United States Department of Labor
Employees' Compensation Appeals Board

G.R., Appellant	)	
and	)	**Docket No. 24-0376**
	)	**Issued: June 12, 2024**
DEPARTMENT OF THE NAVY, MARINE CORPS AIR STATION, Beaufort, SC, Employer	)	

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 February 27, 2024 appellant filed a timely appeal from a February 5, 2024 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]

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that following the February 5, 2024 decision, appellant submitted additional evidence to OWCP. 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*.

ISSUE

The issue is whether appellant has 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.

FACTUAL HISTORY

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

On September 24, 2008 appellant, then a 45-year-old security clerk, filed a traumatic injury claim (Form CA-1) alleging that on September 9, 2008, she sustained a pinched nerve in her neck causing muscle spasms in her neck and back when she lifted a box while in the performance of duty. On December 5, 2008 OWCP accepted her claim for brachial neuritis or radiculitis not otherwise specified (cervical radiculopathy). On January 9, 2009 appellant underwent OWCP-authorized anterior discectomy and fusion at C3-4. Thereafter, OWCP expanded the acceptance of her claim to include right shoulder impingement syndrome.

On October 21, 2019 appellant underwent OWCP-authorized anterior cervical discectomy and decompression of the spinal cord and nerve roots at C4-5 and C5-6, anterior arthrodesis at C4-5 and C5-6, cage placement at the C4-5 and C5-6 interspace, anterior instrumentation from C4 to C6 with integrated plate and screws and morcellated bone autograft.

In a January 17, 2020 report, Dr. Leland C. Stoddard, Jr., a Board-certified orthopedic surgeon, recounted a history of bilateral shoulder impingement with upper extremity complications following cervical spine surgery. On examination, he observed impingement signs in the shoulders with bilateral hand paresthesias. Dr. Stoddard diagnosed impingement syndrome of the shoulders.

On March 11, 2020 appellant underwent OWCP-authorized surgical removal of a left-sided cervical spine osteophyte at C6-7.

On March 20, 2020 OWCP expanded the acceptance of the claim to include cervical vertebral osteophyte and cervical disc degeneration.

On June 18, 2020 OWCP expanded the acceptance of the claim to include impingement of the left shoulder. On August 5, 2020 appellant underwent arthroscopic excision of the left distal clavicle, subacromial decompression with acromioplasty and division of the coracoacromial ligament, and arthroscopic rotator cuff repair of the left shoulder.

[3] Docket No. 11-616 (issued October 17, 2011).

In a February 22, 2021 report, Dr. Stoddard opined that appellant had reached maximum medical improvement (MMI). He found 15 percent permanent impairment of the left upper extremity due to the accepted shoulder conditions.

On March 8, 2021 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On March 9, 2021 OWCP requested that Dr. Kenechukwu Ugokwe, a Board-certified neurological surgeon serving as OWCP's district medical adviser (DMA), review the medical record and statement of accepted facts (SOAF) and opine whether the accepted cervical spine conditions had resulted in any permanent impairment of the upper extremities according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) and *The Guides Newsletter*, *Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009).[4] In his March 31, 2021 report, Dr. Ugokwe opined that appellant had no permanent impairment of either upper extremity causally related to the accepted cervical spine conditions.

On April 9, 2021 OWCP requested that Dr. Stoddard review Dr. Ugokwe's report and indicate his concurrence or disagreement.

In an April 29, 2021 report, Dr. Stoddard opined that according to Table 15-5 (Shoulder Regional Grid) and Table 15-7 (Functional History Adjustment: Upper Extremities) of the A.M.A., *Guides*, appellant had unspecified permanent impairment of the bilateral upper extremities due to cervical radiculopathy, bilateral rotator cuff tears with repairs, residual pain, limited motion, and weakness.

Thereafter, OWCP expanded the acceptance of the claim to include other disease of vocal cords, and edema of the larynx.

On October 27, 2021 OWCP referred appellant, the medical record, a statement of accepted facts (SOAF), and a series of questions to Dr. John P. George, a Board-certified orthopedic surgeon, for a second opinion evaluation regarding the extent of any employment-related permanent impairment. In a report dated November 18, 2021, Dr. George reviewed the medical record and SOAF. He opined that appellant had not yet reached MMI as she still had limited range of motion (ROM) of the left shoulder. Dr. George utilized the diagnosis-based impairment (DBI) rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 403, the class of diagnosis impairment (CDX) for appellant's full-thickness left rotator cuff tear resulted in a Class 1 impairment with a default value of 3. He assigned a grade modifier for functional history (GMFH) of 2, and a grade modifier for physical examination (GMPE) of 2. Dr. George found that a grade modifier for clinical studies (GMCS) was not applicable. He utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (2 - 1) + (2 - 1) + (0 - 1) = 2, which moved the default grade C impairment two places to the right, which resulted in 13 percent permanent impairment of the left upper extremity.

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

In a development letter dated November 29, 2021, OWCP advised appellant that no action could be taken on the schedule award claim as Dr. George had opined that the accepted employment conditions had not yet reached MMI.

In a February 28, 2022 report, Dr. Stoddard opined that appellant's left shoulder condition had reached MMI. He found 12 percent permanent impairment of the left upper extremity due to a rotator cuff tear and radicular symptoms from the cervical spine injury. Dr. Stoddard characterized his impairment rating as consistent with Dr. George's determination of 13 percent permanent impairment of the left upper extremity.

In a January 6, 2022 report, Dr. Stoddard observed 10 degrees external rotation and abduction of the left shoulder. He reiterated his prior finding of 12 percent permanent impairment of the left upper extremity.

On March 21, 2022 OWCP requested a report from Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA, regarding the appropriate percentage of permanent impairment of the left upper extremity. In a March 22, 2022 report, Dr. Harris reviewed the medical record and SOAF. He noted that appellant had reached MMI as of November 18, 2021. He utilized the DBI rating method to find seven percent permanent impairment of the left upper extremity according to Table 15-5, the maximum allowable impairment for a rotator cuff tear. Dr. Harris also provided a (ROM) impairment rating of six percent permanent impairment of the left upper extremity, three percent for loss of shoulder extension, and three percent for loss of flexion. He found that the DBI method was preferred as it offered the greater percentage of permanent impairment.

By decision dated April 20, 2022, OWCP granted appellant a schedule award for seven percent permanent impairment of the left upper extremity (left arm). The date of MMI was found to be November 18, 2021. The period of the award ran for 21.84 weeks from March 24 through August 23, 2022.

On April 25, 2022 appellant requested reconsideration.

By decision dated July 21, 2022, OWCP denied modification.

OWCP received reports from Dr. Stoddard dated from August 15 and December 19, 2022, wherein he reiterated that appellant had reached MMI and found 13 percent impairment of the upper extremities.

On January 25, 2023 appellant filed a Form CA-7 for an additional schedule award.

In a development letter dated February 1, 2023, OWCP requested that appellant provide a medical report from her physician, which included an impairment rating utilizing the A.M.A., *Guides*, addressing whether she had sustained additional permanent impairment.

Thereafter, OWCP received a December 14, 2022 magnetic resonance imaging (MRI) scan of the left shoulder, which demonstrated post-surgical status with no recurrent tear, mild degenerative changes of the acromioclavicular joint, and minimal fluid within the bicipital groove.

On April 19, 2023 OWCP referred appellant, the medical record, SOAF, and a series of questions to Dr. George to obtain an updated second opinion evaluation and impairment rating for the left upper extremity. In a May 9, 2023 report, Dr. George noted his review of the medical record and SOAF and opined that appellant had reached MMI. On examination of the left upper extremity, he observed decreased pinprick sensation in the C6 dermatome, and conducted three trials of ROM. Dr. George referred to Table 15-5, page 403, finding a CDX for left rotator cuff tear resulting in a Class 1 impairment with a default value of three. He assigned a GMFH of 2 and GMPE of 2, which provided a net adjustment of 2, raising the default grade from C upward to E, for a final 13 percent permanent impairment of the left upper extremity. Dr. George then referred to Table 17-2 (Cervical Spine Regional Grid: Spine Impairments) to find a Class 3, impairment of the cervical spine. He assigned a GMFH of 1, GMPE of 2, and GMCS of 2, which resulted in 9 percent permanent impairment of the left upper extremity. Dr. George added the 13 and 9 percent impairments to total 22 percent permanent impairment of the left upper extremity. Utilizing the ROM rating method to evaluate the left upper extremity, he found 3 percent impairment due to shoulder flexion at 120 degrees, 1 percent permanent impairment for extension at 30 degrees, 3 percent for shoulder abduction limited to 120 degrees, 1 percent for adduction limited to 20 degrees, and 4 percent for internal rotation limited to 80 degrees, to total 12 percent permanent impairment of the left upper extremity. Dr. George explained that the DBI method was preferable as it afforded the greater percentage of impairment.

On June 28 and August 24, 2023 OWCP requested a supplemental report from Dr. George to clarify if the 22 percent permanent impairment of the left upper extremity was in addition to the percentage previously awarded. In reports dated August 15 and 24, 2023, Dr. George indicated that appellant had a total of 22 percent permanent impairment of the left upper extremity.

On August 30, 2023 OWCP routed the medical record, SOAF, and a series of questions to Dr. Michael M. Katz, a Board-certified orthopedic surgeon, serving as a DMA, to obtain an impairment rating for the left upper extremity. In his September 2, 2023 report, Dr. Katz reviewed Dr. George's May 9, 2023 impairment rating and disagreed with his findings and methods of calculation. Referring to Proposed Table 1 (Spinal Nerve Impairment, Upper Extremity Impairment) of *The Guides Newsletter*, he found a CDX of 1 for mild sensory deficit in the C6 dermatome with a default value of 1. Dr. Katz assigned a GMFH of 2, a GMCS of 2, and found that GMPE was not applicable. He applied the net adjustment formula (GMFH - CDX) + (GMCS - CDX), (2 - 1) + (2 - 1), to equal a net adjustment of +2, which raised the default grade C upward to grade E, to equal two percent permanent impairment of the left upper extremity. Dr. Katz then referred to Table 15-5 to find a Class 1 diagnosis for full thickness rotator cuff tear, with a default value of 5. He utilized the DBI rating method to find one percent permanent impairment of the left upper extremity due to mild sensory deficit. Dr. Katz assessed a GMFH of 2, GMPE of 2, and no applicable GMCS. Applying the net adjustment formula, (GMFH - CDX) + (GMPE - CDX), (2-1) + (2 - 1), to equal a net adjustment of +2, which raised the default grade C upward to grade E, to equal seven percent permanent impairment of the left upper extremity. Dr. Katz concurred with Dr. George's calculation of 12 percent permanent impairment of the left upper extremity based on the ROM rating method. He opined that as the ROM impairment percentage exceeded the DBI impairment percentage, the ROM rating was preferred. Dr. Katz combined the 12 percent ROM impairment with the 2 percent impairment for spinal nerve impairment to total 14 percent permanent impairment of the left upper extremity, or 7 percent permanent impairment in addition

to the 7 percent previously awarded. He noted that appellant reached MMI as of May 9, 2023, the date of Dr. George's examination.

In a September 20, 2023 letter, OWCP requested a supplemental report from Dr. George regarding the appropriate percentage of permanent impairment as his rating differed from Dr. Katz' opinion. In an October 16, 2023 note, Dr. George indicated that appellant had a total of 22 percent permanent impairment of the left upper extremity.

In an October 20, 2023 letter, OWCP requested that Dr. George review Dr. Katz' September 2, 2023 report and indicate if he was in agreement with the 14 percent permanent impairment rating. In a November 29, 2023 report, Dr. George agreed with Dr. Katz' rating of an additional seven percent permanent impairment of the left upper extremity, and assessed an additional 15 percent permanent impairment for cervical spine impairment based on portions of Table 17-2. He added the 7 and 15 percent impairments to total 22 percent permanent impairment of the left upper extremity.

On December 6, 2023 OWCP requested that Dr. Harris review Dr. George's November 29, 2023 impairment rating and provide the appropriate percentage of permanent impairment of the left upper extremity. In a December 13, 2023 addendum report, Dr. Katz reiterated that appellant had 14 percent permanent impairment of the left upper extremity, 7 percent in addition to the 7 percent previously awarded. He explained that Dr. George improperly utilized Table 17-2 to assess upper extremity impairment originating in the spine whereas he should have referred to *The Guides Newsletter*.

By decision dated February 5, 2024, OWCP granted appellant a schedule award for 7 percent permanent impairment of the left upper extremity in addition to the 7 percent permanent impairment previously awarded, to total 14 percent permanent impairment of the left upper extremity. The period of the award ran for 21.84 weeks from October 20, 2023 through January 27, 2024.

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 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.[7] As of May 1, 2009, schedule awards are determined in

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id. See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

accordance with the sixth edition of the A.M.A., *Guides* (2009).[8] 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.[9]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's *International Classification of Functioning Disability and Health (ICF): A Contemporary Model of Disablement*.[10] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by a GMFH, GMPE, and/or GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[13]

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.[14] However, a schedule award is permissible where the employment-related condition affects the upper and/or lower extremities.[15] The sixth edition of the A.M.A., *Guides* provides a specific methodology for rating spinal nerve extremity impairment using *The Guides Newsletter*, which is a supplemental publication of the sixth edition of the A.M.A., *Guides*. It offers an approach to rating spinal nerve impairments based on evidence of radiculopathy affecting the upper and/or lower extremities.[16]

FECA Bulletin No. 17-06 provides guidance in applying ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities.[17] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "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

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

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

[10] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3.

[11] *Id*. at 494-531.

[12] *Id*. at 411.

[13] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[14] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

[15] *Supra* note 9 at Chapter 2.808.5c(3) (March 2017).

[16] *Supra* note 9 at Chapter 3.700, Exhibit 4 (January 2010).

[17] 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).

"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*." (Emphasis in the original.)[18]

The Bulletin further provides:

"If the medical evidence of record is [in]sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.[19]

"Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physicians' evaluation, the CE should route that report to the DMA for a final determination."[20]

ANALYSIS

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

OWCP referred appellant to Dr. George for a second opinion evaluation regarding permanent impairment of appellant's left upper extremity due to her accepted September 24, 2008 employment injury in accordance with the sixth edition of the A.M.A., *Guides*. In a May 9, 2023 report, he noted his review of the March 20, 2023 SOAF and conducted an examination. Dr. George did not indicate the accepted conditions in the claim but provided an impairment rating for the left upper extremity.

[18] *Id*.

[19] *Id*.; *S.B.*, Docket No. 24-0153 (issued March 28, 2024); *R.L.*, Docket No. 19-1793 (issued August 7, 2020).

[20] *Id*. *See also W.H.*, Docket No. 19-0102 (issued June 21, 2019).

The Board finds that the March 20, 2023 SOAF provided to Dr. George was deficient, as it failed to list the conditions accepted in the claim. OWCP's procedures dictate that, when a DMA, second opinion specialist, or referee physician renders a medical opinion based on a SOAF, which is incomplete or inaccurate, or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[21] OWCP did not provide the second opinion specialist, Dr. George, with an accurate SOAF as it failed to mention the conditions accepted as causally related to the September 9, 2008 employment injury.[22] As Dr. George based his May 9, 2023 report on an inaccurate SOAF, the probative value of his opinion is diminished.[23] Additionally, Dr. George misapplied the A.M.A., *Guides* by utilizing Table 17-2 to rate impairment of the spine instead of referencing the July/August 2009 edition of *The Guides Newsletter* to rate upper extremity impairment originating in the spine. This error further reduces the probative quality of his opinion.[24]

The Board has held that, while the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[25] Once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[26] It must do a complete job in securing from its referral physician an opinion, which adequately addresses the relevant issues.[27]

Accordingly, the case must be remanded for further development. On remand, OWCP shall refer appellant, along with the case record and an updated SOAF, to a new second opinion physician in the appropriate field of medicine for a rationalized medical opinion regarding permanent impairment of appellant's left upper extremity. After this and other such further proceedings as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[21] *R.W.*, Docket No. 19-1109 (issued January 2, 2020); *supra* note 9 at Chapter 3.600.3 (October 1990).

[22] *C.E.*, Docket No. 19-1923 (issued March 30, 2021); *M.B.*, Docket No. 19-0525 (issued March 20, 2020); *J.N.*, Docket No. 19-0215 (issued July 15, 2019); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

[23] *C.M.*, Docket No. 22-1260 (issued February 27, 2024); *C.F., (S.F.)*, Docket No. 20-0430 (issued March 6, 2023); *L.F.*, Docket No. 22-0754 (issued October 14, 2022); *G.C.*, Docket No. 18-0842 (issued December 20, 2018).

[24] *M.G.*, Docket No. 20-0078 (issued December 22, 2020).

[25] *See D.V.*, Docket No. 17-1590 (issued December 12, 2018); *Russell F. Polhemus*, 32 ECAB 1066 (1981).

[26] *See A.K.*, Docket No. 18-0462 (issued June 19, 2018); *Robert F. Hart*, 36 ECAB 186 (1984).

[27] *C.M., supra* note 23; *T.B.*, Docket No. 20-0182 (issued April 23, 2021); *L.V.*, Docket No. 17-1260 (issued August 1, 2018); *Mae Hackett*, 34 ECAB 1421, 1426 (1983).

ORDER

IT IS HEREBY ORDERED THAT the February 5, 2024 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: June 12, 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