United States Department of Labor
Employees' Compensation Appeals Board

B.W., Appellant	)	
and	)	
DEPARTMENT OF VETERANS AFFAIRS, EUGENE J. TOWBIN HEALTHCARE CENTER, North Little Rock, AK, Employer	)	**Docket No. 24-0223** **Issued: July 17, 2024**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On January 2, 2024 appellant filed a timely appeal from a November 9, 2023 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.

ISSUE

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

[1] 5 U.S.C. § 8101 *et seq*.

FACTUAL HISTORY

On November 7, 2020 appellant, then a 63-year-old licensed practical nurse, filed a traumatic injury claim (Form CA-1) alleging that on October 10, 2020 he injured his right shoulder when he attempted to sit in a rolling office chair and fell while in the performance of duty. He stopped work on October 10, 2020. On April 19, 2021 OWCP accepted appellant's claim for several right shoulder conditions, including complete rotator cuff tear or rupture, labrum fraying, bicipital tendinitis, and impingement syndrome.

A magnetic resonance imaging (MRI) scan of the right shoulder dated October 16, 2020 revealed a complete tear of the supraspinatus and infraspinatus tendons with minimal atrophy and edema, tendons retracted from the distal footprint to the glenohumeral joint line, strain of the lateral fibers of the deltoid, strain of the teres minor muscle, mild tendinosis of the intra-articular portion of the biceps tendon, mild acromioclavicular (AC) joint degeneration, and mild glenohumeral joint effusion.

On December 29, 2020 Dr. James T. Howell, Jr., a Board-certified orthopedist, performed OWCP-authorized right shoulder surgery, including rotator cuff arthroscopic repair, acromioplasty with coracoacromial ligament release, and extensive debridement with anterior, superior, posterior labrum, and biceps tenotomy. He diagnosed several right shoulder conditions, including rotator cuff tear, labral fraying, impingement syndrome, and anterior, superior, and posterior biceps tendinitis.

A May 10, 2021 MRI arthrogram of the right shoulder revealed a large full-thickness tear with muscular atrophy of the supraspinatus and infraspinatus, evidence of prior rotator cuff repair, findings at the bicipital groove level consistent with a superior labral biceps tendon complex tear with distal retraction, and superior and slight posterior subluxation of the humeral head.

On July 29, 2022 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a development letter dated August 2, 2022, OWCP requested that appellant submit an impairment evaluation from his attending physician addressing whether he had obtained maximum medical improvement (MMI) and providing a permanent impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] It afforded him 30 days to submit the necessary evidence.

Appellant submitted a September 27, 2022 report from Dr. John W. Ellis, an osteopath and Board-certified family medicine specialist, who reported examination findings and indicated that he was providing permanent impairment ratings under the standards of the sixth edition of the A.M.A., *Guides*. Dr. Ellis applied the diagnosis-based impairment (DBI) rating method and found, using Table 15-5 (Shoulder Regional Grid), page 404, that appellant had 25 percent permanent impairment of the right upper extremity for right shoulder instability and recurrent subluxation. He then applied the range of motion (ROM) rating method and found, using Table 15-33 and Table 15-34, pages 474 and 475, respectively, that appellant had 34 percent permanent impairment

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

of the right upper extremity due to ROM deficits of the shoulder.[3] Dr. Ellis opined that the ROM rating method best represented appellant's upper extremity permanent impairment because it provided a greater impairment rating than that derived utilizing the DBI rating method. He determined that MMI was reached on the date of his evaluation.

On November 26, 2022 Dr. Herbert White, Jr., a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), reviewed the medical record, including Dr. Ellis' September 27, 2022 findings. He found that appellant had seven percent permanent impairment of the right upper extremity based on his right rotator cuff tear using the DBI method. Dr. White noted that Dr. Ellis obtained a DBI impairment rating of 25 percent for shoulder instability; however, the physical examination did not indicate shoulder instability. He further noted that he was unable to obtain a ROM impairment rating because of the unreliable ROM findings obtained by Dr. Ellis. Dr. White recommended appellant be referred for a second opinion evaluation to verify the ROM figures obtained by Dr. Ellis. He determined that the date of MMI was September 27, 2022, the date of Dr. Ellis' impairment evaluation. Dr. White noted discrepancies in Dr. Ellis' impairment rating.

On February 1, 2023 OWCP referred appellant, the medical record, a statement of accepted facts (SOAF), and a series of questions to Dr. Charles D. Varela, a Board-certified orthopedist, for a second opinion evaluation of his permanent impairment for schedule award purposes.

In a February 6, 2023 report, Dr. Varela noted appellant's history of injury and medical treatment. He reviewed the SOAF and medical records. Dr. Varela noted that active ROM measurements were obtained of the right shoulder, which revealed 40 degrees of forward flexion, 40 degrees of abduction, 50 degrees of internal rotation, and 20 degrees of external rotation. He noted that ROM testing for the unaffected left shoulder revealed 170 degrees of flexion, 80 degrees of abduction, 50 degrees of external rotation, and 90 degrees of internal rotation. Dr. Varela diagnosed irreparable rotator cuff tear of the right shoulder, following previous rotator cuff repair, which was now stable.

Dr. Varela referred to the sixth edition of the A.M.A., *Guides*, and utilized the DBI rating method to find that, under Table 15-5, page 403, the class of diagnosis (CDX) for appellant's full-thickness rotator cuff tear resulted in a Class 1 impairment. He assigned a grade modifier for functional history (GMFH) of 2 for moderate problems with the ability to perform activities with modification, and a grade modifier for physical examination (GMPE) of 3 for severe decreased right shoulder ROM in comparison to the uninjured side. A grade modifier for clinical studies (GMCS) was not applicable because the clinical studies were the basis of the assigned class. Dr. Varela applied the net adjustment formula, (GMFH – CDX) + (GMPE – CDX) = (2 – 1) + (3 – 1) = +3, which resulted in a shift from the default position of grade C to grade E. He opined that a grade E impairment resulted in eight percent permanent impairment of the right upper extremity.

[3] Dr. Ellis related that on physical examination of appellant's right shoulder he recorded appellant's ROM findings: 20 degrees of forward flexion equaling nine percent impairment, 50 degrees of extension equaling zero percent impairment, 30 degrees of abduction equaling six percent impairment, 0 degrees of adduction equaling zero percent impairment, -20 degrees of internal rotation equaling eight percent impairment, and -60 degrees of external rotation equaling nine percent impairment.

On February 13, 2023 OWCP requested that the DMA, Dr. White, review Dr. Varela's February 6, 2023 report, and indicate whether he agreed with his findings.

In a February 16, 2023 report, Dr. White reviewed Dr. Varela's report. Utilizing the DBI method of the sixth edition of the A.M.A., *Guides*, he identified the CDX for the diagnosis of full-thickness rotator cuff tear as a Class 1 impairment under Table 15-5, page 403. Dr. White assigned a GMFH of 2, in accordance with Table 15-7, page 406, as appellant had pain and symptoms with normal activity. He reported that a GMPE was unknown because of the inconsistent ROM findings. Dr. White assigned a GMCS of 4, in accordance with Table 15-9, page 410, for biceps tendon and labral pathology. He applied the net adjustment formula, (GMFH – CDX) + (GMCS – CDX) = (2 – 1) + (4 – 1) = +4, resulting in movement from the default class of grade C to grade E, and corresponding to seven percent permanent impairment of the right upper extremity. The final right upper extremity impairment using the DBI method was seven percent.

Dr. White indicated that he was unable to obtain a ROM impairment rating as Dr. Varela did not provide ROM for extension or adduction for the right and left shoulders. He further noted that there were inconsistent ROM figures provided, which could not be used to rate impairment. Dr. White indicated that Dr. Ellis, on September 27, 2022, provided ROM findings for internal rotation of -20 degrees equaling eight percent impairment, and external rotation of 60 degrees equaling zero percent impairment.[4] He noted that in comparison, on February 6, 2023, Dr. Varela obtained ROM findings for internal rotation of 50 degrees that would equal two percent impairment and external rotation of 50 degrees that would equal two percent impairment, which were inconsistent findings.[5] He related that the A.M.A., *Guides*, page 407, indicates that if multiple previous evaluations have been documented and there is inconsistency in the rating class between the findings of two observers, or in the findings on separate occasions by the same observer, the results are considered invalid and cannot be used to rate impairment. Dr. White recommended that Dr. Varela be contacted to provide the ROM figures for extension and adduction for both shoulders.

On August 25, 2023 OWCP referred appellant, the medical record, and a series of questions to Dr. Varela for a supplemental second opinion regarding additional ROM figures for the shoulders.

In a September 12, 2023 addendum report, Dr. Varela noted that ROM measurements were obtained of the right shoulder, which revealed 60 degrees of extension, 130 degrees of flexion, 80 degrees of abduction, and 35 degrees of adduction. He indicated that ROM for the unaffected left side revealed 70 degrees of extension, 160 degrees of flexion, 45 degrees of adduction, and 120 degrees of abduction.

On November 4, 2023 Dr. White reviewed Dr. Varela's September 12, 2023 addendum report. Utilizing the DBI method of the A.M.A., *Guides*, he identified the CDX for the diagnosis of full-thickness rotator cuff tear as a Class 1 impairment under Table 15-5, page 403. Dr. White assigned a GMFH of 2, in accordance with Table 15-7, page 406, as appellant had pain and

[4] Dr. Ellis actually noted external rotation of -60 degrees.

[5] Dr. Varela actually noted external rotation of 20 degrees.

symptoms with normal activity. He assigned a GMPE of 1 for mild motion deficits. Dr. White noted a GMCS of 4, in accordance with Table 15-9, page 410, for biceps tendon pathology and labral pathology. He applied the net adjustment formula, (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX) = (2 – 1) + (1 - 1) + (4 – 1) = +4, resulting in movement from the default value of grade C to grade E, and corresponding to seven percent permanent impairment of the right upper extremity.

Dr. White noted that instability and subluxation could not be used to rate impairment. He indicated that on September 27, 2022 Dr. Ellis reported that appellant had instability/subluxation; however, Dr. Varela in his evaluation on February 6, 2023 did not indicate that instability was present. Dr. White found that these were inconsistent findings and advised that, pursuant to the A.M.A., *Guides*, if multiple previous evaluation have been documented and there is inconsistency in the rating class between the findings of two observers, the results are considered invalid and cannot be used to rate impairment.

Dr. White also noted inconsistencies in the ROM findings between Dr. Ellis and Dr. Varela. He indicated that Dr. Ellis, on September 27, 2022, advised that appellant had flexion of 20 degrees equaling nine percent impairment, adduction of 4 degrees equaling one percent impairment, internal rotation of -20 degrees equaling eight percent impairment, and external rotation of 60 degrees, which was normal.[6] Dr. White noted in comparison that Dr. Varela, on September 12, 2023, reported that appellant had flexion of 130 degrees equaling three percent impairment, and adduction of 40 degrees, which was normal.[7] He indicated that, in an earlier ROM examination conducted on February 6, 2023, Dr. Varela found internal rotation of 50 degrees equaling two percent impairment, and external rotation of 50 degrees equaling two percent impairment.[8] Dr. White noted that the ROM findings for flexion, adduction, internal rotation, and external rotation were excluded from the impairment calculation because they constituted inconsistent findings. He utilized the ROM rating method found at Table 15-34, page 475, to determine that appellant had zero percent permanent impairment of the right upper extremity for extension of 60 degrees and three percent permanent impairment for abduction of 80 degrees.[9] Dr. White concluded that appellant's total permanent impairment for the right upper extremity was seven percent given that he had a higher rating for permanent impairment under the DBI rating method.

By decision dated November 9, 2023, OWCP granted appellant a schedule award for seven percent permanent impairment of the right upper extremity (right arm). The period of the award ran for 21.84 weeks from September 12, 2023 through February 11, 2024 and was based on the medical opinion of Dr. White, the DMA.

[6] Dr. Ellis actually noted adduction of 0 degrees and external rotation of -60 degrees.

[7] Dr. Varela actually noted adduction of 35 degrees on September 12, 2023.

[8] Dr. Varela actually noted 20 degrees of external rotation on February 6, 2023.

[9] In making this determination, Dr. White considered the ROM values for appellant's unaffected left shoulder to calculate base-line normal ROM values. It is noted that Dr. Varela found right shoulder extension of 60 degrees and right shoulder abduction of 80 degrees on September 12, 2023.

LEGAL PRECEDENT

The schedule award provisions of FECA[10] and its implementing regulations[11] 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.[12] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[13] 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.[14]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment CDX condition, which is then adjusted by grade modifiers for GMFH, GMPE, and GMCS.[15] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16] 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.[17]

The A.M.A., *Guides* also provide that the ROM impairment method 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.[18] 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.[19] Adjustments for functional history may be made if the evaluator

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

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

[13] *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).

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

[15] A.M.A., *Guides* 383-492.

[16] *Id.* at 411.

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

[18] *Id.* at 461.

[19] *Id.* at 473.

determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[20]

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*."[21] (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.[22]

ANALYSIS

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

In accordance with its procedures, OWCP properly referred the medical record to Dr. White, a DMA,[23] for review and a determination on whether appellant sustained permanent impairment of his right upper extremity, and the date of MMI. In a November 26, 2022 report, Dr. White disagreed with Dr. Ellis' September 27, 2022 report, in which Dr. Ellis determined that appellant had 25 percent right upper extremity impairment rating for shoulder instability. However, he explained that the physical examination did not indicate shoulder instability. Dr. White also noted that the ROM findings obtained by Dr. Ellis were unreliable. He recommended a second opinion impairment evaluation to determine appellant's permanent impairment.

[20] *Id.* at 474.

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

[22] *See supra* note 13 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).

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

OWCP properly referred appellant to Dr. Varela for a second opinion evaluation to determine the nature and extent of his employment-related permanent impairment. In his February 6, 2023 report, Dr. Varela determined that, under the DBI rating method, appellant had eight percent permanent impairment of the right upper extremity for a full-thickness rotator cuff tear as calculated under the A.M.A., *Guides.* The Board notes that his calculation was erroneous, as the A.M.A., *Guides* indicate a maximum impairment of seven percent.[24] Dr. Varela failed to provide ROM findings for extension or adduction for the right and left shoulders. He provided an addendum report dated September 12, 2023 with additional ROM values, but he did not calculate an impairment rating using the ROM rating method.

In accordance with its procedures, following the second opinion evaluation, OWCP properly referred the evidence of record to the DMA, Dr. White, for review.[25] In reports dated February 16 and November 4, 2023, Dr. White noted his disagreement with Dr. Varela's impairment calculation. He utilized the DBI rating method, and determined that appellant had seven percent permanent impairment of the right upper extremity due to the full-thickness tear of his right rotator cuff. Dr. White also used the ROM method to rate appellant's right upper extremity permanent impairment, and noted inconsistencies in the ROM findings between Dr. Ellis and Dr. Varela. He noted that due to the inconsistency in the rating class between the findings of the two physicians, the results were considered invalid and could not be used to rate impairment. Dr. White, therefore, excluded ROM findings for flexion, adduction, internal rotation, and external rotation from the impairment calculation. He based his ROM calculation on just extension and abduction findings. However, Dr. White did not adequately explain how he chose these particular ROM findings, or why he felt he could undertake his ROM calculation without a complete set of ROM findings.

By decision dated November 9, 2023, OWCP granted appellant a schedule award for seven percent permanent impairment of the right upper extremity. It found that the weight of the medical evidence rested with Dr. White serving as OWCP's DMA.

The Board finds that OWCP failed to properly develop the evidence following the DMA's November 4, 2023 report.

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares the responsibility in the development of the evidence to see that justice is done.[26] Once it undertakes development of the record, it must do a complete job in

[24] A.M.A., *Guides* 403.

[25] *Id*.

[26] *See L.F.*, Docket No. 20-0549 (issued January 27, 2021).

procuring medical evidence that will resolve the relevant issues in the case.[27] Accordingly, the Board finds that the case must be remanded to OWCP.[28]

On remand OWCP shall refer appellant, the case record, and a detailed SOAF to a new second opinion physician for the purpose of obtaining a new examination to include three independent ROM measurements of the right upper extremity per FECA Bulletin No. 17-06, and a rationalized medical opinion on the issue of permanent impairment for schedule award purposes.[29] After this and such other 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.

[27] *Id*.

[28] *Id*.

[29] *J.H.*, Docket No. 19-1476 (issued March 23, 2021); *R.O.*, Docket No. 19-0885 (issued November 4, 2019); *Talmadge Miller*, 47 ECAB 673 (1996).

ORDER

IT IS HEREBY ORDERED THAT the November 9, 2023 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 17, 2024
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board