United States Department of Labor
Employees' Compensation Appeals Board

K.C., Appellant	)	
and	)	**Docket No. 24-0917**
	)	**Issued: November 1, 2024**
FEDERAL JUDICIARY, U.S. PROBATION & PRETRIAL SERVICES-WESTERN DISTRICT OF MISSOURI, Kansas City, MO, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
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 September 13, 2024 appellant, through counsel, filed a timely appeal from an August 21, 2024 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 16 percent permanent impairment of her right upper extremity for which she previously received schedule award compensation.

FACTUAL HISTORY

On August 21, 2021 appellant, then a 59-year-old federal retirement benefits examiner, filed an occupational disease claim (Form CA-2) alleging that she sustained rotator cuff syndrome/tendinopathy of the right shoulder due to factors of her federal employment including using a computer eight hours per day, five days per week. She noted that she first became aware of her claimed condition on November 21, 2017 and realized its relationship to her federal employment on August 31, 2018. OWCP assigned that claim File No. xxxxxx280.[3]

On November 22, 2021 OWCP initially accepted the claim for right upper limb cubital tunnel syndrome. It subsequently expanded the acceptance of the claim to include lesion of ulnar nerve, right upper limb and complete rotator cuff tear or rupture of right shoulder.

On September 12, 2022 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a development letter dated December 16, 2022, OWCP requested that appellant submit a permanent impairment evaluation addressing whether she had reached maximum medical improvement (MMI) and providing an impairment rating using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] It afforded her 30 days to submit the necessary evidence.

In a January 3, 2023 report, Dr. M. Stephen Wilson, an orthopedic surgeon, reviewed appellant's medical record and provided his examination findings. He applied the diagnosis-based impairment (DBI) rating method of the sixth edition of the A.M.A., *Guides*, and found that, at most appellant had 11 percent permanent impairment of the right upper extremity due to distal clavicle resection. Dr. Wilson also applied the range of motion (ROM) rating method and found that, under Table 15-34, 110 degrees of flexion resulted in 3 percent impairment, 30 degrees of extension resulted in a 1 percent impairment, 110 degrees of abduction resulted in 3 percent impairment, 30 degrees of adduction resulted in 1 percent impairment, 30 degrees of internal

[3] Appellant has prior claims. In an occupational disease claim, to which OWCP assigned OWCP File No. xxxxxx841, OWCP accepted that appellant sustained cubital tunnel syndrome, right upper limb. She underwent OWCP-authorized right ulnar release on March 22, 2018. By decision dated January 30, 2020, OWCP granted appellant a schedule award for six percent permanent impairment of the right upper extremity. In a traumatic injury claim (Form CA-1), to which OWCP assigned OWCP File No. xxxxxx673, OWCP accepted that on February 5, 2018 appellant sustained a right rotator cuff tear and right shoulder superior glenoid labrum lesion. She underwent right shoulder arthroscopy, decompression, acromioplasty, distal clavicle resection, rotator cuff debridement and biceps tenotomy on August 31, 2018. OWCP has administratively combined OWCP File Nos. xxxxxx841 and xxxxxx673 with the present claim, OWCP File No. xxxxxx841, serving as the master file.

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

rotation resulted in 3 percent impairment, and 80 degrees of external rotation resulted in 0 percent impairment, for a total of 11 percent permanent impairment. Under Table 15-35, he found that the impairment rating was consistent with grade modifier of 1. Based on Table 15 7, Dr. Wilson assigned a grade modifier for functional history (GMFH) of 2 due to appellant's *Quick*DASH score of 56.8 (moderate problem). He noted that her functional history, as defined in Table 15-7, was one grade higher at a grade modifier of 2, making it one grade higher compared to the ROM grade 1 assigned to her motion deficit. Dr. Wilson referred to Table 15-36, page 477, and explained that, since the GMFH was one grade higher than the ROM score, appellant's total impairment was increased by one percent for a total of 12 percent permanent impairment of the right shoulder. He opined that the ROM rating method best represented appellant's right shoulder permanent impairment because it provided a greater impairment rating than that derived utilizing the DBI rating method. Dr. Wilson concluded that appellant had 12 percent permanent impairment of the right shoulder. He determined that MMI was reached on the date of his impairment evaluation.

On January 25, 2023 OWCP referred appellant's case to Dr. Herbert White, Jr., a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA) for determination of appellant's date of MMI and permanent impairment of her right upper extremity under the sixth edition of the A.M.A., *Guides*. It specifically requested that Dr. White review Dr. Wilson's January 3, 2023 report.

In a January 28, 2023 report, Dr. White reviewed Dr. Wilson's January 3, 2023 report and determined that appellant had a tentative 11 percent right upper extremity permanent impairment using the DBI method, explaining that a report for the distal clavicle resection referenced in Dr. Wilson's report was not mentioned in the statement of accepted facts (SOAF) and was necessary for his review. Further, he advised that he was unable to rate permanent impairment of appellant's right shoulder using the ROM rating methodology because the left upper extremity (uninjured) shoulder motions obtained by Dr. Wilson were not provided for his review.

On February 17, 2023 OWCP referred appellant, along with an updated SOAF, the medical record, and a series of questions, to Dr. Edwin Roeder, a Board-certified surgeon, for a second opinion evaluation. It requested that Dr. Roeder provide an opinion regarding permanent impairment of appellant's right upper extremity under the A.M.A., *Guides* and date of MMI.

In a March 24, 2023 report, Dr. Roeder discussed appellant's factual and medical history, and reviewed the SOAF and the medical record, including the results of an electromyogram/nerve conduction velocity (EMG/NCV) studies of the right and left ulnar nerves performed on April 24, 2014. He referred to Table 13-5 (Shoulder Regional Grid), page 403, of the sixth edition of the A.M.A., *Guides*, and found that appellant's accepted full-thickness rotator cuff tear with residual loss resulted in five percent permanent impairment. Dr. Roeder noted that healing of her rotator cuff was documented on a magnetic resonance imaging scan. He further noted that appellant had additional loss of shoulder motion due to her employment injury and its treatment, accounting for additional upper extremity impairment. Dr. Roeder indicated that appellant had rheumatoid arthritis that involved the right upper extremity, however, there was no measurable loss attributable to rheumatoid arthritis that accounted for any impairment. He reported his findings on physical examination of both shoulders, which included ROM measurements. Dr. Roeder noted that these measurements were reproduced on three consecutive measurements. He utilized the ROM rating methodology and found under Table 15-34 (Shoulder Range of

Motion), page 475, regarding the right shoulder, that 120 degrees of flexion resulted in three percent impairment, 30 degrees of extension resulted in one percent impairment, 120 degrees of abduction resulted in three percent impairment, 30 degrees of adduction resulted in one percent impairment, 60 degrees of external rotation resulted in two percent impairment, and 60 degrees of internal rotation also resulted in two percent impairment for a total of 12 percent permanent impairment of the right upper extremity. Dr. Roeder then found that, under Table 15-35, page 477, appellant's 12 percent ROM right upper extremity impairment rating was consistent with a grade 2 modifier. He further found that, under Table 15-7, she had symptoms with less than normal activity (including pain with use and walking) consistent with a grade 3 modifier. Dr. Roeder noted that as appellant's functional history adjustment was one grade higher than her ROM impairment rating, she had a net modifier of 1 based on Table 15-36, page 477. He then noted that her 12 percent ROM impairment rating was increased by five or 0.6 percent, resulting in 12.6 percent, rounded up to 13 percent ROM right upper extremity permanent impairment. Regarding the left shoulder, Dr. Roeder reported 120 degrees of flexion, 30 degrees of extension, 120 degrees of abduction, 30 degrees of adduction, 60 degrees of external rotation, and 60 degrees of internal rotation. Regarding permanent impairment to the right ulnar nerve, he utilized the DBI rating method, finding that, under Table 15-23, page 449, EMG/NCV studies of the ulnar nerve, which revealed reduced amplitudes and slowed conduction velocities at the elbow but, no motor block or axonal loss, represented a grade modifier of 2 for test findings. Dr. Roeder reported that appellant described constant numbness along the ulnar border of the hand and in the little and ring fingers consistent with a GMFH of 3. Appellant also had decreased sensation along the ulnar border of the hand and in the little and ring fingers consistent with a grade modifier for physical examination (GMPE) of 2. Dr. Roeder averaged these grade modifiers, resulting in 2.33 or 2 rounded down with a five percent mid-range default impairment on the same table. He, thus, concluded that she had five percent permanent impairment for right ulnar nerve pathology. Utilizing the Combined Values Chart, page 604, Dr. Roeder combined the 5, 13, and 5 percent impairments for a total 21 percent permanent impairment of the right upper extremity. He determined that appellant had reached MMI on July 10, 2022, the date her care was completed by Dr. Boyd Crockett, a Board-certified physiatrist.

On April 26, 2023 OWCP routed the case file, including Dr. Roeder's March 24, 2023 report, and a SOAF, to Dr. White as the DMA for OWCP. It requested that he provide an evaluation of appellant's permanent impairment under the sixth edition of the A.M.A., *Guides* and date of MMI.

In a May 3, 2023 report, Dr. White reviewed appellant's medical records, including Dr. Roeder's March 24, 2023 report, and her prior claims. Utilizing the sixth edition of the A.M.A., *Guides*, he determined that appellant had 12 percent DBI permanent impairment of the right shoulder, 4 percent ROM permanent impairment of the right shoulder, and 5 percent DBI permanent impairment of the right elbow ulnar nerve. Dr. White utilized the DBI rating methodology in the sixth edition of the A.M.A., *Guides* and found that, under Table 15-5 (Shoulder Regional Grid), page 403, class of diagnosis (CDX) for a distal clavicle resection represented a Class 2 impairment, with a default rating of 10 percent. He assigned a GMFH of 3 due to pain with less than normal activity under Table 15-7, page 406. Dr. White assigned a GMPE of 2 due to moderate tenderness under Table 15-8, page 408. He assigned a grade modifier for clinical studies (GMCS) of 4 due to a superior labral anterior-to-posterior (SLAP) tear, biceps tendon pathology, and rotator cuff tear under Table 15-9, page 410. Dr. White applied the net adjustment

formula, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) = (3 – 1 = 2) + (2 – 1 = 1) + (4 – 1 = 3) = 6, which moved the default grade C or 10 percent impairment, to the left resulting in grade E or 12 percent permanent impairment of the right shoulder. He also utilized the ROM rating methodology to determine appellant's right shoulder permanent impairment. Dr. White found that 120 degrees of flexion resulted in three percent impairment, 30 degrees of extension resulted in one percent impairment, 120 degrees of abduction resulted in three percent impairment, 30 degrees of adduction resulted in one percent impairment, 60 degrees of internal rotation resulted in two percent impairment, and 60 degrees of external rotation resulted in zero percent impairment. He then subtracted the ROM measurements for the contralateral left shoulder and determined that appellant had a total of four percent permanent impairment of the right shoulder. Dr. White noted that the DBI method yielded a higher impairment rating than the ROM method and, therefore, the DBI rating of 12 percent permanent impairment of the right shoulder was the proper rating for permanent impairment of appellant's right shoulder. He further utilized the DBI rating methodology to determine permanent impairment of appellant's right ulnar nerve of the right elbow. Referring to Table 15-23 (Entrapment/Compression Neuropathy Impairment), page 449, Dr. White assigned a GMFH of 3 due to constant symptoms, GMPE of 2 due to decreased sensation, and GMCS of 2 due to motor block. He added the modifiers to total 7, then divided by 3 to equal 2.33, rounded down to 2, which represented a default value of five percent impairment. Dr. White noted that the five percent impairment rating remained unchanged based on a grade modifier of 2 for appellant's *Quick*DASH score. He explained that the ROM rating method could not be used because there was no asterisk next to the diagnosis of compressive neuropathies. Utilizing the Combined Values Chart, Dr. White combined the 12 and 5 percent DBI impairment ratings for a total 16 percent permanent impairment of the right upper extremity.

Dr. White noted the discrepancies in Dr. Roeder's impairment evaluation. He noted that Dr. Roeder did not use the most impairing diagnosis when rating appellant's right shoulder permanent impairment under the DBI rating method, which resulted in their different impairment ratings. Dr. White further noted that their ROM impairment ratings were different because Dr. Roeder did not compare the motions of the right shoulder with the uninjured left shoulder, and he incorrectly determined that 60 degrees of internal rotation resulted in two percent impairment rather than zero percent impairment. Referring to page 461 of the A.M.A., *Guides*, he noted that Dr. Roeder improperly combined the ROM and DBI impairment ratings for the right shoulder as only the most favorable method was permitted. Dr. White concluded that appellant had 16 percent permanent impairment of the right upper extremity. He determined that she reached MMI on March 24, 2023, the date of Dr. Roeder's impairment evaluation.

By decision dated May 31, 2023, OWCP granted appellant a schedule award for an additional 10 percent permanent impairment of the right upper extremity for a total of 16 percent permanent impairment of the right upper extremity, based on the opinion of the DMA, Dr. White. OWCP noted that it had previously granted appellant a schedule award for six percent right upper extremity impairment under OWCP File No. xxxxxx841. The period of the award ran for 31.2 weeks from March 24 through October 28, 2023.

On June 2, 2023 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated January 30, 2024, an OWCP hearing representative vacated the May 31, 2023 schedule award decision. The hearing representative remanded the case and instructed OWCP to provide an updated SOAF to its DMA and requested that the DMA consider the medical evidence in OWCP File No. xxxxxx841 and determine whether appellant had more than 16 percent permanent impairment of the right upper extremity.

On February 8, 2024 OWCP routed an updated SOAF and the case records in the current claim under OWCP File No. xxxxxx280 and the prior claim under OWCP File No. xxxxxx841 to Dr. White for review and a determination of appellant's date of MMI and permanent impairment of her right upper extremity in accordance with the sixth edition of the A.M.A., *Guides*.

In an amended report dated February 21, 2024, Dr. White indicated that he had reviewed OWCP File Nos. xxxxxx841 and xxxxxx673. He reiterated his calculations and comments from his May 3, 2023 report. Dr. White found that appellant was entitled to a DBI permanent impairment of 12 percent for the right shoulder due to distal clavicle resection, and a DBI permanent impairment of 5 percent for right ulnar nerve impairment, for a combined upper extremity permanent impairment rating of 16 percent. He concluded that since appellant was previously granted a schedule award for six percent permanent impairment of the right upper extremity, an additional award of 10 percent was warranted. Dr. White determined that MMI was reached on March 24, 2023, the date of Dr. Roeder's impairment evaluation.

By decision dated March 7, 2024, OWCP denied appellant's claim for an additional schedule award. The decision was based on the February 21, 2024 report from the DMA, Dr. White.

On March 12, 2024 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review, which was held on June 6, 2024.

By decision dated August 21, 2024, OWCP's hearing representative affirmed the March 7, 2024 decision.

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]

In addressing upper extremity impairment, the sixth edition requires identification of the CDX, which is then adjusted by grade modifiers or GMFH, GMPE, and GMCS.[10] The net adjustment formula is (GMH - CDX) + (GME - CDX) + (GMS - CDX).[11] 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.[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 diagnosis-based sections are applicable.[13] 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.[14] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[15]

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*

[8] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *see also* Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, 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* 383-492.

[11] *Id.* at 411.

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

[13] *Id.* at 461.

[14] *Id.* at 473.

[15] *Id.* at 474.

impairment rating for the diagnosis in question, the method producing the higher rating should be used."[16] (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.[17]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than 16 percent permanent impairment of her right upper extremity, for which she previously received schedule compensation.

In support of her schedule award claim, appellant submitted a January 3, 2023 report from Dr. Wilson. The Board notes that Dr. Wilson opined that appellant had 11 percent DBI right upper extremity impairment rating based on her distal clavicle resection. He further opined that she had 12 percent ROM right upper extremity impairment. The Board finds that DMA White reviewed Dr. Wilson's January 3, 2023 report on January 28, 2023 and correctly determined that his permanent impairment rating of appellant's right shoulder using the ROM rating methodology was improper because appellant's left upper extremity (uninjured) shoulder ROM measurements were not provided.[18] Thus, Dr. Wilson's impairment rating was insufficient to meet appellant's burden of proof.

OWCP referred appellant to Dr. Roeder for a second opinion evaluation to rate her right upper extremity permanent impairment. On March 24, 2023 Dr. Roeder obtained ROM measurements of appellant's right shoulder. He utilized the DBI rating method and found that, under Table 15-34 on page 403, appellant had five percent permanent impairment for a full-thickness rotator cuff tear. Dr. Roeder also utilized the DBI rating method to find that, under Table 15-23, page 449, she had five percent permanent impairment of the right upper extremity due to right ulnar nerve of the right elbow. Further, he utilized the ROM rating method and found that, under Tables 15-34 and 15-35 on pages 475 and 477, respectively, appellant had 12 percent permanent impairment of the right shoulder that was increased to a final rating of 13 percent after application of the functional history grade modifier. Utilizing the Combined Values Chart, page 604, Dr. Roeder combined the two 5 percent DBI impairment ratings and the 13 percent ROM impairment rating for a total 21 percent permanent impairment of the right upper extremity.

On May 3, 2023 and February 21, 2024 the DMA, Dr. White, reviewed Dr. Roeder's March 24, 2023 report. Utilizing the sixth edition of the A.M.A., *Guides*, he determined that appellant had 12 percent DBI permanent impairment of the right shoulder and 5 percent DBI permanent impairment for right ulnar nerve impairment, totaling 16 percent permanent impairment

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

[17] *See supra* note 9 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).

[18] *See U.R.*, Docket No. 23-0614 (issued September 26, 2024).

of the right upper extremity impairment. Referring to Table 15-5, Dr. White noted that a CDX for distal clavicle resection was a Class 2 impairment, grade C default impairment of 10 percent. He assigned a GMFH of 3 for pain with less than normal activity, a GMPE of 2 for moderate tenderness, and a GMCS of 4 for a SLAP tear, biceps tendon pathology, and rotator cuff tear. Dr. White applied the net adjustment formula and concluded that appellant had 12 percent DBI permanent impairment of the right shoulder. He also utilized the ROM rating methodology to determine appellant's right shoulder permanent impairment. Referencing Table 15-34 on page 475, he subtracted the ROM measurements from appellant's left shoulder from the ROM measurements of appellant's right shoulder, and determined that appellant had four percent permanent impairment of the right shoulder due to loss of ROM. Dr. White noted that the DBI method yielded a higher impairment rating than the ROM method and, therefore, concluded that appellant had 12 percent permanent impairment of the right shoulder. He again utilized the DBI rating methodology to determine permanent impairment of appellant's right ulnar nerve of the right elbow. Referring to Table 15-23, Dr. White found a GMFH of 3 based on constant symptoms, GMPE of 2 based on decreased sensation, and GMCS of 2 based on motor block. He added the modifiers to total 7, then divided by 3 to equal 2.33, rounded upward to 2, which represented a default value of five percent impairment. Dr. White noted that the five percent impairment rating remained unchanged based on a grade modifier of 2 for appellant's *Quick*DASH score. He explained that the ROM rating method could not be used for rating the ulnar nerve because there was no asterisk next to the diagnosis of compressive neuropathies. Utilizing the Combined Values Chart, Dr. White combined the 12 percent permanent impairment of appellant's right shoulder and 5 percent permanent impairment of her right ulnar nerve, for a total 16 percent permanent impairment of the right upper extremity.

Dr. White concurred with Dr. Roeder's five percent DBI impairment rating for the right elbow ulnar nerve impairment. However, he disagreed with Dr. Roeder's five percent DBI impairment rating for the accepted rotator cuff tear, explaining that the distal clavicle resection was the most impairing diagnosis for rating appellant's right shoulder permanent impairment under the DBI rating methodology. Dr. White also disagreed with Dr. Roeder's 13 percent ROM permanent impairment rating of the right shoulder because it was not supported by the required ROM findings for the left shoulder. He also noted that, based on page 461 of the A.M.A., *Guides*, ROM and DBI ratings could not be combined to account for Dr. Roeder's total 21 percent right upper extremity impairment rating.

The Board finds that Dr. White properly explained how he arrived at appellant's right upper extremity permanent impairment rating by listing the specific table in the A.M.A., *Guides*. The Board also finds that he properly interpreted and applied the standards of the sixth edition of the A.M.A., *Guides* to conclude that appellant had 16 percent permanent impairment of the right upper extremity. The opinion of the DMA therefore represents the weight of the medical evidence and supports that she has no greater than 16 percent permanent impairment of the right upper extremity.

As there is no medical evidence of record, in conformance with the A.M.A., *Guides*, establishing greater than 16 percent permanent impairment of the right upper extremity previously awarded, the Board finds that appellant has not met her burden of proof.[19]

Appellant may request a schedule award or increased schedule award at any time based 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 16 percent permanent impairment of her right upper extremity for which she previously received schedule compensation.

ORDER

IT IS HEREBY ORDERED THAT the August 21, 2024 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 1, 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

[19] *See R.R.*, Docket No. 23-1140 (issued July 8, 2024); *A.R.*, Docket No. 21-0346 (issued August 17, 2022).