United States Department of Labor
Employees' Compensation Appeals Board

U.R., Appellant	)	
and	)	**Docket No. 23-0614**
	)	**Issued: September 26, 2024**
DEPARTMENT OF VETERANS AFFAIRS, DALLAS VA MEDICAL CENTER, Dallas, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On February 1, 2023 appellant filed a timely appeal from a January 10, 2023 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 January 10, 2023 decision and on appeal, appellant submitted 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.*

ISSUE

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

FACTUAL HISTORY

On May 19, 2020 appellant, then a 64-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that on May 17, 2020 she sustained right shoulder and arm conditions when a patient she was assisting fell onto her right arm while in the performance of duty.[3] OWCP accepted the claim for right shoulder other joint derangements and right shoulder rotator cuff muscle and tendon strain. It subsequently expanded the acceptance of the claim to include right shoulder superior glenoid labrum lesion. OWCP paid appellant wage-loss compensation on the supplemental rolls commencing July 6, 2020 and on the periodic rolls commencing July 19, 2020.[4]

On August 4, 2020 appellant underwent a right shoulder arthroscopy, subacromial decompression, bursectomy, superior labral anterior to posterior (SLAP) debridement, and mini open rotator cuff repair, performed by Dr. Terry Madsen, a Board-certified orthopedic surgeon. During the procedure, Dr. Madsen noted that appellant had full-thickness tearing of the supraspinatus and a portion of the visible infraspinatus.

On September 22, 2022 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In support of her claim, appellant submitted a permanent impairment rating report dated July 12, 2022 from Dr. Lashondria Simpson-Camp, a Board-certified general surgeon, noting appellant's diagnoses of right shoulder other specific joint derangements, right shoulder rotator cuff tendon and muscle strain, and right shoulder superior glenoid labrum lesion. Dr. Simpson-Camp referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] and rated appellant's permanent impairment under both the diagnosis-based impairment (DBI) and range of motion (ROM) methods. She first discussed the DBI methodology using the Shoulder Regional Grid from Table 15-5, page 434 and placed appellant's impairment in Class 1 based upon a diagnosis of labral lesions with SLAP tears, which yielded a default value of three percent. Dr. Simpson-Camp assigned a grade modifier for functional history (GMFH) of 1 under Table 15-7, page 406, a grade modifier for physical examination (GMPE) of 1 under Table 15-8, page 408, and a grade modifier for clinical studies (GMCS) of 1 under Table 15-9, page 410. She concluded that appellant had three percent permanent impairment of the right upper extremity. Dr. Simpson-Camp also utilized the ROM impairment rating methodology and recorded three sets of ROM measurements for both the right

[3] OWCP assigned the present claim OWCP File No. xxxxxx735. On November 29, 2012 appellant filed a traumatic injury claim (Form CA-1) alleging that on November 25, 2012 she sustained a left shoulder injury while assisting a patient. OWCP assigned that claim File No. xxxxxx697. Appellant's claims have not been administratively combined.

[4] Appellant retired from the employing establishment effective January 31, 2022. She elected to receive retirement benefits from the Office of Personnel Management effective May 22, 2022.

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

and left shoulders. She measured right shoulder flexion of 95/90/85 degrees, extension of 38/35/32 degrees, abduction of 87/83/83 degrees, adduction of 39/35/32 degrees, internal rotation of 75/75/68 degrees, and external rotation of 18/20/20 degrees. For the left shoulder, Dr. Simpson-Camp measured 129/125/120 degrees flexion, 44/48/48 degrees extension, 90/95/95 degrees abduction, 40/48/48 degrees adduction, 90/90/90 degrees external rotation, and 15/19/22 degrees internal rotation. She indicated that she elected to use the stand-alone ROM methodology for calculating permanent impairment because appellant did not have normal right shoulder ROM. Dr. Simpson-Camp calculated 11 percent permanent impairment of the right upper extremity due to loss of ROM after applying grade modifiers. She further indicated that, when the DBI and ROM ratings were different, the greater rating was used. Therefore, Dr. Simpson-Camp concluded that appellant had 11 percent right upper extremity permanent impairment.

On December 30, 2022 OWCP forwarded appellant's medical records, including Dr. Simpson-Camp's report dated July 12, 2022, and a statement of accepted facts (SOAF), to a district medical adviser (DMA) for evaluation of appellant's right shoulder permanent impairment.

The December 30, 2022 SOAF did not note appellant's prior November 25, 2012 traumatic left shoulder injury under OWCP File No. xxxxxx697.

In a report dated December 31, 2022, Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as DMA for OWCP, indicated that he had reviewed the SOAF and appellant's medical records. He opined that appellant had reached maximum medical improvement (MMI) on July 12, 2022. Utilizing the DBI rating method, under Table 15-5, page 403, Dr. Katz found that appellant's most impairing diagnosis was full-thickness rotator cuff tear, with normal motion, which represented a CDX 1 with a default value of five percent impairment. He assigned a GMFH of 1, a GMPE of 1, and a GMCS of 2. Dr. Katz applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1 - 1) + (1 - 1) + (2 - 1) = 1, yielding net adjustment of 1 and moving one place to the right of the default position, to D, to find that appellant had six percent right upper extremity permanent impairment. He utilized the ROM methodology in Table 15-34, page 475, and found 11 percent impairment for right shoulder ROM. Dr. Katz noted that there was no documentation in the record indicating prior contralateral left shoulder injury or pathology. Using the measurements for the left shoulder resulted in 10 percent impairment, which reduced the right shoulder ROM net impairment to one percent. Dr. Katz thus concluded that appellant had one percent permanent impairment of her right upper extremity under the ROM methodology, which was less than the DBI rating of six percent permanent impairment of the right upper extremity.

By decision dated January 10, 2023, OWCP granted appellant a schedule award for six percent permanent impairment of the right upper extremity. The award was for 18.72 weeks and ran from July 12 through November 20, 2022.

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. 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.[8] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[9] 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.[10]

In addressing upper extremity impairments, the sixth edition requires identification of the class of diagnosis (CDX), which is then adjusted by a GMFH, a GMPE, and/or a GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] 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.[13]

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.[14] 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.[15] 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.[16]

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[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id. See also G.H.*, Docket No. 23-1116 (issued June 4, 2024); *Ronald B. Kraynak*, 53 ECAB 130 (2001).

[9] *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).

[10] *G.H.*, *supra* note 8; *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

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

[12] *Id.* at 411.

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

[14] *Id.* at 461.

[15] *Id.* at 473.

[16] *Id.* at 474.

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.[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:

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

The Bulletin further advises:

> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the [claims examiner]."[19]

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.[20]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the percentage of permanent impairment using the A.M.A., *Guides*.[20]

ANALYSIS

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

In a report dated July 12, 2022, Dr. Simpson-Camp, appellant's attending physician, found that, using the DBI impairment method, based on the diagnosis of labral lesions including SLAP tears, appellant had a three percent permanent impairment of the right upper extremity. She further provided three sets of ROM measurements and calculated 11 percent permanent impairment of appellant's right shoulder due to loss of ROM.

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

[18] A.M.A., *Guides* 477.

[19] FECA Bulletin No. 17-06 (issued May 8, 2017); *K.K.*, Docket No. 23-0745 (issued February 1, 2024); *A.H.,* Docket No. 23-0335 (issued July 28, 2023); *V.L.,* Docket No. 18-0760 (issued November 13, 2018); *A.G.,* Docket No. 18-0329 (issued July 26, 2018).

[20] *Supra* note 9 at Chapter 2.808.6f (March 2017); *K.K.*, *id.*; *D.S.,* Docket No. 20-0670 (issued November 2, 2021); *B.B.,* Docket No. 18-0782 (issued January 11, 2019).

On April 18, 2022 Dr. Katz, the DMA, rated appellant's right shoulder permanent impairment utilizing both the DBI method under Table 15-5 and the ROM method under Table 15-34. According to the DBI rating method, he concluded that under Table 15-5 appellant had six percent permanent impairment of the right shoulder due to her full-thickness rotator cuff tear. Dr. Katz then rated appellant's right shoulder permanent impairment under the ROM methodology. He noted that the A.M.A., *Guides* on page 461 provided that if the opposite member is neither involved, nor previously injured, any losses should be made in comparison to the opposite normal extremity. Dr. Katz then related that there was no documentation in the record indicating prior contralateral left shoulder injury or pathology. Using the measurements for the left shoulder resulted in 10 percent impairment, which reduced the right shoulder ROM net impairment to one percent. Dr. Katz thus concluded that appellant had one percent permanent impairment of her right upper extremity under the ROM methodology. As the impairment under the DBI rating method was higher than that, found under the ROM methodology, he concluded that appellant's permanent impairment was best represented by the DBI rating of six percent permanent impairment of the right upper extremity.

It is OWCP's responsibility to provide a complete and proper frame of reference for a physician by preparing a SOAF. OWCP's procedures dictate that when an OWCP medical adviser, second opinion specialist, or IME 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] Dr. Katz was not provided a complete and accurate SOAF as it did not note appellant's prior left shoulder injury and the status of that condition under OWCP File No. xxxxxx697. The framework which he used in forming his opinion that appellant did not have a prior shoulder injury or pathology was therefore incomplete.[22]

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[23] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[24] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the issue in the case.[25]

Accordingly, the Board finds that the case must be remanded to OWCP.[26] On remand OWCP shall administratively combine appellant's claims and prepare a complete and accurate SOAF, which includes reference to appellant's left shoulder injury under OWCP File No.

[21] *See N.W.*, Docket No. 16-1890 (issued June 5, 2017).

[22] *Id.*; *see also Y.D.*, Docket No. 17-0461 (issued July 11, 2017).

[23] *N.L.*, Docket No. 19-1592 (issued March 12, 2020); *M.T.*, Docket No. 19-0373 (issued August 22, 2019); *B.A.*, Docket No. 17-1360 (issued January 10, 2018).

[24] *P.T.*, Docket No. 21-0138 (issued June 14, 2021); *S.S.*, Docket No. 18-0397 (issued January 15, 2019); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[25] *L.N.*, Docket No. 22-0497 (issued September 14, 2023); *G.M.*, Docket No. 19-1931 (issued May 28, 2020); *W.W.*, Docket No. 18-0093 (issued October 9, 2018).

[26] *S.J.*, Docket No. 22-0714 (issued March 31, 2023); *P.W.*, Docket No. 22-0218 (issued November 28, 2022).

xxxxxx697. OWCP shall thereafter request that Dr. Katz review the updated SOAF and provide a supplemental opinion regarding appellant's right shoulder permanent impairment, utilizing the ROM methodology. Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the January 10, 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: September 26, 2024
Washington, DC

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

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

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