United States Department of Labor
Employees' Compensation Appeals Board

D.W., Appellant	)	
and	)	**Docket No. 26-0605**
	)	**Issued: October 6, 2026**
U.S. POSTAL SERVICE, KENT POST OFFICE, Kent, OH, 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
JANICE B. ASKIN, Judge

JURISDICTION

On June 17, 2026 appellant filed a timely appeal from a March 26, 2026 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 14 percent permanent impairment of the left 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 March 26, 2026 decision, OWCP received additional evidence. However, 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 June 11, 2012 appellant, then a 52-year-old sales, service, and distribution associate, filed a traumatic injury claim (Form CA-1) alleging that, on June 8, 2012, she injured her left shoulder when she tripped and fell while in the performance of duty.[3] OWCP accepted the claim for left rotator cuff sprain and tear.

On November 14, 2013 appellant underwent OWCP-authorized surgery to her left shoulder performed by Dr. Curtis R. Noel, a Board-certified orthopedic surgeon, including large rotator cuff tear repair and biceps tenotomy.

On October 29, 2025 appellant filed a claim for compensation (Form CA-7) for a schedule award. In support thereof, she submitted a March 3, 2025 permanent impairment evaluation report by Dr. Kathryn Beale, who opined that she had reached maximum medical improvement (MMI) as of that date.[4] Dr. Beale observed physical examination findings in the left shoulder, applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), and found that appellant had seven percent permanent impairment of the left upper extremity due to the left shoulder.[5]

OWCP referred the medical record, including Dr. Beale's March 3, 2025 report, and a statement of accepted facts (SOAF) to Dr. David I. Krohn, a Board-certified internist serving as a district medical advisor (DMA), for review.

In a report dated December 1, 2025, Dr. Krohn reviewed the SOAF and medical record, including Dr. Beale's March 3, 2025 report. He noted that the sixth edition of the A.M.A., *Guides* directed that "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."[6] Dr. Krohn indicated that Dr. Beale did not adequately explain how she arrived at her opinion of permanent impairment.

On January 21, 2026 OWCP referred appellant, along with the medical record, SOAF, and a series of questions, to Dr. Gerald Rosenberg, a Board-certified orthopedic surgeon, for a second opinion examination and evaluation of appellant's permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.

In a report dated February 10, 2026, Dr. Rosenberg reviewed the SOAF and medical record. Regarding the left shoulder, he diagnosed rotator cuff tear of left shoulder and strain of left shoulder. Regarding the right shoulder, Dr. Rosenberg noted that appellant "had strictly conservative treatment for her right shoulder, which is the better one, less symptoms and more

[3] The June 11, 2012 Form CA-1 indicates an injury to the right shoulder; however, this appears to be a typographical error as the substance of the medical record indicates that appellant's injury was to her left shoulder.

[4] The Board notes that the physician's specialty could not be determined.

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

[6] *Id*. at 461.

function."[7] He related his physical examination findings, including three measurements for each range of motion (ROM) test in the shoulders. For the left shoulder, Dr. Rosenberg observed reduced strength, forward flexion to 100 degrees, extension to 30 degrees, abduction to 90 degrees, adduction to 30 degrees, external rotation to 20 degrees, and internal rotation to 70 degrees. With regard to his examination of the right shoulder, he observed full ROM and normal function. Utilizing the ROM rating methodology, Dr. Rosenberg found 14 percent permanent impairment of the left upper extremity for the left shoulder. He opined that appellant reached MMI as of February 10, 2026.

On March 11, 2026 Dr. Krohn, serving as OWCP's DMA, reviewed Dr. Rosenberg's February 10, 2026 report. He noted Dr. Rosenberg's comments regarding prior conservative treatment to the right shoulder and indicated that "as there is prior history of injury to the right shoulder by Dr. Rosenberg's report, ROM of the right shoulder therefore cannot be considered to be 'normal' in comparison to the left shoulder."[8] Dr. Krohn utilized the ROM rating methodology for the left shoulder and referenced Table 15-34 (Shoulder ROM), page 475, to find permanent impairment of three percent for flexion of 100 degrees, one percent for extension of 30 degrees, three percent for abduction of 90 degrees, one percent for adduction of 30 degrees, four percent for external rotation of 20 degrees, and two percent for internal rotation of 70 degrees. He added these values and applied Tables 15-35 and 15-36, page 477, and found a final permanent impairment rating of 14 percent of the left upper extremity for the left shoulder. Dr. Krohn noted that "as there is not normal motion of the left shoulder, impairment using the diagnosis-based impairment (DBI) rating methodology cannot be used to determine impairment." He opined that appellant reached MMI on February 10, 2026, the date of Dr. Rosenberg's evaluation.

By decision dated March 26, 2026, OWCP granted appellant a schedule award for 14 percent permanent impairment of the left upper extremity. It accorded the weight of the medical evidence to the March 11, 2026 report of Dr. Krohn, as DMA. The award ran for 43.68 weeks from February 10 through December 12, 2026.

LEGAL PRECEDENT

The schedule award provisions of FECA[9] and its implementing regulations[10] 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 of loss of a member shall be determined. The method used in making such a determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and

[7] Appellant previously filed CA-1 forms for injuries to her right shoulder on June 6, 2012 and August 18, 2020, which OWCP denied under OWCP File No. xxxxxx336 and processed as a short form closure under OWCP File No. xxxxxx609, respectively. Her claims have not been administratively combined.

[8] *See supra* note 7.

[9] *Supra* note 1.

[10] 20 C.F.R. § 10.404.

the Board has concurred in such adoption.[11] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[12]

It is the claimant's burden of proof to establish permanent impairment of the scheduled member or function of the body as a result of an employment injury.[13] OWCP procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred (date of MMI), describes the impairment in sufficient detail so that it can be visualized on review, and computes the percentage of impairment in accordance with the A.M.A., *Guides*.[14]

In addressing 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.[15] After a class of diagnosis (CDX) is determined (including identification of a default grade value), the impairment class is then adjusted by grade modifiers based on a grade modifier for functional history (GMFH), a grade modifier for physical examination (GMPE), and/or a grade modifier for clinical studies (GMCS).[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17] 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.[18]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology versus the ROM methodology for rating upper extremity impairment.[19] 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

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

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (version 1.0, issued March 16, 2026); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (version 1.0, issued March 16, 2026).

[13] *E.D.*, Docket No. 19-1562 (issued March 3, 2020); *Edward Spohr*, 54 ECAB 806, 810 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[14] *Supra* note 12 at Chapter 2.808.5 (March 2017).

[15] *M.D.*, Docket No. 20-0007 (issued May 13, 2020); *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

[16] A.M.A., *Guides* 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[17] *Id.* at 405-12. Table 15-4 and Table 15-5 also provide that, if motion loss is present for a claimant with certain diagnosed elbow and shoulder 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 398-05, 475-78.

[18] *Id.* at 23.

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

determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s)."[20]

The FECA Bulletin further advises:

"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.*"[21] (Emphasis in the original).

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.[22]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than 14 percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

In his March 11, 2026 report, Dr. Krohn reviewed the medical record and SOAF and properly applied the sixth edition of the A.M.A., *Guides* to Dr. Rosenberg's physical examination findings. Using the ROM rating methodology, he referenced Tables 15-34, 15-35, and 15-36 and found a final permanent impairment of 14 percent of the left upper extremity for the left shoulder. Dr. Krohn correctly noted that the DBI rating methodology could not be used, as there was not normal motion of the left shoulder.[23]

The Board finds that OWCP properly relied upon the opinion of Dr. Krohn, serving as the DMA, as he appropriately applied the ROM rating methodology found in the sixth edition of the A.M.A., *Guides* in determining that appellant had 14 percent permanent impairment of the left

[20] *Id.*; *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[21] *Id.*

[22] *V.K.*, Docket No. 21-1006 (issued September 25, 2023); *D.C.*, Docket No. 23-0455 (issued August 28, 2023); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts*, 31 ECAB 1010 (1980).

[23] *See E.G.*, Docket No. 25-0383 (issued April 18, 2025).

upper extremity.[24] There is no probative medical evidence of record demonstrating greater impairment than that previously awarded.[25]

On appeal, appellant disputed the date of MMI of February 10, 2026. The Board notes that the determination of the date of MMI is factual in nature and depends primarily on the medical evidence.[26] The date of MMI is usually considered to be the date of the evaluation accepted as definitive by OWCP.[27] As Dr. Krohn reported that appellant reached MMI when she was evaluated by Dr. Rosenberg, the Board finds that OWCP properly determined that appellant's date of MMI for schedule award purposes was February 10, 2026.

As the medical evidence of record is insufficient to establish greater impairment than that which was previously awarded, the Board finds that appellant has not met her burden of proof.

Appellant may request a schedule award or increased schedule award based at any time on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased permanent impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish greater than 14 percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

[24] *See S.W.*, Docket No. 23-0804 (issued January 2, 2024); *B.L.*, Docket No. 22-0068 (issued October 12, 2022); *J.S.*, Docket No. 19-1567 (issued April 1, 2020); *J.M.*, Docket No. 18-1334 (issued March 7, 2019).

[25] *See S.W., id.*; *D.S.*, Docket No. 20-0670 (issued November 2, 2021); *D.F.*, Docket No. 17-1474 (issued January 26, 2018); *A.T.*, Docket No. 16-0738 (issued May 19, 2016).

[26] *J.B.,* Docket No. 11-1469 (issued February 14, 2012); *Franklin L. Armfield* 29 ECAB 500 (1978).

[27] *Supra* note 12 at Chapter 3.700.3(a)(1)(c) (January 2010).

ORDER

IT IS HEREBY ORDERED THAT the March 26, 2026 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 6, 2026
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board