

tendinosis of the supraspinatus tendon and biceps tendon due to factors of her federal employment, including lifting heavy parcels and the repetitive motions of casing and delivering mail. She noted that she first became aware of her condition on January 2, 2023, and realized its relation to her federal employment on October 24, 2023. OWCP accepted the claim for impingement syndrome of left shoulder; incomplete rotator cuff tear or rupture of left shoulder, not specified as traumatic; and bicipital tendinitis, left shoulder.²

On December 20, 2023 appellant underwent OWCP-authorized left shoulder arthroscopic surgery with rotator cuff repair; extensive debridement which included debridement of intraarticular biceps, partial articular-sided tearing of supraspinatus as well as bursal-sided partial tearing of supraspinatus, perihumeral debridement and debridement of residual intraarticular biceps; left open subpectoral biceps tenodesis; acromioplasty; and application of rotator cuff collagen patch.

In an April 22, 2025 medical report, Dr. Jack L. Rook, a Board-certified physiatrist, related appellant's history of injury and medical treatment, noted his review of the medical record, and discussed the findings of his physical examination. He obtained three sets of range of motion (ROM) for appellant's right and left shoulders. Appellant's right shoulder reflected measurements in degrees of 180 degrees, 180 degrees, and 180 degrees for flexion; 57 degrees, 55 degrees, and 55 degrees for extension; 180 degrees, 180 degrees, and 180 degrees for abduction; 75 degrees, 75 degrees, and 75 degrees for adduction; 90 degrees, 90 degrees, and 90 degrees for external rotation; and 40 degrees, 40 degrees, and 40 degrees for internal rotation. Her left shoulder reflected 148 degrees, 148 degrees, and 145 degrees for flexion; 48 degrees, 48 degrees, and 48 degrees for extension; 155 degrees, 150 degrees, and 150 degrees for abduction; 60 degrees, 60 degrees, and 60 degrees for adduction; 80 degrees, 75 degrees, and 75 degrees for external rotation; and 40 degrees, 40 degrees, and 40 degrees for internal rotation. Dr. Rook determined that appellant had reached maximum medical improvement (MMI) as of April 22, 2025, the date of his impairment evaluation. Regarding permanent impairment of the left shoulder, he utilized the diagnosis-based impairment (DBI) methodology of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),³ Table 15-5 (Shoulder Regional Grid), page 403. For the class of diagnosis (CDX) of full-thickness rotator cuff tear, Dr. Rook assigned a grade modifier for functional history (GMFH) of 1 under Table 15-7, page 406 and a grade modifier for physical examination (GMPE) of 1 under Table 15-8. He indicated that a grade modifier for clinical studies (GMCS) was not applicable since it was required to place appellant in the regional grid. Utilizing the net adjustment formula, Dr. Rook calculated that appellant had a net adjustment of 0, which yielded a grade C or five percent permanent impairment of the left upper extremity. He also utilized the ROM rating methodology for the left shoulder and referenced Table 15-34, page 475, to find 10

² OWCP assigned the present claim OWCP File No. xxxxxx925. Appellant has prior claims before OWCP. Under OWCP File No. xxxxxx029, OWCP accepted appellant's June 11, 2003 occupational disease claim for bilateral carpal tunnel syndrome (CTS). Under OWCP File No. xxxxxx056, it accepted appellant's March 23, 2006 occupational disease claim for bilateral CTS. By decision dated April 10, 2007, OWCP granted appellant a schedule award for six percent permanent impairment of the left upper extremity. Under OWCP File No. xxxxxx041, it accepted appellant's traumatic injury claim (Form CA-1) for a March 2, 2011 bilateral wrist sprain and closed dislocation of right index finger.

³ A.M.A., *Guides* (6th ed. 2009).

percent permanent impairment of the left upper extremity. Dr. Rook determined that appellant had four percent ROM permanent impairment of the right shoulder. He subtracted the right shoulder four percent ROM impairment rating from the 10 percent left shoulder ROM impairment rating, resulting in six percent ROM permanent impairment of the left upper extremity. Dr. Rook found that the ROM methodology produced the higher impairment rating and, thus, concluded that appellant had six percent permanent impairment of the left upper extremity.

On June 17, 2025 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On June 30, 2025 OWCP referred the case record, including Dr. Rook's report, along with 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 permanent impairment.

In a July 8, 2025 report, Dr. Hammel concurred with Dr. Rook's opinion that appellant had reached MMI on April 22, 2025, and that she had six percent permanent impairment of the left upper extremity using the ROM methodology under Table 15-34, page 475, when correcting for the contralateral side. He also used the DBI methodology in calculating appellant's permanent impairment under the sixth edition of the A.M.A., *Guides*, and found, under Table 15-5, page 403, that the CDX for rotator cuff tear resulted in a Class 1, grade C impairment. Dr. Hammel assigned a GMFH of 1 due to continued pain and a GMPE of 1 due to motion loss, but found that a GMCS was not applicable as it was used to set the class. He applied the net adjustment formula, which he found resulted in no adjustment to the grade C default rating of five percent permanent impairment of the left upper extremity. Dr. Hammel found that the ROM methodology produced the higher impairment rating and, thus, concluded that appellant had six percent ROM permanent impairment of the left upper extremity.

On July 29, 2025 OWCP administratively combined OWCP File Nos. xxxxxx041, xxxxxx029, xxxxxx056, and xxxxxx925, with the latter serving as the master file.

On August 5, 2025 OWCP requested that the DMA, Dr. Hammel, provide an addendum report reviewing appellant's previous schedule award for six percent permanent impairment of the left upper extremity, which was granted on April 10, 2007, under OWCP File No. xxxxxx056. It further requested that he determine whether she was entitled to an additional schedule award.

In an August 16, 2025 report, Dr. Hammel reiterated his prior impairment calculations and opinions that appellant had six percent ROM permanent impairment of the left upper extremity when normalizing for the uninjured side and that MMI was reached on April 22, 2025. He noted that appellant was previously awarded six percent permanent impairment of the left upper extremity under OWCP File No. xxxxxx056, and opined that the current award "would replace the prior award and since it is identical imports no additional impairment."

By decision dated August 22, 2025, OWCP denied appellant's claim for an increased schedule award, as she was previously awarded six percent permanent impairment of the left upper extremity under OWCP File No. xxxxxx056.

On September 11, 2025 appellant requested reconsideration.

Appellant submitted a September 8, 2025 outpatient progress note, wherein Dr. Rook maintained that appellant's left upper extremity impairment rating should be calculated combining both 6 percent impairment ratings, resulting in 12 percent permanent impairment of the left upper extremity. Thus, Dr. Rook concluded that she was entitled to an additional schedule award for six percent permanent impairment of the left upper extremity.

By decision dated December 10, 2025, OWCP denied modification of its August 22, 2025 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA⁴ and its implementing regulations⁵ 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.⁶ As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).⁷ 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.⁸

The sixth edition requires identifying the impairment class for CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and/or GMCS.⁹ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).¹⁰

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404.

⁶ *Id.*; see also *Ronald R. Kraynak*, 53 ECAB 130 (2001).

⁷ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.* at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

⁸ *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

⁹ A.M.A., *Guides* 494-531.

¹⁰ *Id.* at 521.

The A.M.A., *Guides* also provides 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.¹¹ 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.¹² 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.¹³

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 an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*”¹⁴ (Emphasis in the original.)

The Bulletin further advises:

“If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow 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.”¹⁵

It is well established that benefits payable under 5 U.S.C. § 8107(c) are reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or

¹¹ *Id.* at 461.

¹² *Id.* at 473.

¹³ *Id.* at 474.

¹⁴ FECA Bulletin No. 17-06 (issued May 8, 2017).

¹⁵ *Id.*

function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.¹⁶

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.¹⁷

ANALYSIS

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

In an August 16, 2025 supplemental report, Dr. Hammel, the DMA, reiterated his prior opinion that appellant had six percent ROM permanent impairment of the left upper extremity. He noted that she was previously awarded six percent permanent impairment of the left upper extremity on April 10, 2007, and opined that the current award "would replace the prior award and since it is identical imports no additional impairment." However, Dr. Hammel did not sufficiently explain why appellant was not entitled to an increased schedule award for her left upper extremity. The Board has held that simply comparing the prior percentage of permanent impairment awarded to the current impairment for the same member is not always sufficient to deny an increased schedule award claim.¹⁸ The issue is not whether the current permanent impairment rating is greater than the prior impairment ratings, but whether it duplicates in whole or in part the prior impairment rating.¹⁹ Dr. Hammel did not sufficiently explain whether her current left upper extremity impairment rating duplicated the prior left upper extremity permanent impairment schedule award.²⁰

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.²¹ While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that

¹⁶ *E.C.*, Docket No. 24-0686 (issued December 19, 2024); *R.P.*, Docket No. 25-0025 (issued December 4, 2024); *T.S.*, Docket No. 16-1406 (issued August 9, 2017); *T.S.*, Docket No. 09-1308 (issued December 22, 2009).

¹⁷ *See D.J.*, Docket No. 19-0352 (issued July 24, 2020).

¹⁸ *See D.P.*, Docket No. 19-1514 (issued October 21, 2020); *S.M.*, Docket No. 17-1826 (issued February 26, 2018).

¹⁹ *Id.*

²⁰ *M.F.*, Docket No. 20-1434 (issued April 26, 2021).

²¹ *N.L.*, Docket No. 19-1592 (issued March 12, 2020); *M.T.*, Docket No. 19-0373 (issued August 22, 2019); *B.A.*, Docket No. 17-1360 (issued January 10, 2018).

justice is done.²² As OWCP undertook development of the evidence, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.²³

The case shall, therefore, be remanded for the DMA, Dr. Hammel to sufficiently explain whether appellant's current left upper extremity impairment rating duplicated the prior left upper extremity permanent impairment schedule award. Following this and other such further development as deemed necessary, OWCP 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 December 10, 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: April 17, 2026
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

²² *S.S.*, Docket No. 18-0397 (issued January 15, 2019); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

²³ *G.M.*, Docket No. 19-1931 (issued May 28, 2020); *W.W.*, Docket No. 18-0093 (issued October 9, 2018).