United States Department of Labor
Employees' Compensation Appeals Board

K.C., Appellant	)	
and	)	**Docket No. 21-0662**
	)	**Issued: February 22, 2023**
U.S. POSTAL SERVICE, POST OFFICE, St. Ann, MO, 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, Deputy Chief Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On March 15, 2021 appellant filed a timely appeal from a January 5, 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.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 12 percent permanent impairment of the left upper extremity for which he previously received a schedule award.

FACTUAL HISTORY

On September 13, 2010 appellant, then a 55-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on September 9, 2010 he sustained injuries to his head, stomach,

[1] 5 U.S.C. § 8101 *et seq.*

left hand, left knee, and left shoulder, when he slipped on the lip of a driveway and fell while in the performance of duty.[2] He stopped work on the date of injury. OWCP accepted the claim for frontal sinus fracture and subsequently expanded the acceptance of the claim to include crushing face injury, left visual disturbance, bilateral tinnitus, post-traumatic intractable headache, nose and nasal sinus cyst and mucocele, bilateral eyelids ptosis, left eye exposure keratoconjunctivitis, left shoulder and upper arm acromioclavicular sprain, left closed acromioclavicular dislocation, and left shoulder bursae and tendons disorder.[3] OWCP paid wage-loss compensation on the supplemental rolls commencing October 25, 2010.

In a report dated October 4, 2011, Dr. Richard Lehman, a Board-certified orthopedic surgeon, utilized the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[4] to rate appellant's permanent impairment. He referred to Table 15-5, on page 401 of the A.M.A., *Guides* and concluded that appellant had 11 percent left shoulder permanent impairment.

On November 30, 2011 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On December 21, 2011 OWCP forwarded appellant's medical records to a district medical adviser (DMA) for evaluation of his left shoulder permanent impairment. In a December 22, 2011 report, Dr. Daniel D. Zimmerman, a Board-certified family practitioner, serving as a DMA for OWCP, indicated that he had reviewed appellant's surgical and medical history, and found that appellant had reached maximum medical improvement (MMI) on October 4, 2011. Using the A.M.A., *Guides*, he calculated that appellant sustained 12 percent permanent impairment of his left upper extremity. Dr. Zimmerman indicated that appellant had used the most favorable diagnosis from the shoulder regional grid, distal clavicle excision, to rate appellant's left shoulder permanent impairment.

By decision dated January 6, 2012, OWCP granted appellant a schedule award for 12 percent permanent impairment of the left upper extremity. The period of the award ran from October 4, 2011 through June 22, 2012.

On February 4, 2018 and May 26, 2019 appellant filed a claim for an increased schedule award.

In a development letter dated May 31, 2019, OWCP requested that appellant submit a report from his attending physician, which addressed whether appellant had reached MMI and, if

[2] OWCP assigned the claim OWCP File No. xxxxxx893. Appellant also has a traumatic injury claim (Form CA-1) under OWCP File No. xxxxxx344, accepted for an August 12, 2018 closed injury of the head. Appellant's claims have been administratively combined with OWCP File No. xxxxxx893 serving as the master file.

[3] OWCP authorized left shoulder arthroscopic rotator cuff tear repair, which occurred on March 21, 2011. Appellant's postoperative diagnoses were listed as massive recurrent rotator cuff tear, torn subscapularis, torn supraspinatus, recurrent torn infraspinatus. On May 12, 2010 appellant underwent left shoulder arthroscopic decompression, left shoulder arthroscopic distal clavicle resection, left shoulder arthroscopic rotator cuff repair, and left shoulder arthroscopic glenohumeral and labral debridement.

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

so, to evaluate permanent impairment in accordance with the standards of the A.M.A., *Guides*. It afforded him 30 days to submit the requested information.

In a report dated July 8, 2019, Dr. Andrew Brown, a Board-certified orthopedic surgeon, determined that appellant had reached MMI. He diagnosed left shoulder rotator cuff tear with impingement and acromioclavicular joint osteoarthritis. Dr. Brown related appellant's left shoulder range of motion (ROM) measurements. Using the sixth edition of the A.M.A., *Guides*, he found that appellant had 20 percent left shoulder permanent impairment due to loss of ROM, with pain.

On August 29, 2019 OWCP routed Dr. Brown's report, a statement of accepted facts (SOAF), and the case record to Dr. Jovito Estaris, Board-certified in occupational medicine serving as a DMA, for review and evaluation of appellant's permanent impairment pursuant to the sixth edition of the A.M.A., *Guides*. The DMA was also asked to provide a date of MMI.

In a report dated September 14, 2019, the DMA noted that Dr. Brown's impairment rating did not provide three sets of measurements of appellant's left shoulder ROM, nor did he follow A.M.A., *Guides* procedures. Dr. Estaris requested that OWCP obtain from Dr. Brown a detailed medical history, physical examination findings, and an impairment rating pursuant to the sixth edition of the A.M.A., *Guides* in providing a left shoulder impairment rating.

By letter dated September 27, 2019, OWCP asked Dr. Brown to provide detailed physical examination findings, including three independent left shoulder ROM measurements and three ROM right shoulder ROM for comparison. Dr. Brown was also asked to follow the procedures outlined in the sixth edition of the A.M.A., *Guides*.

In a report dated December 13, 2019, Dr. Brown noted that appellant's shoulder ROM was measured three times. He related that appellant's left shoulder ROM reflected 130 degrees forward flexion, 30 degrees extension, 120 degrees abduction, 30 degrees adduction, 80 degrees external rotation, and 0 degrees internal rotation. ROM measurements for the right shoulder were also provided. Dr. Brown determined that appellant had reached MMI. He reported left shoulder strength as 4/5 in internal rotation with abduction, positive impingement, and positive enhancement. Using the sixth edition of the A.M.A., *Guides*, Dr. Brown determined that appellant had 16 percent left upper extremity permanent impairment and 10 percent whole person impairment. In reaching his impairment determination, he referenced Table 15-7 at page 406, Table 15-34 at page 475, Table 15-35 at page 477, and Table 15-36 at page 477, but did not further explain his rating.

On April 2, 2020 OWCP routed Dr. Brown's December 13, 2019 report, a SOAF, and the case record to Dr. Estaris, the DMA, for review and evaluation of appellant's permanent impairment pursuant to the sixth edition of the A.M.A., *Guides*. In a report dated April 16, 2020, the DMA advised that he was unable to determine how Dr. Brown reached his impairment rating. Utilizing the diagnosis-based impairment (DBI) rating method, under Table 15-5, page 403, the DMA found that appellant's diagnosis of full thickness rotator cuff tear represented a class of diagnosis (CDX) of 1 with a default value of five percent impairment. Dr. Estaris assigned a grade modifier for functional history (GMFH) of 1 under Table 15-7, page 406, a grade modifier for physical examination (GMPE) of 2 under Table 15-8, page 408, and a grade modifier for clinical

studies (GMCS) of 4 under Table 15-9, page 410. The DMA applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1 - 1) + (2 - 1) + (4 - 1) = 4, yielding net adjustment of 4 and moving two places to the right of the default position, to E, to find that appellant had a seven percent left upper extremity permanent impairment. Additionally, he utilized the ROM rating method to determine permanent impairment of the left upper extremity and found that, under Table 15-34 on page 475, 130 degrees of flexion yielded zero percent permanent impairment, 30 degrees of extension yielded one percent permanent impairment, 120 degrees of abduction yielded three percent permanent impairment, 30 degrees of adduction yielded one percent permanent impairment, 10 degrees of internal rotation yielded two percent permanent impairment, and 80 degrees of external rotation yielded zero percent permanent impairment, totaling seven percent permanent impairment of the left upper extremity. The DMA determined that, under Table 15-36 on page 477, a grade modifier of 1 for seven percent left upper extremity ROM permanent impairment rating. He found no net modifier for ROM grade modifier under the Table 15-35 on page 477 resulting in no change and seven percent permanent impairment of the left upper extremity. The DMA noted that both DBI and ROM methods reached the same impairment rating of seven percent left upper extremity permanent impairment.

On September 25, 2020 OWCP referred appellant for a second opinion evaluation with Dr. Sivakoti R. Katta, a Board-certified physiatrist.

In a report dated October 15, 2020, Dr. Katta noted appellant's history of injury, medical treatment, and diagnoses. Utilizing the DBI method at Table 15-5 page 403 of the sixth edition of the A.M.A., *Guides*, he determined that appellant had 10 percent permanent impairment of the left upper extremity for a diagnosis of acromioclavicular joint dislocation requiring distal clavicle resection. Dr. Katta assigned a GMFH of 2 under Table 15-7, page 406, a GMPE of 2 under Table 15-8, page 408, and a GMCS of 0 under Table 15-9, page 410. He applied the net adjustment formula and found that appellant had 12 percent left upper extremity permanent impairment under the DBI method. Regarding appellant's ROM findings for the left shoulder, Dr. Katta related that he had measured appellant's left shoulder three times. He noted left shoulder flexion of 90 degrees, extension of 30 degrees, abduction of 90 degrees, no limitation of adduction, internal rotation of 50 degrees, and external rotation of 50 degrees. Using Table 15-34, Dr. Katta found 11 percent left upper extremity permanent impairment based upon his ROM measurements. He determined that appellant reached MMI on March 27, 2017.

On November 16, 2020 OWCP routed Dr. Katta's report to Dr. Estaris, OWCP's DMA for review. In a report dated December 10, 2020, the DMA referenced findings in Dr. Katta's October 15, 2020 report. Utilizing the DBI rating method, under Table 15-5, page 403, the DMA found that appellant's diagnosis of full-thickness rotator cuff tear represented a CDX of 1 with a default value of five percent impairment. He assigned a GMFH of 2 under Table 15-7, page 406, a GMPE of 1 under Table 15-8, page 408, and a GMCS of 2 under Table 15-9, page 410. The DMA applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (2 - 1) + (1 - 1) + (2 - 1) = 2, yielding net adjustment of 2 and moving two places to the right to E, to a finding of seven percent left upper extremity permanent impairment. Additionally, he utilized the ROM rating method to determine permanent impairment to the left upper extremity and found that, under Table 15-34 on page 475, 90 degrees of flexion yielded 3 percent permanent impairment, 30 degrees of extension yielded 1 percent permanent impairment, 90 degrees of abduction yielded 3 percent permanent impairment, 40 degrees of adduction yielded 0 percent

permanent impairment, 50 degrees of internal rotation yielded 2 percent permanent impairment, and 50 degrees of external rotation yielded 2 percent permanent impairment, totaling 11 percent permanent impairment of the left upper extremity. The DMA determined that, under Table 15-35 on page 477, a grade modifier 1 for 11 percent left upper extremity ROM permanent impairment rating. He found a net modifier of 2 for GMFH under Table 15-36 on page 477. The DMA multiplied 11 percent impairment by 5 percent impairment, which totaled 11.55 percent or 12 percent permanent impairment of the left upper extremity for loss of ROM. While Dr. Katta used distal clavicle resection under the DBI method, the DMA excluded the May 12, 2010 clavicle resection as not being relevant as it predated the accepted employment injury and noted that a more recent distal clavicle resection had not been performed. The DMA advised that the correct diagnosis to use was full thickness rotator cuff tear repair.

By decision dated January 5, 2021, OWCP denied appellant's claim for an increased schedule award based on the opinion of Dr. Estaris, OWCP's DMA.

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. However, FECA does not specify the manner in which the percentage of loss of a member 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 has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[7] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[8] 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.[9]

Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment for the CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS and the net adjustment formula is applied. The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[10] OWCP procedures provide that, after obtaining all necessary medical evidence, the

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id. See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

[9] *T.G.*, Docket No. 20-0660 (issued June 3, 2021); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[10] A.M.A., *Guides* 387.

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 permanent impairment specified.[11]

The A.M.A., *Guides* also provide that 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.[12] 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.[13] 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.[14]

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.[15] 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.,] *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 [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.)[16]
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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

[11] *T.G.*, *supra* note 9; *M.S.*, Docket No. 19-0282 (issued August 2, 2019); *supra* note 8 at Chapter 2.808.6(f) (March 2017).

[12] A.M.A., *Guides* 461.

[13] *Id.* at 473.

[14] *Id.* at 474.

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

[16] *See* A.M.A., *Guides* 477.

should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the [claims examiner]."[17]

ANALYSIS

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

In his October 15, 2020 second opinion report, Dr. Katta noted appellant's history of injury, medical treatment, and diagnoses. Utilizing the DBI method at Table 15-5 page 403 of the sixth edition of the A.M.A., *Guides*, he determined that appellant had 10 percent permanent impairment of the left upper extremity for a diagnosis of acromioclavicular joint dislocation requiring distal clavicle resection. Dr. Katta assigned a GMFH of 2 under Table 15-7, page 406, a GMPE of 2 under Table 15-8, page 408, and a GMCS of 0 under Table 15-9, page 410. He applied the net adjustment formula and found that appellant had 12 percent left upper extremity permanent impairment under the DBI method. Regarding appellant's ROM findings for the left shoulder, Dr. Katta related that he had measured appellant's left shoulder three times. He noted left shoulder flexion of 90 degrees, extension of 30 degrees, abduction of 90 degrees, no limitation of adduction, internal rotation of 50 degrees, and external rotation of 50 degrees. Using Table 15-34, Dr. Katta found 11 percent left upper extremity permanent impairment for ROM measurements. He determined that appellant reached MMI on March 27, 2017.

In his December 11, 2020 report, Dr. Estaris, OWCP's DMA, calculated appellant's left upper extremity impairment applying the sixth edition of the A.M.A., *Guides*. He utilized the ROM rating method to determine permanent impairment of the left shoulder. Utilizing Table 15-34, page 475, the DMA determined that 90 degrees of flexion and 90 degrees abduction each yielded 3 percent permanent impairment, 30 degrees extension yielded 1 percent permanent impairment, 50 degrees of external rotation and 50 degrees internal rotation each yielded 2 percent impairment, and 40 degrees of adduction yielded 0 percent permanent impairment, resulting in 11 percent permanent impairment of the left upper extremity. Utilizing Table 15-35 and Table 15-36 on page 477, he assigned a grade modifier 1 for the 11 percent ROM impairment rating and a GMFH of 2. The DMA multiplied 11 percent impairment by 5 percent impairment, which totaled 11.55 percent and was rounded up to 12 percent permanent impairment of the left upper extremity. Utilizing the DBI rating method, under Table 15-5, page 403, the DMA found that appellant's diagnosis of full- thickness rotator cuff tear resulted in a seven percent permanent impairment of appellant's left shoulder. He concluded that appellant had 12 percent right upper extremity permanent impairment under the ROM method as it resulted in greater impairment than the DBI rating method.

OWCP, however, did not request that Dr. Estaris clarify whether appellant's left shoulder permanent impairment should be rated for appellant's preexisting clavicle diagnosis, which necessitated his distal clavicle resection.

[17] *Id.* at 474; *P.W.*, Docket No. 19-1493 (issued August 12, 2020); *A.R.*, Docket No. 19-1284 (issued January 14, 2020); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[18] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[19] As OWCP undertook development of the evidence by referring appellant to an OWCP medical adviser, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.[20]

The case will, therefore, be remanded for further clarification from the DMA, Dr. Estaris, to determine the appropriate diagnosis, based on appellant's preexisting and accepted left shoulder conditions in calculating appellant's permanent impairment. Following this and other such development as deemed necessary, it shall issue a *de novo* decision.

CONCLUSION

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

[18] *V.G.*, Docket No. 20-0455 (issued June 17, 2021); *N.L.*, Docket No. 19-1592 (issued March 12, 2020); *M.T.*, Docket No. 19-0373 (issued August 22, 2019); *B.A.*, Docket No. 17-1360 (issued January 10, 2018).

[19] *V.G.*, *id.*; *S.S.*, Docket No. 18-0397 (issued January 15, 2019); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[20] *V.G.*, *id.*; *G.M.*, Docket No. 19-1931 (issued May 28, 2020); *W.W.*, Docket No. 18-0093 (issued October 9, 2018).

ORDER

IT IS HEREBY ORDERED THAT the January 5, 2021 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: February 22, 2023
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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