United States Department of Labor
Employees' Compensation Appeals Board

R.K., Appellant	)	
and	)	**Docket No. 25-0624**
	)	**Issued: July 24, 2025**
DEPARTMENT OF VETERANS AFFAIRS, PERRY POINT VA MEDICAL CENTER, Perry Point, MD, Employer	)	

Appearances:
Alan J. Shapiro, 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 June 16, 2025 appellant, through counsel, filed a timely appeal from a May 27, 2025 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.

ISSUE

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

[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.*

FACTUAL HISTORY

On October 4, 2022 appellant, then a 59-year-old motor vehicle operator, filed a traumatic injury claim (Form CA-1) alleging that on September 13, 2022, he injured his right shoulder when he grabbed a wheelchair lift handlebar with his right hand while in the performance of duty. By decision dated November 16, 2022, OWCP accepted the claim for complete rotator cuff tear or rupture of right shoulder. It paid appellant wage-loss compensation on the supplemental and periodic rolls effective November 8, 2022.

On November 8, 2022 appellant underwent OWCP-authorized right shoulder arthroscopic surgery, with extensive debridement of the glenohumeral joint, subacromial decompression, rotator cuff repair for full-thickness rotator cuff tear, arthroscopic biceps tenodesis, and manipulation under anesthesia. On July 17, 2023 appellant underwent OWCP-authorized right shoulder arthroscopy and extensive glenohumeral debridement, subacromial decompression, arthroscopic removal of foreign bodies, and recurrent rotator cuff repair.

In a January 27, 2024 note, Dr. Jeremie M. Axe, a Board-certified orthopedic surgeon, advised that appellant would reach maximum medical improvement (MMI) on March 21, 2024.

On April 29, 2024 appellant filed a claim for compensation (Form CA-7) for a schedule award.[3]

In a development letter dated May 2, 2024, OWCP informed appellant of the deficiencies of his claim. It requested that he submit a detailed narrative medical report from his treating physician based on a recent examination, setting forth an opinion on the date of MMI and a rating of permanent impairment in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

In a June 6, 2024 report, Dr. Axe noted appellant's history of right shoulder arthroscopic procedures and related that appellant had reached MMI. He related that physical examination of appellant's right shoulder revealed forward flexion to 150 degrees, proximally 20 degrees less than the contralateral side; abduction to approximately 100 degrees; external rotation to 20 degrees, with a slight limitation compared to the contralateral side. Dr. Axe also noted that appellant had mild weakness with supraspinatus testing; however, it was adequate, and he noted mild pain throughout motion and strength testing. He opined that appellant had 13 percent permanent impairment of the right shoulder, which he indicated was due to his rotator cuff and biceps tendon impairments. Dr. Axe again advised that appellant had reached MMI.

In a June 10, 2024 medical report, Dr. Robert W. Macht, a general surgeon, noted that he examined appellant on June 4, 2024. He recounted a history of appellant's medical treatment. Dr. Macht presented findings on physical examination of appellant's right and left shoulders, which included three separate range of motion (ROM) measurements. The right shoulder had 160/160/160 degrees of flexion, the left shoulder had 170/170/170 degrees of flexion. The right and left shoulders had 50/50/50 degrees of extension. The right shoulder had 150/150/150

[3] A notice of personnel action (Standard Form (SF) 50) indicated that appellant retired from the employing establishment effective March 23, 2024.

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

degrees of abduction, the left shoulder had 160/160/165 degrees of abduction. The right shoulder had 30/30/30 degrees of adduction, the left shoulder had 50/50/50 degrees of adduction. The right shoulder had external rotation of 50/50/50 degrees, the left shoulder 80/80/80 degrees of external rotation. Internal rotation of the right shoulder was 50/50/50 degrees, left shoulder 70/70/70 degrees. Dr. Macht found that ROM of elbows, forearms, wrists, and hand was intact bilaterally based on the sixth edition of the A.M.A., *Guides*. He reported that appellant had a *Quick*DASH score of 57, resulting in a grade modifier for functional history (GMFH) of 2. Dr. Macht referred to the sixth edition of the A.M.A., *Guides,* noted that appellant's active ROM was measured three times and compared to the contralateral side. He utilized the ROM rating methodology to find, that under Table 15-34, page 475, appellant's right shoulder loss of flexion resulted in 3 percent permanent impairment, loss of abduction resulted in 3 percent permanent impairment, loss of adduction resulted in 1 percent permanent impairment, loss of external rotation resulted in 2 percent permanent impairment, and loss of internal rotation resulted in 2 percent permanent impairment, for a total of 11 percent right upper extremity permanent impairment.[5] Dr. Macht noted that since appellant's functional history score was 1 higher than the Class of impairment, he multiplied the impairment by five percent, which yielded 11.55 percent impairment rounded up to 12 percent impairment. He found a grade modifier of 2 for ROM under Table 15-35, page 477. Dr. Macht referred to Table 15-8, page 408, and found a grade modifier for physical examination (GMPE) of 2 based on ROM.

Dr. Macht also utilized the diagnosis-based impairment (DBI) rating methodology. He found that under Table 15-5 (Shoulder Regional Grid), page 402, appellant had multiple Class 1 impairments, including full-thickness rotator cuff tear, labral tear, and impingement. Based on Table 15-9, page 410, Dr. Macht assigned a grade modifier for clinical studies (GMCS) of 1 for a rotator cuff tear and torn labrum. He determined that appellant had a grade E or seven percent permanent impairment of the right upper extremity due to the full-thickness rotator cuff tear, five percent permanent impairment of the right upper extremity due to the labral tear, and five percent permanent impairment of the left upper extremity due to the impingement. As the ROM methodology produced the higher impairment rating, Dr. Macht concluded that appellant had 12 percent permanent impairment of the right upper extremity. He further concluded that appellant had reached MMI on June 4, 2024, the date of his impairment evaluation.

In a June 14, 2024 report, Dr. Axe again diagnosed the accepted condition of right rotator cuff injury, full-thickness tear with functional loss. He recounted appellant's physical findings from his June 6, 2024 report. Dr. Axe noted that appellant was approximately one year post revision rotator cuff surgery for recurrent tear of the right rotator cuff. He referred to Table 15-5 (Shoulder Regional Grid), page 402, and opined that appellant had 13 percent permanent impairment of the right upper extremity. Dr. Axe concluded that this rating appropriately defined the rating for rotator cuff injury, full-thickness tear, with functional loss under Class 1, with a range of 1 to 13 percent ratable upper extremity impairment. He reiterated that appellant had reached MMI.

On June 28, 2024 OWCP routed the medical evidence of record, including Dr. Macht's June 10, 2024 report and a statement of accepted facts (SOAF), to Dr. David I. Krohn, a Board-certified internist serving as an OWCP district medical adviser (DMA), for review and a

[5] The Board notes that Dr. Macht did not provide a right shoulder ROM impairment rating for his finding of 50 degrees of extension.

determination of appellant's date of MMI and any permanent impairment of his right upper extremity under the sixth edition of the A.M.A., *Guides*.

In a report dated July 10, 2024, Dr. Krohn noted his review of the SOAF and appellant's medical record, including Dr. Macht's June 10, 2024 report. He noted that he had been specifically asked to address Dr. Macht's report. Utilizing the DBI methodology to rate impairment of appellant's right shoulder, Dr. Krohn referred to Table 15-5, page 403 of the A.M.A., *Guides*, and found that the class of diagnosis (CDX) for rotator cuff injury, full-thickness tear, residual; loss, functional with normal motion was a Class 1 impairment with a default value of grade C or five percent impairment. He noted that he was aware that appellant's ROM was not normal. Dr. Krohn advised that based on the A.M.A., *Guides*, a DBI impairment may be assigned even in the event of lack of normal ROM of the left shoulder. He indicated that subscript to Table 15-5, page 405, indicated: "If motion loss is present, this impairment may alternately be assessed using Section 15.7, Range of Motion impairment." Dr. Krohn related that it did not state that impairment must be rated according to the ROM methodology, which indicated that the DBI methodology of impairment may be used in the event of loss of ROM. Further, he related that a GMPE (used in the determination of impairment using the DBI methodology) clearly allows for the presence of diminished ROM. Dr. Krohn assigned a GMFH of 2 based on pain with normal activities and *Quick*DASH score of 57, under Table 15-7, page 406. He assigned a GMPE of 0 based on a mild decrease in ROM under Table 15-8, page 408. Dr. Krohn assigned a GMCS of 4 because studies confirmed symptomatic diagnoses of rotator cuff tear/biceps tendon pathology under Table 16, page 519. He applied the net adjustment formula which moved the default value two positions, resulting in seven percent permanent impairment of the right shoulder.

Dr. Krohn also utilized the ROM methodology to rate permanent impairment of the right shoulder. He found that under Table 15-34, page 475, 160 degrees of flexion resulted in 3 percent impairment, 50 degrees of extension resulted in 0 percent impairment, 150 degrees of abduction resulted in 3 percent impairment, 30 degrees of adduction resulted in 1 percent impairment, 50 degrees of internal rotation resulted in 2 percent impairment, and 50 degrees of external rotation resulted in 2 percent impairment, for a total of 11 percent right shoulder permanent impairment. Dr. Krohn noted that page 461 of the A.M.A., *Guides* provided: "If the opposite extremity is neither involved nor previously injured, it must be used to define normal for that individual; any losses should be made in comparison to the opposite normal extremity." He indicated that since there was no prior history of injury to the contralateral left shoulder according to Dr Macht's report, ROM of the right shoulder was determined by subtracting impairment of the left shoulder from that of the right shoulder. Thus, Dr. Krohn subtracted 5 percent left shoulder impairment rating from the 11 percent right shoulder impairment rating (due to flexion and internal rotation contralateral measurements) for a total of 6 percent right upper extremity permanent impairment. Referring to Table 15-35 and Table 15-36, page 477, the DMA assigned a GMFH of 2 and the ROM grade modifier (12 percent) of 1 percent. Dr. Krohn subtracted 2 percent impairment from 1 percent impairment, and multiplied by 6 percent which resulted in 1.6 percent and then multiplied 1.6 percent by 0.05, which resulted in 0.3 percent. He then added .03 percent to 6 percent which resulted in 6.3 percent, rounded down to 6 percent permanent impairment of the right upper extremity. Dr. Krohn advised that there was no increase in the right upper extremity impairment rating under the ROM rating methodology. He opined that as the DBI impairment rating of seven percent was greater than the ROM impairment rating of six percent, the final impairment rating was seven percent for the right upper extremity. Dr. Krohn determined that appellant had reached MMI on June 4, 2024,

the date of Dr. Macht's impairment evaluation. Regarding Dr. Macht's impairment evaluation, the DMA noted that since there was no prior history of injury to the left shoulder reported, ROM of the contralateral left shoulder by the A.M.A., *Guides* is considered "normal" in comparison to ROM of the right shoulder. ROM of the right shoulder was therefore determined by subtracting the "impairment" of the uninjured left shoulder from that of the right shoulder. Dr. Krohn concluded that the ROM impairment rating for the right upper extremity was 6 percent rather than 12 percent assigned by Dr. Macht.

By decision dated September 27, 2024, OWCP granted appellant a schedule award for seven percent permanent impairment of the right upper extremity, based on the opinion of the DMA, Dr. Krohn. The award ran for 22 weeks for the period June 4 through November 3, 2024.

On October 2, 2024 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. In support thereof, counsel submitted a September 11, 2024 report, wherein Dr. Macht, noted his review of the July 10, 2024 report of the DMA, Dr. Krohn. Dr. Macht contended that the DMA incorrectly subtracted the impairment of 160 degrees of flexion of the right shoulder from the impairment of 170 degrees of flexion of the uninjured left shoulder to arrive at zero percent right upper extremity permanent impairment. He related that by that methodology, appellant could have flexion of 90 degrees on the right, which would be 80 degrees less than his left, and have zero percent impairment, and he opined that an individual who flexes 170 degrees on his normal side and 90 degrees on his injured side does not have zero percent impairment. Dr. Macht related that the DMA's methodology of subtracting the two impairments does not make the opposite side of the defined normal, but makes all ROM loss in GM of 1 become meaningless, and the impairments of GM of 2 and GM of 3 become less valuable. He further contended that the DMA's rating methodology did not follow the A.M.A., *Guides* on how to define "normal" based on examination of the uninjured limb.

Following a preliminary review, by decision dated December 4, 2024, an OWCP hearing representative set aside the September 27, 2024 decision, and remanded the case for further medical development. The hearing representative noted that OWCP's DMA, Dr. Krohn, did not review Dr. Axe's June 6 and 14, 2024 reports, which discussed appellant's right upper extremity permanent impairment. He related that the DMA should discuss the additional reports and address whether there was sufficient discussion of the findings to establish a greater right upper extremity impairment using the DBI or ROM methodologies, and to explain any discrepancies with the examining physician's confusions and impairment calculations. The hearing representative also asked the DMA to address Dr. Macht's discussion of the labral tear, for which he rated at five percent permanent impairment using the DBI methodology. The hearing representative remanded the case for OWCP to refer a SOAF and the medical record, including Dr. Axe's June 2024 and Dr. Macht's September 2024 reports, to Dr. Krohn for an opinion on appellant's right upper extremity permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.

On January 30, 2025 OWCP requested that the DMA, Dr. Krohn, provide an addendum report addressing the concerns expressed by OWCP's hearing representative in the December 4, 2024 decision.

In a February 11, 2025 report, Dr. Krohn explained the discrepancies between his and Dr. Macht's ROM impairment rating calculations. He related that as there was no prior history

of injury to the contralateral left shoulder by Dr Macht's report, ROM impairment of the right shoulder was determined by subtracting the 11 percent impairment of the left shoulder from the 5 percent impairment of the right shoulder, resulting in 6 percent ROM permanent impairment of the right upper extremity. Dr. Krohn further explained that if flexion for the shoulder was 170 degrees, the impairment rating by Table 15-34 was 3 percent. If flexion of the shoulder was 90 degrees the impairment rating would be the same three percent. Dr. Krohn added that in Table 15-34, the same percentage impairment using the ROM methodology was assigned for widely divergent degrees of motion shoulder, but that is what the authors of the A.M.A., *Guides* intended. He advised that there was no change in his prior assignment of impairment of the injured right shoulder using the ROM methodology. Dr. Krohn, therefore, concluded that as the seven percent DBI impairment rating was greater than the six percent ROM impairment rating, appellant had seven percent permanent impairment of the right upper extremity. He also added that Dr. Axe had noted in his March 2024 report that appellant had reached MMI on March 21, 2024.

By decision dated March 14, 2025, OWCP granted appellant a schedule award for seven percent permanent impairment of the right upper extremity. The award ran for 22 weeks from June 4 through November 3, 2024.

On March 18, 2025 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. The request was later converted to a request for a review of the written record.

By decision dated May 27, 2025, OWCP's hearing representative affirmed the March 14, 2025 decision.

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]

In addressing upper extremity impairment, the sixth edition requires identification of the CDX, which is then adjusted by a GMFH, GMPE, and/or GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] 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.[13]

The A.M.A., *Guides* also provide that the 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 diagnosis-based sections are applicable.[14] 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.[15] 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.[16]

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[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); *see also*, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, 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* 383-492.

[12] *Id.* at 411.

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

[14] *Id.* at 461.

[15] *Id.* at 473.

[16] *Id.* at 474.

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 impairment rating for the diagnosis in question, the method producing the higher rating should be used.*"[17] (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.[18]

ANALYSIS

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

In his February 11, 2025 report, Dr. Krohn explained the discrepancies between his and Dr. Macht's ROM impairment rating calculations. He related that as there was no prior history of injury to the contralateral left shoulder by Dr. Macht's report, ROM impairment of the right shoulder was determined by subtracting the 11 percent impairment of the left shoulder from the 5 percent impairment of the right shoulder, resulting in 6 percent ROM permanent impairment of the right upper extremity. Dr. Krohn further explained that if flexion for the shoulder was 170 degrees, the impairment rating by Table 15-34 was 3 percent. If flexion of the shoulder was 90 degrees the impairment rating would be the same three percent. Dr. Krohn added that in Table 15-34, the same percentage impairment using the ROM methodology was assigned for widely divergent degrees of motion shoulder, but that is what the authors of the A.M.A., *Guides* intended. He advised that there was no change in his prior assignment of impairment of the injured right shoulder using the ROM methodology. Dr. Krohn, therefore, concluded that as the seven percent DBI impairment rating was greater than the six percent ROM impairment rating, appellant had seven percent permanent impairment of the right upper extremity. He also added that Dr. Axe had noted in his March 2024 report that appellant had reached MMI on March 21, 2024. Dr. Krohn, however, did not address Dr. Macht's labral tear rating, or his right shoulder impingement rating, nor did he address Dr. Axe's June 6 and 14, 2024 reports.

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

[18] *See supra* note 9 at Chapter 2.808.6f (March 2017). *See also P.W.,* Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan,* 57 ECAB 349 (2006).

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden of proof to establish entitlement to compensation. However, OWCP shares responsibility in the development of the evidence to see that justice is done.[19] 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.[20]

On remand, OWCP shall request a supplemental opinion from the DMA, Dr. Krohn, which includes a complete review of appellant's treating physicians' reports. Following this and other such 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.

ORDER

IT IS HEREBY ORDERED THAT the May 27, 2025 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: July 24, 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

[19] *See C.L.,* Docket No. 25-0217 (issued February 13, 2025); *D.C.*, Docket Nos. 22-0020 and 22-0279 (issued April 25, 2023); *L.B.*, Docket No. 19-0432 (issued July 23, 2019); *William J. Cantrell,* 34 ECAB 1223 (1983).

[20] *Id.*; *see also S.A.*, Docket No. 18-1024 (issued March 12, 2020).