United States Department of Labor
Employees' Compensation Appeals Board

J.W., Appellant	)	
and	)	**Docket No. 23-0088**
	)	**Issued: October 11, 2024**
U.S. POSTAL SERVICE, CLARKSVILLE MAIN POST OFFICE, Clarksville, TN, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 24, 2022 appellant filed a timely appeal from a September 15, 2022 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 her burden of proof to establish greater than 12 percent permanent impairment of the left arm for which she previously received a schedule award.

FACTUAL HISTORY

On November 22, 2010 appellant, then a 50-year-old rural letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on November 17, 2010 she injured her left shoulder after pulling a tray of mail while in the performance of duty. She did not immediately stop work. On

[1] 5 U.S.C. § 8101 *et seq*.

August 19, 2011 OWCP accepted appellant's claim for left shoulder adhesive capsulitis and left shoulder impingement syndrome.[2]

On January 9, 2012 OWCP granted appellant a schedule award for 12 percent impairment of the left arm. The period of the award ran for 37.44 weeks for the period from November 1, 2011 through July 20, 2012. Effective August 7, 2014, OWCP paid appellant wage-loss compensation on the supplemental rolls.[3]

On February 8, 2022 appellant filed a claim for compensation (Form CA-7) for an additional schedule award.

In a state form report dated January 3, 2022, Dr. Charles L. Cox, III, a Board-certified orthopedist, referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[4] and found that appellant had 15 percent permanent impairment of the left shoulder. He opined that the date of maximum medical improvement (MMI) was December 14, 2021.

In a development letter dated February 16, 2022, OWCP requested that appellant submit an impairment evaluation from her attending physician that addressed whether she had obtained MMI and to provide a permanent impairment rating in accordance with the sixth edition of the A.M.A., *Guides*. It afforded her 30 days to submit the necessary evidence.

Appellant submitted a January 10, 2022 report from Dr. Cox, who evaluated permanent impairment of the left shoulder referring to Table 15-34, page 475 (Shoulder Range of Motion (ROM)) of the A.M.A., *Guides,* which yielded 15 percent permanent impairment of the left shoulder. He related that on physical examination of appellant's left shoulder, appellant's range of motion was: 110 degrees of forward flexion equaling three percent impairment; symmetric extension equaling zero percent impairment; 70 degrees of abduction equaling six percent impairment; symmetric adduction equaling zero percent impairment; 20 degrees of internal rotation equaling four percent impairment; and 30 degrees of external rotation equaling two percent impairment. Dr. Cox evaluated appellant on February 22, 2022 for left shoulder pain. He noted that appellant underwent arthroscopic surgery of the left shoulder and reached MMI on December 14, 2021. Dr. Cox noted examination of the left shoulder revealed 110 degrees of flexion, 20 degrees of external rotation, and 60 degrees of abduction. He diagnosed left shoulder stiffness and returned appellant to full-duty work.

[2] OWCP assigned the present claim OWCP File No. xxxxxx011. Appellant has a prior claim for a February 2, 2010 traumatic injury to the right shoulder. OWCP assigned that claim OWCP File No. xxxxxx028 and accepted it for right shoulder sprain. It subsequently expanded the acceptance of the claim to include right shoulder adhesive capsulitis. By decision dated March 31, 2011, OWCP granted appellant a schedule award for 9 percent permanent impairment of the right upper extremity (shoulder). OWCP has not administratively combined appellant's claims.

[3] On June 21, 2021 Dr. Cox performed a left shoulder mini open subpectoral biceps tenodesis, left shoulder arthroscopic extensive debridement including a partial articular sided rotator cuff tear, grade II chondromalacia of the humeral head, type I superior labrum anterior and posterior (SLAP) tear, intracapsular synovitis, and subacromial bursitis. He diagnosed left shoulder intracapsular biceps tendinopathy and tendinitis, left shoulder partial articular sided rotator cuff tear, left shoulder subacromial bursitis, left shoulder intracapsular synovitis, left shoulder grade II chondromalacia of the humeral head, and left shoulder type I SLAP tear.

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

On April 27, 2022 OWCP routed the case record, including Dr. Cox's January 10 and February 22, 2022 reports and a statement of accepted facts (SOAF), to Dr. Amanda Trimpey, a Board-certified physiatrist serving as an OWCP district medical adviser (DMA), for review and an impairment evaluation.

In a May 11, 2022 report, Dr. Trimpey, utilized the findings from Dr. Cox's January 10, 2022 report. She noted that there was no clinical history, diagnosis-based impairment (DBI) calculation, motor or sensory examination of the upper extremities, or neurologic testing of the upper extremities, and ROM measurements were provided for some planes of the left shoulder with no findings for the right shoulder. The DMA further noted that Dr. Cox did not use the ROM methodology according to the instructions provided by the A.M.A., *Guides* including, after warmup, ROM measured three times, with the greatest of three measurements used to calculate impairment. She further noted that it was unclear whether appellant had reached MMI, as Dr. Cox's January and February 2022 reports recommended a home exercise program to improve range of motion of the left shoulder. The DMA concluded that the impairment rating was not performed according to the standards of the A.M.A., *Guides* and therefore could not be used to calculate permanent impairment.

On May 26, 2022 OWCP requested that Dr. Cox review Dr. Trimpey's May 11, 2022 report and determine whether he agreed with her findings.

In a June 7, 2022 response, Dr. Cox noted that appellant underwent arthroscopic surgery of the left shoulder on June 21, 2021. He further noted that she reached MMI on December 14, 2021. Dr. Cox diagnosed left shoulder stiffness and recommended home exercise to improve scapular mechanics and core strength and returned her to full-duty work.

On July 5, 2022 OWCP referred appellant, along with the medical record, a SOAF, and a series of questions to, Dr. John Stanton, a Board-certified orthopedist, for a second opinion evaluation.

In a July 20, 2022 report, Dr. Stanton related appellant's complaints of limitations on lifting and carrying heavy items and a decreased ability to reach overhead and behind the back with her left arm. He noted examination findings of the right shoulder revealed no tenderness of the distal clavicle, subacromial space, biceps tendon or deep joint. Dr. Stanton's examination of the left shoulder revealed tenderness in the subacromial joint, pain with abduction and external rotation, good strength in the motor groups of both upper extremities, diminished strength with external rotation and abduction, 4/5 grip strength on the left compared to the right, good pulses bilaterally at the distal radius, and intact sensation bilaterally in all dermatomes. He noted that active ROM measurements were obtained on three successive trials for each shoulder which included: left shoulder flexion at 90, 85, and 90 degrees; extension of 30, 30, and 25 degrees; abduction of 60, 60, and 55, degrees; adduction of 20, 20, and 20 degrees; internal rotation of 45, 60, and 60; external rotation of 10, 5, and 10. Dr. Stanton measured right shoulder flexion of 130, 130, and 130 degrees; extension of 60, 60, and 60 degrees; abduction of 130, 130, and 130 degrees; adduction of 45, 45, and 45 degrees; internal rotation of 60, 60, and 60 degrees; and external rotation of 50, 50 and 50 degrees.

Dr. Stanton referred to the A.M.A., *Guides*, and utilized the DBI rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 402, the class of diagnosis (CDX) for appellant's

partial thickness rotator cuff tear resulted in a Class 1 impairment. He assigned a grade modifier for physical examination (GMPE) of 2, a grade modifier for functional history (GMFH) of 2, and a grade modifier for clinical studies (GMCS) of 1 and applied the net adjustment formula, which resulted in a grade E or 2 percent permanent impairment of the left upper extremity. With regard to the diagnosis of biceps tendinitis, Dr. Stanton found a Class 1 impairment. He assigned a GMPE of 2, a GMFH of 2, and a GMCS of 2 and applied the net adjustment formula, which resulted in a grade E or 5 percent permanent impairment of the left upper extremity. With regard to the CDX for diagnosis of labral lesion, Dr. Stanton found a Class 1 impairment. He assigned a GMPE of 2, a GMFH of 2, and a GMCS of 2 and applied the net adjustment formula, which resulted in a shift from the default position to grade E or 5 percent permanent impairment of the left upper extremity. Dr. Stanton combined the impairment ratings for the three diagnoses to find a total of 12 percent permanent impairment of the left upper extremity using the DBI methodology. Regarding the ROM methodology, he noted 90 degrees of forward flexion equaling 3 percent impairment; 30 degrees of extension equaling 1 percent impairment; 60 degrees of abduction equaling 6 percent impairment; 20 degrees of adduction equaling 1 percent impairment; 45 degrees of internal rotation equaling 4 percent impairment; and 10 degrees of external rotation equaling 4 percent impairment. Dr. Stanton found that the ROM methodology resulted in 19 percent permanent impairment of the left upper extremity, which was the higher of the two methodologies. He advised that appellant reached MMI on December 14, 2021.

On August 10, 2022 OWCP requested that the DMA, Dr. Trimpey, review Dr. Stanton's July 20, 2022 report, and provide whether she agreed with his findings.

In an August 21, 2022 report, Dr. Trimpey contended that, with regard to the DBI method, Dr. Stanton did not show all of his calculations or steps in the impairment rating process. In addition, Dr. Stanton's impairment rating process was incorrect in that he rated the shoulder condition three times, using three different diagnoses then added these impairment values together. Dr. Trimpey noted that although appellant had several diagnoses of the left shoulder, the A.M.A., *Guides*, 15.2, page 387, provides that if a patient has two or more diagnoses the examiner should use the diagnosis with the highest causally related impairment rating. In this instance, she found the diagnoses of rotator cuff injury, partial thickness tear, as the diagnosis with the highest impairment rating. Utilizing the DBI method of the A.M.A., *Guides*, Dr. Trimpey identified the CDX for the diagnosis of rotator cuff injury, partial thickness tear under Table 15-5, page 402 as a Class 1 impairment. She assigned a GMFH of 2, in accordance with Table 15-7, page 406, as appellant had a moderate problem, pain and symptoms with normal activity. Dr. Trimpey reported a GMPE of 2, in accordance with Table 15-8, page 408, as appellant had mild palpatory findings, mild motor weakness in some muscles, and no instability. She noted a GMCS of 1, in accordance with Table 15-9, page 410, clinical studies confirmed the diagnosis. Dr. Trimpey applied the net adjustment formula, resulting in movement from the default grade of C to E and corresponding to five percent permanent impairment of the left upper extremity. The final left upper extremity impairment using the DBI method was five percent.

Regarding the ROM method, Dr. Trimpey noted 90 degrees forward flexion equaling 3 percent impairment; 30 degrees extension equaling 1 percent impairment; 60 degrees abduction equaling 6 percent impairment; 20 degrees adduction equaling 1 percent impairment; 60 degrees

internal rotation equaling 2 percent impairment;[5] and 10 degrees external rotation equaling 4 percent impairment. She found that the ROM method resulted in 17 percent permanent impairment of the left upper extremity. Pursuant to Table 15-35, page 477, Dr. Trimpey applied the ROM grade modifiers. The 17 percent upper extremity impairment rating for the left shoulder was consistent with a grade modifier of two. Dr. Trimpey referenced Table 15-7, page 406, and assigned a GMFH of 2 because appellant had a moderate problem and pain with normal activity. Referencing Table 15-36, page 477, she found that since the GMFH was equal to the ROM grade modifier, no modification would be made to ROM impairment, it remained at 17 percent permanent impairment. With regard to the right upper extremity, Dr. Trimpey noted 130 degrees forward flexion equaled 3 percent impairment; 60 degrees extension equaled zero percent impairment; 130 degrees abduction equaled 3 percent impairment; 45 degrees adduction equaled zero percent impairment; 60 degrees internal rotation equaled 2 percent impairment;[6] and 50 degrees external rotation equaled 2 percent impairment. The total right upper extremity impairment was 10 percent permanent impairment. Dr. Trimpey noted pursuant to the A.M.A., *Guides*, page 461, appellant's uninvolved right upper extremity ROM impairment was 10 percent subtracted from the injured left upper extremity ROM impairment of 17 percent to determine the final left upper extremity impairment. The final left upper extremity pursuant to the A.M.A., *Guides* was seven percent permanent impairment. Dr. Trimpey indicated that Dr. Stanton, in the ROM assessment, failed to use appellant's untreated, uninjured side to define normal. The DMA concluded that the left upper extremity impairment based on the DBI method was five percent permanent impairment and the left upper extremity impairment based on the ROM method was seven percent permanent impairment. The method producing the higher rating was the ROM method of seven percent permanent impairment of the left upper extremity. Dr. Trimpey noted the date of MMI was July 20, 2022.

By decision dated September 15, 2022, OWCP denied appellant's claim for an additional schedule award, finding that the medical evidence of record was insufficient to establish greater than the 12 percent permanent impairment of the left arm previously awarded. It accorded the weight of the medical evidence to Dr. Trimpey, the DMA.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and its implementing regulations[8] 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.

[5] The DMA noted that Dr. Stanton performed an error in his ROM assessment for internal rotation as he was to use the greatest of the three values of 45, 60 and 60 degrees or 60 degrees not 45 degrees.

[6] The DMA noted that Dr. Stanton performed an error in his ROM assessment for internal rotation as he incorrectly used the lowest of the three values of 45, 60 and 60 degrees in his calculation instead of the greatest of the three values or 60 degrees.

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[9] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[10] 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.[11]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment CDX condition, which is then adjusted by grade modifiers or GMFH, GMPE, and GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] 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.[14]

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.[15] 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.[16] 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.[17]

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

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

[10] *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).

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

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

[13] *Id.* at 411.

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

[15] *Id.* at 461.

[16] *Id.* at 473.

[17] *Id.* at 474.

> 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*."[18] (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.[19]

ANALYSIS

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

On April 27, 2022 OWCP routed the case record, including Dr. Cox's January 10 and February 22, 2022 reports and a SOAF, to Dr. Trimpey, OWCP's DMA, for review and an impairment evaluation. In a May 11, 2022 report, Dr. Trimpey concluded that Dr. Cox's impairment rating was not performed in accordance with the A.M.A., *Guides* and therefore could not be used to determine appellant's permanent impairment.

On July 5, 2022 OWCP referred appellant, along with a SOAF, the medical record, and a series of questions to Dr. Stanton for a second opinion evaluation. In a July 20, 2022 report, Dr. Stanton related appellant's complaints of limitations on lifting and carrying heavy items and a decreased ability to reach overhead and behind the back with her left arm. He examined both the right and left shoulders and noted that active ROM measurements were obtained on three successive trials for each shoulder. Dr. Stanton referred to the A.M.A., *Guides*, and utilized the DBI rating method to find that appellant had a total of 12 percent permanent impairment of the left upper extremity. He further found 19 percent permanent impairment of the left upper extremity using the ROM methodology. Dr. Stanton advised that appellant reached MMI on December 14, 2021.

On August 10, 2022 OWCP referred the case record and a SOAF to the DMA, Dr. Trimpey, for review of Dr. Stanton's July 20, 2022 report and an opinion on whether she agreed with his findings. In her August 21, 2022 report, Dr. Trimpey initially found 17 percent permanent impairment of the left upper extremity using the ROM method. However, she further found 10 percent permanent impairment of the right upper extremity and subtracted that rating to determine a final left upper extremity impairment rating of 7 percent. Dr. Trimpey noted that this was higher than her rating of five percent permanent impairment of the left upper extremity based on the DBI method.

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

[19] *See supra* note 11 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).

It is OWCP's responsibility to provide a complete and proper frame of reference for a physician by preparing a SOAF.[20] 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 Drs. Stanton and Trimpey with an accurate SOAF, as it did not list appellant's accepted right upper extremity conditions under OWCP File No. xxxxxx028 or the previous schedule award for her right upper extremity. Thus, the Board finds that reports from the second opinion physician and DMA were not based on an accurate factual framework and cannot represent the weight of the medical evidence sufficient to deny appellant's claim for an additional schedule award.[22]

Once OWCP undertakes development of the medical evidence, it has the responsibility to do so in a manner that will resolve the relevant issues in the case.[23] Accordingly, the Board finds that the case must be remanded to OWCP. On remand OWCP shall, for full and fair adjudication of the case, administratively combine OWCP File Nos. xxxxxx011 and xxxxxx028. It shall then prepare a complete and accurate SOAF, and request a supplemental opinion clarifying whether appellant has additional left upper extremity permanent impairment. 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.

[20] *J.N.*, Docket No. 19-0215 (issued July 15, 2019); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

[21] *R.W.*, Docket No. 19-1109 (issued January 2, 2020); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

[22] *G.C.*, Docket No 18-0842 (issued December 20, 2018).

[23] *D.S.*, Docket No. 19-0292 (issued June 21, 2019); *G.C.*, *id.*

ORDER

IT IS HEREBY ORDERED THAT the September 15, 2022 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: October 11, 2024
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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