# United States Department of Labor
# Employees' Compensation Appeals Board

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| **V.D., Appellant** | ) | |
| **and** | ) | **Docket No. 25-0779** |
| | ) | **Issued: September 23, 2025** |
| **U.S. POSTAL SERVICE, CHICAGO SOUTH WEST CARRIER ANNEX, Chicago, IL, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

### ***JURISDICTION***

On August 13, 2025 appellant filed a timely appeal from a May 29, 2025 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]

### ***ISSUE***

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

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the May 29, 2025 decision, OWCP received additional evidence. 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*.

## ***FACTUAL HISTORY***

On May 1, 2012 appellant, then a 39-year-old carrier technician, filed a traumatic injury claim (Form CA-1) alleging that on April 30, 2012 she injured her right arm, shoulder, and elbow, right knee, and back when she slipped and fell on grass and mud while in the performance of duty.[3] OWCP accepted the claim for right shoulder strain, adhesive capsulitis of the right shoulder, and aggravation of disc protrusions at C4-5 and C5-6. Appellant stopped work on April 30, 2012. OWCP paid appellant wage-loss compensation on the supplemental rolls commencing June 16, 2012 and on the periodic rolls commencing August 26, 2012.

On April 21, 2016 appellant underwent an unauthorized right shoulder arthroscopy, open Neer acromioplasty, and removal of a large lipoma.

In a May 14, 2024 permanent impairment evaluation report, Dr. Neil Allen, a Board-certified internist and neurologist, opined that she had reached maximum medical improvement (MMI) and diagnosed sprain of the right shoulder and upper arm, adhesive capsulitis, right shoulder, cervical disc displacement, osteophyte, left ankle, cartilage disorders left foot, and sprain of the deltoid ligament left ankle. He related residual symptoms of neck pain, with burning numbness, and tingling extending from her neck down her spine, right shoulder pain, and left ankle and foot pain. On physical examination Dr. Allen documented normal sensation and muscle strength in the cervical dermatomes. With regard to the right shoulder, he related findings of diffuse tenderness, no instability, mild crepitus, and normal muscle strength. Dr. Allen provided range of motion (ROM) examination of appellant's right shoulder, listing three ROM efforts of 134, 125, and 115 degrees of flexion, 40 degrees of extension, 71, and 76 degrees of abduction, 57 degrees of adduction, 47, 41, and 38 degrees of internal rotation, and 71, and 74 degrees of external rotation with the left unaffected shoulder demonstrating 157 degrees of flexion, 57 degrees of extension, 116 degrees of abduction, 78 degrees of adduction, 62 degrees of internal rotation, and 86 degrees of external rotation. He applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[4] ROM methodology, Table 15-34, page 475, to his examination findings. Dr. Allen determined that appellant had 3 percent right upper extremity permanent impairment due to 130 degrees of flexion, 1 percent permanent impairment due to 40 degrees of extension, 6 percent permanent impairment due to 80 degrees of abduction, and 2 percent permanent impairment due to 50 degrees of internal rotation, totaling 12 percent permanent impairment of the right upper extremity due to right shoulder ROM deficits. Alternatively, using the diagnosis-based impairment (DBI) rating methodology, Dr. Allen opined with respect to the right shoulder, under Table 15-5 that appellant had two percent permanent impairment of the right upper extremity.

[3] OWCP assigned the present claim OWCP File No. xxxxxx149. Appellant has a prior traumatic injury claim, which OWCP accepted for a January 6, 2024 left ankle sprain/strain under OWCP File No. xxxxxx691. OWCP granted appellant a schedule award on April 6, 2010 for seven percent permanent impairment of the left lower extremity under that claim. It subsequently expanded the acceptance of that claim to include the additional conditions of left ankle osteophyte and left foot articular cartilage disorders. On March 8, 2023 OWCP granted appellant a schedule award for two percent permanent impairment of the right lower extremity and an additional two percent permanent impairment of the left lower extremity. It has administratively combined OWCP File Nos. xxxxxx691 and xxxxxx149, with the latter serving as the master file.

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

Dr. Allen utilized *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), which is a supplemental publication of the sixth edition of the A.M.A., *Guides*. He applied the standards of Proposed Table 2 of *The Guides Newsletter* and found no sensory and motor deficits associated with the C5-T1 nerve distributions bilaterally and therefore no permanent impairment rating of the right upper extremity.

On September 3, 2024 appellant filed a claim for compensation (Form CA-7) for a schedule award. She specified that she was requesting a schedule award for her "shoulder/ spine."

On December 19, 2024 OWCP expanded the acceptance of appellant's claims to include the additional conditions of bilateral knee primary osteoarthritis.

In a development letter dated January 2, 2025, OWCP informed appellant of the deficiencies of her schedule award claim. It requested that she submit a detailed narrative medical report from her 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 A.M.A., *Guides*.

On March 26, 2025 OWCP referred the case record, including Dr. Allen's May 14, 2024 report, and a statement of accepted facts (SOAF), to Dr. Nathan Hammel, a Board-certified orthopedic surgeon, serving as a district medical adviser (DMA), for review and an opinion regarding appellant's permanent impairment.

In an April 15, 2025 report, Dr. Hammel opined that appellant reached MMI on May 14, 2024 and limited his review to the right upper extremity. Utilizing the DBI methodology he calculated two percent permanent impairment due to right shoulder strain under Table 15-5, page 401. Utilizing the ROM methodology he calculated four percent right upper extremity impairment for loss of ROM, under Table 15-34, when normalized against the unaffected shoulder. He concluded that the four percent ROM-based permanent impairment rating should be selected.

By decision dated May 29, 2025, OWCP granted appellant a schedule award for two percent permanent impairment of the right upper extremity, based on the medical findings and report of Dr. Allen and the opinion of the DMA, Dr. Hammel. The award ran for 6.24 weeks for the period May 12 through June 24, 2025.

## ***LEGAL PRECEDENT***

The schedule award provisions of FECA[5] and its implementing regulations[6] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss of a member shall be determined. For

[5] *Supra* note 1.

[6] 20 C.F.R. § 10.404.

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

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology versus the ROM methodology for rating of upper extremity impairments.[9] FECA Bulletin No. 17-06 provides:

> "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*."[10] (Emphasis in the original.)

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. With respect to the fingers and hand, the relevant portions of the arm for the present case, reference is made to Table 15-2 (Digital Regional Grid) beginning on page 391. After the class of diagnosis (CDX) is determined from the appropriate regional grid (including identification of a default grade value), the net adjustment formula is applied using a grade modifier for functional history (GMFH), a grade modifier for physical examination (GMPE), and/or a grade modifier for clinical studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] 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.[12]

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.[13] 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

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

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

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

[10] *Id.*

[11] *See* A.M.A., *Guides* (6th ed. 2009) at 405-12. Table 15-2 also provides that, if motion loss is present for a claimant with certain diagnosed digit conditions, permanent impairment may alternatively be assessed using Section 15.7 (ROM impairment). Such a ROM rating stands alone and is not combined with a DBI rating. *Id*. at 394, 468-469.

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

[13] *Id*. at 461.

are measured and added.[14] 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.[15]

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)."[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] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[18] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*.

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's 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 appellant has established four percent permanent impairment of the right upper extremity.

In his April 15, 2025 report, Dr. Hammel calculated, utilizing the DBI methodology, two percent permanent impairment due to right shoulder strain under Table 15-5, page 401, and four percent right upper extremity impairment for loss of ROM, under Table 15-34, when normalized against the unaffected shoulder. FECA Bulletin No. 17-06 provides in pertinent part: "*If the [A.M.A., Guides] allow for the use of both the DBI and ROM methods to calculate an*

[14] *Id*. at 473.

[15] *Id*. at 474.

[16] *Id*. at 544.

[17] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see A.G.*, Docket No. 18-0815 (issued January 24, 2019); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[18] *Supra* note 8 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5c(3) (March 2017).

[19] *See supra* note 8 at Chapter 2.808.6f (March 2017); *see also J.T.*, Docket No. 17-1465 (issued September 25, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

*impairment rating for the diagnosis in question, the method producing the higher rating should be used*."[20] (Emphasis in the original.) As Dr. Hammel's four percent rating was the higher rating of the methodologies applied, the Board finds that appellant has established four percent permanent impairment of the right upper extremity.

On return of the case record, OWCP shall grant appellant a schedule award for an additional two percent permanent impairment of the right upper extremity, for a total four percent.[21]

## ***CONCLUSION***

The Board finds that appellant has established four percent permanent impairment of the right upper extremity.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the May 29, 2025 decision of the Office of Workers' Compensation Programs is affirmed as modified.

Issued: September 23, 2025
Washington, DC

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

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

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

[20] *Supra* note 9.

[21] The Board notes that appellant claimed additional permanent impairment of her left lower extremity. As OWCP has not issued a final decision regarding this claim, it is not currently before the Board. *See* 20 C.F.R. §§ 501.2(c) and 501.3.