United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	**Docket No. 24-0429**
	)	**Issued: May 30, 2024**
U.S. POSTAL SERVICE, HOUSTON MEDICAL CENTER, Houston, TX, 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
JANICE B. ASKIN, Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On March 15, 2024 appellant filed a timely appeal from an October 4, 2023 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.

[1] The Board notes that, following the October 4, 2023 OWCP decision, it received additional evidence on appeal. 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.*

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met his burden proof to establish greater than six percent permanent impairment of his left upper extremity for which he previously received a schedule award.

FACTUAL HISTORY

On May 15, 2016 appellant, then a 63-year-old carrier technician, filed a traumatic injury claim (Form CA-1) alleging that on February 25, 2016 he injured his left shoulder when he stumbled when carrying a tub of circulars to mailboxes while in the performance of duty. He stopped work on April 30, 2016 and returned to a modified-duty position on October 31, 2016. OWCP accepted the claim for sprain of the left shoulder joint and left shoulder joint derangement.

On March 20, 2017 appellant underwent OWCP-authorized left shoulder rotator cuff repair, superior labral anterior posterior lesion (SLAP) repair, biceps tenodesis, and subacromial decompression. OWCP paid wage-loss compensation on the supplemental rolls beginning March 20, 2017.

On October 27, 2022 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In an October 28, 2022 development letter, OWCP informed appellant of the deficiencies of his schedule award claim. It advised him of the type of medical evidence needed and afforded him 30 days to provide the necessary evidence.

On March 4, 2022 Dr. Jeremy Szeto, an osteopath Board-certified in family medicine, submitted an impairment rating of appellant's left shoulder in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment, (*A.M.A., *Guides*).[3] He opined that appellant reached maximum medical improvement (MMI) on March 2, 2022. Dr. Szeto diagnosed status post left shoulder arthroscopy full-thickness tear of the supraspinatus and infraspinatus tendon with medial retraction, severe subscapularis tendinosis, tear and fraying of the posterior, superior, and anterior labrum, and severe glenohumeral joint osteoarthritis. He recommended a left shoulder reverse total shoulder arthroplasty. Dr. Szeto referred to the sixth edition of the A.M.A., *Guides*, and utilized the diagnosis-based impairment (DBI) rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 404, the class of diagnosis (CDX) for multidirectional shoulder instability resulted in a Class 1 impairment with a default value of 11. Dr. Szeto assigned a grade modifier for functional history (GMFH) of 2, and a grade modifier for physical examination (GMPE) of 2 and grade modifier for clinical studies (GMCS) of 2. He utilized the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) = (2-1) + (2-1) + (2-1) = +3, resulting in the default value of grade E corresponding to 13 percent permanent impairment of the left upper extremity. Dr. Szeto indicated that range of motion (ROM) of the left shoulder was recorded in Figure 1, Part 2, but did not provide this information within his March 4, 2022 report.

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

On September 13, 2023 OWCP routed Dr. Szeto's March 4, 2022 report, along with the case record, and a statement of accepted facts (SOAF) to Dr. Michael Minev, an internist serving as an OWCP district medical adviser (DMA), for review and a determination of appellant's date of MMI and the permanent impairment of his left upper extremity under the sixth edition of A.M.A., *Guides*. It requested that Dr. Minev review Dr. Szeto's March 4, 2022 report and provide an opinion discussing whether he agreed with its findings.

In a September 25, 2023 report, Dr. Minev discussed the findings in Dr. Sveto's March 4, 2022 report. He diagnosed left shoulder rotator cuff tear or rupture. Dr. Minev referred to the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 403, the CDX for appellant's full-thickness rotator cuff tear resulted in a Class 1 impairment with a default value of five percent. He assigned a GMFH of 2, and a GMPE of 1. Dr. Minev found that a GMCS was not applicable. He utilized the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) = (2-1) + (1-1) = +1, which resulted in a grade D or six percent permanent impairment of the left upper extremity. Regarding the ROM impairment rating method, Dr. Minev indicated that the report of Dr. Sveto did not contain measurements for the left shoulder to calculate an impairment rating by the ROM method. He concluded that Dr. Sveto's impairment rating was not performed according to the standards of the A.M.A., *Guides*. Dr. Minev found that appellant reached MMI on March 4, 2022.

By decision dated October 4, 2023, OWCP granted appellant a schedule award for six percent permanent impairment of his left upper extremity. The award ran for 18.72 weeks from March 4 through July 13, 2022.

LEGAL PRECEDENT

The schedule award provisions of FECA[4] and its implementing regulations[5] 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[6] 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 accordance with the sixth edition of the A.M.A., *Guides* (2009).[8] The Board has approved the use

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

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

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

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

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).[10] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by a GMFH, GMPE, and/or GMCS. 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]

FECA Bulletin No. 17-06 provides guidance in applying ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities.[13] 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." (Emphasis in the original.)[14]

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

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[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, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

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

[14] *Id*.

> impairment rating using the DBI method, if possible, given the available evidence.[15]
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> "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."[16]

ANALYSIS

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

In his March 4, 2022 report, Dr. Szeto failed to provide his ROM measurements for the left shoulder. OWCP referred Dr. Szeto's report to Dr. Minev, its DMA, who opined that appellant had six percent upper extremity impairment for full-thickness rotator cuff tear under the DBI methodology. Dr. Minev advised that Dr. Szeto's report did not contain ROM measurements for the left shoulder to calculate an impairment rating using the ROM method.

Pursuant to FECA Bulletin No. 17-06, if OWCP advises the claimant of the evidence necessary to evaluate permanent impairment using the ROM method, but does not receive such evidence, it should refer the claimant for a second opinion evaluation to obtain the evidence necessary to complete the rating.[17] OWCP failed to follow the procedures outlined in FECA Bulletin No. 17-06 by referring appellant for a second opinion after Dr. Szeto did not rate her impairment using the ROM method.

The Board notes that proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[18] 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. While OWCP began to develop the evidence, it failed to complete its obligation to secure a proper evaluation regarding permanent

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[15] *Id.*; *R.L.*, Docket No. 19-1793 (issued August 7, 2020).

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

[17] *Id.*; *see R.L.*, Docket No. 19-1793 (issued August 7, 2020).

[18] *See E.W.*, Docket No. 17-0707 (issued September 18, 2017).

impairment of the upper extremities based upon the ROM methodology.[19] The case must therefore be remanded for further development.[20]

On remand OWCP shall refer appellant for a second opinion examination to obtain the evidence necessary to calculate his left upper extremity impairments using both ROM and DBI methods. Following this and such other further development as deemed necessary, it 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 October 4, 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: May 30, 2024
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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[19] *K.D.,* Docket No. 23-0901 (issued February 27, 2024); *M.A.*, Docket No. 19-1732 (issued September 9, 2020).

[20] *See X.Y.*, Docket No. 19-1290 (issued January 24, 2020); *K.G.*, Docket No. 17-0821 (issued May 9, 2018).