United States Department of Labor
Employees' Compensation Appeals Board

D.F., Appellant	)	
and	)	**Docket No. 20-1286**
	)	**Issued: June 17, 2021**
U.S. POSTAL SERVICE, HICKORY HILL POST OFFICE, Memphis, TN, 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 June 8, 2020 appellant filed a timely appeal from December 12 and 13, 2019 merit decisions 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]

ISSUE

The issue is whether appellant has met her burden of proof to establish more than 12 percent permanent impairment of her right upper extremity for which she previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the December 13, 2019 decision, OWCP received additional evidence. 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 evidence for the first time on appeal. *Id.*

FACTUAL HISTORY

On January 17, 2009 appellant, then a 45-year-old carrier, filed a traumatic injury claim (Form CA-1) alleging that on January 14, 2009 she injured her right shoulder while in the performance of duty. In an attached statement, she explained that she was placing mail into a customer's mailbox when a dog charged towards her. In an attempt to quickly drive away, she hyperextended her arm and hurt her shoulder when she pulled her hand from the mailbox. OWCP assigned the claim OWCP File No. xxxxxx702 and accepted it for a sprain of the right shoulder and upper arm supraspinatus and other affectations of the right shoulder region not elsewhere classified. On May 14, 2009 appellant underwent an OWCP-authorized right shoulder arthroscopy, with debridement of an anterior labral tear, acromioplasty, and min-open rotator cuff repair.

On January 19, 2010 appellant filed a schedule award claim (Form CA-7).

In a January 14, 2010 report, Dr. Stephen Waggoner, Board-certified in orthopedic surgery, opined that appellant had reached maximum medical improvement (MMI). He noted his use of the diagnosis-based impairment (DBI) methodology of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*),[3] to calculate that appellant sustained five percent permanent impairment of her right upper extremity for a full-thickness rotator cuff tear.

On January 29, 2010 OWCP forwarded appellant's medical records to a district medical adviser (DMA) for a schedule award review. In a January 29, 2010 report, Dr. James Dyer, a Board-certified orthopedic surgeon serving as OWCP's DMA, indicated that he had reviewed appellant's surgical and medical history and indicated that she had reached MMI on January 14, 2010. Using the A.M.A., *Guides*, he calculated that appellant sustained five percent permanent impairment of her right upper extremity.

By decision dated February 4, 2010, OWCP granted appellant a schedule award for five percent permanent impairment of her right upper extremity. The award ran for 15.6 weeks from January 14 to May 3, 2010.[4]

A September 30, 2010 operative report signed by Dr. Christopher Pokabla, a Board-certified orthopedic surgeon, noted that appellant underwent arthroscopic right shoulder surgery with rotator cuff repair, subacromial decompression, distal clavicle excision, biceps tenodesis, and debridement of labral fraying and degenerative tearing.

On October 8, 2012 appellant filed a Form CA-7 claim for an increased schedule award.

In a development letter dated November 9, 2012, OWCP informed appellant that additional evidence was needed in support of her increased schedule award claim. It advised her of the

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

[4] On June 19, 2010 appellant filed a notice of recurrence (Form CA-2a) under OWCP File No. xxxxxx702, which OWCP converted to an occupational disease claim and assigned OWCP File No. xxxxxx699. Under OWCP File No. xxxxxx699, OWCP also accepted sprain of the right rotator cuff. OWCP's files have been administratively combined, with OWCP File No. xxxxxx609 serving as the master file.

medical evidence necessary to establish her claim and provided 30 days for her to submit the requested evidence.

On December 10, 2012 OWCP referred appellant's medical records to a DMA for review regarding appellant's entitlement for an increased schedule award.

A December 11, 2012 report from the DMA, containing an illegible signature reviewed appellant's surgical history and used the DBI methodology from the A.M.A., *Guides* to calculate that appellant sustained 10 percent permanent impairment of her right upper extremity. The DMA indicated that appellant should, therefore, be awarded a schedule award of an additional five percent permanent upper extremity impairment.

By decision dated December 18, 2012, OWCP granted appellant a schedule award for an additional five percent permanent impairment of her right upper extremity. The award ran for 15.6 weeks from October 21, 2012 to February 7, 2013.

In a May 3, 2017 operative report, Dr. Robert Jones, a Board-certified orthopedic surgeon, indicated that appellant underwent authorized right shoulder arthroscopy with arthroscopic subacromial decompression, extension of the distal clavicle, and rotator cuff repair with coracoacromial ligament release.

On March 8, 2019 appellant filed a Form CA-7 claim for an increased schedule award.

In a development letter dated March 14, 2019, OWCP informed appellant that additional evidence was needed in support of her increased schedule award claim. It advised her of the medical evidence necessary to establish her claim and provided 30 days for her to submit the requested evidence. No evidence was submitted.

By decision dated July 2, 2019, OWCP denied appellant's claim for an increased schedule award, finding that the evidence of record was insufficient to establish an increased permanent impairment.

In an August 28, 2019 report, Dr. Jones indicated that appellant presented with right shoulder pain, swelling, and limited range of motion. He reviewed appellant's history of injury, medical history, and medical records. Dr. Jones conducted a physical examination of appellant's right shoulder, revealing an active range of motion of: flexion of 130, 130, and 130 degrees; abduction of 140, 140, and 135 degrees; external rotation of 90, 90, and 90 degrees; internal rotation of 70, 70, and 70 degrees; a passive range of motion of flexion and abduction of 180 degrees; external rotation of 45 degrees; internal rotation of T4-T8, and an additional range of motion of extension of 30, 30, and 40 degrees; and abduction of 40 degrees. The examination additionally revealed a palpable exostosis in the superior distal clavicle and tenderness upon palpation in the acromioclavicular joint. Dr. Jones diagnosed a strain of the muscles and tendons of the rotator cuff of the right shoulder and listed associated diagnoses as osteoarthritis, supraspinatus tear, and shoulder impingement.

Utilizing the range of motion (ROM) methodology of the A.M.A., *Guides*, Dr. Jones opined that appellant's flexion of 130 degrees resulted in three percent permanent impairment, extension of 40 degrees resulted in one percent permanent impairment, abduction of 140 degrees resulted in three percent impairment, adduction of 40 degrees resulted in zero percent impairment,

internal rotation of 70 degrees resulted in two percent impairment, and external rotation of 90 degrees resulted in zero percent impairment. He concluded that appellant, therefore, sustained nine percent total upper extremity permanent impairment. Dr. Jones indicated that, since Dr. Waggoner's five percent impairment rating of appellant's right upper extremity was based on appellant's rotator cuff repair, his own DBI rating would be based on appellant's excision of the distal clavicle. Using the DBI methodology of the A.M.A., *Guides*, Dr. Jones calculated that she sustained 10 percent permanent impairment of her upper extremity. He referenced appendix A of the Combined Values Chart on page 604 of the A.M.A., *Guides*, and stated that, since appellant had separate surgeries for her rotator cuff and her distal clavicle, his impairment rating should be added onto Dr. Waggoner's impairment rating, totaling 15 percent permanent impairment of her right upper extremity.

On September 16, 2019 appellant requested reconsideration.

On September 25, 2019 OWCP referred appellant's medical records to Dr. Herbert White, Board-certified in preventive medicine and DMA, for a schedule award evaluation. In an October 2, 2019 report, Dr. White, indicated that OWCP had not referred a SOAF for him to review. Dr. Jones noted appellant's accepted diagnoses of right shoulder and upper arm supraspinatus sprain and right shoulder affection, and he indicated that appellant previously received a right upper extremity award of five percent.

Using the DBI method, Dr. White indicated that appellant's diagnosis was right shoulder acromioclavicular joint injury or disease on the DBI Regional Grid, page 403, and assigned a class of diagnosis (CDX) of one for this diagnosis. He assigned a grade modifier for functional history (GMFH) of 2 due to appellant's pain with normal activity, and he assigned a grade modifier for physical examination (GMPE) of 1 due to appellant's mild range of motion deficits. Dr. White assigned a grade modifier for clinical studies (GMCS) of 4 due to her rotator cuff and labral tears. He calculated a total of 12 percent right upper extremity impairment. Using the ROM methodology, Dr. White utilized Table 15-34 on page 475 and indicated that appellant's flexion of 130 degrees equaled three percent impairment, her extension of 40 degrees equaled one percent impairment, her abduction of 140 degrees equaled three percent impairment, her adduction of 40 degrees equaled zero percent impairment, her internal rotation of 70 degrees equaled two percent impairment, and her external rotation of 90 degrees equaled zero percent impairment. He assigned a ROM grade modifier of 1, a functional history grade modifier of 2 due to pain with normal activity, and calculated a functional history net modifier of 1. Dr. White calculated that appellant sustained a total 9 percent permanent impairment of the right upper extremity, according to the ROM methodology, and concluded that, as appellant's impairment percentage was higher using the DBI method, appellant, therefore, sustained 12 percent permanent impairment of her right upper extremity.

Dr. White stated that he had reviewed Dr. Jones' impairment evaluation, and he reported that Dr. Jones did not indicate the grade modifiers that he used when he calculated appellant's permanent impairment according to the DBI method. He stated that he disagreed with Dr. Jones' addition of appellant's permanent impairment of the distal clavicle to the previously calculated rotator cuff impairment because the A.M.A., *Guides* indicated that, if there was more than one diagnosis in a region, the specific diagnosis that provides the most clinically accurate causally related impairment should be utilized. Dr. White opined that the impairment calculation based on appellant's distal clavicle should be used because it yielded a larger impairment than the impairment calculation based on the rotator cuff. He additionally stated that, while Dr. Jones

added appellant's distal clavicle impairment rating to her previous rotator cuff impairment rating because appellant had multiple surgeries, the A.M.A., *Guides*, did not rate impairments based on that metric. Dr. White further reported that appellant reached MMI on August 28, 2019.

On October 17, 2019 OWCP informed appellant that it was submitting the DMA's October 2, 2019 report to Dr. Jones for review.

A November 1, 2019 e-mail from appellant to Dr. Jones' office indicated that she did not agree with the DMA's permanent impairment rating. She related that Dr. Jones did not note that her rotator cuff was a 90 percent or greater tear and did not mention the deformity that developed on her distal clavicle. Appellant requested that Dr. Jones send her August 28, 2019 x-ray report to OWCP. She also mentioned that the DMA failed to mention the five percent permanent impairment rating that was provided to her by Dr. Pokabla. Appellant asked if her permanent impairment rating should be the sum of Dr. Pokabla's permanent impairment rating, Dr. Waggoner's impairment rating, and Dr. Jones' impairment rating.

In November 4 and December 4, 2019 letters, Dr. Jones indicated that he agreed with Dr. White's permanent impairment rating.

By decisions dated December 12, and 13, 2019, OWCP granted appellant a schedule award for an additional 2 percent permanent impairment of her right upper extremity, for a total award of 12 percent permanent impairment of the right upper extremity. The award ran for 6.24 weeks, from August 28 to October 10, 2019.

LEGAL PRECEDENT

The schedule award provisions of FECA,[5] and its implementing regulations,[6] 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.[7] 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.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9] The sixth edition requires identifying the CDX, which is then adjusted by GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10] Regarding the upper extremities, the A.M.A., *Guides*, provide the following: "[i]f more than 1 diagnosis can be used, the highest

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*.

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

[9] *Id*.

[10] *Id.*

causally related impairment rating should be used, this generally will be the more specific diagnosis."[11]

Regarding the application of ROM or DBI impairment 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.)

ANALYSIS

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

OWCP indicated that on September 25, 2019 it sent appellant's medical records to a DMA for a schedule award evaluation; however, the DMA, Dr. White, related in his October 2, 2019 report that no SOAF was provided from OWCP for him to review. Dr. White additionally stated that appellant had previously received a right upper extremity award of five percent.

It is OWCP's responsibility to provide a complete and proper frame of reference for a physician by preparing a SOAF. OWCP's procedures dictate that, when an OWCP medical adviser, second opinion specialist, or referee physician renders a medical opinion based on a SOAF which is incomplete or inaccurate or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[12] Dr. White related that appellant's accepted conditions were right shoulder/upper arm supraspinatus sprain and right shoulder affection; however, he did not note the right shoulder rotator cuff conditions accepted under OWCP File No. xxxxxx699. He also did not note that appellant had, in fact, previously received a schedule award for 10 percent permanent impairment of the right upper extremity. As OWCP did not provide a SOAF to Dr. White, the Board finds that his opinion is of diminished probative value.

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares the responsibility in the development of the evidence to see that

[11] *Supra* note 3 at 389.

[12] *C.C.*, Docket No. 19-1948 (issued January 8, 2021).

justice is done.[13] 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.[14] Accordingly, the Board finds that the case must be remanded to OWCP.[15]

On remand OWCP shall provide Dr. White with an updated complete SOAF and case record, including the December 11, 2012 DMA medical report containing an illegible signature, for a reasoned opinion regarding the extent of appellant's permanent impairment of her right upper extremity. Following this and any such further development as 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 December 12 and 13, 2019 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: June 17, 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

[13] *See L.F.*, Docket No. 20-0549 (issued January 27, 2021),

[14] *Id.*

[15] *Id*.