremity permanent impairment of nine percent. He opined that one of the reasons his right upper extremity rating was different from Dr. Schwartz' 14 percent rating was that Dr. Schwartz did not compare the motions of the affected right shoulder to those of the unaffected left shoulder. Dr. White opined that, if this were done in appellant's case, then the ROM findings for flexion would be considered normal and a three percent impairment rating would not have been applied for that motion. He asserted that another reason that his impairment rating was different from Dr. Schwartz' 14 percent rating was that Dr. Schwartz erroneously rated appellant's right shoulder external rotation of 55 degrees as two percent impairment. Dr. White advised that the sixth edition of the A.M.A., *Guides* provides, "[m]easurements should be rounded up or down to the nearest number ending in 0 (*e.g.*, 20 degrees instead of 24 degrees and 30 degrees instead of 25 degrees)."[16]

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

[13] The Board notes that, under Table 16-2, the ROM rating method was not available for application to appellant's left ankle condition. *See* A.M.A., *Guides* 503, Table 16-2.

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

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

[16] *Id.* at 464.

He indicated that Dr. Schwartz failed to round the 55 degrees of external rotation motion up to 60 degrees, a figure that equaled zero percent impairment.

The Board finds that, while Dr. White derived DBI ratings for appellant's left lower extremity and right upper extremity, it remains unclear whether Dr. Schwartz' ROM findings for the right upper extremity allowed for a proper evaluation of permanent impairment of this member under the ROM method. The Board notes that appellant's accepted medical conditions allowed for assessment under the ROM method for the right upper extremity, but not for the left lower extremity.[17]

The Board notes that, although Dr. Schwartz and Dr. White attempted to conduct rating calculations under the ROM method, the case record does not contain a clear indication that Dr. Schwartz obtained proper ROM findings for appellant's right shoulder, including three measurements for each type of ROM. FECA Bulletin No. 17-06 provides detailed instructions for obtaining sufficient evidence to conduct a complete permanent impairment evaluation. However, such instructions were not fully carried out in this case and therefore further development of the medical evidence is required in accordance with FECA Bulletin No. 17-06.[18] In addition, section 15.7 of the sixth edition of the A.M.A., *Guides* provides that ROM should be measured after a "warm up," in which the individual moves the joint through its maximum ROM at least three times. The ROM examination is then performed by recording the active measurements from three separate ROM efforts and all measurements should fall within 10 degrees of the mean of these three measurements. The maximum observed measurement is used to determine the ROM impairment.[19] There currently is no evidence in the case record that these requirements for evaluating permanent impairment due to ROM deficits have been met.

In order to conduct a full evaluation of appellant's permanent impairment, including his right upper extremity permanent impairment, the Board finds that the case shall be remanded to OWCP in order for it to make an attempt to obtain the raw data from Dr. Schwartz' ROM testing for the right upper extremity. If the data is obtained, it should be evaluated and considered under the relevant standards of the A.M.A., *Guides*, including referral to a DMA, as a possible basis for an impairment rating for the right upper extremity. If no such data is obtained, OWCP should take appropriate action for further examination to obtain the necessary ROM measurements.[20]

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[17] A.M.A., *Guides* 403, Table 15-5; 503, Table 16-2.

[18] *Id.*

[19] A.M.A., *Guides* 464.

[20] The record contains a May 1, 2017 report from Dr. O'Connell, an attending physician, who found that appellant had 12 percent permanent impairment of the right upper extremity under the ROM method. However, after being provided an opportunity by OWCP, appellant failed to obtain a complete impairment rating assessment from Dr. O'Connell, including a rating of the right upper extremity under the DBI method. Therefore, OWCP properly referred appellant in late-2017 for a second opinion examination with Dr. Schwartz.

This case shall therefore be remanded for full application of OWCP procedures found in FECA Bulletin No. 17-06 and the standards of the sixth edition of the A.M.A., *Guides*.[21] Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's permanent impairment.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the July 16, 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: June 16, 2021
Washington, DC

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

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

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

[21] Application of these standards shall also include evaluation of the permanent impairment of appellant's left lower extremity and right upper extremity under the DBI rating method. *See supra* note 17.