United States Department of Labor
Employees' Compensation Appeals Board

M.W., Appellant	)	
and	)	**Docket No. 20-0252**
	)	**Issued: May 24, 2021**
U.S. POSTAL SERVICE, POST OFFICE, Plainfield, IL, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On November 8, 2019 appellant, through counsel, filed a timely appeal from an August 13, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that following the August 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.*

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish greater than five percent permanent impairment of her right upper extremity, for which she previously received a schedule award; and (2) whether appellant has met her burden of proof to establish any permanent impairment of her left lower extremity or greater than two percent permanent impairment of her right lower extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On September 21, 2012 appellant, then a 38-year-old rural carrier, filed a traumatic injury claim (Form CA-1) alleging that on that date she injured her lower back, right shoulder, right buttocks, and right hamstring when she slipped on wet grass while in the performance of duty. She stopped work on September 21, 2012. On December 6, 2012 OWCP accepted the claim for a right hip (labral tear) sprain, a right shoulder rotator cuff sprain, and a right shoulder superior glenoid labrum lesion. OWCP paid appellant wage-loss compensation on the supplemental rolls commencing November 10, 2012, and on the periodic rolls commencing February 10, 2013.

On May 5, 2013 appellant underwent arthroscopic right shoulder debridement of the labral tear and undersurface rotator cuff tear, as well as subacromial decompression bursectomy. On September 4, 2013 it expanded the acceptance of the claim to include lumbar sprain and cervical sprain.

On January 27, 2014 appellant underwent right hip arthroscopic surgery for a labral tear, and on February 29, 2016 appellant underwent a L4-5, L5-S-1 bilateral laminectomy and discectomy with interbody fusion, posterior lateral fusion with pedicle fixation, and bone graft.

By decision dated March 16, 2017, OWCP terminated appellant's wage-loss compensation, effective March 5, 2017, based upon a finding that she could return to work without restrictions.

On March 14, 2018 appellant filed a claim (Form CA-7) for a schedule award.

On March 23, 2018 OWCP again expanded the acceptance of her claim to include a herniated disc and right-side sciatica, and it listed all of the accepted conditions as including herniated disc at L5-S1, right-side sciatica, right hip and thigh sprain, right shoulder and upper arm rotator cuff sprain, right shoulder and upper arm sprain/glenoid labrum lesion, and lumbar sprain.

In a development letter dated April 9, 2018, OWCP informed appellant that additional evidence was needed to establish her schedule award claim. It advised her of the type of medical evidence necessary to establish her claim and afforded 30 days for her to submit the requested evidence.

An April 6, 2018 medical report by Dr. Neil Allen, a Board-certified neurologist, reviewed appellant's history of injury, medical history, diagnostic imaging and conducted a physical examination. Dr. Allen noted that appellant complained of intermittent pain in her neck, lower back, right shoulder, and right hip, reduced right hip mobility, and right hip and low back weakness. Aggravating factors included lifting over 25 pounds, work duties, standing, dressing, self-care, ascending and descending stairs, and climbing in and out of her vehicle. Relieving factors included icing, bracing, and pain medication.

Dr. Allen related cervical and lumbar spine physical examination findings. Physical examination of appellant's right shoulder revealed forward flexed posture, tenderness upon palpation, diminished sharp/dull discrimination, and a range of motion (ROM) of flexion of 180, 178, and 181 degrees, extension of 60 degrees, 51 degrees, and 53 degrees, abduction of 184, 179, and 180 degrees, adduction of 90 degrees, internal rotation of 70, 72, and 68 degrees, and external rotation of 100, 102, and 98 degrees. Physical examination of appellant's right hip revealed tenderness upon palpation and ROM of flexion of 121, 120, and 118 degrees, extension of 16, 11, and 12 degrees, external rotation of 68, 61, and 63 degrees, internal rotation of 41, 30, and 26 degrees, abduction of 11, 7, and 10 degrees, and adduction of 31, 28, and 30 degrees. Physical examination of appellant's right knee revealed patellofemoral crepitus with active extension.

Dr. Allen listed appellant's diagnoses as neck sprain, lumbar sprain, sprain of the rotator cuff in the right shoulder and upper arm, right glenoid labrum lesion, and sprain of the right hip and upper thigh. He indicated that appellant had reached maximum medical improvement (MMI). Using *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*) to calculate appellant's upper extremity permanent impairment for appellant's C5-C8 and C5-T1 conditions, Dr. Allen assigned a class of diagnosis (CDX) of zero based on no C5-C8 motor deficit findings and no C5-T1 sensory deficit findings in the medical records or physical examination findings. He assigned a grade modifier for functional history (GMFH) of two because she had pain with normal activity, was able to perform self-care activities with modification and unassisted, and had a *Quick*DASH score of 25 for both conditions. Dr. Allen also assigned a grade modifier for clinical studies (GMCS) of zero based on her cervical spine magnetic resonance imaging (MRI) scan that revealed no disc herniation or spinal stenosis. He calculated that appellant therefore sustained zero percent upper extremity permanent impairment from her cervical conditions. To calculate appellant's right shoulder impairment, Dr. Allen used the diagnosis-based (DBI) method under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] He assigned a CDX of one based on appellant's tendinitis and residual loss, indicating a default of three percent impairment. Dr. Allen assigned a GMFH of two based on appellant's pain with normal activity, ability to perform self-care activities with modification, but unassisted, and a *Quick*DASH score of 25. He assigned a grade modifier for physical examination (GMPE) of one due to mild palpatory findings and mild motion deficit, and he assigned a GMCS of two based on a right shoulder MRI scan which revealed a possible labral tear. Dr. Allen calculated a total right shoulder permanent impairment of five percent.

To calculate appellant's lower extremity permanent impairment for her L4-S1 and L5-S1 conditions, Dr. Allen used *The Guides Newsletter* and assigned CDX of zero based on no sensory deficits in the medical records or physical examination findings. He assigned a GMFH of one based on her normal gait and American Academy of Orthopedic Surgeons (AAOS) lower limb questionnaire score of 77. Dr. Allen assigned a GMCS of two based on an MRI scan of her lumbar spine that revealed minimal levocurvature with straightening of the normal lumbar lordosis, central disc protrusion superimposed on a diffuse disc bulge at L4-5, mild spinal stenosis and bilateral neural foraminal narrowing, and mild degenerative changes at L5-S1 resulting in left neural foraminal narrowing. Dr. Allen calculated appellant's right hip impairment using the ROM method in the A.M.A., *Guides*. He used appellant's hip ROM measurements, indicating that the eleven degree abduction indicated 10 percent lower extremity impairment and the 16 degree

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

extension, 31 degree adduction, 41 degree internal rotation, and 68 degree external rotation indicated 0 percent lower extremity impairment. Dr. Allen assigned a GMFH of one based on appellant's antalgic gait and an AAOS score of 77, and he calculated a total of 10 percent permanent impairment of the right lower extremity. He explained that he used the ROM method because it resulted in a larger and more accurate impairment percentage than using the DBI method for a labral repair, which would have resulted in a zero to three percent permanent impairment rating.

On June 7, 2018 OWCP prepared a statement of accepted facts (SOAF) that listed appellant's accepted conditions as including a herniated disc at L5-S1, right-side sciatica, a sprain of the right hip and thigh, a right shoulder and upper arm rotator cuff sprain, a right shoulder and upper arm sprain/superior glenoid labrum lesion, and a lumbar sprain. Appellant's case record was thereafter referred to Dr. Arthur Harris, a Board-certified orthopedic surgeon, serving as OWCP's DMA, for review.

In a June 9, 2018 report, Dr. Harris indicated that he reviewed appellant's SOAF, history of injury, and medical records. Using the DBI method of the A.M.A., *Guides* to calculate appellant's right shoulder impairment, he classified her labral tear as CDX 1, grade E and found that she sustained five percent permanent impairment of her right shoulder. Utilizing the ROM method of the A.M.A., *Guides*, he calculated that appellant sustained two percent permanent impairment of her right shoulder. Dr. Harris concluded that as the DBI method resulted in the greater impairment percentage, appellant sustained five percent permanent impairment of her right upper extremity. He also used the DBI method to calculate appellant's impairment of her bilateral extremities that she sustained from her accepted lumbar spine condition. Dr. Harris related that he used Table 16-11 on page 533 and Table 16-12 on page 534 to calculate that appellant sustained zero percent permanent impairment of her bilateral lower extremities due to lumbar radiculopathy. Dr. Harris additionally used the DBI method to calculate appellant's impairment of her right lower extremity due to her labral tear. He referenced Table 16-4: Hip Regional Grid -- Lower Extremity Impairments on page 513 and classified appellant's labral tear as CDX 1, grade C and calculated that appellant sustained two percent right lower extremity permanent impairment. Dr. Harris stated that the A.M.A., *Guides* prohibited the use of the ROM method for appellant's right hip diagnosis because there was no asterisk after the diagnosis on the grid in Table 16-4, and therefore appellant sustained two percent right lower extremity impairment. He indicated that Dr. Allen erred by using the ROM method of rating appellant's hip impairment, and he stated that appellant reached MMI on April 6, 2018.

By decision dated August 1, 2018, OWCP granted appellant a schedule award for five percent permanent impairment of her right upper extremity, two percent permanent impairment of her right lower extremity, and zero percent permanent impairment of her left lower extremity. The award ran for 21.36 weeks from April 6 to September 2, 2018. OWCP noted that the schedule award was based on the April 6, 2018 report by Dr. Allen and the July 9, 2018 DMA report. It noted that the July 9, 2018 DMA report and the April 6, 2018 differed regarding the impairment rating of appellant's right hip, and it stated that it used the DMA report to determine appellant's lower extremity schedule award.

In an undated addendum to his report of April 6, 2018, Dr. Allen indicated that he reviewed Dr. Harris' June 9, 2018 DMA report. He indicated that Dr. Harris' statement that the A.M.A., *Guides* provided that only diagnoses with asterisks could be additionally evaluated with the ROM method applied to upper extremity impairments and not lower extremity impairments. Dr. Allen

further indicated that the A.M.A., *Guides* instructed that if the ROM impairment percentage is greater than the DBI impairment percentage, than the ROM impairment percentage is used.

On September 26, 2018 appellant, through counsel, requested reconsideration. In an accompanying letter, he argued that Dr. Harris was incorrect in relating that the A.M.A., *Guides* provided that only diagnoses with asterisks could be additionally evaluated with the ROM method, and that this dispute should be sent to a DMA.

On November 19, 2018 OWCP requested clarification by Dr. Harris. It requested that Dr. Harris calculate appellant's permanent impairment(s) using *The Guides Newsletter* as appropriate, and use the ROM method to calculate appellant's lower extremity impairments if possible. Dr. Harris was also asked to address the date of appellant's MMI.

On December 7, 2018 OWCP received a copy of Dr. Harris' previously submitted June 9, 2018 DMA report.

By decision dated February 28, 2019, OWCP denied modification of its October 24, 2018 decision.

On April 18, 2019 appellant, through counsel, requested reconsideration. In an attached letter, counsel argued that OWCP's February 28, 2019 decision should have been based on the DMA's review of Dr. Allen's addendum to his April 6, 2018 report, which demonstrated that the DMA erred by not using the ROM method of evaluation to calculate appellant's right lower extremity impairment. Appellant provided a copy of FECA Bulletin No. 17-06.

On July 11, 2019 OWCP again sought clarification from DMA Dr. Harris regarding his June 9, 2018 report. It requested that Dr. Harris review Dr. Allen's addendum report to his April 6, 2018 medical report and explain any disagreements.

In a July 25, 2019 report, Dr. Harris indicated that he reviewed Dr. Allen's addendum to his April 6, 2018 medical report. He stated that the A.M.A., *Guides*, on page 543, indicated that the ROM evaluation method should be used as a stand-alone rating for lower extremity impairment evaluations only when there were no diagnosis-based sections that were applicable or in very rare cases where severe injuries resulted in a passive ROM loss. Dr. Harris contended that since the DBI evaluation method does contain appellant's hip diagnosis, use of the ROM method was prohibited. He indicated that as such, there were no changes in appellant's permanent impairment ratings from his previous report. Dr. Harris additionally related that appellant reached MMI on July 25, 2019.

By decision dated August 13, 2019, OWCP denied modification of its February 28, 2019 decision.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA,[5] and its implementing federal regulations,[6] set forth the number of weeks of compensation payable to employees sustaining permanent

[5] *Supra* note 2.

[6] 20 C.F.R. § 10.404.

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*, published in 2009.[7] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[8]

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).[9] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by a GMFH, GMPE, and GMCS.[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[11] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[12]

FECA Bulletin No. 17-06 provides guidance in applying ROM or DBI methodologies in rating permanent impairment of the upper extremities. 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*

[7] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[8] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[9] A.M.A., *Guides* (6th ed. 2009) p.3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[10] *Id.* at 383-492.

[11] *Id.* at 411.

[12] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)

Neither FECA, nor its implementing regulations, provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[13] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[14] The sixth edition of the A.M.A., *Guide*s provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was designed for situations in which a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in OWCP's procedure manual.[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 -- ISSUE 1

The Board finds that this case is not in posture for decision regarding the extent of appellant's right upper extremity permanent impairment.

While appellant's physician Dr. Allen included appellant's neck sprain in his list of accepted conditions and conducted a physical examination and impairment rating for this condition, the June 7, 2018 SOAF presented to the DMA Dr. Harris only listed appellant's accepted conditions as including a herniated disc at L5-S1, right-side sciatica, a sprain of the right hip and thigh, a right shoulder and upper arm rotator cuff sprain, a right shoulder and upper arm sprain/superior glenoid labrum lesion, and a lumbar sprain. It did not include appellant's accepted neck sprain, which OWCP accepted in its September 4, 2013 decision.

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.[17] As OWCP did not provide the DMA with a complete SOAF, it did not identify all of appellant's accepted upper extremity conditions.

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

[13] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see C.S.*, Docket No. 19-0851 (issued November 18, 2019).

[14] *Supra* note 7 at Chapter 2.808.5(c)(3) (March 2017).

[15] *Id.* at Chapter 2.808.6(f)(2) (February 2013). *See also C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

[16] *See supra* note 7 at Chapter 2.808.6(f) (March 2017).

[17] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

to compensation, OWCP shares the responsibility in the development of the evidence to see that justice is done.[18] 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.[19] Accordingly, the Board finds that the case must be remanded to OWCP.[20]

On remand OWCP shall clarify the accepted conditions and prepare an updated SOAF. It shall then refer the case record, together with the SOAF, back to Dr. Harris for a reasoned opinion regarding the extent of appellant's permanent impairment of the upper extremities. Following this and any such further development as deemed necessary, OWCP shall issue a *de novo* decision.

LEGAL PRECEDENT -- ISSUE 2

As noted above, the schedule award provisions of FECA,[21] and its implementing federal regulations,[22] 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*, published in 2009.[23] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[24]

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).[25] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by a GMFH, GMPE, and GMCS.[26] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[27] Evaluators are directed to provide reasons for their impairment

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

[19] *Id.*

[20] *Id*.

[21] *Supra* note 2.

[22] 20 C.F.R. § 10.404.

[23] *Supra* note 7.

[24] *Supra* note 8.

[25] *Supra* note 9.

[26] *Id.* at 493-556.

[27] *Id.* at 521.

choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[28]

For lower extremity impairment ratings, the ROM impairment method is to be used as a stand-alone rating when other grids refer to the ROM impairment section or when no other diagnosis-based sections are applicable for impairment rating of a condition.[29]

Neither FECA, nor its implementing regulations, provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[30] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[31] The sixth edition of the A.M.A., *Guide*s provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was designed for situations in which a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in OWCP's procedure manual.[32]

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.[33]

ANALYSIS -- ISSUE 2

The Board also finds that this case is not in posture for decision regarding the extent of permanent impairment of appellant's lower extremities.

Dr. Allen's April 6, 2018 medical report reviewed appellant's history of injury, medical history, and diagnostic imaging. Appellant complained of intermittent pain in her lower back and right hip, reduced right hip mobility, and right hip and low back weakness. Dr. Allen listed appellant's lower extremity diagnoses as including a lumbar sprain and a sprain of the right hip and upper thigh, and he indicated that appellant had reached MMI. He conducted a physical examination of appellant's lumbar spine and used the DBI method of *The Guides Newsletter* to calculate a permanent impairment of zero percent for appellant's bilateral extremities due to appellant's accepted lumbar condition. Dr. Allen then calculated that appellant sustained 10 percent permanent right hip impairment using the range of motion (ROM) method in the A.M.A., *Guides*, and he concluded that she therefore sustained a total of 10 percent permanent impairment of the right lower extremity. He explained that he used the ROM method because it resulted in a

[28] *R.R.*, Docket No. 17-1947 (issued December 19, 2018)*; R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[29] *Supra* note 9 at 543.

[30] *Supra* note 14.

[31] *Supra* note 7 at Chapter 2.808.5(c)(3) (March 2017).

[32] *Id.* at Chapter 2.808.6(f)(2) (February 2013). *See also C.K.* and *Frantz Ghassan*, *supra* note 16.

[33] *See supra* note 7 at Chapter 2.808.6(f) (March 2017).

greater and more accurate impairment percentage than using the DBI method for a labral repair, which would have resulted in a zero to three percent permanent impairment.

The June 9, 2018 report by Dr. Harris, OWCP's DMA, indicated that he reviewed appellant's SOAF, history of injury, and medical records. Dr. Harris stated that he used the DBI method of the A.M.A., *Guides* to calculate the percentage of permanent impairment of appellant's bilateral extremities that she sustained from her accepted lumbar spine condition. He related that he used Table 16-11 on page 533 and Table 16-12 on page 534 to calculate that appellant sustained zero percent permanent impairment of her bilateral lower extremities due to her lumbar radiculopathy. Dr. Harris also used the DBI method of the A.M.A., *Guides* to calculate appellant's impairment of the right lower extremity due to her labral tear. He referenced Table 16-4: Hip Regional Grid -- Lower Extremity Impairments on page 513 and classified appellant's labral tear as CDX 1, grade C and calculated that appellant sustained two percent right lower extremity impairment. Dr. Harris stated that the A.M.A., *Guides* prohibited the use of the ROM method for appellant's diagnosis because there was no asterisk after the diagnosis on the grid in Table 16-4, and therefore appellant sustained two percent right lower extremity impairment. He indicated that Dr. Allen erred by using the ROM method of rating appellant's hip impairment, and he stated that appellant reached MMI on April 6, 2018.

In an undated addendum to his April 6, 2018 report, Dr. Allen indicated that Dr. Harris' statement that the A.M.A., *Guides* provided that only diagnoses with asterisks can be additionally evaluated with the ROM method applied only to upper extremity impairments and not lower extremity impairments. He additionally indicated that the A.M.A., *Guides* instructed that if the ROM impairment percentage is greater than the DBI impairment percentage, then the ROM impairment percentage is used.

Dr. Harris explained in his July 25, 2019 report that the A.M.A., *Guides*, on page 543, indicated that the ROM evaluation method should be used as a stand-alone rating when there are no diagnosis-based sections that are applicable or in very rare cases where severe injuries result in a passive range of motion loss. He contended that since appellant's hip diagnosis could be rated under the DBI method, use of the ROM method is prohibited. Dr. Harris indicated that, as such, there were no changes in appellant's permanent impairment percentages from his previous report. He additionally related that appellant reached his MMI on July 25, 2019.

As stated above, for the lower extremity impairment ratings, the ROM impairment method is to be used as a stand-alone rating when other grids refer to the ROM impairment section or when no other diagnosis-based sections are applicable for impairment rating of a condition.[34] As the DBI method of evaluating lower extremity impairments includes Table 16-4: Hip Regional Grid on pages 512-13 which contains the diagnosis of acetabular labrum tear, the Board finds that the DMA correctly used the DBI method of evaluation to evaluate appellant's right hip permanent impairment.

However, this case is not in posture for decision regarding the extent of permanent impairment of appellant's lower extremities because the DMA did not rate appellant's lower extremity permanent impairment arising from the accepted lumbar conditions under *The Guides Newsletter.*

[34] *Supra* note 30.

On remand OWCP shall refer the case record back to the DMA Dr. Harris, or to another DMA, for a reasoned opinion regarding the extent of appellant's permanent impairment of her lower extremities, and it should instruct him to use *The Guides Newsletter* when evaluating lower extremity permanent impairment resulting from appellant's accepted lumbar spine condition. Following this and any other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision regarding appellant's upper extremity schedule award. The Board further finds that the case is not in posture for decision regarding appellant's lower extremity schedule award.

ORDER

IT IS HEREBY ORDERED THAT the August 13, 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: May 24, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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