United States Department of Labor
Employees' Compensation Appeals Board

L.B., Appellant	)	
and	)	**Docket No. 20-0715**
	)	**Issued: March 11, 2021**
U.S. POSTAL SERVICE, POST OFFICE, Fort Worth, TX, 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
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 12, 2020 appellant filed a timely appeal from a September 17, 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]

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 23 percent permanent impairment of his right upper extremity for which he previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that OWCP received additional evidence following the September 17, 2019 decision. 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.*

FACTUAL HISTORY

On August 3, 2017 appellant, then a 49-year-old motor vehicle operator, filed a traumatic injury claim (Form CA-1) alleging that on that date he injured his right shoulder when he attempted to move an over the road container to load into a truck while in the performance of duty. He initially stopped work on August 3, 2017 and returned on August 10, 2017.

An August 11, 2017 magnetic resonance imaging (MRI) scan of the right shoulder, interpreted by Dr. Tuong Huu Le, a Board-certified radiologist, revealed a partial thickness rotator cuff tear and bony contusion.

OWCP accepted the claim for right shoulder rotator cuff muscle and tendon strain, brachial plexus injury, and rotator cuff tear or rupture of the right shoulder. (ICD 10) It paid appellant intermittent wage-loss compensation on the supplemental rolls, effective October 14, 2017, and on the periodic rolls, effective November 12, 2017. Appellant later received intermittent wage-loss compensation again on the supplemental rolls as of November 13, 2018.

OWCP received a January 8, 2018 electromyography/nerve conduction velocity (EMG/NCV) study, which revealed bilateral carpal tunnel syndrome, and bilateral ulnar motor and sensory neuropathy.

On March 14, 2019 appellant filed a claim for a schedule award (Form CA-7).

In a November 30, 2018 report, Dr. Rory Allen, an osteopath specializing in family medicine, noted appellant's history of injury and medical treatment. He utilized the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[3] to provide a permanent impairment rating based upon appellant's diagnoses of right rotator cuff strain, rotator cuff partial tear, and brachial plexus injury. Dr. Allen found five percent permanent impairment under the diagnosis-based impairment (DBI) method based upon appellant's right rotator cuff strain, with a partial thickness tear and residual loss of normal function. He explained that, using Table 15-5 page 402 of the A.M.A., *Guides*, for a right rotator cuff injury, partial thickness tear, appellant would be rated as a class of diagnosis (CDX) 1, grade C, with a default rating of three percent. The grade modifier for functional history (GMFH) was 4 due to a *Quick*DASH score of 93, per Table 15-7 page 406, the grade modifier for physical examination (GMPE) was 2 due to moderate palpatory findings and decreased range of motion (ROM) per Table 15-8 page 408, the grade modifier for clinical studies (GMCS) was 2 per Table 15-9 page 410. Dr. Allen applied the net adjustment formula and concluded that appellant had five percent right upper extremity permanent impairment.

Dr. Allen related three ROM measurements for appellant's right shoulder. Appellant's ROM for the right shoulder was noted as flexion of 43, 45, and 45 degrees, extension 5, 7, and 8, degrees, abduction 44, 45, and 45 degrees, adduction 14, 15, and 15 degrees, internal rotation 24, 25, and 26 degrees, and external rotation of 30, 32, and 32 degrees. Dr. Allen rounded each of these findings to 50 degrees loss of flexion, 10 degrees loss of extension, 50 degrees loss of abduction, 20 degrees loss of adduction, 30 degrees loss of internal rotation, and 30 degrees loss of external rotation, and found that appellant had nine percent impairment due to loss of flexion,

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

two percent impairment due to loss of extension, six percent impairment due to loss of abduction, one percent impairment due to loss of adduction, four percent impairment due to loss of internal rotation, and two percent impairment due to loss of external rotation. He found that these findings totaled 24 percent. Dr. Allen then applied the 5 percent adjustment per Table 15-36 page 477 for GMFH and found 25 percent permanent impairment under the ROM method.

Dr. Allen then provided detailed findings and ratings under Table 15-20 page 434 and 435 for right brachial plexus upper and middle trunk injuries and determined that appellant's right brachial plexus injury caused 44 percent permanent upper extremity impairment. He combined the 25 percent permanent impairment due to appellant's right shoulder rotator cuff impairment with right brachial plexus upper trunk injury and concluded that appellant had 52 percent right upper extremity permanent impairment.

On March 20, 2019 OWCP prepared a statement of accepted facts (SOAF) wherein it noted the accepted condition as right shoulder rotator cuff muscle and tendon strain.

In an April 13, 2019 report, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), reviewed Dr. Allen's November 30, 2018 report. He explained that Dr. Allen's findings on examination were much greater than expected for the diagnosed conditions and objective findings based on the diagnostic studies. Dr. Harris recommended a second opinion examination because of the discrepancy.

On May 28, 2019 OWCP referred appellant to Dr. Jack Henry, a Board-certified orthopedic surgeon, for a second opinion permanent impairment evaluation. In a July 18, 2019 report, Dr. Henry noted review of appellant's history of injury, medical treatment, and the SOAF. He provided physical examination findings for appellant's right shoulder, and utilized the sixth edition of the A.M.A., *Guides*.[4] Dr. Henry noted that he had taken three sets of ROM measurements and reported the maximum measurements, including 50 degrees flexion, 30 degrees extension, 55 degrees abduction, 30 degrees adduction, 30 degrees internal rotation, and 40 degrees external rotation. He referred to Table 15-34 at page 475 and found that flexion of 50 degrees was equal to nine percent upper extremity impairment, extension of 30 degrees was equal to one percent upper extremity impairment, abduction of 55 degrees was equal to six percent upper extremity impairment, adduction of 30 degrees was equal to one percent impairment, internal rotation of 30 degrees was equal to four percent upper extremity impairment, and external rotation of 40 degrees was equal to two percent upper extremity impairment. Dr. Henry explained that appellant had a grade 2 ROM modifier using Table 15-35 at page 477 and a GMFH of 2 using Table 15-7 at page 406, and; therefore, no modification of the impairment was required pursuant to Table 15-36 at page 477 of the A.M.A., *Guides*. He advised that appellant had 23 percent right upper extremity impairment using the ROM method.

Dr. Henry referred to Table15-5 at page 402 and explained that using the DBI-based method, appellant was rated CDX 1 for the accepted right shoulder rotator cuff strain/tear with residual loss. He applied a GMFH of 2, with pain/symptoms during normal activities, and to perform all self-care activities independently, based on Table 15-7 at page 406. Dr. Henry applied a GMPE of 2 for moderate ROM loss, based on Table 15-8 at page 408. He applied a GMCS of 2, based on Table 15-9 at page 410. Dr. Henry utilized the net adjustment formula and determined

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

+3 to the right of the default grade of C, which resulted in a grade E, or 5 percent right upper extremity impairment using the DBI method. He advised that, since the ROM impairment rating was higher than the DBI rating, appellant was assigned 23 percent right upper extremity impairment.

Dr. Henry noted that he concurred with the findings provided by Dr. Allen, with the exception of an award for a brachial plexus injury, which was not an accepted condition. He indicated that appellant had reached maximum medical improvement (MMI).

In accordance with procedure, Dr. Henry's report was forwarded to the DMA for review.

In an August 9, 2019 report, Dr. Harris, the DMA, reviewed the medical findings provided by Dr. Henry. He applied the A.M.A. *Guides* and used July 18, 2019, the date of Dr. Henry's report, as the date of MMI. The DMA advised that, using the DBI method under Table 15-5 of the A.M.A., *Guides*, at pages 401 to 405, appellant had five percent permanent impairment for partial thickness tear of the rotator cuff, the maximum permanent impairment value for the diagnosis. Regarding ROM method, he concurred with the findings provided by Dr. Henry.

By decision dated September 17, 2019, OWCP granted appellant a schedule award for 23 percent permanent impairment of the right upper extremity. The award ran for 71.76 weeks for the period July 18, 2019 to December 1, 2020.

LEGAL PRECEDENT

The schedule award provisions of FECA and its implementing regulations 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.[5] 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[6] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (6th ed. 2009).[7]

[5] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[6] 20 C.F.R. § 10.404; *L.T.*, Docket No. 18-1031 (issued March 5, 2019); *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[7] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017).

In addressing upper extremity impairments, the sixth edition requires identification of the impairment CDX condition, which is then adjusted by grade modifiers or GMFH, GMPE, and GMCS.[8] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[9]

The A.M.A., *Guides* also provide that the ROM impairment methodology 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.[10] 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.[11] 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.[12]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating of upper extremity impairments.[13] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "As the [A.M.A.,] *Guide*s 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.)[14]
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> The Bulletin further advises:
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> "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

[8] A.M.A., *Guides* 383-492.

[9] *Id*. at 411.

[10] *Id.* at 461.

[11] *Id*. at 473.

[12] *Id.* at 474.

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

[14] A.M.A., *Guides* 477.

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

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[16]

ANALYSIS

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

OWCP's record reflects that the accepted conditions in this case are right shoulder strain of the muscles and tendons, right shoulder rotator cuff tear or rupture, and right brachial plexus injury.

Appellant's treating physician, Dr. Allen, provided a permanent impairment rating of appellant's right upper extremity based upon the diagnoses of right rotator cuff partial thickness tear and brachial plexus injury. OWCP referred the case record to Dr. Henry for a second opinion evaluation and thereafter to the DMA, Dr. Harris, for review.

The March 20, 2019 SOAF presented to Dr. Henry, however, only listed the accepted conditions of right shoulder rotator cuff muscle and tendon strain. It is OWCP's responsibility to provide a complete and proper frame of reference for a physician by preparing a SOAF.[17] OWCP's procedures dictate that, when a DMA, 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.[18] OWCP did not provide Dr. Henry, the second opinion physician with an accurate SOAF as it did identify all of appellant's accepted right upper extremity conditions, which also included a right shoulder tear or rupture and a brachial plexus injury. The Board finds that the report from OWCP's second opinion physician was not based on an accurate factual framework.[19] The Board is therefore unable to determine which diagnosis and examination findings related to appellant's right upper extremity resulted in the highest permanent impairment rating.

[15] *Id*.; *A.G*., Docket No. 18-0329(issued July 26, 2018).

[16] *See* Federal (FECA) Procedure Manual, *supra* note 7 at Chapter 2.808.6(f) (March 2017); *B.B.*, Docket No. 18-0782 (issued January 11, 2019).

[17] *M.B.*, Docket No. 19-0525 (issued March 20, 2020); *J.N*., Docket No. 19-0215 (issued July 15, 2019); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

[18] *Supra* note 7 at *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

[19] *B.K*, Docket No. 19-0976 (issued December 15, 2020); *G.C.*, Docket No. 18-0842 (issued December 20, 2018).

Once OWCP undertakes development of the record, it has the responsibility to do so in a manner that will resolve the relevant issues in the case.[20] Accordingly, the Board finds that the case must be remanded to OWCP. On remand OWCP shall prepare a complete and accurate SOAF and refer appellant for a new second opinion evaluation to determine his right upper extremity permanent impairment. Following this and such further development as deemed necessary, it shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the September 17, 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: March 11, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

[20] *R.W.*, Docket No. 19-1109 (issued January 2, 2020); *D.S.*, Docket No. 19-0292 (issued June21, 2019); *G.C.*, *id.*