United States Department of Labor
Employees' Compensation Appeals Board

K.D., Appellant	)	
and	)	**Docket No. 23-0901**
	)	**Issued: February 27, 2024**
DEPARTMENT OF VETERANS AFFAIRS, DURHAM VA MEDICAL CENTER, Durham, NC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On June 20, 2023 appellant filed a timely appeal from an April 19, 2023 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 April 19, 2023 decision, appellant submitted additional evidence to OWCP. 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 new evidence for the first time on appeal. *Id*.

ISSUE

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

FACTUAL HISTORY

On January 9, 2018 appellant, then a 62-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that on December 14, 2017 he injured his left arm and shoulder when assisting with transitioning a patient from an examination table to a chair while in the performance of duty. He did not immediately stop work. By decision dated April 20, 2018, OWCP accepted appellant's claim for rotator cuff tear or rupture of the left shoulder. It paid him wage-loss compensation on the supplemental rolls, effective January 31, 2018.

In an April 24, 2019 report, Dr. Joseph Wilson, a Board-certified orthopedist, noted that appellant sustained a work-related left shoulder injury on December 14, 2017. He reported a magnetic resonance imaging (MRI) scan of the left shoulder, which revealed a high-grade partial supraspinatus tear.[3] Dr. Wilson noted that, upon physical examination, the left shoulder lacked five degrees of forward flexion and five degrees of external rotation and noted slight pain at the acromioclavicular (AC) joint, bicipital groove, and supraspinatus. He diagnosed left shoulder pain. Dr. Wilson noted that appellant did not wish to proceed with arthroscopic surgery. He determined that appellant reached maximum medical improvement (MMI) at the time of the examination. Dr. Wilson noted that in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[4] appellant had three percent permanent impairment of the left upper extremity due to restricted range of motion, and difficulty performing activities of daily living (ADL).

On June 5, 2019 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On June 13, 2019 OWCP requested Dr. Wilson submit an impairment evaluation that addressed whether appellant had obtained MMI and to provide a permanent impairment rating in accordance with the A.M.A., *Guides*.[5] It afforded him 30 days to submit the necessary evidence. No response was received.

On July 12, 2019 OWCP routed Dr. Wilson's April 24, 2019 report and the case record to Dr. Herbert White, Jr., a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for review and a determination of appellant's date of MMI and the permanent

[3] An MRI scan of the left shoulder dated February 19, 2018 revealed high-grade predominantly interstitial tear of the distal insertion of the supraspinatus with associated bursitis, AC arthrosis with undersurface spurring, and type-two acromion with lateral and medial arch narrowing.

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

[5] *Id.*

impairment of his left upper extremity under the sixth edition of the A.M.A., *Guides*. It requested that Dr. White review Dr. Wilson's April 25, 2019 report, and provide an opinion discussing whether he agreed with its findings.

In a July 20, 2019 report, Dr. White discussed the findings in Dr. Wilson's April 24, 2019 report. He diagnosed left shoulder rotator cuff tear. Dr. White referred to the sixth edition of the A.M.A., *Guides*, and utilized the diagnosis-based impairment (DBI) rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 402, the class of diagnosis (CDX) for appellant's partial-thickness rotator cuff tear resulted in a Class 1 impairment with a default value of 3. He calculated that appellant had a net adjustment of zero resulting in the default value of grade C corresponding to three percent permanent impairment of the left upper extremity. Dr. White noted that Dr. Wilson did not show all his calculations or steps in the impairment rating process. Regarding the range of motion (ROM) impairment rating method, he noted that there was insufficient information contained in the case record to calculate impairment utilizing that method as the report of Dr. Wilson did not contain complete measurements for the left shoulder. He concluded that Dr. Wilson's impairment rating was not performed according to the standards of the A.M.A., *Guides* and therefore could not be used to calculate permanent impairment.

On July 23, 2019 OWCP advised Dr. Wilson that additional evidence was required to calculate the final impairment rating. It specifically asked him to clarify whether appellant had a loss of ROM of the left shoulder and, if so, to provide three independent measurements of appellant's left shoulder ROM. No response was received.

By decision dated August 28, 2019, OWCP granted appellant a schedule award for three percent permanent impairment of the left arm. The period of the award ran for 9.36 weeks from May 25 through July 29, 2019.

OWCP received additional evidence. An MRI scan of the left shoulder dated July 11, 2021 revealed full-thickness frayed irregular tear, a mid to distal supraspinatus tear that extends posteriorly to involve the anterior infraspinatus, interstitial and articular surface partial-thickness tearing of the distal subscapularis, chronic posterior superior labral tear, outlet-related cuff impingement secondary to AC joint hypertrophy, lateral down sloping hypertrophied type 2 acromion, AC arthrosis, and chronically torn biceps long head. The radiologist noted that when compared to his prior study the findings have progressed and the cuff tear propagated.

On October 7, 2021 Dr. Wilson performed an arthroscopy, left shoulder surgical rotator cuff repair, decompression of subacromial space with partial acromioplasty with coracoacromial release, lysis of adhesions, distal claviculectomy including distal articular surface, and extensive debridement of glenohumeral joint. He diagnosed left rotator cuff rupture, adhesive capsulitis, AC joint arthritis, and subacromial bursitis.

In a September 14, 2022 report, Dr. Wilson diagnosed left shoulder joint pain and noted that appellant reached MMI as of that date. He advised that appellant underwent arthroscopic rotator cuff repair on October 7, 2021. On physical examination, Dr. Wilson reported ROM findings for the left shoulder of approximately 175 degrees of forward flexion, which was 5 degrees compared to the contralateral side, external rotation of 55 degrees, which was -5 degrees compared to the contralateral side, minor pain at the end of range of motion, and slight weakness

with rotator cuff testing. He evaluated appellant's impairment and found 15 percent permanent impairment of the left upper extremity.

On March 22, 2023 appellant filed a Form CA-7 for an increased schedule award.

In a development letter dated March 23, 2023, OWCP informed appellant of the deficiencies of his increased schedule award claim. It requested that he submit an impairment evaluation from his attending physician that addressed whether he had obtained MMI and to provide a permanent impairment rating in accordance with the A.M.A., *Guides*. OWCP afforded appellant 30 days to submit the necessary evidence. No response was received.

On April 10, 2023 OWCP routed Dr. Wilson's September 14, 2022 report, along with the case record, and a statement of accepted facts (SOAF) to Dr. Nathan Hammel, a Board-certified orthopedist, serving as an OWCP DMA, for review and a determination of appellant's date of MMI and the permanent impairment of his left upper extremity under the sixth edition of A.M.A., *Guides*. It requested that Dr. Hammel review Dr. Wilson's September 14, 2022 report and provide an opinion discussing whether he agreed with its findings.

In an April 18, 2023 report, Dr. Hammel discussed the findings in Dr. Wilson's September 14, 2022 report. He diagnosed left shoulder rotator cuff tear or rupture. Dr. Hammel referred to the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 403, the CDX for appellant's full-thickness rotator cuff tear resulted in a Class 1 impairment with a default value of 5. He assigned a grade modifier for functional history (GMFH) of 1, and a grade modifier for physical examination (GMPE) of 1. Dr. Hammel found that a grade modifier for clinical studies (GMCS) was not applicable. He utilized the net adjustment formula (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX) = (1 – 1) + (1 – 1) = 0, which resulted in a grade C or five percent permanent impairment of the left upper extremity. Dr. Hammel noted that Dr. Wilson did not show all his calculations or steps in the impairment rating process. Regarding the ROM impairment rating method, he noted that there was insufficient information contained in the case record to calculate impairment utilizing the ROM method due to lack of triplicate measurements. Dr. Hammel indicated that the report of Dr. Wilson did not contain complete measurements for the left shoulder. He concluded that Dr. Wilson's impairment rating was not performed according to the standards of the A.M.A., *Guides* and therefore could not be used to calculate permanent impairment.

By decision dated April 19, 2023, OWCP granted appellant a schedule award for an additional two percent permanent impairment of the left upper extremity (total of five percent permanent impairment of the left upper extremity). The period of the award ran for 6.24 weeks from September 14 through October 27, 2022.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing regulations[7] 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 shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[8] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (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 (ICF).[11] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by a GMFH, GMPE, and/or 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]

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

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

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

[9] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.* at Chapter 2.808.5a (March 2017).

[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, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

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

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 impairment rating for the diagnosis in question, the method producing the higher rating should be used*." (Emphasis in the original.)[16]

The Bulletin further provides:

"If the medical evidence of record is [in]sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.[17]

"Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physicians' evaluation, the CE should route that report to the DMA for a final determination."[18]

ANALYSIS

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

In his September 14, 2022 report, Dr. Wilson provided partial ROM measurements for the left shoulder, and failed to provide ROM measurements of retained shoulder extension, internal rotation, abduction, and adduction. OWCP referred Dr. Wilson's report to Dr. Hammel, its DMA, who opined that appellant had five percent upper extremity impairment for full-thickness rotator cuff tear under the DBI methodology. Dr. Hammel advised that Dr. Wilson's report did not contain complete ROM measurements for the left shoulder and lacked triplicate measurements.

[16] *Id.*

[17] *Id.*; *R.L.*, Docket No. 19-1793 (issued August 7, 2020).

[18] *Id. See also W.H.*, Docket No. 19-0102 (issued June 21, 2019).

Subsequently, OWCP requested that appellant submit a report from his physician rating any permanent impairment using both the DBI and ROM method. It advised that the A.M.A., *Guides* required three independent ROM measurements with the greatest of the measurements used to determine the extent of any impairment. OWCP indicated that it would refer appellant for a second opinion examination if his physician could not provide such a report. No additional information was submitted. Based on Dr. Wilson's September 14, 2022 report, on April 18, 2023 the DMA found that appellant had five percent permanent impairment of the left upper extremity using the DBI method.

Pursuant to FECA Bulletin No. 17-06, if OWCP advises the claimant of the evidence necessary to evaluate permanent impairment using the ROM method, but does not receive such evidence, it should refer the claimant for a second opinion evaluation to obtain the evidence necessary to complete the rating.[19] OWCP failed to follow the procedures outlined in FECA Bulletin No. 17-06 by referring appellant for a second opinion after Dr. Wilson did not rate her impairment using the ROM method.

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.[20] 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. While OWCP began to develop the evidence, it failed to complete its obligation to secure a proper evaluation regarding permanent impairment of the upper extremities based upon the ROM methodology.[21] The case must therefore be remanded for further development.[22]

On remand OWCP shall refer appellant for a second opinion examination to obtain the evidence necessary to calculate his upper extremity impairments using both ROM and DBI methods.[23] Following this and such other further development as deemed necessary, it shall issue a *de novo* decision.

CONCLUSION

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

[19] *Id*. *See R.L.*, Docket No. 19-1793 (issued August 7, 2020).

[20] *See E.W.*, Docket No. 17-0707 (issued September 18, 2017).

[21] *M.A.*, Docket No. 19-1732 (issued September 9, 2020).

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

[23] *See R.C.*, Docket No. 19-1385 (issued September 8, 2020).

ORDER

IT IS HEREBY ORDERED THAT the April 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 27, 2024
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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