

ISSUE

The issue is whether appellant has greater than 12 percent permanent impairment of his left upper extremity for which he previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board on a different issue.³ The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On August 15, 2019 appellant, then a 50-year-old lieutenant, filed a traumatic injury claim (Form CA-1) alleging that on that date he injured his left shoulder when pulling a compound side door while in the performance of duty.⁴ He did not stop work. OWCP accepted the claim for strain of the muscle and tendons of the left rotator cuff. On January 27, 2020 it expanded acceptance of the claim to include sprain of the ligaments of the cervical spine. On July 20, 2021 OWCP expanded the acceptance of appellant's claim to include cervical disc degeneration at C5-6 with cervical disc disorder at C5-6 with radiculopathy.

On August 7, 2023 Dr. Justin Bundy, an orthopedic surgeon, performed an OWCP-authorized anterior cervical discectomy with interbody device, interbody fusion and anterior instrumentation C5-6. OWCP paid appellant wage-loss compensation on the supplemental rolls from September 24 through October 22, 2023.

In a May 20, 2024 report, Gregory C. Pancake, a physical therapist, found that appellant had reached maximum medical improvement (MMI) and provided a whole person impairment

³ Docket No. 22-0348 (issued April 28, 2023).

⁴ OWCP assigned the present claim OWCP File No. xxxxxx474. Appellant previously filed a March 30, 2023 Form CA-1 alleging right thumb cut and right shoulder tenderness under OWCP File No. xxxxxx224. OWCP accepted that claim for sprain of the right shoulder and upper arm and open wound of the thumb. By decision dated April 10, 2013, it granted appellant a schedule award for 10 percent permanent impairment of the right arm. The period of the award ran for 31.2 weeks from December 11, 2012 through July 17, 2013. Under OWCP File No. xxxxxx033 appellant filed a Form CA-1 for a February 3, 2014 left shoulder injury. OWCP accepted that claim for left rotator cuff sprain. By decision dated December 24, 2014, it granted appellant a schedule award for 12 percent permanent impairment of the left arm. The period of the award ran for 37.44 weeks from October 14, 2014 through July 3, 2015. On September 30, 2017 appellant filed a Form CA-1 due to a knee injury. OWCP assigned that claim OWCP File No. xxxxxx381 and accepted it for left knee sprain and tear of the left medial meniscus. By decision dated June 14, 2019, it granted appellant a schedule award for two percent permanent impairment of the left leg. The period of the award ran for 5.76 weeks from August 17, 2018 through September 26, 2018. Appellant filed a February 27, 2018 Form CA-1 alleging that he injured his left shoulder. OWCP assigned OWCP File No. xxxxxx531 and accepted this claim for left rotator cuff tear and strain, left shoulder impingement syndrome, and bicipital tendinitis. By decision dated October 15, 2019, OWCP determined that appellant had no greater than 12 percent permanent impairment of the left upper extremity for which he previously received schedule award compensation. OWCP has administratively combined OWCP File Nos. xxxxxx224; xxxxxx033; xxxxxx381; xxxxxx531 and xxxxxx474 with the latter serving as the master file.

rating in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).⁵

On May 29, 2024 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On October 31, 2024 OWCP referred appellant, along with a June 16, 2023 statement of accepted facts (SOAF), the medical record, and a series of questions to Dr. Seth L. Jaffe, an osteopath specializing in orthopedic surgery, for a second opinion examination and permanent impairment evaluation in accordance with the sixth edition of the A.M.A., *Guides*.⁶

In a November 12, 2024 report, Dr. Jaffe noted appellant's history of injury and medical treatment, and his review of the SOAF. He performed a physical examination of appellant's upper extremities and cervical spine. Regarding permanent impairment of the left upper extremity, Dr. Jaffe utilized the diagnosis-based impairment (DBI) methodology of the sixth edition of the A.M.A., *Guides*, 4 Table 15-5 (Shoulder Regional Grid), pages 403-04, and found six percent permanent impairment due to a diagnosis of left shoulder full-thickness rotator cuff tear and four percent permanent impairment due to biceps tendon dislocation/subluxation. He also applied the range of motion (ROM) methodology, Table 15-34, page 475, and found, based on a single measurement, three percent permanent impairment due to 165 degrees of flexion, three percent permanent impairment for 125 degrees of abduction, and two percent impairment for 80 degrees of external rotation or eight percent permanent impairment due to the ROM methodology.

In a December 16, 2024 addendum, Dr. Jaffe applied *The Guides Newsletter, Rating Spinal Nerve Impairment Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*) and found no applicable impairment of the upper extremities related to the accepted cervical spine injury as sensation and motor strength were normal throughout both upper extremities.

OWCP referred the case record to Dr. Michael M. Katz, a Board-certified orthopedic surgeon, serving as an OWCP district medical adviser (DMA), for review. In March 3 and 24, 2025 reports, Dr. Katz reviewed the medical evidence including Dr. Jaffe's impairment findings. He concurred with Dr. Jaffe's opinion that appellant had 10 percent permanent impairment of the left upper extremity. Dr. Katz utilized Table 15-34 on page 475 of the sixth edition of the A.M.A., *Guides* and determined that appellant had eight percent impairment due to ROM deficits relying on Dr. Jaffe's single ROM measurements. Alternatively, using the DBI rating methodology, he found, under Table 15-5, page 403, that appellant had 10 percent impairment of the left upper extremity due to left shoulder acromioclavicular (AC) joint injury or disease status post distal clavicle resection. Dr. Katz assigned a grade modifier for functional history (GMFH) of 1 and a grade modifier for physical examination (GMPE) of 1 and determined that the grade modifier for clinical studies (GMCS) was not applicable. He noted that the average value for the three grade modifier values was 1 and, therefore, found that the DBI methodology was more

⁵ A.M.A., *Guides* (5th ed. 2001).

⁶ A.M.A., *Guides* (6th ed. 2009).

appropriate as it provided the greater percentage of impairment. Dr. Katz disagreed with Dr. Jaffe's application of DBI impairment methodology. He applied the A.M.A., *Guides*, page 387, which states, "If a patient has two significant diagnoses ... the examiner should use the diagnosis with the highest causally-related impairment for the impairment calculation." Therefore, Dr. Katz determined that appellant was not entitled an impairment rating calculated by combined diagnoses of left shoulder full-thickness rotator cuff tear, and biceps tendon dislocation/subluxation. He found that, in accordance with *The Guides Newsletter*, there were no motor or sensory deficits in either upper extremity. Therefore, Dr. Katz concluded that there was no ratable impairment.

By decision dated April 23, 2025, OWCP denied appellant's claim for a schedule award for increased permanent impairment of the left upper extremity.

On October 3, 2025 appellant requested reconsideration. In a June 27, 2025 report, Dr. Richard Alexander, an orthopedic surgeon, diagnosed chronic pain of both shoulders, and provided single ROM figures for the shoulders. In the right shoulder, he found 160 degrees of flexion, 40 degrees of extension, 150 degrees of abduction, 40 degrees of adduction, 65 degrees of internal rotation, 60 degrees of external rotation. On the left, Dr. Alexander measured 145 degrees of flexion, 50 degrees of extension, 130 degrees of abduction, 40 degrees of adduction, 50 degrees of internal rotation, and 45 degrees of external rotation. He determined that appellant had 12.5 percent permanent impairment of the right shoulder, and 21 percent permanent impairment of the left shoulder in accordance with the ROM methodology.

On November 17, 2025 OWCP referred the case record, including Dr. Alexander's June 27, 2025 report, to Dr. Katz, serving as a DMA, for review. In his November 25, 2025 report, Dr. Katz determined that, using the single ROM measurements submitted by Dr. Alexander, appellant had 8 percent permanent impairment of the right shoulder and 10 percent permanent impairment of the left shoulder in accordance with the sixth edition of the A.M.A., *Guides*, page 475. He further noted that the A.M.A., *Guides* page 464 requires three separate ROM efforts, and that the maximum observed measurement is used to determine ROM impairment. Dr. Katz found that Dr. Alexander did not provide the necessary three measurements and that he failed to properly correlate his findings with the A.M.A., *Guides*.

By decision dated December 8, 2025, OWCP denied modification.

LEGAL PRECEDENT

The schedule award provisions of FECA,⁷ and its implementing federal 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. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The methodology used in making such a determination is a matter, which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has

⁷ 5 U.S.C. § 8107.

⁸ 20 C.F.R. § 10.404.

authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 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 requires identifying the impairment class for the class of diagnosis (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE, and/or GMCS.¹¹ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).¹²

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.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 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 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*

⁹ For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2, Exhibit 1 (January 2010).

¹⁰ *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

¹¹ A.M.A., *Guides* 494-531.

¹² *Id.* at 521.

¹³ *Id.* at 461.

¹⁴ *Id.* at 473.

¹⁵ *Id.* at 474.

*calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.”*¹⁶ (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.”¹⁷

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.¹⁸ However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.¹⁹ The sixth edition of the A.M.A., *Guides* provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the Federal (FECA) Procedure Manual.²⁰

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.²¹

ANALYSIS

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

In March 3 and 24, 2025 reports, Dr. Katz, serving as the DMA, calculated the permanent impairment of appellant’s left upper extremity based on November 12, 2024 physical examination findings obtained by Dr. Jaffe, an OWCP referral physician. Dr. Katz utilized the DBI rating methodology to find that, under Table 15-5, page 403, (Shoulder Regional Grid), the CDX for left AC joint injury shoulder or disease status post distal clavicle resection that

¹⁶ FECA Bulletin No. 17-06 (issued May 8, 2017).

¹⁷ *Id.*

¹⁸ 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).

¹⁹ *Supra* note 9 at Chapter 2.808.5c(3) (February 2022).

²⁰ *Id.* at Chapter 3.700, Exhibit 4 (January 2010); *see L.H.*, Docket No. 20-1550 (issued April 13, 2021); *N.G.*, Docket No. 20-0557 (issued January 5, 2021).

²¹ *See D.J.*, Docket No. 19-0352 (issued July 24, 2020).

appellant had 10 percent impairment of the left upper extremity due to left shoulder AC joint injury or disease status post distal clavicle resection. He found that this was a Class 1 impairment with a GMFH of 1, GMPE of 1, and noted that a GMCS was inapplicable. After applying the net adjustment formula, he found a default grade C or 10 percent permanent impairment of the left upper extremity.²² Dr. Katz disagreed with Dr. Jaffe's application of DBI impairment methodology. He applied the A.M.A., *Guides*, page 387, which states, "If a patient has two significant diagnoses ... the examiner should use the diagnosis with the highest causally-related impairment for the impairment calculation." Therefore, Dr. Katz determined that appellant was not entitled an impairment rating calculated by combined diagnoses of left shoulder full-thickness rotator cuff tear, and biceps tendon dislocation/subluxation. He concurred that utilizing *The Guides Newsletter* there were no motor or sensory deficits in either upper extremity hence no ratable impairment of any spinal nerve or ratable impairments for the accepted spinal conditions.²³

Dr. Katz further found that, utilizing the ROM rating methodology of Table 15-34 to determine, as had Dr. Jaffe, that appellant had eight percent permanent impairment of the left upper extremity due to left shoulder ROM deficits, which was comprised of three percent permanent impairment flexion of 170 degrees, three percent permanent impairment due to abduction of 130 degrees and two percent permanent impairment due to external rotation of 40 degrees.

In his November 25, 2025 report, Dr. Katz reviewed Dr. Alexander's June 27, 2025 report and determined that using the single ROM measurements submitted by Dr. Alexander the calculated ROM impairments in accordance with the sixth edition of the A.M.A., *Guides*, page 475, would be 8 percent permanent impairment of the right shoulder and 10 percent permanent impairment of the left shoulder.

Since Dr. Katz provided a rating using the DBI rating methodology and appellant's condition provided for application of the ROM rating methodology, he was required to independently calculate his impairment using both the DBI and ROM rating methodologies and identify the higher rating for the claims examiner.²⁴ As noted above, FECA Bulletin No. 17-06 provides detailed instructions for obtaining sufficient evidence to conduct a complete permanent impairment evaluation.

The Board notes that, although Dr. Katz attempted to conduct an impairment calculation under the ROM rating methodology, the case record does not contain complete recent ROM findings of appellant's left shoulder for properly conducting a left upper extremity permanent impairment rating under the ROM rating method. Neither Dr. Jaffe nor Dr. Alexander indicated that he conducted three measurements for each type of motion of the left upper extremity and the relevant instructions for conducting the ROM rating methodology were not fully carried out in

²² *B.W.*, Docket No. 25-0622 (issued November 18, 2025); *M.W.*, Docket No. 23-0832 (issued December 27, 2023).

²³ *B.W., id.; R.S.*, Docket No. 24-0030 (issued March 19, 2024).

²⁴ See FECA Bulletin No. 17-06 (issued May 8, 2017).

this case. Therefore, it is necessary to further develop the medical evidence in accordance with FECA Bulletin No. 17-06.²⁵

Section 15.7 of the sixth edition of the A.M.A., *Guides* provides that ROM should be measured after a “warm up,” in which the individual moves the joint through its maximum ROM at least three times. The ROM examination is then performed by recording the active measurements from three separate ROM efforts and all measurements should fall within 10 degrees of the mean of these three measurements. The maximum observed measurement is used to determine the ROM impairment.²⁶ There currently is no evidence in the case record that these requirements for evaluating permanent impairment due to ROM deficits have been met.

In order to conduct a full evaluation of appellant’s permanent impairment, the Board finds that the case shall be remanded to OWCP. On remand, OWCP shall refer appellant, along with the SOAF, and the case record, to a new second opinion physician in the appropriate field of medicine. The second opinion physician shall provide an impairment rating in accordance with the sixth edition of the A.M.A., *Guides*, including three sets of ROM measurements of the upper extremities. The permanent impairment rating provided by the second opinion physician shall then be referred to a DMA for review. 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.

²⁵ See *id.* See also *N.G.*, Docket No. 25-0628 (issued August 1, 2025); *C.J.*, Docket No. 25-0440 (issued May 12, 2025).

²⁶ A.M.A., *Guides* 464.

ORDER

IT IS HEREBY ORDERED THAT the December 8, 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: May 1, 2026
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