United States Department of Labor
Employees' Compensation Appeals Board

L.R., Appellant	)	
	)	
and	)	**Docket No. 22-0096**
	)	**Issued: August 3, 2022**
DEPARTMENT OF DEFENSE, DEFENSE LOGISTICS AGENCY, DEFENSE DISTRIBUTION DEPOT-RED RIVER, Texarkana, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On October 25, 2021 appellant filed a timely appeal from a May 19, 2021 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 May 19, 2021 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 additional evidence for the first time on appeal. *Id*.

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 42 percent permanent impairment of the right upper extremity and 41 percent permanent impairment of the left upper extremity for which she received schedule award compensation.

FACTUAL HISTORY

On May 15, 1995 appellant, then a 39-year-old laborer, filed an occupational disease claim (Form CA-2) alleging that she sustained pain in her right shoulder and arm causally related to factors of her federal employment.[3] OWCP accepted the claim for a sprain of the right shoulder and upper arm, bilateral carpal tunnel syndrome, chronic pain syndrome, and a bilateral sprain of the rotator cuff. Appellant was intermittently disabled from work until December 7, 1995, when she stopped work and did not return. Effective October 15, 1997, she elected disability retirement.

Appellant underwent a left carpal tunnel release on February 4, 2004 and right carpal tunnel releases on March 17, 2004 and October 9, 2013. She further underwent a right shoulder subacromial decompression and resection of the distal clavicle on October 18, 2006 and a repair of a torn right rotator cuff on September 15, 2010.

By decision dated November 21, 1996, OWCP granted appellant a schedule award for 24 percent permanent impairment of the right upper extremity. It rated her impairment based on loss of range of motion (ROM) of the right shoulder and altered shoulder sensation. By decision dated September 20, 2004, OWCP granted appellant a schedule award for three percent permanent impairment of the left upper extremity due to motor loss of the median nerve.[4]

By decision dated November 26, 2007, OWCP granted appellant a schedule award for an additional two percent permanent impairment of the right upper extremity. By decision dated June 10, 2008, it granted her a schedule award for 23 percent bilateral impairment of the upper extremities, finding 7 percent right upper extremity impairment and 16 percent left upper extremity impairment due to loss of ROM of the shoulders bilaterally.

By decisions dated June 10, 2011 and April 16, 2012, OWCP denied appellant's claim for an increased schedule award. In its April 16, 2012 decision, it noted that it had previously paid her schedule award compensation for 33 percent permanent impairment of the right upper extremity and 19 percent permanent impairment of the left upper extremity.

On October 1, 2013 OWCP expanded its acceptance of the claim to include a bilateral ganglion and cyst of the synovium, tendon, and bursae.

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[3] The claim form is not contained in the case record.

[4] By decision dated December 29, 2004, OWCP denied appellant's request for reconsideration of its September 20, 2004 decision as she had not raised an argument or submitted evidence sufficient to warrant reopening her case for further merit review under 5 U.S.C. § 8128(a).

On May 5, 2014 appellant filed a claim for compensation (Form CA-7) requesting an increased schedule award.

In a report dated November 20, 2014, Dr. Henry Mobley, a Board-certified internist serving as a district medical adviser (DMA), applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] and found that appellant had 24 percent permanent impairment of each upper extremity due to bilateral loss of ROM of the shoulders. He further found 18 percent permanent impairment of the right upper extremity and 14 percent permanent impairment of the left upper extremity due to ganglion cysts using the diagnosis-based impairment (DBI) method, 6 percent permanent impairment of the right upper extremity and 9 percent permanent impairment of the left upper extremity due to bilateral entrapment neuropathy, or carpal tunnel syndrome. Dr. Mobley combined the impairment ratings to find an additional 9 percent permanent impairment of the right upper extremity and 22 percent permanent impairment of the left upper extremity.

By decision dated March 17, 2015, OWCP granted appellant a schedule award for an additional 9 percent permanent impairment of the right upper extremity and an additional 22 percent permanent impairment of the left upper extremity. It noted that she had a total right upper extremity impairment of 42 percent and left upper extremity impairment of 41 percent.

On June 1, 2016 appellant filed a Form CA-7 requesting an increased schedule award.

By decision dated January 9, 2017, OWCP denied appellant's claim for an increased schedule award.

On January 14, 2017 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on July 12, 2017.

By decision dated September 26, 2017, OWCP's hearing representative set aside the January 9, 2017 decision. She remanded the case for OWCP to apply FECA Bulletin No. 17-06[6] in determining the extent of appellant's upper extremity impairment.

On November 27, 2017 appellant underwent a decompression of the median nerve of the left carpal tunnel to treat recurrent left carpal tunnel syndrome.

By decision dated May 16, 2019, OWCP denied appellant's claim for an increased schedule award.

In an impairment evaluation dated August 6, 2020, Dr. Robert R. Ippolito, a Board-certified plastic surgeon, found that appellant had six percent permanent impairment of the left upper extremity due to her rotator cuff tear under the A.M.A., *Guides*. He measured normal ROM of the shoulder.

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

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

On September 4, 2020 appellant filed a Form CA-7 claim for an increased schedule award.

On September 26, 2020 Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA, reviewed Dr. Ippolito's report and found that appellant had 10 percent permanent impairment due to her acromioclavicular (AC) joint disease according to Table 15-5 on page 403. He noted that Dr. Ippolito had found normal ROM of the shoulder. Dr. Katz opined that appellant had previously received a schedule award of 24 percent due to her left shoulder condition and thus was not entitled to an additional schedule award.

By decision dated October 28, 2020, OWCP denied appellant's claim for an increased schedule award.

On November 9, 2020 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

A telephonic hearing was held on March 4, 2021. OWCP's hearing representative advised appellant that she needed to submit a medical report showing greater permanent impairment than that previously awarded to support her claim for an increased schedule award.

In an impairment evaluation dated March 9, 2021, Dr. Michael Smith, who specializes in emergency medicine, discussed appellant's complaints of bilateral wrist and shoulder pain. Referencing the sixth edition of the A.M.A., *Guides*, he found 13 percent permanent impairment of each upper extremity due to loss of ROM of the shoulders according to Table 15-34 on page 475. Dr. Smith further found 11 percent permanent impairment of each upper extremity due to AC joint disease after a distal clavicle resection according to Table 15-5 on page 403. He noted that the A.M.A., *Guides* provided that the DBI method should be used if it exceeded the ROM method. Applying table 15-23 on page 449 of the A.M.A., *Guides*, Dr. Smith found six percent permanent impairment due to left carpal tunnel syndrome and three percent permanent impairment due to right carpal tunnel syndrome. He further found three percent permanent impairment of the right upper extremity due to cubital tunnel syndrome. For the left upper extremity, Dr. Smith combined the impairment ratings of 13 percent for the shoulder and 6 percent for carpal tunnel syndrome to find 18 percent permanent impairment. For the right upper extremity, he combined the ratings of 13 percent for the shoulder, 3 percent for right carpal tunnel syndrome, and 3 percent for right cubital tunnel syndrome to find 19 percent permanent impairment.

By decision dated May 19, 2021, OWCP's hearing representative affirmed the October 28, 2020 decision. She found that Dr. Smith's impairment rating had yielded an impairment less than the previously found 42 percent permanent impairment of the right upper extremity and 41 percent permanent impairment of the left upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA,[7] and its implementing federal regulations,[8] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. 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.[9] 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.[10]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's *International Classification of Functioning Disability and Health*: *A Contemporary Model of Disablement* (ICF).[11] Under the sixth edition, the evaluator identifies the impairment class of diagnosis (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[14]

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.[15]

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[7] *Supra* note 1.

[8] 20 C.F.R. § 10.404.

[9] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* at Chapter 3.700, Exhibit 1 (January 2010).

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

[11] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3.

[12] *Id*. at 494-531.

[13] *Id*. at 411.

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

[15] *See supra* note 9 at Chapter 2.808.6(f) (March 2017).

ANALYSIS

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

In decisions dated 2004 through 2015, OWCP granted appellant schedule awards that together totaled 42 percent permanent impairment of the right upper extremity and 41 percent permanent impairment of her left upper extremity.

On September 4, 2020 appellant filed a Form CA-7 claim for an increased schedule award. She submitted an August 6, 2020 impairment evaluation from Dr. Ippolito, who advised that she had six percent permanent impairment of the left upper extremity due to her rotator cuff tear. He measured normal ROM of the shoulder.

Dr. Katz, a DMA, reviewed Dr. Ippolito's report on September 26, 2020. He found that appellant had 10 percent permanent impairment of the left upper extremity due to AC joint disease under Table 15-5 on page 403 of the A.M.A., *Guides* and no impairment due to loss of ROM. Dr. Katz found that, as she had previously received a schedule award for 24 percent permanent impairment of the left upper extremity, she was not entitled to an additional award.

Appellant subsequently submitted an impairment evaluation dated March 9, 2021 from Dr. Smith, who found that she had 18 percent permanent impairment of the left upper extremity and 19 percent permanent impairment of the right upper extremity. OWCP's hearing representative reviewed Dr. Smith's report and found that it was insufficient to support a greater percentage of impairment than that previously awarded. She did not, however, refer it to a DMA for review. OWCP's procedures provide that, if the claimant's physician provides an impairment evaluation, the case should be referred to the DMA for review.[16]

It is well established that proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter.[17] While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence and to see that justice is done.[18]

On remand OWCP should further develop the medical evidence by referring the medical record to a DMA to determine the extent of appellant's employment-related permanent impairment based on the A.M.A., *Guides*. Following this and such further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.

CONCLUSION

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

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[16] *Supra* note 9 at Chapter 2.808.6e (March 2017); *see also H.H.*, Docket No .21-0055 (issued September 9, 2021).

[17] *T.O.*, Docket No. 18-0659 (issued August 8, 2019).

[18] *T.O.*, *id.*; *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *Jimmy A. Hammons*, 51 ECAB 219 (1999).

ORDER

IT IS HEREBY ORDERED THAT the May 19, 2021 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: August 3, 2022
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board