United States Department of Labor
Employees' Compensation Appeals Board

T.C., Appellant	)	
and	)	**Docket No. 17-1741**
	)	**Issued: October 9, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Indianapolis, IN, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 8, 2017 appellant, through counsel, filed a timely appeal from a May 30, 2017 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.

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish permanent impairment of her lower extremities entitling her to schedule award compensation; and (2) whether

[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.*

appellant met her burden of proof to establish entitlement to schedule award compensation for additional permanent impairment of her right upper extremity.

FACTUAL HISTORY

On January 14, 2012 appellant, then a 41-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that, on January 13, 2012, she sustained injury, including epicondylitis of her right elbow, due to a fall at work. She stopped work on January 13, 2012 and returned to limited-duty work on January 20, 2012 without wage loss. OWCP accepted this claim (OWCP File No. xxxxxx361) for back contusion, right elbow contusion, lumbar sprain, aggravation of pseudoarthrosis, and aggravation of lumbosacral sprain.[3]

The findings of a March 7, 2012 magnetic resonance imaging (MRI) scan of appellant's lumbar spine shows a normally configured L5-S1 disc (with normal disc contour), transitional L5 segment with bilateral L5-S1 pseudoarthoses and minimal circumferential bulging annulus at L4-5 without associated neural impingement.

In an April 10, 2012 report, Dr. Husameddin R. El-Bakri, an attending Board-certified family practitioner, noted that the straight leg tests he conducted on that date were negative for both of appellant's lower extremities. He diagnosed lumbar contusion, lumbar strain, and sacroiliac strain.

In a July 30, 2013 report, Dr. Anthony W. Mimms, an attending Board-certified physical medicine and rehabilitation physician, indicated that, upon physical examination, appellant exhibited a normal gate and 5/5 strength in the muscles of her lower extremities. He noted that appellant reported experiencing pain mostly in the "lower region of back, tailbone, bottom, and leg."

On March 6, 2014 Dr. Eric D. Aitken, an attending Board-certified physical medicine and rehabilitation physician, noted that appellant did not report weakness in any muscle group during the physical examination conducted on that date.

In a November 8, 2014 report, Dr. Neil Allen, an attending Board-certified internist and neurologist, reported the findings of the physical examination he conducted on October 6, 2014, noting that range of motion (ROM) testing of appellant's right elbow showed 140 degrees of flexion, 10 degrees of extension, 95 degrees of supination, and 90 degrees of pronation.[4] He indicated that appellant had 5/5 strength for the L4 and L5 spinal nerve levels bilaterally, and 3/5 strength for the S1 spinal nerve level bilaterally. Dr. Allen applied the diagnosis-based impairment (DBI) method for evaluating permanent impairment under Table 15-4 (Elbow Regional Grid) on page 398 of the sixth edition of the American Medical Association, *Guides to the Evaluation of*

[3] Appellant stopped work from May 16 to 27, 2012 and received disability compensation on the daily rolls for this period. She also stopped work from March 9 to 15, 2013, using leave to cover her time off work, and returned to limited-duty work on March 16, 2013.

[4] Dr. Allen indicated that appellant presented at the examination with complaints of right elbow pain and low back pain radiating into her buttocks and both thighs.

Permanent Impairment (A.M.A., *Guides*),[5] noting that appellant's right elbow contusion (class 1) fell under the default value of two percent permanent impairment of the right upper extremity. Under Table 15-7 through Table 15-9 on pages 506 through 511, he determined that appellant had a functional history grade modifier of 2, physical examination grade modifier of 1, and clinical studies grade modifier of 0. Dr. Allen advised that application of the net adjustment formula caused no movement from the default impairment value on Table 15-4 and concluded that appellant had two percent permanent impairment of her right upper extremity under the A.M.A., *Guides*. He also determined that appellant had nine percent permanent impairment of each lower extremity by using *The Guides Newsletter*, "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" (July/August 2009).[6] Dr. Allen noted that appellant had a class 1 moderate motor deficit associated with the S1 nerve in each lower extremity which fell under the default value of eight permanent impairment for each lower extremity. Appellant had a functional grade modifier of 2 and clinical studies grade modifier of 1, thereby requiring movement from the eight percent default impairment value to the nine percent impairment value (one space to the right) for each lower extremity.

On July 27, 2015 appellant filed a claim for schedule award compensation (Form CA-7) alleging permanent impairment due to her accepted employment conditions.

On August 8, 2015 OWCP referred appellant's case to Dr. Morley Slutsky, a Board-certified occupational medicine physician, in his role as a district medical adviser (DMA) for OWCP. It requested that he review the medical evidence of record, including Dr. Allen's November 8, 2014 report, and provide an assessment of appellant's permanent impairment.

In an August 15, 2015 report, Dr. Slutsky applied the DBI rating method under Table 15-4 of the sixth edition of the A.M.A., *Guides*, noting that appellant's right elbow contusion (class 1) fell under the default impairment value of two percent permanent impairment of the right upper extremity. He determined that appellant had a functional history grade modifier of 2 and physical examination grade modifier of 1, and that the clinical studies grade modifier was not applicable because clinical studies were used to place appellant in the correct diagnostic class. Application of the net adjustment formula caused movement one space to the right of the default impairment value on Table 15-4 to an impairment value which also was two percent. Therefore, Dr. Slutsky concluded that appellant had two percent permanent impairment of her right upper extremity under the A.M.A., *Guides*. He further determined that appellant had no permanent impairment of her lower extremities under the standards of *The Guides Newsletter*. Dr. Slutsky explained that appellant consistently displayed no lower extremity sensory or motor deficits related to her low back with the exception of Dr. Allen's October 6, 2014 examination finding of 3/5 muscle strength associated with the S1 nerve distribution in each lower extremity. He indicated that reference should be made to Dr. Mimms' July 30, 2013 report and Dr. Aitken's March 6, 2014 report for contrary examination findings. Dr. Slutsky advised that MRI scans of record did not demonstrate nerve root involvement and indicated that other reports of record did not document clinical testing for lower extremity neurological deficits.

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

[6] *See infra* notes 16 and 17.

On October 21, 2015 Dr. Allen disputed Dr. Slutsky's assertion that appellant consistently showed no lower extremity sensory or motor deficits related to the low back. He asserted that he tested specific muscle groups on October 6, 2014 and found 3/5 strength in the muscles associated with the S1 nerve distribution in each lower extremity.

OWCP determined that there was a conflict in the medical opinion evidence between Dr. Allen and Dr. Slutsky regarding "the percentage of upper and lower extremity's [sic] impairment" and referred appellant to Dr. John K. Schneider, a Board-certified orthopedic surgeon, for an impartial medical examination and opinion on the matter.

In a February 25, 2016 report, Dr. Schneider detailed appellant's factual and medical history and indicated that appellant presented to him with complaints of chronic pain in her right elbow, low back/buttocks pain, and occasional pain radiating down her left lower extremity to approximately the mid-calf level. He reported the findings of the physical examination he conducted on February 24, 2016, noting ROM findings for the right elbow including 110 degrees of flexion and 2 to 3 degrees of flexion contracture. Appellant's right upper extremity did not exhibit any neurologic or muscular abnormality. Dr. Schneider indicated that appellant's lumbar spine exhibited paraspinous muscle tightness/tenderness without spasm and noted that bilateral straight leg testing was negative to 90 degrees. There was no muscle atrophy of either leg or foot/ankle, and jerk reflexes were present and symmetric in both knees/ankles. Dr. Schneider also noted that dorsi/plantar flexion was strong in both great toes and that sensation was intact in all dermatomes of the lower extremities.

With respect to the lower extremity permanent impairment, Dr. Schneider indicated that appellant had congenital conditions which had nothing to do with trauma, *i.e.*, transitional anatomy at L5 with bilateral pseudoarthroses at L5-S1, and indicated that such congenital conditions were not employment related and therefore not ratable as impairments under the A.M.A., *Guides*. He noted that appellant had no loss of motor or sensory function detectable by physical examination in either lower extremity. Appellant exhibited excellent strength in the musculature innervated by the L5 and S1 nerves, muscle strength was present and symmetric in both knees/ankles, and straight leg raising was negative bilaterally. Dr. Schneider determined that, under Table 17-4 (Lumbar Spine Regional Grid) on page 570, appellant's bilateral lumbar spine condition fell under class 0 such that she had zero permanent impairment of her lumbar spine.[7]

With regard to the lower extremity permanent impairment, Dr. Schneider applied the DBI rating method under Table 15-4, noting that appellant's right elbow contusion (class 1) fell under the default impairment value of two percent permanent impairment of the right upper extremity. He determined that appellant had a physical examination grade modifier of 1, and that a clinical studies grade modifier was not applicable because clinical studies were used to place her in the correct diagnostic class. Dr. Schneider noted that appellant's *Quick*DASH (Disabilities of the Arm, Shoulder, and Hand) score suggested a functional history grade modifier of 3, but noted that this value was two or more points higher than the physical examination grade modifier of 1. Therefore, the functional history grade modifier was considered unreliable and not applicable

[7] Dr. Schneider noted that Dr. Allen used *The Guides Newsletter* to rate appellant's lower extremity permanent impairment and indicated that Dr. Allen's finding of significant weakness in the lower extremity musculature innervated by the S1 nerves was inconsistent with his own physical examination of appellant's lower extremities.

under the A.M.A., *Guides*. Dr. Schneider noted that application of the net adjustment formula required no movement from the default impairment value on Table 15-4 and he concluded that appellant had two percent permanent impairment of her right upper extremity. He determined that appellant's date of maximum medical improvement (MMI) was April 10, 2012, noting that her condition did not improve after she was examined by Dr. El-Bakri on that date.

On March 9, 2016 OWCP advised Dr. Schneider that schedule awards could not be paid under FECA for permanent impairment of the spine. It requested that he produce a supplemental report which evaluated appellant's lower extremity permanent impairment using *The Guides Newsletter*.

In a March 18, 2016 report, Dr. Schneider discussed the use of *The Guides Newsletter* in evaluating lower extremity permanent impairment and he indicated that appellant had a normal physical examination of both lower extremities at the time of his February 24, 2016 evaluation. He explained that, according to the standards delineated in Proposed Table 2 of *The Guides Newsletter*, appellant's bilateral lower extremity condition fell under class 0, which was equivalent to zero percent permanent impairment of each lower extremity.

On April 6, 2016 OWCP referred appellant's case to Dr. Michael Katz, a Board-certified orthopedic surgeon, in his role as a DMA. It advised that Dr. Schneider had been asked to resolve a conflict in the medical opinion evidence regarding the percentage of permanent impairment of appellant's "right upper extremity and bilateral lower extremities" and requested that Dr. Katz evaluate whether Dr. Schneider, in his February 25 and March 18, 2016 reports, properly calculated appellant's permanent impairment under the sixth edition of the A.M.A., *Guides*. OWCP indicated that appellant had previously been awarded schedule award compensation for seven percent permanent impairment of her right upper extremity and requested that Dr. Schneider stipulate whether his calculation of the percentage of permanent impairment "includes the prior percentage awarded or if it should be considered an addition to the prior percentage awarded."

In an April 7, 2016 report, Dr. Katz indicated that the records he reviewed did not reflect the issuance of a schedule award under the present claim. He discussed Dr. Schneider's evaluation of the permanent impairment of appellant's right upper extremity and both lower extremities, and he concluded that Dr. Schneider properly applied the relevant standards to determine that appellant had two percent permanent impairment of her right upper extremity and no permanent impairment of either lower extremity. Dr. Katz indicated that appellant's date of MMI was February 24, 2016.

On July 1, 2016 OWCP advised that appellant had previously received schedule award compensation for seven percent permanent impairment of her right upper extremity and requested that Dr. Schneider stipulate whether his calculation of the percentage of permanent impairment "includes the prior percentage awarded or if it should be considered an addition to the prior percentage awarded."

In a July 1, 2016 report, Dr. Katz again noted that he was unable to locate information "as to the specifics of the region of the [right upper extremity]" for which the prior schedule award mentioned by OWCP was awarded." He requested that OWCP provide the reports "authorizing the prior award" in the amount of seven percent of the right upper extremity in order to determine whether overlapping impairments existed.

OWCP added additional documents to the case record for the present claim which initially had appeared in the files for appellant's prior claims under OWCP File Nos. xxxxxx760 and xxxxxx329. These documents included a functional capacity evaluation report from 2012 and medical reports of Dr. Allen and Dr. Slutsky from 2012 and 2014 containing permanent impairment ratings of appellant's right upper and bilateral lower extremities.

In an August 19, 2016 report, Dr. Katz again concluded that Dr. Schneider properly determined that appellant had two percent permanent impairment of her right upper extremity and no permanent impairment of either lower extremity. He noted that, since appellant's present right upper extremity permanent impairment of two percent was lower than the prior award for seven percent permanent impairment of the right upper extremity, no additional schedule award was due for the right upper extremity.

In a September 21, 2016 decision, OWCP determined that appellant had two percent permanent impairment of her right upper and zero percent permanent impairment of each lower extremity. It noted that on December 17, 2014 appellant received a schedule award for seven percent permanent impairment of her right upper extremity due to right upper extremity conditions accepted prior to the filing of the present claim. OWCP advised that therefore appellant received an overpayment of compensation of five percent permanent impairment (the previously paid seven percent right upper extremity permanent impairment minus the current two percent right upper extremity permanent impairment).[8] It determined that the weight of the medical opinion evidence regarding appellant's right upper extremity permanent impairment and bilateral lower extremity permanent impairment rested with the February 25 and March 18, 2016 reports of Dr. Schneider, the impartial medical specialist, and the August 19, 2016 report of Dr. Katz, the DMA.

On October 4, 2016 appellant, through counsel, requested a telephone hearing with a representative of OWCP's Branch of Hearings and Review.

During the hearing held on April 28, 2017, OWCP's hearing representative discussed appellant's prior compensation claims -- a traumatic injury claim under OWCP File No. xxxxxx760 and an occupational disease claim under OWCP File No. xxxxxx329 -- and noted that on December 17, 2014 OWCP had issued a schedule award for seven percent permanent impairment of appellant's right upper extremity. Counsel argued that there was confusion over how the prior award affected the current evaluation of whether appellant was entitled to additional schedule award compensation for permanent impairment of her right upper extremity.[9]

In a May 30, 2017 decision, OWCP's hearing representative affirmed OWCP's September 21, 2016 decision. He indicated that on December 17, 2014 OWCP issued a schedule award for seven percent permanent impairment of appellant's right upper extremity in connection with claims filed prior to the present claim (OWCP File Nos. xxxxxx760 and xxxxxx329), noting

[8] OWCP indicated that the dollar amount of the overpayment of compensation would be discussed in a separate decision. The Board notes that the case record does not contain such a decision.

[9] After the hearing, appellant submitted an office visit note dated February 20, 2017 and laboratory test results from November 7, 2016.

that these claims had been accepted for several right upper extremity conditions.[10] The hearing representative advised that, since appellant's present right upper extremity permanent impairment of two percent was lower than the previous calculation of seven percent permanent impairment of the right upper extremity, no additional schedule award was warranted for the right upper extremity. He also noted that no evidence had been submitted which showed that appellant had permanent impairment of either lower extremity.

LEGAL PRECEDENT -- ISSUE 1

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to implement the FECA program with the Director of the Office of Workers' Compensation Programs.[11] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[12] FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of 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.[13]

Neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[14] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[15] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment.[16] It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the Federal (FECA) Procedure Manual.[17]

[10] OWCP indicated that OWCP File Nos. xxxxxx760 and xxxxxx329 had been administratively combined.

[11] *See* 20 C.F.R. §§ 1.1-1.4.

[12] For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

[13] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[14] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[15] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5c(3) (March 2017).

[16] The methodology and applicable tables were initially published in *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009). *Id.*

[17] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

FECA provides that, if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[18] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[19] Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well reasoned and based upon a proper factual background, must be given special weight.[20]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met her burden of proof to establish permanent impairment of her lower extremities entitling her to schedule award compensation.

OWCP properly determined that there was conflict in the medical opinion evidence between Dr. Allen, an attending physician, and Dr. Slutsky, a DMA, regarding appellant's bilateral lower extremity permanent impairment and referred appellant to Dr. Schneider for an impartial medical examination and opinion relative to the impairment assessment.[21]

The Board finds that the special weight of the medical opinion evidence rests with the well-rationalized February 25 and March 18, 2016 reports of Dr. Schneider, who properly determined that appellant had no permanent impairment of either lower extremity under the standards of the sixth edition of the A.M.A., *Guides.*[22]

In his March 18, 2016 report, Dr. Schneider properly determined that appellant had zero percent permanent impairment in each lower extremity under the relevant standards. He discussed the use of *The Guides Newsletter* in evaluating lower extremity permanent impairment and he indicated that appellant had a normal physical examination of both lower extremities at the time of his February 24, 2016 evaluation.[23] Dr. Schneider explained that, according to the standards delineated in Proposed Table 2 of *The Guides Newsletter,* appellant's bilateral lower extremity condition fell under class 0, which was equivalent to zero percent permanent impairment of each lower extremity.

In his February 25, 2016 report detailing the findings of his February 24, 2016 physical examination, Dr. Schneider provided medical rationale in support of his opinion that appellant did not have an employment-related spinal condition causing permanent impairment to the lower

[18] 5 U.S.C. § 8123(a); *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

[19] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[20] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

[21] *See supra* notes 18 and 19. In a November 8, 2014 report, Dr. Allen determined that appellant had nine percent permanent impairment of each lower extremity under *The Guides Newsletter*. In contrast, Dr. Slutsky found on August 15, 2015 that appellant had zero percent permanent impairment of each lower extremity under *The Guides Newsletter*.

[22] *See supra* note 20.

[23] *See supra* notes 16 and 17.

extremities. He explained his opinion that appellant had no motor/sensory loss of the lower extremities detectable on February 24, 2016 by emphasizing that she exhibited excellent strength in the musculature innervated by the L5 and S1 nerves, muscle strength was present and symmetric in both knees/ankles, straight leg raising was negative bilaterally, and sensation was intact in all dermatomes of the lower extremities.[24]

LEGAL PRECEDENT -- ISSUE 2

The Board further finds that the case is not in posture for decision with respect to appellant's right upper extremity permanent impairment.

As noted above, through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[25] The sixth edition requires identifying the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS).[26] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[27]

Regarding the application of ROM or DBI impairment 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*

[24] Dr. Schneider also noted that appellant had congenital conditions, *i.e.*, transitional anatomy at L5 with bilateral pseudoarthroses at L5-S1, and indicated that such congenital conditions were not employment related and therefore not ratable as impairments under the A.M.A., *Guides.* It is well established that, in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included. However, when a claimant does not demonstrate any permanent impairment caused by the accepted exposures, the claim is not ripe for consideration of any preexisting impairment. *R.G.*, Docket No. 13-0220 (issued May 9, 2013); *D.F.*, 59 ECAB 288 (2007). Because appellant did not demonstrate any permanent impairment caused by the accepted exposures, Dr. Schneider properly found that her preexisting congenital conditions were not ratable at present.

[25] *See supra* note 13.

[26] A.M.A., *Guides* 494-531.

[27] *Id.* at 521.

impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)[28]

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 CE.

"If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* do not allow for the use of ROM for the diagnosis in question, the DMA should independently calculate impairment using the DBI method and clearly explain in the report, citing applicable tables in Chapter 15 of the [A.M.A.,] *Guides*, that ROM is not permitted as an alternative rating method for the diagnosis in question.

"If the rating physician provided an assessment using the DBI 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 CE.

"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."[29]

ANALYSIS -- ISSUE 2

The Board finds that the case is not in posture for decision regarding whether appellant has established entitlement to schedule award compensation for additional permanent impairment of her right upper extremity.

As noted above, FECA Bulletin No. 17-06 provides that, if the rating physician provided an assessment using the ROM method and the A.M.A., *Guides* allows 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 CE.[30]

OWCP determined that there was a conflict in the medical opinion evidence between Dr. Allen and Dr. Slutsky regarding appellant's right upper extremity permanent impairment (as well as regarding bilateral lower extremity permanent impairment as discussed above) and

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

[29] *Id*.

[30] *See supra* note 29.

referred appellant to Dr. Schneider for an impartial medical examination.[31] The Board notes, however, that there was no conflict in the medical opinion evidence between Dr. Allen and Dr. Slutsky regarding appellant's right upper extremity permanent impairment (both physicians finding two percent permanent impairment). Therefore, Dr. Schneider would be considered a second opinion physician on this issue rather than as an impartial medical specialist.[32] In his capacity as an OWCP referral physician, Dr. Schneider used the DBI method of rating permanent impairment on February 25, 2016 and determined that appellant had two percent permanent impairment of her right upper extremity. On August 19, 2016 Dr. Katz, serving as a DMA, used the DBI method of rating permanent impairment and also determined that appellant had two percent permanent impairment of her right upper extremity.

OWCP based its September 21, 2016 and May 30, 2017 determinations regarding appellant's right upper extremity permanent impairment on the opinions of Dr. Schneider and Dr. Katz. The Board notes that Dr. Katz should have independently calculated appellant's impairment using both the ROM and DBI methods and identified the higher rating for the claims examiner. If the medical evidence of record was not sufficient for Dr. Katz to render a rating using the ROM or DBI method, he should have advised as to the medical evidence necessary to complete the rating.[33]

The Board further notes that the record does not currently contain all the relevant evidence necessary to make a reasoned determination regarding appellant's right upper extremity permanent impairment. For example, OWCP indicated that appellant had prior claims for the right upper extremity (referenced as OWCP File Nos. xxxxxx760 and xxxxxx329) and noted that she received a prior schedule award for right upper extremity permanent impairment, but the record does not contain appellant's prior schedule award and only contains a few documents from her prior claims involving the right upper extremity. Pursuant to 20 C.F.R. § 501.2(c)(1), 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 and the Board has held that all evidence that forms the basis of a decision must be in a given claimant's case record.[34] Therefore, on remand, OWCP should obtain evidence from OWCP File Nos. xxxxxx760 and xxxxxx329 relevant to the determination of the permanent impairment of appellant's right upper extremity. In reaching its determination about right upper extremity permanent impairment, OWCP should evaluate the basis for any prior schedule award granted for

[31] Dr. Allen, an attending physician, used the DBI method of rating permanent impairment on November 8, 2014 to determine that appellant had two percent permanent impairment of her right upper extremity. Dr. Slutsky, a DMA, also used the DBI method on August 15, 2015 to find that she had the same degree of right upper extremity permanent impairment.

[32] *See R.H.*, Docket No. 17-1477 (issued March 14, 2018) (finding that, due to the lack of a conflict in the medical evidence at the time of the referral to the putative impartial medical specialist, the physician actually served as an OWCP referral physician rather than an impartial medical specialist).

[33] *See supra* note 29.

[34] *See* 20 C.F.R. § 501.2(c)(1); *K.P.*, Docket No. 15-1945 (issued February 10, 2016). *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Initial Development of Claims*, Chapter 2.800.5a (June 2011). In particular, the Board notes that OWCP made reference to a December 17, 2014 schedule award that is not found in the case record.

right upper extremity permanent impairment and calculate any nonoverlapping permanent impairment of the right upper extremity.[35]

This case will therefore be remanded for development of the case record as described above and application of the new OWCP procedures found in FECA Bulletin No. 17-06. After such further development of the evidence as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish permanent impairment of her lower extremities entitling her to schedule award compensation. The Board further finds that the case is not in posture for decision regarding whether appellant has established entitlement to schedule award compensation for additional permanent impairment of her right upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the May 30, 2017 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part and the case is remanded for further action consistent with this decision.

Issued: October 9, 2018
Washington, DC

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

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

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

[35] Section 8108 of FECA provides that the period of schedule award compensation payable under the schedule in section 8107(c) is reduced by the period of compensation paid or payable under the schedule for an earlier injury if compensation in both cases is for disability of the same member or function or different parts of the same member or function or for disfigurement, and if that compensation payable for the later disability in whole or in part would duplicate the compensation payable for the preexisting disability. 5 U.S.C. § 8108.