United States Department of Labor
Employees' Compensation Appeals Board

B.B., Appellant	)	
and	)	**Docket No. 17-1949**
	)	**Issued: October 16, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Hinsdale, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On September 18, 2017 appellant filed a timely appeal from an April 6, 2017 merit decision and an August 25, 2017 nonmerit 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 the claim.[2]

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish more than 13 percent permanent impairment of her left upper extremity, for which she previously received schedule award compensation; (2) whether appellant has met her burden of proof to establish permanent impairment of her lower extremities due to her accepted lumbar conditions; and

[1] 5 U.S.C. § 8101 *et seq.*

[2] The record on appeal includes evidence received after OWCP issued its August 25, 2017 decision. 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. 20 C.F.R. § 501.2(c)(1). Therefore, evidence not before OWCP at the time of the August 25, 2017 decision will not be considered by the Board for the first time on appeal. *Id.*

(3) whether OWCP properly denied appellant's request for reconsideration of the merits of her schedule award claims pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On December 1, 2009 appellant, then a 53-year-old sales and service associate, filed a traumatic injury claim (Form CA-1) alleging that, while at work on November 30, 2009, she sustained a lower back and left shoulder injury while placing heavy boxes onto a cart. OWCP accepted the claim, assigned OWCP File No. xxxxxx704, for lumbar sprain and left shoulder and rotator cuff sprain. Appellant underwent authorized left shoulder rotator cuff repair, acromioplasty, and distal clavicle resection on April 14, 2010.[3] She retired effective April 21, 2011.[4]

On June 26, 2012, under the current claim, appellant filed a claim for a schedule award (Form CA-7) due to her accepted left shoulder and lumbar sprain conditions.

In a September 26, 2012 report, Dr. Allan Brecher, a Board-certified orthopedic surgeon and second opinion examiner, reviewed the statement of accepted facts (SOAF) and the medical evidence of record.[5] In pertinent part, he opined that maximum medical improvement (MMI) for all conditions was reached on the date of his examination. Dr. Brecher opined that there was no permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent* Impairment (A.M.A., *Guides*)[6] for the left CTS or rotator cuff as the conditions were resolved. He also opined that there was no permanent impairment of the back or lower extremities as appellant's back pain was subjective.

In an October 1, 2012 report, Dr. Samuel J. Chmell, a Board-certified orthopedic surgeon, advised that appellant had reached MMI on May 24, 2012 for the left shoulder torn rotator cuff/strain. In an attached September 13, 2012 upper extremity worksheet, he opined that she had a total 30 percent left upper extremity permanent impairment after combining range of motion (ROM) and diagnosis-based impairment (DBI) calculations.

[3] OWCP previously accepted that appellant sustained a sprain of lumbosacral (joint) (ligament), displacement of lumbar intervertebral disc at L4-5 without myelopathy; and thoracic or lumbosacral left-sided neuritis or radiculitis due to a September 3, 1991 employment injury, assigned OWCP File No. xxxxxx544. It also previously accepted that she sustained bilateral carpal tunnel syndrome (CTS) due to a September 2, 1991 employment injury, assigned OWCP File No. xxxxxx845. In October 1995, OWCP granted appellant a schedule award for 10 percent permanent impairment of the right upper extremity. On May 26, 2012 appellant filed a claim for a schedule award (Form CA-7) due to her accepted bilateral CTS under OWCP File No. xxxxxx845.

[4] OWCP File Nos. xxxxxx704, xxxxxx544, and xxxxx845 have been administratively combined, with the former serving as the master file.

[5] On August 14, 2012 OWCP determined that a second opinion evaluation was necessary to determine appellant's work status attributable to her accepted lumbar strain and left shoulder and rotator cuff conditions. The second opinion examiner was asked to provide an assessment of appellant's permanent partial impairment of her lumbar strain and left shoulder and rotator cuff conditions. The SOAFs noted that bilateral CTS was an accepted condition under OWCP File No. xxxxxx845 and OWCP provided a copy of the case file.

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

On October 15, 2012 OWCP declared a conflict in medical opinion between Dr. Brecher and Dr. Chmell regarding the assessment of appellant's permanent impairment of the left upper extremity. Appellant was referred to Dr. S.I. Yen, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict in medical opinion. However, in his December 31, 2012 report, Dr. Yen failed to resolve the conflict as he indicated that he did not perform permanent impairment ratings.

Dr. David H. Garelick, a Board-certified orthopedic surgeon, serving as an OWCP district medical adviser (DMA), reviewed Dr. Chmell's June 30 and October 1, 2012 impairment ratings respectively on March 4 and October 21, 2013. He indicated that both Dr. Chmell's June 30 and October 1, 2012 impairment ratings were not acceptable as the A.M.A., *Guides* prohibited combining ROM and DBI impairments. In his October 21, 2013 report, Dr. Garelick noted Dr. Chmell's examination findings for the left shoulder, which had full ROM with no signs of impingement. He opined that MMI was reached one year following the rotator cuff repair and that, under Table 15-5, page 403 of the A.M.A., *Guides*, appellant had 10 percent left upper extremity permanent impairment for distal clavicle resection. Dr. Garelick noted that, since the shoulder was essentially asymptomatic, no additional award was given for the rotator cuff repair. He also found no objective evidence for any lower extremity impairment.[7]

By decision dated January 2, 2014, OWCP granted appellant a schedule award for 10 percent permanent impairment of her left upper extremity. The award ran 31.2 weeks for the period July 28, 2013 to March 3, 2014 and was based on Dr. Garelick's impairment rating for a distal clavicle resection.

On January 9, 2014 appellant requested an oral hearing before an OWCP hearing representative. A video hearing was held on May 14, 2014.

The record reflects that, under OWCP File No. xxxxxx845, Dr. James P. Elmes, a Board-certified orthopedic surgeon serving as a second opinion physician, performed an upper extremity impairment evaluation for appellant's accepted bilateral CTS on March 24, 2014. He opined that appellant reached MMI for the left wrist in May 2011, for the right wrist in May 2012, and for the left shoulder in January 2011. Dr. Elmes opined that she had 21 percent total impairment of the left upper extremity and 1 percent impairment of the right upper extremity. He noted his examination findings and provided his calculations. In a March 29, 2014 addendum, Dr. Elmes indicated that Table 15-21, page 438 of the A.M.A., *Guides* was used because of median nerve entrapment at the left wrist and that appellant had 12 percent permanent impairment for the left CTS and 1 percent permanent impairment for the right CTS.

On May 5, 2014 Dr. Garelick opined that Dr. Elmes' impairment recommendations should not be used as Dr. Elmes had used Table 15-21, Table 15-8, and Table 16-23 to compute his 12 percent permanent impairment for the left upper extremity and the A.M.A., *Guides* used Table 15-

[7] Based on the examination findings provided by Dr. Chmell, the DMA noted that the predominance of appellant's complaints with regard to the back were on the left side. Appellant was able to toe and heel walk and had no pain with straight leg raise. The lower extremity strength was normal except for some slight loss of strength in the quadriceps and hamstring musculature. The DMA indicated the lumbar MRI scan demonstrated questionable narrowing of the L4-5 disc space without mention of nerve root impingement with a disc protrusion/herniation more pronounced on the right.

23 for peripheral nerve entrapment syndromes. Using Dr. Elmes' October 24, 2014 examination findings, the Dr. Garelick opined that appellant had eight percent left upper extremity permanent impairment and eight percent right upper extremity permanent impairment due to the bilateral CTS. He set forth his calculations. As appellant already received 10 percent permanent impairment for the right upper extremity due to CTS, Dr. Garelick opined that no additional award was warranted. Using the Combined Values Chart, Dr. Garelick opined that appellant had 17 percent total left upper extremity permanent impairment (8 percent for CTS and 10 percent for left shoulder previously awarded). The date of MMI was March 24, 2014, the date of Dr. Elmes' examination.

By decision dated July 16, 2014, an OWCP hearing representative set aside OWCP's January 2, 2014 left upper extremity schedule award decision. He found that a conflict of medical opinion still remained between Drs. Brecher and Chmell with regard to the assessment of appellant's left upper extremity permanent impairment and a new impartial medical specialist was required as Dr. Yen had indicated that he did not perform impairment evaluations. The hearing representative further found that Dr. Brecher's September 25, 2012 opinion that appellant had no impairment in her back or lower extremities was of diminished probative value as the SOAFs upon which his opinion was based had no information regarding appellant's 1991 back injury that OWCP had accepted under OWCP File No. xxxxxx544. OWCP was directed to combine appellant's case files and further develop the issue of permanent impairment of both the upper and lower extremities given the approved conditions of the upper extremities and low back under File Nos. xxxxxx704 and xxxxxx544.

On December 31, 2014 OWCP issued a new SOAF which included the accepted conditions under File Nos. xxxxxx704, xxxxxx544, and xxxxxx845.[8]

On February 13, 2015 OWCP requested that Dr. Gary Klaud Miller, a Board-certified orthopedic surgeon, perform an impartial medical evaluation to rate appellant's permanent impairment of the left upper extremity.

In a March 12, 2015 report, Dr. Brecher performed another second opinion evaluation of appellant's lumbar spine at the request of OWCP. He reviewed the SOAFs, which included information regarding the combined cases, and the medical record. Examination findings of the left shoulder, bilateral wrists, and back were provided. Dr. Brecher opined that MMI was reached for appellant's back on December 22, 2011 when she saw her treating physician. Utilizing Table 16-12 of the A.M.A., *Guides*, he opined that there was a class 1 mild problem of the sciatic nerve as there was mild sensory and motor loss. Dr. Brecher assigned a zero for physical examination modifier as she had normal gait. He assigned grade modifier 1 for functional history as she had a mild problem which did not interfere with activities. Dr. Brecher assigned grade modifier 1 for clinical studies as the MRI scan showed a herniated disc. Therefore, he opined that appellant had a grade B or 3 percent sensory deficit and 7 percent mild motor deficit for the sciatic nerve, which totaled 10 percent lower extremity impairment. A copy of Dr. Brecher's March 6, 2015 impairment calculations worksheet for the lower extremity was provided.

[8] OWCP previously issued an October 8, 2014 SOAF which included the accepted conditions under File Nos. xxxxxx704 and xxxxxx845, but not File No. xxxxxx544.

In an April 2, 2015 report, Dr. Miller indicated that an impairment evaluation of appellant's left upper extremity only was performed on March 11, 2015. He indicated that she had nearly full left shoulder motion. Dr. Miller noted that all shoulder motions were painful and appellant had 175 degrees of abduction with 80 degrees of external rotation and 80 degrees of external rotation. For the accepted left rotator cuff tear, he indicated that appellant had seven percent permanent impairment of the left upper extremity. Dr. Miller assigned grade 1 modifier for clinical studies, grade 1 modifier for physical examination, and grade 3 modifier for functional history, which he indicated moved the base impairment level of five percent to seven percent impairment. For the left CTS, he utilized Table 15-23 on page 449 and opined that appellant had six percent permanent left upper extremity impairment. Dr. Miller assigned 3 for physical examination, 1 for testing, 3 for functional limitations, and 1 history, which averaged 2. He placed appellant in class 2 or five percent impairment. The *Quick*Dash score of 75 raised her grade modification one level.

In a May 25, 2015 DMA report, Dr. Garelick rereviewed appellant's medical record to determine her permanent impairment of both upper extremities due to CTS and a left shoulder rotator cuff tear.[9] For the left upper extremity, he reviewed Dr. Miller's April 2, 2015 report and indicated that Dr. Miller's award recommendations of seven percent left upper extremity impairment for the rotator cuff tear and six percent left upper extremity impairment for the CTS were reasonable. Dr. Garelick used the Combined Values Chart on page 604 of the A.M.A., *Guides* and found that the total left upper extremity permanent impairment was 13 percent.

For the lower extremity, Dr. Garelick reviewed Dr. Brecher's March 10, 2015 report.[10] He found that Dr. Brecher's recommended 10 percent left lower extremity impairment was based on Table 16-12, page 534 of the A.M.A., *Guides*, but the July/August 2009 *The Guides Newsletter* was utilized to rate lower extremity impairment. Dr. Garelick indicated that Dr. Brecher had noted mild subjective decreased sensation in the lateral aspect of the left calf into the foot, negative straight leg raise, and no mention of any lower extremity weakness. He also indicated that, while a previous MRI scan of the lumbar spine demonstrated a herniated disc at L4-5, there did not appear to be any radicular signs or symptoms at this time based on Dr. Brecher's negative straight leg raise and no documented weakness in the lower extremities. The DMA noted that subjective complaints of diminished sensation were multifactorial. He noted that under *The Guides Newsletter,* nonverifiable radicular complaints were assigned a class 1 impairment, which under Table 17-4, page 570 resulted in 0 percent lower extremity permanent impairment. Thus, the DMA found that there was no objective basis for a finding of lower extremity permanent impairment. He further indicated that MMI occurred on March 24, 2014, as indicated by the prior second opinion physician, Dr. James Elmes.

Dr. Garelick concluded that appellant had total left upper extremity impairment of 13 percent and total right upper extremity impairment of 10 percent, but no impairment of her lower extremities.

[9] In its May 19, 2015 referral to the DMA, OWCP had listed all the accepted conditions under File Nos. xxxxxx704, xxxxxx544, and xxxxxx845. It also noted that appellant had received 10 percent schedule award for permanent impairment of the right upper extremity under File No. xxxxxx845 and 10 percent schedule award for permanent impairment of the left upper extremity under File No. xxxxxx704.

[10] The Board notes that Dr. Brecher's report is dated March 12, 2015.

By decision dated June 19, 2015, OWCP granted appellant a schedule award for an additional 3 percent permanent impairment of the left upper extremity, for 13 percent total impairment, but denied entitlement to a schedule award for the lower extremities. The period of the additional award ran for 9.36 weeks from March 24 to May 28, 2014. The decision noted that the rating was based upon evidence in master OWCP File No. xxxxxx704 and subsidiary File Nos. xxxxxx544 and xxxxxx845.

On July 3, 2015 appellant requested an oral hearing before an OWCP hearing representative. A telephonic hearing was held on October 28, 2015, during which she questioned why she did not receive a schedule award for 17 percent permanent impairment in keeping with the May 5, 2014 recommendation of Dr. Garelick. Appellant also questioned why she did not receive a schedule award for her back problems as Dr. Brecher indicated in his March 10, 2015 supplemental report that she had 10 percent left lower extremity impairment.

OWCP received July 23, November 19, and December 23, 2015 reports from Dr. Chmell, a January 10, 1992 bilateral lower extremity nerve conduction velocity study, and a report of appellant having undergone a lumbar facet joint block injection on September 26, 1992.

By decision dated January 14, 2016, the hearing representative affirmed OWCP's June 19, 2015 decision. He found that the medical evidence of record in appellant's multiple cases failed to establish additional permanent impairment of the upper or lower extremities. With regard to the left upper extremity, the hearing representative noted that Dr. Miller's impartial report of March 11, 2015, which the DMA indicated resulted in 13 percent permanent impairment of the left upper extremity, was properly used rather than Dr. Elmes' second opinion left upper extremity rating, which the DMA indicated resulted in 17 percent total impairment.

On December 19, 2016 appellant requested reconsideration. In support of her request, she resubmitted a copy of Dr. Chmell's June 29 and 30, 2012 reports pertaining to impairment of her bilateral upper extremities. Appellant also submitted multiple physical therapy notes, a May 27, 2015 magnetic resonance imaging (MRI) scan of the lumbar spine,[11] a June 23, 2016 electromyogram and nerve conduction velocity (EMG/NCV) study,[12] and multiple progress reports from Dr. Chmell dated February 4, 2016 to April 20, 2017.

On October 20, 2016 Dr. Chmell performed an impairment evaluation of appellant's lower extremities as a result of her accepted work-related accepted lumbar conditions. In an October 31, 2016 report, he opined that appellant had 13 percent permanent impairment of each of her lower extremities and that the July/August 2009 *The Guides Newsletter* was used in calculating the impairment. Dr. Chmell noted that appellant had all of the criteria to document and demonstrate lower extremity impairment on both sides as a result of her accepted work-related injury. This included continued low back pain on both sides, positive straight leg raising on examination bilaterally, weakness at both ankles and feet with regard to dorsiflexion, sensory deficit on the

[11] The May 27, 2015 MRI scan of the lumbar spine indicated advanced spondylosis L4-5 with disc bulging extending into the foramina, a central protrusion with associated annular tear and moderate bilateral foraminal stenosis; L3-4 disc bulging with mild right and borderline left foraminal stenosis; and L2-3 minimal far left lateral protrusion without significant left foraminal stenosis.

[12] The June 23, 2016 EMG/NCV report noted bilateral L4-5 and L5-S1 active radiculopathy with sensory nerve action, but negative for polyneuropathy.

dorsum of both feet. Dr. Chmell also related that appellant's June 23, 2016 EMG demonstrated bilateral lower extremity radiculopathy and that the MRI scan of her lumbar spine demonstrated L4-5 advanced spondylolysis with disc herniation and extension of the disc herniation into bilateral neural foramina. He also opined that appellant had reached MMI on November 13, 2014. A spinal nerve impairment worksheet indicated that the L5 nerve root caused 13 percent permanent impairment of the lower extremities due to the above findings.

In a March 30, 2017 report, Dr. David Slutsky, a Board-certified orthopedic surgeon serving as a DMA, opined that the medical evidence failed to establish any impairment of the lower extremities. He opined that Dr. Chmell's October 31, 2016 impairment rating of 13 percent impairment was insufficient as the physician did not provide any physical examination findings to grade the apparent sensory loss and apparent motor loss, functional history, or any data to explain the reasons for his impairment rating. Dr. Slutsky concluded that additional information was required to determine the impairment rating and date of MMI.

By decision dated April 6, 2017, OWCP denied modification of its January 14, 2016 decision. It found that Dr. Chmell's October 31, 2016 report was insufficient to establish additional permanent impairment that would justify an increased schedule award.

On May 31, 2017 appellant requested reconsideration of OWCP's April 6, 2017 decision. She alleged that the December 31, 2014 SOAF was outdated and did not include reference to the MRI scan report of May 27, 2015 or the EMG/NCV report of June 23, 2016. Appellant further alleged that those reports as well as Dr. Chmell's spinal nerve impairment worksheet was not sent to Dr. Slutsky, a DMA, for review. She also alleged that OWCP did not allow her the opportunity to complete the DMA's request for additional information.

In support of her request, appellant resubmitted copies of the May 27, 2015 MRI scan of the lumbar spine and June 23, 2016 EMG/NCV reports, Dr. Chmell's October 31, 2016 letter and October 20, 2016 spinal nerve impairment worksheet. Also submitted were letters from Dr. Chmell dated April 20 and 29, 2017 and reports on appellant's status from June 9, 2017 onward and physical therapy reports.

By decision dated August 25, 2017, OWCP denied appellant's request for reconsideration, finding that the evidence submitted was either repetitious or irrelevant.

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 FECA program with the Director of OWCP.[13] 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.[14] 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

[13] *See* 20 C.F.R. §§ 1.1-1.4.

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

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.[15]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A., issued a 52-page document entitled, Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment*. The document included various changes to the original text, intended to serve as an *erratum*/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[16] 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.[17]

ANALYSIS -- ISSUE 1

The Board finds that this case is not in posture for a decision regarding the extent of permanent impairment of appellant's left upper extremity impairment.

Appellant was granted a schedule award totaling 13 percent permanent impairment of the left upper extremity based upon the April 2, 2015 report of the IME, Dr. Miller. Dr. Miller provided ROM findings regarding appellant's left shoulder, but rated appellant's left shoulder impairment based upon the diagnosis of left rotator cuff tear.

The Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation has been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[18] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[19] In *T.H.*, the Board concluded that OWCP's physicians were at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both the DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board has observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians have been inconsistent in the application of the

[15] 20 C.F.R. § 10.404; *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[16] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

[17] *Isidoro Rivera*, 12 ECAB 348 (1961).

[18] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

[19] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

A.M.A., *Guides*, the Board found that OWCP could no longer ensure consistent results and equal justice under the law for all claimants.[20]

In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the April 6, 2017 decision which denied modification of the January 14, 2016 decision which found that appellant had 13 percent total left upper extremity impairment. Utilizing a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and such other development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for a left upper extremity schedule award.[21]

LEGAL PRECEDENT -- ISSUE 2

Neither FECA nor its implementing 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.[22] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[23] The sixth edition of the A.M.A., *Guides* provides a specific methodology for rating spinal nerve extremity impairment.[24] 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 procedure manual.[25]

OWCP's procedures provide that, if a claimant's physician provides an impairment rating, the case should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[26]

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden to establish entitlement to FECA benefits; however, OWCP shares responsibility in the development of the evidence to see that justice is done.[27] Once OWCP

[20] 5 U.S.C. § 8123(a); *see N.D.,* Docket No. 15-1392 (issued December 9, 2015); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[21] FECA Bulletin No. 17-0006 (issued May 8, 2017).

[22] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see Jay K. Tomokiyo,* 51 ECAB 361, 367 (2000).

[23] *Supra* note 16 at Chapter 2.808.5c(3) (March 2017).

[24] 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.*

[25] *See supra* note 16 at Chapter 3.700, Exhibit 4.

[26] *See supra* note 16 at Chapter 2.808.6(e) (March 2017); *Tommy R. Martin,* 56 ECAB 273 (2005).

[27] *William J. Cantrell*, 34 ECAB 1223 (1983).

undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[28]

ANALYSIS -- ISSUE 2

The Board also finds that this case is not in posture for decision regarding whether appellant has established permanent impairment of her lower extremities as a result of her accepted lumbar conditions.

By decision dated June 19, 2015, OWCP denied appellant's claim for a schedule award for her lower extremities. Appellant requested a hearing and by decision dated January 14, 2016, a hearing representative affirmed OWCP's June 19, 2015 decision.

On December 19, 2016 appellant requested reconsideration and submitted additional evidence including an October 31, 2016 report of Dr. Chmell, wherein he opined that appellant had 13 percent permanent impairment of each of her lower extremities. The July/August 2009 *The Guides Newsletter* was used in calculating the impairment and he cited to specific physical examination findings and diagnostic test results which noted pain, weakness, and sensory deficits.

In a March 30, 2017 report, Dr. Slutsky, serving as a DMA rejected the lower extremity impairment ratings as calculated by Dr. Chmell. However, the DMA noted that additional information was required to properly calculate the extent of permanent impairment of appellant's bilateral lower extremities. He noted that he needed a detailed history of appellant's current functional history and gait analysis, a thorough sensory examination of the involved lower extremity to both light touch and pinprick, and a motor examination of the involved lower extremity and grading according to the British medical research and Council criteria.

It is well established that proceedings under FECA are not adversarial in nature, and while the employee has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[29] Once OWCP undertook development of the evidence by referring appellant to a second opinion physician and Dr. Slutsky, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.[30] The Board will, therefore, set aside OWCP's April 6, 2017 decision and remand the case for a physician to conduct a full physical examination followed by a proper analysis under the A.M.A., *Guides* in order to determine the extent of appellant's lower extremity impairment, if any. After such further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for a lower extremity schedule award.

[28] *Richard F. Williams*, 55 ECAB 343, 346 (2004).

[29] *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[30] *Peter C. Belkind*, 56 ECAB 580 (2005); *Ayanle A. Hashi*, 56 ECAB 234 (2004).

CONCLUSION

The Board finds that the case is not in posture for decision.[31]

ORDER

IT IS HEREBY ORDERED THAT the August 25 and April 6, 2017 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further action consistent with this decision.

Issued: October 16, 2018
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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

[31] In light of the disposition of Issues 1 and 2, the third issue is rendered moot and will not be addressed.