United States Department of Labor
Employees' Compensation Appeals Board

T.E., Appellant	)	
and	)	**Docket No. 24-0369**
	)	**Issued: May 24, 2024**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, West Sacramento, CA, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 24, 2024 appellant filed a timely appeal from a February 9, 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]

ISSUE

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

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that following the February 9, 2024 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 October 2, 2019 appellant, then a 54-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that on October 1, 2019 she injured her right shoulder when pulling a dolly with both hands while in the performance of duty.

On December 26, 2019 OWCP accepted the claim for right shoulder strain.

In a report dated October 17, 2022, Dr. John Michael Panuska, Board-certified in occupational medicine, noted diagnoses of right shoulder rotator cuff tear and osteoarthritis of the right shoulder. He related that appellant's condition was permanent and stationary and had reached maximum medical improvement (MMI) on May 29, 2020.

On March 15, 2023 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a March 31, 2023 development letter, OWCP informed appellant of the deficiencies of her schedule award claim. It advised her of the type of medical evidence necessary to establish her claim, which included an impairment rating from her treating physician utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*).[3] OWCP afforded appellant 30 days to submit the necessary evidence.

In an April 3, 2023 report, Dr. Panuska explained that appellant's condition was permanent and stationary as of June 22, 2020, and deemed at MMI. He explained that he was unfamiliar with the sixth edition of the A.M.A., *Guides* and that he and Dr. Helen Weinrit, a Board-certified anesthesiologist, used the fifth edition of the A.M.A., *Guides* to evaluate appellant's permanent impairment.[4]

On August 21, 2023 OWCP referred appellant, a statement of accepted facts (SOAF), the medical record, and a series of questions to Dr. Charles F. Xeller, a Board-certified orthopedic surgeon, for a second opinion examination.

In a September 9, 2023 report, Dr. Xeller recounted appellant's history of injury. He noted an accepted right shoulder sprain and that she had declined reparative surgery. Dr. Xeller related that appellant could not lift the right arm above horizontal, and she had ongoing pain in the right shoulder of 1 to 2 on a scale of 10, which escalated with attempted elevation of the right arm. He observed that appellant's right shoulder was limited to 120 degrees of flexion, 40 degrees of extension, 80 degrees of abduction, 50 degrees of adduction, and 30 degrees of both internal and external rotation. For the drop arm test, Dr. Xeller noted pain with resistance full can but pain/weakness with empty can. He also noted no numbness, but with elevation there was tingling in the right hand at the second, fourth and fifth digits; no signs of carpal or cubital tunnel syndrome. Dr. Xeller diagnosed a torn rotator cuff/labrum, right shoulder, with acromioclavicular (AC) impingement and an element of adhesive capsulitis. He utilized the sixth edition of the A.M.A., *Guides* and noted the date of MMI as May 9, 2020. Dr. Xeller explained that the diagnosis based

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

[4] A.M.A., *Guides* (5th ed. 2001).

(DBI) rating method, utilizing Table 15-5, the Shoulder Regional Grid Upper Extremity Impairments, at page 403, yielded a maximum impairment rating of seven percent, and that appellant would have a greater rating using the range of motion (ROM) method. He referred to Table 15-34, Shoulder Range of Motion, at page 475, and related: flexion of 120 degrees was a 3 percent upper extremity impairment; extension of 40 degrees resulted in 1 percent permanent impairment; abduction of 80 degrees resulted in 6 percent permanent impairment; adduction of 50 degrees was resulted in 0 percent impairment; internal rotation of 30 degrees resulted in 4 percent permanent impairment; and external of 30 degrees resulted in 2 percent permanent impairment; for a total permanent impairment rating of 16 percent.

On October 17, 2023 OWCP referred Dr. Xeller's report to Dr. Jack Miller, a Board-certified neurologist, serving as an OWCP district medical adviser (DMA).

In an October 30, 2023 report, Dr. Miller, the DMA, noted appellant's accepted condition. He utilized the sixth edition of the A.M.A., *Guides* and referred to Table 15-5, Shoulder Regional Grid Upper Extremity Impairment, at page 403, to rate appellant's permanent impairment under the DBI method. Dr. Miller noted that for the class of diagnosis (CDX) of rotator cuff injury, a full-thickness tear with residual loss resulted in a Class 1 impairment with a default grade C or 5 percent permanent impairment. The DMA applied the grade modifiers and found a grade modifier for functional history (GMFH) of 2 based on pain with normal activities, a grade modifier for physical examination (GMPE) of 1 for mild loss of motion, and a grade modifier for clinical studies (GMCS) of 4 based on involvement of the rotator cuff, biceps tendon, and labrum. Dr. Miller applied the net adjustment formula and computed [GMFH(2) - CDX(1)] + [GMPE(1) - CDX(1)] +(GMCS(4) - CDX(1)] = +4 (maximum is +2) and found that appellant had a Class 1, grade E permanent impairment or 7 percent permanent impairment using the DBI methodology.[5]

With regard to the ROM methodology, the DMA noted that Dr. Weinrit and Dr. Xeller only provided one measurement for each shoulder motion, and that Dr. Xeller did not perform passive ROM measurements of the right shoulder, although there were significant differences from Dr. Weinrit's measurements. He referred to page 475 of the A.M.A., *Guides*, Shoulder Range of Motion in Table 15-34, and explained that where there are inconsistencies in the ROM measurements, the ROM impairments for that motion are considered invalid. Based on the inconsistent measurements by Dr. Weinrit and Dr. Xeller, the DMA advised that the ROM impairment ratings were invalid.

On November 15, 2023 OWCP determined that a supplemental report was needed. It explained that Dr. Miller, the DMA, disagreed with the impairment rating based on the ROM methodology in Dr. Xeller's report, and recommended that Dr. Xeller should be given an opportunity to respond. OWCP requested that Dr. Xeller review the DMA's report.

In a January 6, 2024 addendum report, Dr. Xeller noted, "I have reviewed comments from the DMA -- accept 7 percent right upper extremity rating."

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[5] The DMA formula showed GMFH of 1; however, this appears to be a typographical error as he previously indicated that the GMFH was 2 and he computed a total adjustment of +4.

By decision dated February 9, 2024, 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 9, 2023 to February 8, 2024.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing regulations[7] 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. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such adoption.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[9]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must identify the CDX, which is then adjusted by a GMFH, a GMPE, and/or a GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids, and calculations of modifier scores.[12]

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 DBI sections are applicable.[13] If the ROM method is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated.[14] All values for the joint are measured and added. Adjustments for functional history may be made if the evaluator determines that the resulting degree of permanent impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[15]

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[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404(a); *see R.M.*, Docket No. 20-1278 (issued May 4, 2022); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5.a (March 2017); *id.* at Part 3 -- Medical, *Schedule Awards,* Chapter 3.700.2 and Exhibit 1 (January 2010).

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

[11] *Id.* at 411.

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

[13] A.M.A., *Guides* 461.

[14] *Id*. at 473.

[15] *Id*.

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology versus the ROM methodology for rating of upper extremity impairments.[16] 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 determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
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> "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*."[17] (Emphasis in the original.)
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> The Bulletin further advises:
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> "If the medical evidence of record is not 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."

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.[18]

ANALYSIS

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

In support of her schedule award claim, appellant submitted reports wherein Drs. Weinrit and Panuska noted that they utilized the fifth edition of the A.M.A., *Guides,* rather than the sixth edition, to rate appellant's permanent impairment of the right extremity.[19] Accordingly, this

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

[17] *Id.*

[18] *See supra* note 9 at Chapter 2.808.6f (March 2017).

[19] *See supra* note 9 at Chapter 2.808.5a. (March 2017); *see also supra* note 9 at Chapter 3.700.2 and Exhibit 1 (January 2010); *see T.S.*, Docket No. 22-0977 (issued October 31, 2022; *G.M.*, Docket No. 19-1931 (issued May 28, 2020).

evidence did not comport with OWCP's procedures and is insufficient to establish appellant's schedule award claim.[20]

In accordance with its procedures, OWCP properly referred the evidence of record to Dr. Xeller for a second opinion examination and permanent impairment evaluation. Dr. Xeller utilized the sixth edition of the A.M.A., *Guides* and advised that, according to the DBI methodology, appellant would have a maximum impairment rating of seven percent based upon the diagnosis of rotator cuff injury, full-thickness tear. He further advised that appellant had a greater permanent impairment rating of 16 percent using the ROM methodology.

OWCP then properly referred the evidence of record, including Dr. Xeller's report, to the DMA, Dr. Miller, for review and an impairment rating. Dr. Miller applied the DBI methodology to the diagnosis of rotator cuff injury, full-thickness tear and opined that appellant had a right upper extremity permanent impairment of seven percent. With regards to Dr. Xeller's rating using the ROM methodology, the DMA noted that Dr. Xeller had only provided one set of measurements, whereas three measurements were required, and the measurements taken by Dr. Xeller and Dr. Weinrit were inconsistent. As such, Dr. Miller advised that Dr. Xeller's ROM-based permanent impairment rating of 16 percent was invalid, and that appellant had 7 percent impairment based on the DBI methodology.

The Board finds that the case record does not contain three ROM measurements necessary to properly evaluate appellant's permanent impairment rating under the ROM method.[21] As noted above, FECA Bulletin No. 17-06 provides detailed instructions for obtaining sufficient evidence to conduct a complete permanent impairment evaluation. However, such instructions were not fully carried out in this case, and therefore further development of the medical evidence is required in accordance with FECA Bulletin No. 17-06.[22]

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden of proof to establish entitlement to compensation. However, OWCP shares responsibility in the development of the evidence to see that justice is done.[23] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[24]

On remand, shall refer appellant, along with the SOAF and the case record, to a new second opinion physician in the appropriate field of medicine consistent with OWCP's procedures. The

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[20] *See M.M.*, Docket No. 17-0197 (issued May 1, 2018).

[21] Section 15.7 of the sixth edition of the A.M.A., *Guides* provides that ROM should be measured after a warmup, 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. A.M.A., *Guides* 464.

[22] *Supra* note 17.

[23] *See L.L.*, Docket No. 21-0625 (issued January 17, 2023); *M.T.*, Docket No. 19-0373 (issued August 22, 2019); *B.A.*, Docket No. 17-1360 (issued January 10, 2018).

[24] *T.C.*, Docket No. 17-1906 (issued January 10, 2018).

second opinion physician shall reference the sixth edition of the A.M.A., *Guides* and explain the selection of the diagnosis upon which the rating is based. The second opinion physician shall also provide three sets of ROM measurements of appellant's right shoulder. The permanent impairment rating provided by the second opinion physician, based on both the DBI and ROM methodologies, 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.

ORDER

IT IS HEREBY ORDERED that the February 9, 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: May 24, 2024
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