United States Department of Labor
Employees' Compensation Appeals Board

B.M., Appellant	)	
	)	**Docket No. 22-1161**
and	)	**Issued: April 11, 2025**
U.S. POSTAL SERVICE, HAMILTON POST OFFICE, Hamilton, OH, Employer	)	

Appearances:
Wayne Johnson, Esq., for the appellant[1]
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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 2, 2022 appellant, through counsel, filed a timely appeal from a February 3, 2022 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.

[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*.

ISSUE

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

FACTUAL HISTORY

On August 8, 2010 appellant, then a 38-year-old city mail carrier, filed a traumatic injury claim (Form CA-1) alleging that on August 6, 2010 she strained her right shoulder after falling in a hole when crossing the street delivering mail while in the performance of duty. OWCP accepted the claim for sprain of right shoulder and upper arm. It subsequently expanded the acceptance of appellant's claim to include right rotator cuff tear. OWCP paid her wage-loss compensation.[3]

On May 11, 2018 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a development letter dated May 15, 2018, OWCP requested that appellant submit an impairment evaluation from her attending physician that addressed whether she had obtained maximum medical improvement (MMI) and to provide a permanent impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides)*.[4] It afforded her 30 days to submit the necessary evidence.

Appellant submitted a December 12, 2014 report, wherein Dr. Robert A. Helsten, a physical medicine and rehabilitation specialist, diagnosed sprain of the right shoulder and right wrist. He noted the date of MMI as December 12, 2014, which was the date of his examination. Dr. Helsten calculated 9 percent impairment for the right shoulder and 3 percent impairment for the right wrist for, a total of 12 percent permanent impairment of the right upper extremity pursuant to the A.M.A., *Guides*.

In a letter dated July 5, 2018, OWCP acknowledged receipt of the December 12, 2014 report from Dr. Helsten, but found that this report was too stale to determine schedule award impairment. It advised appellant that she must submit an impairment rating rendered within the

[3] Appellant had previously filed a Form CA-1 for a traumatic injury sustained on February 9, 2010 to her left arm, shoulder, and head when she turned and stumbled into a car bumper while delivering mail. OWCP assigned that claim OWCP File No. xxxxxx992 and accepted it for sprain of the left elbow and forearm radial collateral ligament, sprain of the neck, sprain of the back, lumbar, and thoracic region, and sprain of the right shoulder and upper arm, rotator cuff. On October 21, 2013 appellant lost her balance and fell injuring her right arm, hip, and foot while delivering mail. OWCP assigned that claim OWCP File No. xxxxxx540 and accepted it for sprain of the right shoulder and upper arm and sprain of the right wrist. It subsequently expanded the acceptance of appellant's claim under OWCP File No. xxxxxx540 to include sprain of the right elbow, cervical radiculopathy, and complex regional pain syndrome (CRPS) of the right upper extremity.

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

prior six months before a decision can be made on her request for a schedule award. OWCP afforded her 30 days to submit the necessary evidence. No additional evidence was received.

By decision dated August 29, 2018, OWCP denied appellant's schedule award claim.

On August 29, 2018 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

Appellant submitted a September 28, 2018 report from Dr. Ahmed Khalifa, a Board-certified physiatrist, who related that on physical examination of appellant's right shoulder he recorded appellant's range of motion (ROM) findings for 52 degrees of flexion, 41 degrees of extension, 47 degrees of extension and adduction, internal rotation, and external rotation could not be evaluated due to appellant's pain. Examination of the right elbow demonstrated limited ROM with 40 degrees of pronation and 23 degrees of supination but flexion and extension could not be evaluated due to pain. Dr. Khalifa further noted that appellant's right wrist and right upper extremity sensory testing could not be evaluated due to pain. He indicated that appellant reached MMI on December 12, 2014, the date of Dr. Helsten's evaluation. Utilizing the ROM rating method, Table 15-34, page 475 of the A.M.A., *Guides*, Dr. Khalifa found a total of 10 percent impairment of the right shoulder. He also calculated three percent permanent impairment of the right wrist using Table 15-32, page 473 of the A.M.A., *Guides*, for a combined award of 13 percent permanent impairment of the right upper extremity.

By decision dated January 3, 2019, after a preliminary review, OWCP's hearing representative vacated OWCP's August 29, 2018 decision denying appellant's schedule award claim, finding that the case was not in posture for decision. The hearing representative remanded the case for OWCP to administratively combine appellant's files pertaining to the accepted work-related injuries involving the right upper extremity. It then instructed OWCP to provide an updated statement of accepted facts (SOAF) and the medical record to a district medical adviser (DMA) for a report to identify the diagnosed conditions causally related to the work injury claims and explain whether appellant has any impairment of the right upper extremity pursuant to the A.M.A., *Guides*. Following any further development deemed necessary, OWCP was to issue a *de novo* decision.

OWCP administratively combined appellant's claims under OWCP File Nos. xxxxxx992, xxxxxx540, and xxxxxx245, with the latter serving as the master file.

On April 10, 2019, OWCP routed Dr. Khalifa's September 28, 2018 report, along with a SOAF, and the case record to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP DMA, for review and a determination of permanent impairment of appellant's upper extremity under the A.M.A., *Guides*, and her date of MMI. It requested that Dr. Harris review Dr. Khalifa's September 28, 2018 report and indicate whether he agreed with his findings.

In an April 16, 2019 report, the DMA, Dr. Harris, noted his review of the findings in Dr. Khalifa's September 28, 2018 report and noted that appellant did not have any neurologic deficit in the upper extremities consistent with cervical radiculopathy. He referred to the A.M.A., *Guides* and utilized the diagnosis-based impairment (DBI) rating method to find that under Table 1 of *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition*

(July/August 2009) (*The Guides Newsletter*), appellant had zero percent permanent impairment of the right upper extremity for cervical radiculopathy. He indicated that the ROM method was not applicable for this diagnosis.

Utilizing the DBI rating method under Table 15-5 on page 402 of the A.M.A., *Guides*, for the diagnosed rotator cuff tendinitis, he identified Class 1, grade E impairment, with a value of five percent. With regard to the right elbow, the DMA found that, under the DBI methodology, appellant had an elbow strain under Table 15-4, page 398. He identified a Class 1, grade E impairment, with a value of two percent impairment.[5] With regard to the right wrist, the DMA found that, under the DBI methodology, appellant had a wrist strain under Table 15-3, page 395. He noted a Class 1, grade E impairment, with a value of two percent impairment.[6] The DMA explained that there was insufficient information contained in the case file to calculate impairment rating utilizing the ROM method due to appellant's pain on examination. He further noted that Dr. Khalifa's report did not contain complete measurements for the right shoulder, elbow or wrist and there was no documentation of retained shoulder adduction, internal rotation, external rotation, elbow flexion, extension or right wrist.

Utilizing the A.M.A., *Guides* Combined Values Chart, the DMA found nine percent permanent impairment of the right upper extremity. He noted that Dr. Khalifa did not diagnose CRPS of the right upper extremity. The DMA noted that the subjective complaints and objective findings contained in the evaluation did not support a diagnosis of CRPS and therefore he did not believe appellant was entitled to any impairment rating for this diagnosis.

By decision dated August 20, 2019, OWCP granted appellant a schedule award for nine percent permanent impairment of the right upper extremity. The period of the award ran for 28.08 weeks from September 28, 2018 through April 12, 2019.

On September 18, 2019 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. The hearing was held on January 9, 2020.

By decision dated March 24, 2020, OWCP's hearing representative vacated OWCP's August 20, 2019 decision, finding that the case was not in posture for decision. The hearing representative indicated that appellant's claim was accepted for the diagnosis of CRPS and should be considered for any related impairment. She further noted that since ROM measurements were not provided to the DMA appellant should be referred for a second opinion evaluation to obtain valid ROM measurements in order to complete the ROM method of impairment. The hearing representative remanded the case for OWCP to refer appellant, along with an updated SOAF and the case record, for a second opinion evaluation regarding permanent impairment in conformance with the A.M.A., *Guides*. Following any further development deemed necessary, OWCP was to issue a *de novo* decision.

[5] *Id.*

[6] *Id.*

On August 31, 2020 OWCP referred appellant, together with a SOAF and the case file to, Dr. Charles W. Kennedy, a Board-certified orthopedist, for a second opinion evaluation of her permanent impairment for schedule award purposes.

In a November 19, 2020 report, Dr. Kennedy noted his review of the SOAF and medical record, including appellant's history of injury and medical treatment. He diagnosed sprain of the right shoulder and upper arm and repaired right rotator cuff tear and indicated that appellant sustained another work-related injury affecting her right upper extremity where she was diagnosed with CRPS. Dr. Kennedy noted severe allodynia from the middle arm down to the tip of the finger and the extremity was cooler than the opposite side. He was unable to check reflexes and he could not measure the right arm and forearm due to pain. On physical examination of the cervical spine, Dr. Kennedy noted negative Spurling's sign and negative Homan's sign. He opined that appellant had reached MMI four months post a February 11, 2011 right shoulder surgery. Dr. Kennedy referenced a February 11, 2011 report that provided ROM measurements for the right shoulder of flexion 180 degrees bilaterally, abduction 160 degrees bilaterally, external rotation was 90 degrees bilaterally, internal rotation was 45 degrees bilaterally, and adduction was 60 degrees bilaterally. He advised that there was no measurement for extension and he assumed it was normal. Dr. Kennedy used the DBI rating method found at Table 15-5, page 402, for the class of diagnosis (CDX) of partial tear of the rotator cuff, history of painful injury without consistent objective findings and residual loss. He identified Class 1, grade C impairment, with a default value of three percent. Dr. Kennedy assigned a grade modifier for functional history (GMFH) of 1 for mild problems. He found that a grade modifier for physical examination (GMPE) was not applicable due to "no problem" and a grade modifier for clinical studies (GMCS) could not be used. Dr. Kennedy concluded that appellant had two percent permanent impairment of the right upper extremity.

On December 23, 2020 OWCP requested that the DMA, Dr. Harris, review Dr. Kennedy's November 19, 2020 report and note whether he agreed with his findings.

In a December 29, 2020 report, the DMA, Dr. Harris, utilized the findings in Dr. Kennedy's November 19, 2020 report. He diagnosed status post right shoulder arthroscopic subacromial decompression and acromioplasty and CRPS. Dr. Harris disagreed with Dr. Kennedy's impairment rating because Dr. Kennedy based it on a review of a February 11, 2011 medical report that did not document whether appellant had reached MMI. He noted that the case file did not contain medical records establishing that appellant had reached MMI any time prior to Dr. Kennedy's November 19, 2020 report, and determined that the most accurate date of MMI was November 19, 2020. Using the DBI rating method, found at Table 15-26, page 454 of the A.M.A., *Guides*, for the diagnosis of CRPS, the DMA found a Class 1, grade C impairment, with a default value of seven percent. He noted that the A.M.A., *Guides* do not permit impairment ratings to be calculated based on ROM for this diagnosis. The DMA noted that OWCP had previously awarded appellant nine percent permanent impairment of the right upper extremity and opined that there was no increase in the schedule award.

By decision dated January 25, 2021, OWCP denied appellant's claim for an increased schedule award finding that appellant had not established greater than nine percent permanent impairment of the right upper extremity previously awarded.

On January 25, 2022 appellant through counsel, requested reconsideration.

In support of her request, appellant provided an October 14, 2020 report, wherein Dr. Khalifa noted findings on examination of tenderness at C2-C7 regions, tenderness of the right shoulder, elbow, and wrist globally, sensory testing revealed moderate-to-severe hypersensitivity on the right side, and the skin on the right upper extremity was mildly mottled and demonstrated lymphedema-like swelling, allodynia, and hypersensitivity. Dr. Khalifa noted ROM for the right shoulder for 52 degrees of flexion, 32 degrees of extension, 46 degrees of abduction, eight degrees of adduction, 52 degrees of internal rotation, and 28 degrees of external rotation. Right elbow ROM revealed 52 degrees of flexion, -85 degrees of extension and he noted that he was unable to measure pronation and supination. With regard to right wrist ROM, Dr. Khalifa noted 84 degrees of flexion, 40 degrees of extension, 16 degrees of radial deviation, and 38 degrees of ulnar deviation. He determined MMI was May 10, 2016, the date that appellant presented to her treating physician after an intra-articular steroid injection. Dr. Khalifa noted that the ROM measurements in the medical records that coincide with the date of MMI were from Dr. Helsten, dated December 12, 2014.

Utilizing the ROM method, under Table 15-34, page 475 of the A.M.A., *Guides*, Dr. Khalifa found 11 percent impairment of the right shoulder. He also found four percent impairment of the right elbow and two percent impairment of the right wrist. Dr. Khalifa noted CRPS findings including mottled skin, hand atrophy, cool temperature, joint stiffness, and decreased motion. He referenced Table 15-25 and Table 15-26, page 453 and 454 of the A.M.A., *Guides*, and calculated seven percent impairment for CRPS. Dr. Kalifa further calculated impairment for cervical radiculopathy, pursuant to Table 17-2, page 564, which resulted in a Class 1 impairment with a default value of two percent, which converted to four percent impairment. Using the A.M.A., *Guides*, Combined Values Chart, he calculated a total of 25 percent permanent impairment of the right upper extremity.

By decision dated February 3, 2022, OWCP denied modification of the January 25, 2021 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and its implementing 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. 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.[9] As of May 1, 2009, schedule awards are determined in

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

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

accordance with the sixth edition of the A.M.A., *Guides* (2009).[10] 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.[11]

In addressing upper extremity impairment, the sixth edition requires identification of the impairment CDX condition, which is then adjusted by grade modifiers or GMFH, GMPE, and GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[14]

The A.M.A., *Guides* also provide that the ROM impairment method 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.[15] 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.[16] 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.[17]

Regarding the application of ROM or DBI 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*

[10] *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).

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

[12] A.M.A., *Guides* 383-492.

[13] *Id.* at 411.

[14] *Id.* at 23-28.

[15] *Id.* at 461.

[16] *Id.* at 473.

[17] *Id.* at 474.

impairment rating for the diagnosis in question, the method producing the higher rating should be used."[18] (Emphasis in the original.)

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.[19]

ANALYSIS

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

Appellant subsequently submitted an October 14, 2020 report, wherein Dr. Khalifa noted findings on examination and provided ROM measurements for the right shoulder, elbow, and wrist. He provided an additional impairment rating for CRPS and the cervical spine based on the examination findings and an application of the sixth edition of the A.M.A., *Guides*, finding that appellant had 25 percent permanent impairment of the right upper extremity.

As Dr. Khalifa provided an impairment rating based on his October 14, 2020 examination using the sixth edition of the A.M.A., *Guides*, pursuant to its procedures, OWCP should have routed the case record, and the additional report of Dr. Khalifa, 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.[20] As this was not done, the case must be remanded for referral to a DMA.[21]

On remand, OWCP shall further develop the medical evidence of record by obtaining an opinion from a new DMA regarding the nature and extent of any increased permanent impairment. The DMA shall apply FECA Bulletin No. 17-06, as appropriate. Following this and other such further development as deemed necessary, it shall issue a *de novo* decision regarding appellant's increased schedule award claim.

CONCLUSION

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

[18] FECA Bulletin No. 17-06 (issued May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[19] *See supra* note 10 at Chapter 2.808.6(f) (March 2017). *See also P.W.*, Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan*, 57 ECAB 349 (2006).

[20] *L.S.*, Docket No. 19-0092 (issued June 12, 2019); *N.I.*, Docket No. 16-1027 (issued January 11, 2017); *Tommy R. Martin*, 56 ECAB 273 (2005); *supra* note 10 at Chapter 2.808.6(f) (March 2017). (If the claimant's physician provides an impairment report the case should be referred to the DMA for review).

[21] *L.S.*, *id.*; *R.H.*, Docket No. 17-1017 (issued December 4, 2018).

ORDER

IT IS HEREBY ORDERED THAT the February 3, 2022 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: April 11, 2025
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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