United States Department of Labor
Employees' Compensation Appeals Board

P.W., Appellant	)	
and	)	**Docket No. 19-1493**
	)	**Issued: August 12, 2020**
U.S. POSTAL SERVICE, POST OFFICE, Fort Worth, 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
CHRISTOPHER J. GODFREY, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 2, 2019 appellant filed a timely appeal from a January 3, 2019 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 to consider the merits of this case.[2]

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish greater than six percent permanent impairment of the right lower extremity, for which she previously received a schedule award; and (2) whether appellant has met her burden of proof to establish greater than

[1] 5 U.S.C. § 8101 *et seq.*

[2] The record provided to the Board includes evidence received after OWCP issued its January 3, 2019 decision. Furthermore, appellant submitted additional evidence on appeal. 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 new evidence for the first time on appeal. *Id.*

34 percent permanent impairment of the right upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On November 7, 2002 appellant, then a 46-year-old customer service supervisor, filed an occupational disease claim (Form CA-2) alleging that she developed bilateral carpal tunnel syndrome on or before April 9, 2002, due to factors of her federal employment, including repetitive hand motions. OWCP assigned the claim File No. xxxxxx250 and accepted that claim for the condition of bilateral carpal tunnel syndrome.[3]

On March 7, 2003 appellant filed a schedule award claim (Form CA-7). In support of her claim, she provided an April 3, 2003 impairment rating by Dr. John A. Sklar, a Board-certified physiatrist. Dr. Sklar opined that appellant had attained maximum medical improvement (MMI) following an August 28, 2002 right carpal tunnel release as of April 3, 2003. He noted that appellant had severe rheumatoid arthritis of both wrists and hands and decreased two-point discrimination in the right median and ulnar nerve distributions. Dr. Sklar diagnosed bilateral median and ulnar neuropathy superimposed on rheumatoid arthritis. He opined that according to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[4] then in effect, appellant had 14 percent permanent impairment of the right upper extremity due to median and ulnar neuropathy. In an April 30, 2003 report, Dr. Ronald H. Blum, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), concurred with Dr. Sklar's impairment rating.

By decision dated May 30, 2003, under File No. xxxxxx250, OWCP granted appellant a schedule award for 14 percent permanent impairment of the right upper extremity. The period of the award ran from April 3, 2003 to February 2, 2004.[5]

On September 24, 2013 appellant filed an occupational disease claim (Form CA-2) alleging that she sustained bilateral carpal tunnel syndrome, a ganglion cyst, and aggravation of rheumatoid arthritis due to factors of her federal employment including repetitive keyboarding, lifting, and grasping. OWCP assigned the claim File No. xxxxxx597. On May 20, 2014 it accepted the claim for aggravation of bilateral carpal tunnel syndrome and bilateral osteoarthritis of the hands.

[3] Appellant subsequently filed additional upper and lower extremity claims. On September 24, 2013 she filed an occupational disease claim, to which OWCP assigned File No. xxxxxx597. On April 4, 2016 appellant filed an occupational disease claim for a right shoulder condition, which it assigned File No. xxxxxx007. On April 25, 2018 OWCP administratively combined her accepted claims under File Nos. xxxxxx250, xxxxxx597, and xxxxxx007. It designated File No. xxxxxx250 as the master file number.

[4] A.M.A., *Guides* (5th ed. 2001).

[5] Appellant underwent a left carpal tunnel release and incision of a lipoma on June 4, 2004. On October 15, 2004 she claimed an additional schedule award (Form CA-7) for permanent impairment of the left upper extremity. In support of her claim, appellant submitted a November 19, 2004 impairment rating by Dr. Sklar, finding 12 percent permanent impairment of the left upper extremity due to sensory loss in the left median nerve distribution. By decision dated March 24, 2005, OWCP granted her a schedule award for 12 percent permanent impairment of the left upper extremity. The period of the award ran from November 19, 2004 to August 8, 2005.

Appellant submitted an October 22, 2014 impairment rating by Dr. Les Benson, an occupational medicine specialist, who opined that appellant had attained MMI. Dr. Benson diagnosed bilateral carpal tunnel syndrome with bilateral osteoarthritis of the hands. Referring to Table 15-32, page 473 of the sixth edition of the A.M.A., *Guides*[6] (Wrist Range of Motion), he found seven percent impairment of the right upper extremity for wrist flexion at 23 degrees, seven percent impairment for wrist extension at 22 degrees, nine percent impairment for radial deviation at 2 degrees, and two percent impairment for ulnar deviation at 17 degrees. Dr. Benson combined these impairments to equal 22 percent permanent impairment of the right upper extremity.

On January 6, 2015 OWCP referred Dr. Benson's impairment rating and a statement of accepted facts (SOAF) to Dr. Henry Mobley, a Board-certified internist serving as DMA. In a January 7, 2015 report, Dr. Mobley concurred with Dr. Benson's utilization of the range of motion (ROM) method of evaluation because of the diagnostic key factor of osteoarthritis of both hands as set forth in Table 15-3 (Wrist Regional Grid) of the A.M.A., *Guides*. He opined, however, that according to Table 15-32, radial deviation of the right wrist at two degrees equaled four percent permanent impairment of the right upper extremity, rather than nine percent as found by Dr. Benson. The DMA combined the 7, 7, 4, and 2 percent impairments of the right wrist to equal 20 percent permanent impairment of the right upper extremity.

By decision dated March 24, 2015, under File No. xxxxxx597, OWCP granted appellant a schedule award for an additional 20 percent permanent impairment of the right upper extremity. The period of the award ran from December 9, 2014 to July 26, 2017.[7]

On April 4, 2016 appellant filed an occupational disease claim (Form CA-2) alleging that she developed a right rotator cuff tear due to factors of her federal employment including repetitive throwing, reaching, and lifting.[8] The employing establishment noted that she had previously retired effective December 31, 2013.[9] OWCP assigned the claim File No. xxxxxx007.

Appellant also submitted medical evidence regarding a right ankle condition. She provided an August 4, 2015 report by Dr. Michael V. Tran, an attending podiatrist, who noted a history of ankle surgery for a torn ligament 10 years prior, with the onset of swelling and tenderness in February 2015. Dr. Tran diagnosed a right ankle sprain, rheumatoid arthritis of the right foot and ankle with tenosynovitis, localized primary arthritis, and arthralgia.

By decision dated May 13, 2016, under File No. xxxxxx007, OWCP accepted that appellant sustained a right rotator cuff sprain and a right ankle sprain. On August 1, 2016 it expanded its acceptance of the claim to include the additional conditions of a longitudinal split

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

[7] The March 24, 2015 decision also granted appellant a schedule award for 24 percent permanent impairment of the left upper extremity.

[8] A March 14, 2016 MRI scan of the right shoulder demonstrated a full-thickness tear of the supraspinatus tendon, peritendinitis, acromioclavicular arthropathy, and a complex joint effusion.

[9] The record indicates that appellant briefly returned to work in February 2015.

tear of the right biceps tendon, other synovitis and tenosynovitis of the right ankle and foot, and chondromalacia of the right foot/ankle.

On September 13, 2016 Dr. Kevin A. Williams, an orthopedic surgeon, performed a right shoulder arthroscopy with subacromial decompression, acromioplasty, labral debridement, open rotator cuff repair, and microtenotomy.

In a May 31, 2017 report, Dr. Rory L. Allen, an osteopath specializing in family medicine, opined that appellant's right shoulder and ankle conditions had reached MMI.

On July 20, 2017, under File No. xxxxxx007, appellant claimed a schedule award (Form CA-7) for permanent impairment of the right upper and right lower extremities.

In support of her claim, appellant provided a June 8, 2017 impairment rating by Dr. Allen. Dr. Allen diagnosed a right rotator cuff tear with capsule sprain and spontaneous tendon rupture. He referenced the A.M.A., *Guides* to find 10 percent permanent impairment of the right upper extremity due to restricted motion, including three percent for flexion at 118 degrees; one percent for extension at 37 degrees; three percent for abduction at 145 degrees; one percent for adduction at 35 degrees; two percent for external rotation at 30 degrees. Regarding the right lower extremity, Dr. Allen diagnosed a right ankle sprain with synovitis, tenosynovitis, and chondromalacia of the ankle and foot. He referenced Table 16-20 (Hindfoot Motion Impairments) and Table 16-22 (Ankle Motion Impairments) at page 549 of the A.M.A., *Guides* to find two percent impairment for inversion at 15 degrees and two percent impairment for eversion at 3 degrees, which combined to four percent permanent impairment of the right lower extremity.

On August 10, 2017 OWCP forwarded a copy of the medical record and an updated SOAF to Dr. Arnold T. Berman, a Board-certified orthopedic surgeon serving as a DMA. In a report dated August 17, 2017, Dr. Berman found that appellant had attained MMI. He opined that according to section 16.2, page 497 of the A.M.A., *Guides*, appellant's right upper and lower extremity impairments should be calculated using the diagnosis-based impairment (DBI) method as the ROM method applied "only when the diagnosis did not adequately describe the impairment." Regarding the right upper extremity, Dr. Berman noted that appellant had received a previous schedule award for 20 percent permanent impairment of the right arm under File No. xxxxxx597. Referring to Table 15-5, page 403 (Shoulder Regional Grid), he noted a class of diagnosis (CDX) of 1 for full-thickness rotator cuff tear with repair, which carried a higher value than pathologies of the acromioclavicular joint. Dr. Berman found a grade modifier for functional history (GMFH) of 2 for pain with normal activity, a grade modifier for physical examination (GMPE) of 2 for moderately limited motion, and a grade modifier for clinical studies (GMCS) of 2 for imaging studies demonstrating a rotator cuff tear. Applying the net adjustment formula resulted in an adjustment of plus two, raising the default grade C upward to grade E, resulting in seven percent impairment of the right upper extremity. Regarding the right lower extremity, Dr. Berman assessed a CDX of 1 for right ankle strain and tendinitis according to Table 16-2, page 501 of the A.M.A., *Guides* (Foot and Ankle Regional Grid -- Lower Extremity Impairment), with a default value of five percent. He found a GMFH of 1, GMPE of 2 for moderately restricted motion, and a GMCS of 1 for mild pathology demonstrated on imaging studies. Applying the net adjustment formula resulted in an adjustment of plus one, raising the five percent default value upward to six percent permanent impairment of the right lower extremity.

By decision dated October 24, 2017, under File No. xxxxxx007, OWCP granted appellant a schedule award for six percent permanent impairment of the right lower extremity. It found that she had not established additional permanent impairment of the right upper extremity beyond the 20 percent previously awarded.

On November 28, 2017 appellant requested reconsideration. She asserted that the accepted right shoulder conditions entitled her to an additional schedule award.

On December 20, 2017 OWCP requested that Dr. Berman submit a supplemental report utilizing both ROM and DBI methodology to rate appellant's right upper and lower extremity impairments. It also requested that he clarify whether the seven percent permanent impairment of the right upper extremity due to rotator cuff tear was in addition to the previous schedule award for carpal tunnel syndrome.

In an April 10, 2018 report, Dr. Berman opined that the 7 percent permanent impairment of the right upper extremity for a torn rotator cuff did not alter the previous 20 percent impairment rating for the right upper extremity. Utilizing Dr. Allen's measurements to calculate the impairment under the ROM method, he found three percent right upper extremity impairment for shoulder flexion at 118 degrees, one percent impairment for extension at 37 degrees, three percent impairment for abduction at 148 degrees, and two percent impairment for external rotation at 30 degrees. Dr. Berman combined these impairments to find nine percent permanent impairment of the right upper extremity. Regarding the right lower extremity, he opined that the DBI impairment rating of the right lower extremity should stand at six percent, which was greater than the four percent impairment based on the ROM method as calculated by Dr. Allen.

On April 25, 2018 OWCP requested that Dr. Berman submit a supplemental report addressing the appropriate percentage of permanent impairment of the right upper extremity. In a report received on May 22, 2018, Dr. Berman opined that, according to the Combined Values Chart on page 604 of the A.M.A., *Guides*, the 20 percent permanent impairment for right carpal tunnel syndrome should be combined with the 9 percent permanent impairment for right rotator cuff tear to equal 27 percent permanent impairment of the right upper extremity.

By decision dated January 3, 2019, OWCP denied modification of its October 24, 2017 decision as the medical evidence of record did not support a greater percentage of permanent impairment than previously awarded. It noted that appellant had received previous schedule awards for a total 34 percent permanent impairment of the right upper extremity, based upon the14 percent award for right carpal tunnel syndrome under File No. xxxxxx250, and the 20 percent award for a torn right rotator cuff under File No. xxxxxx597.[10]

[10] OWCP noted that it would issue a forthcoming overpayment decision as appellant received prior schedule awards for bilateral upper extremity impairment in excess of the percentages supported by the medical record. The Board has jurisdiction to consider and decide appeals from final decisions of OWCP in any case arising under FECA. 20 C.F.R. § 501.2(c). As there is no final decision of record regarding an alleged overpayment of compensation, the Board lacks jurisdiction to consider that issue on the present appeal. *Id*.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[11] and its implementing regulations[12] 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. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[13] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[14]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[15] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment of the CDX, which is then adjusted by grade modifiers of GMFH, GMPE, and GMCS.[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17] The standards for evaluation of permanent impairment of an extremity under the A.M.A., *Guides* are based on all factors that prevent a limb from functioning normally, such as pain, sensory deficit, and loss of strength.[18]

OWCP 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 permanent impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[19]

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[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

[13] *Id.* at § 10.404(a); *see also Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[14] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[15] A.M.A., *Guides*, page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[16] *Id.* at 493-556.

[17] *Id*. at 521.

[18] *C.H.*, Docket No. 17-1065 (issued December 14, 2017); *E.B.*, Docket No. 10-0670 (issued October 5, 2010); *Robert V. Disalvatore*, 54 ECAB 351 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[19] *See* Federal (FECA) Procedure Manual, *supra* note 14 at Chapter 2.808.6(f) (March 2017).

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met her burden of proof to establish more than six percent permanent impairment of her right lower extremity, for which she previously received a schedule award.

To determine the permanent impairment of appellant's right ankle, the DMA reviewed Dr. Allen's clinical findings and diagnosis of a right ankle sprain with tendinitis. In his August 17, 2017 report, the DMA identified a CDX of 1 for a right ankle strain with tendinitis under Table 16-2, page 501 of the A.M.A., *Guides,* which yielded a default (C) value of five percent. The DMA then applied grade modification procedures of the A.M.A., *Guides* to the physical findings provided by Dr. Allen and found, under Table 16-6, Table 16-7, and Table 16-8 of the A.M.A., *Guides,* GMFH of 1, GMPE of 2, and GMCS of 1, respectively. The net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or (1-1) + (2-1) + (1-1), resulted in a net adjustment of +1,which moved the default (C) value upward to grade D, equaling six percent permanent impairment. The DMA opined that the DBI method was superior to the ROM method utilized by Dr. Allen, as it more fully described the nature of appellant's impairment. Additionally, the DMA explained in an April 10, 2018 supplemental report that the six percent DBI impairment rating of the right lower extremity was more advantageous to appellant than the four percent ROM rating.[20] There is no medical evidence of record establishing greater than six percent permanent impairment of the right lower extremity. Therefore, the Board finds that appellant has established six percent permanent impairment of the right lower extremity as there is no evidence of record to support an increased schedule award.

Appellant may request a schedule award or increased schedule award at any time based on evidence of new exposure, or medical evidence showing a progression of an employment-related condition resulting in permanent impairment or increased impairment.

LEGAL PRECEDENT -- ISSUE 2

Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment for the CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS and the net adjustment formula is applied. The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[21] OWCP 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 permanent impairment specified.[22]

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

[21] *See id*. at 387.

[22] *M.S.*, Docket No. 19-0282 (issued August 2, 2019); Federal (FECA) Procedure Manual, *supra* note 14 at Chapter 2.808.6f (March 2017).

The A.M.A., *Guides* also provide that ROM impairment methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other DBI sections are applicable.[23] 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.[24] 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.[25]

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.[26] 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:

> "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 impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)[27]
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> The Bulletin further advises:
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> "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."[28]

[23] A.M.A., *Guides* 461.

[24] *Id.* at 473.

[25] *Id.* at 474.

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

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

[28] *Id.* at 474; *A.R.*, Docket No. 19-1284 (issued January 14, 2020); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

ANALYSIS -- ISSUE 2

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

In support of her July 20, 2017 schedule award claim, appellant submitted a June 8, 2017 impairment rating by Dr. Allen, finding 10 percent permanent impairment of the right upper extremity based on restricted ROM of the right shoulder.

Consistent with its procedures,[29] OWCP referred the matter to a DMA for an opinion regarding appellant's permanent impairment in accordance with the A.M.A., *Guides*. Dr. Berman, serving as DMA, reviewed Dr. Allen's report, and opined that Dr. Allen should not have utilized the ROM rating method as the DBI rating method adequately described appellant's impairments. The DMA found seven percent permanent impairment of the right upper extremity utilizing the DBI rating method. On December 20, 2017 OWCP requested that the DMA provide a supplemental report rating appellant's right upper extremity impairments utilizing both the DBI and ROM methods. In response, the DMA submitted an April 25, 2018 report finding nine percent permanent impairment of the right upper extremity utilizing Dr. Allen's measurements to calculate the impairment under the ROM method to assess the right shoulder. OWCP utilized the DMA's ROM impairment assessment in its January 3, 2019 decision as it was higher than the seven percent DBI rating.[30]

However, Dr. Allen did not specify whether he obtained three independent ROM measurements as required by the A.M.A., *Guides*. Dr. Allen noted only a singular measurement for each ROM, without explaining whether they reflected the greatest ROM of three measurements as required.[31] Additionally, the DMA did not indicate that Dr. Allen properly conducted three trials for each applicable range of shoulder motion. The Board therefore finds that as Dr. Allen failed to render a proper examination and impairment rating, his report, as well as that of the DMA flowing therefrom, is insufficient to resolve this issue in the claim.

On remand OWCP should request a supplemental report from Dr. Allen to clarify whether the ROM measurements provided in his June 8, 2017 impairment rating were the greatest ROM of three measurements obtained in accordance with the A.M.A., *Guides* procedures or obtain new ROM measurements and an updated impairment rating examination. Following this and such further development as deemed necessary, OWCP shall issue a *de novo* decision.[32]

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish greater than six percent permanent impairment of the right lower extremity, for which she previously received a

[29] *Id.* at 464.

[30] *Id.* at 477.

[31] *Id*.

[32] *A.R.*, *supra* note 28.

schedule award. The Board also finds that the case is not in posture for a decision regarding appellant's right upper extremity schedule award claim.

ORDER

IT IS HEREBY ORDERED THAT the January 3, 2019 decision of the Office of Workers' Compensation Programs is affirmed in part regarding impairment of the right lower extremity and set aside in part regarding impairment of the right upper extremity. The case is remanded for further proceedings consistent with this decision of the Board.

Issued: August 12, 2020
Washington, DC

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

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

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