United States Department of Labor
Employees' Compensation Appeals Board

J.C., Appellant	)	
and	)	**Docket No. 23-0889**
	)	**Issued: February 8, 2024**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS AND BORDER PROTECTION, U.S. BORDER PATROL, Brownsville, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On June 12, 2023 appellant filed a timely appeal from a January 19, 2023 merit decision and a February 15, 2023 nonmerit 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]

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish greater than 7 percent permanent impairment of his right upper extremity, 2 percent permanent impairment of

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that following the February 15, 2023 decision, appellant submitted additional evidence to OWCP and with her appeal to the Board. 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*.

his left upper extremity, and 15 percent permanent impairment of his right lower extremity for which he was previously paid schedule award compensation; and (2) whether OWCP properly denied appellant's request for reconsideration of the merits of his claim, pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On November 16, 2018 appellant, then a 38-year-old border patrol agent, filed a traumatic injury claim (Form CA-1) alleging that on November 15, 2018 he experienced pain in both knees, the right side of his lower back and hip area, and the right shoulder when he tripped on rocks and fell down while in the performance of duty.[3] OWCP accepted the claim for tear of the articular cartilage of both knees, sprain of the medial collateral ligament of both knees, derangement of the left knee patella, sprain of the lateral collateral ligament of the right knee, right shoulder joint sprain, right hip sprain, and lumbar intervertebral disc disorder with radiculopathy.

On May 15, 2019 appellant underwent OWCP-authorized left knee arthroscopy medial meniscectomy. The operative report noted a postoperative diagnosis of left knee tear of the medial meniscus.

On March 20, 2020 appellant filed a claim for compensation (Form CA-7) for a schedule award.

Appellant submitted a February 26, 2020 report from Dr. John W. Ellis, an osteopath and Board-certified family medicine specialist, who reviewed appellant's history of injury and noted appellant's accepted conditions. On physical examination of the right shoulder, Dr. Ellis observed tenderness of the acromioclavicular (AC) joint and supraspinatus muscle. He provided appellant's range of motion (ROM) of the right shoulder, finding that appellant exhibited 150 degrees of forward flexion, 20 degrees of extension, 100 degrees of abduction, 10 degrees of adduction, 60 degrees of external rotation, and 50 degrees of internal rotation by averaging three repetitions. Examination of the right knee demonstrated moderate to almost severe laxity of the anterior cruciate ligament (ACL). Dr. Ellis indicated that his examination of the right ankle revealed tenderness of the medial and lateral aspects of the ankle and decreased ROM. He reported normal sensation in the lower extremities and noted that there was no spinal nerve impingement in the lower extremities. Dr. Ellis diagnosed tears of the ACL of the knees, sprains of the MCL of the knees, left knee patella derangement, right knee lateral collateral ligament sprain, right shoulder joint sprain, right hip sprain, right ankle sprain, and intervertebral disc disorder with radiculopathy of the thoracic and lumbar spine. He reported a date of maximum medical improvement (MMI) of February 26, 2020.

[3] OWCP assigned the claim OWCP File No. xxxxxx154. Appellant has a previously-accepted June 17, 2008 traumatic injury claim for a lateral collateral ligament sprain of the right knee under OWCP File No. xxxxxx469. He has another accepted August 23, 2018 traumatic injury claim for medial collateral ligament sprain of the right knee, right ankle sprain, and tear of articular cartilage of the right knee. OWCP assigned that claim OWCP File No. xxxxxx423. By decision dated June 16, 2022, it granted appellant a schedule award for 15 percent permanent impairment of the right lower extremity. OWCP has administratively combined OWCP File No. xxxxxx469, OWCP File No. xxxxxx154, and OWCP File No. xxxxxx423, with the latter serving as the master file.

Dr. Ellis provided permanent impairment ratings pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] Utilizing the diagnosis-based impairment (DBI) rating method, he determined that under Table 15-5 (Shoulder Regional Grid), page 401, appellant had one percent permanent impairment of the right upper extremity for right shoulder sprain/tendinosis and right shoulder supraspinatus rotator cuff tear. Dr. Ellis also utilized the ROM rating method and calculated that under Table 15-34 (Shoulder Range of Motion), page 475, appellant had seven percent permanent impairment due to right shoulder ROM deficits. Regarding appellant's lumbar spine injury, he applied the DBI rating method and found, using *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), that appellant had zero percent permanent impairment of the lower extremities due to spinal nerve impairment.

For appellant's right lower extremity, Dr. Ellis utilized the DBI rating method under Table 16-3 (Knee Regional Grid), beginning on page 509, and found that appellant had 2 precent permanent impairment for medial meniscectomy and 10 percent permanent impairment for ACL reconstruction. He then referred to Table 16-4 (Hip Regional Grid), beginning on page 512, and found that appellant had one percent permanent impairment. Dr. Ellis also applied Table 16-2 (Foot and Ankle Regional Grid), beginning on page 501, and determined that appellant had two percent permanent impairment. He calculated that appellant had a total of 14 percent permanent impairment of the right lower extremity. Dr. Ellis also applied the ROM rating method and found that appellant had nine percent permanent impairment for ROM deficits. For appellant's left lower extremity, he applied the DBI rating method and noted that under Table 16-3, page 509, appellant had two percent permanent impairment for medial meniscectomy. Utilizing the ROM rating method, Dr. Ellis determined that appellant had no ratable permanent impairment for loss of ROM.

OWCP referred the medical record and a statement of accepted facts (SOAF) to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), to provide an impairment rating in conformity with the A.M.A., *Guides* and *The Guides Newsletter*.

In an October 18, 2021 report, Dr. Harris noted his review of the medical record, including Dr. Ellis' February 26, 2020 report, and indicated that the record established the diagnoses of status post left knee arthroscopic partial medial meniscectomy on May 5, 2019, right shoulder rotator cuff tendinitis and impingement syndrome, and right knee partial tear anterior cruciate and medial collateral ligaments. For the right upper extremity, he utilized the DBI rating method and determined that appellant had one percent permanent impairment of the right upper extremity due to right shoulder tendinitis, a Class 1impairment with a value of 1 under Table 15-5, page 402, of the A.M.A., *Guides*. Dr. Harris then determined that appellant had permanent impairment under the ROM rating method and found that appellant had three percent permanent impairment for loss of shoulder flexion, two percent permanent impairment for loss of shoulder extension, and two percent permanent impairment for loss of shoulder internal rotation, resulting in seven percent permanent impairment of the right upper extremity in accordance with Table 15-34, page 475, of the A.M.A., *Guides*.

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

For appellant's lumbar spine injury, Dr. Harris indicated that under *The Guides Newsletter*, Table 2 appellant had a Class 0 impairment for no neurologic deficit in the bilateral lower extremities. Accordingly, appellant had no permanent impairment for his bilateral lower extremities due to his accepted lumbar injury. For appellant's right lower extremity, he applied the DBI rating method to find that appellant had 13 percent permanent impairment of the right lower extremity due to mild anterior cruciate and medial collateral ligament laxity, a Class 1 impairment with a value of 13 under Table 16-3, page 510, of the A.M.A., *Guides*. For appellant's left lower extremity, Dr. Harris utilized the DBI rating method to determine that appellant had two percent permanent impairment of the left lower extremity based on partial medial meniscectomy, a Class 1impairment with a value of 2 under Table 16-3, page 509, of the A.M.A., *Guides*. He explained that pursuant to Section 16.7, page 543, the ROM rating method was not applicable for appellant's bilateral knee injuries. Thus, Dr. Harris concluded that appellant had 7 percent permanent impairment of the right upper extremity, 13 percent permanent impairment of the right lower extremity, and 2 percent permanent impairment of the left lower extremity. He noted a date of MMI of February 26, 2020.

OWCP received a May 19, 2022 electromyogram and nerve conduction velocity (EMG/NCV) study of the bilateral lower extremities, which demonstrated evidence of bilateral L5 radiculopathy.

On July 6, 2022 OWCP requested clarification from the Dr. Harris, in his role as the DMA, and informed him that appellant was previously awarded 15 percent permanent impairment of the right lower extremity under OWCP File No. xxxxxx423.

In a July 13, 2022 report, Dr. Harris indicated that under OWCP File No. xxxxxx423 appellant was found to have 10 percent permanent impairment of the right lower extremity for the knee and 5 percent permanent impairment of the right lower extremity for the ankle. He reported that there was no increase in appellant's right lower extremity permanent impairment.

In a July 20, 2022 report, Dr. Ellis discussed appellant's claims under OWCP File Nos. xxxxxx423 and xxxxxx154. He noted appellant's diagnosed conditions of bilateral knee tear of the articular cartilage, bilateral knee sprains of the medial collateral ligament, left knee patella derangement, right knee lateral collateral ligament sprain, right shoulder joint sprain, right hip sprain, and intervertebral disc disorders with radiculopathy of the thoracic and lumbar spines. For appellant's right upper extremity, Dr. Ellis first applied the DBI rating method to find that appellant had five percent permanent impairment of the right upper extremity based on the class of diagnosis (CDX) of tendinosis of the supraspinatus rotator cuff under Table 15-5, page 402. He then utilized the ROM rating method and found that appellant had 29 percent permanent impairment of the right upper extremity under Table 15-34, page 475, due to shoulder loss of ROM. Dr. Ellis provided examination findings of appellant's right shoulder ROM, noting that appellant exhibited 80 degrees of forward flexion, 20 degrees of extension, 90 degrees of abduction, 20 degrees of adduction, 20 degrees of external rotation, and 30 degrees of internal rotation by averaging three repetitions.

For appellant's right lower extremity, Dr. Ellis determined that appellant had 24 percent permanent impairment of the right lower extremity based on the CDX of right knee arthropathy under Table 16-3, page 511, and 7 percent permanent impairment of the right lower extremity for

the CDX of tendinosis under Table 16-4, page 512. For appellant's lumbar spine injury, he found that appellant had 33 percent permanent impairment of the right lower extremity for spinal nerve impairment under Table 2 of *The Guides Newsletter* for a total of 52 percent permanent impaiment of the right lower extremity. Utilizing the ROM rating method, Dr. Ellis indicated that appellant had 15 percent permanent impairment of the right hip and 11 percent permanent impairment of the right knee for a combined total value of 24 percent permanent impairment of the right lower extremity. For appellant's left lower extremity, he utilized the DBI rating method and found that appellant had 25 percent permanent impairment of the left lower extremity based on the CDX for lateral patellar subluxation under Table 16-3, page 510. Dr. Ellis also determined that appellant had 33 percent permanent impairment of the left lower extremity for spinal nerve impairment to the left lower extremity in accordance with Table 2 of *The Guides Newsletter* for a total of 50 percent permanent impairment of the left lower extremity.

By decision dated August 26, 2022, OWCP granted appellant a schedule award for seven percent permanent impairment of the right upper extremity, two percent permanent impairment of the left lower extremity, and zero percent permanent impairment of the right lower extremity. The period of the award ran for 27.6 weeks from February 26 through September 6, 2020. It was based on the February 26, 2020 report of Dr. Ellis and the July 13, 2022 report of Dr. Harris, the DMA. The award noted that as appellant was previously paid 15 percent permanent impairment of the right lower extremity, he was not entitled to an additional impairment rating for the right lower extremity.

On September 9, 2022 appellant requested reconsideration.

By decision dated January 19, 2023, OWCP denied modification of its August 26, 2022 decision.

On February 3, 2023 appellant requested reconsideration.

By decision dated February 15, 2023, OWCP denied appellant's request for reconsideration of the merits of the claim, pursuant to 5 U.S.C. § 8128(a).

LEGAL PRECEDENT -- ISSUE 1

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. FECA, however, 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

adoption.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[8]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated.[9] The sixth edition requires identifying the CDX, which is then adjusted by grade modifier for functional history (GMFH), grade modifier for physical examination (GMPE), and grade modifier for clinical studies (GMCS).[10] The net adjustment formula is (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX).[11]

The A.M.A., *Guides* also provide that the ROM impairment is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[12] 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]

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*

[7] *Id.* at § 10.404(a); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

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

[9] *K.R.*, Docket No. 20-1675 (issued August 19, 2022); *M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[10] A.M.A., *Guides* 494-531.

[11] *Id.* at 521.

[12] *Id.* at 461.

[13] *Id.* at 473.

[14] *Id.* at 474.

an impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)[15]

The Bulletin further advises:

"If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allows for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[16]

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.[17] Furthermore, the back is specifically excluded from the definition of an organ under FECA.[18] The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that FECA allows ratings for extremities and precludes ratings for the spine, *The Guides Newsletter* offers an approach to rating spinal nerve impairments consistent with sixth edition methodology. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that the July/August 2009 edition of *The Guides Newsletter* is to be applied.[19]

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 permanent impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[20]

ANALYSIS -- ISSUE 1

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

OWCP properly routed appellant's claim to a DMA, Dr. Harris. In reports dated October 18, 2021 and July 13, 2022, Dr. Harris determined that appellant had one percent permanent impairment of the right upper extremity under Table 15-5 for the CDX of right shoulder tendinitis. He also found that under the ROM rating method, appellant had seven percent permanent impairment in accordance with Table 15-34. For appellant's lumbar spine injury, Dr. Harris indicated that under *The Guides Newsletter*, Table 2, appellant had a Class 0 impairment for no neurologic deficit in the bilateral lower extremities. He also found that appellant had 13

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

[16] *Id*.

[17] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

[18] *See id*. at § 8101(19); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

[19] *Supra* note 8 at Chapter 3.700 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[20] *Id*. at Chapter 2.808.6f (March 2017).

percent permanent impairment of the right lower extremity based on the CDX of mild anterior cruciate and medial collateral ligament laxity under Table 16-3. Dr. Harris then determined that appellant had two percent permanent impairment of the left lower extremity for the CDX of partial medial meniscectomy under Table 16-3. He explained that under OWCP File No. xxxxxx423, appellant had 10 percent permanent impairment of the right lower extremity for the knee and 5 percent right lower extremity permanent impairment for the ankle. Accordingly, Dr. Harris explained that there was no increase in appellant's right lower extremity permanent impairment. He concluded, therefore, that appellant had 7 percent permanent impairment of the right upper extremity, 13 percent permanent impairment of the right lower extremity, and 2 percent permanent impairment of the left lower extremity.

In its August 26, 2022 decision, OWCP granted appellant a schedule award for seven percent permanent impairment of the right upper extremity and two percent permanent impairment of the left lower extremity. It noted that there was no additional permanent impairment for appellant's right lower extremity.

The evidence of record received after Dr. Harris' October 18, 2021 report, however, reflects evidence of recent sensory or motor loss in appellant's bilateral lower extremities and increased shoulder ROM deficits, which could possibly affect the current schedule award to the right upper extremity and bilateral lower extremities. Dr. Harris determined that pursuant to *The Guides Newsletter*, appellant had zero permanent impairment for no neurologic deficit in the bilateral lower extremities. Appellant subsequently submitted a May 19, 2022 EMG/NCV study, which demonstrated evidence of bilateral L5 radiculopathy. Thus, the record contains evidence of bilateral sensory or motor loss, which may constitute an increased basis for a schedule award based on *The Guides Newsletter*. Appellant also submitted a July 20, 2022 report by Dr. Ellis who noted right shoulder ROM findings of 80 degrees of forward flexion, 20 degrees of extension, 90 degrees of abduction, 20 degrees of adduction, 20 degrees of external rotation, and 30 degrees of internal rotation by averaging three repetitions. The record, therefore, contains evidence of increased loss of ROM of appellant's right shoulder, which may constitute an increased basis for a schedule award under Table 15-34 of the A.M.A., *Guides*.

The Board notes that proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[21]

Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case. Accordingly, once it undertakes to develop the medical evidence further, OWCP has the responsibility to do so in a manner that will resolve the relevant issues in the case.[22] OWCP issued the August 26, 2022 schedule award decision without consideration of the May 19, 2022 EMG/NCV study and the examination

[21] *See T.C.*, Docket No. 19-0771 (issued March 17, 2021); *E.W.*, Docket No. 17-0707 (issued September 18, 2017).

[22] *See T.K.*, Docket No. 20-0150 (issued July 9, 2020); *T.C.*, Docket No. 17-1906 (issued January 10, 2018).

findings noted in Dr. Ellis' July 20, 2022 report. Therefore, the case must be remanded to OWCP for further development.[23]

The Board will, therefore, set aside OWCP's January 19, 2023 decision and remand the case to OWCP for referral to Dr. Harris, along with the additional medical records, for further review. After such other further development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for the right upper extremity and bilateral lower extremities schedule award.

CONCLUSION

The Board finds that this case is not in posture for decision.[24]

ORDER

IT IS HEREBY ORDERED THAT the January 19, 2023 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: February 8, 2024
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

[23] *See B.B.*, Docket No. 22-1068 (issued June 13, 2023); *X.Y.*, Docket No. 19-1290 (issued January 24, 2020); *K.G.*, Docket No. 17-0821 (issued May 9, 2018).

[24] In light of the Board's disposition of Issue 1, Issue 2 is rendered moot.