United States Department of Labor
Employees' Compensation Appeals Board

N.G., Appellant	)	
and	)	**Docket No. 20-0557**
	)	**Issued: January 5, 2021**
U.S. POSTAL SERVICE, POST OFFICE, New Orleans, LA, 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
JANICE B. ASKIN, Judge

JURISDICTION

On January 14, 2020 appellant filed a timely appeal from an October 18, 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 over the merits of this case.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the October 18, 2019 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant met his burden of proof to establish more than 19 percent permanent impairment of his right upper extremity and 13 percent permanent impairment of his left upper extremity for which he previously received schedule award compensation.

FACTUAL HISTORY

On December 17, 1999 appellant, then a 45-year-old distribution clerk, filed a traumatic injury claim (Form CA-1) alleging that on that date he injured his right shoulder when casing mail while in the performance of duty. He did not stop work. OWCP assigned File No. xxxxxx279 and accepted the claim for the conditions of right shoulder strain, and right rotator cuff tear with tendinitis and subacromial bursitis. On August 22, 2000 appellant underwent OWCP-authorized right shoulder surgery, including rotator cuff repair, distal clavicle resection, and acriomioplasty.

On February 21, 2001 appellant filed a claim for a schedule award (Form CA-7) due to his accepted employment injuries. By decision dated February 11, 2002, OWCP granted him a schedule award for 17 percent permanent impairment of his right upper extremity. The award was based on a September 26, 2001 rating report of Dr. Henry Mobley, a Board-certified internist serving as an OWCP district medical adviser (DMA). The DMA based his permanent impairment rating on the April 10, 2001 examination findings of Dr. Gregg A. Bendrick, a Board-certified occupational medicine physician serving as an OWCP referral physician.

On February 12, 2002 appellant filed a traumatic injury claim (Form CA-1) alleging that on that date he sustained a neck injury when sweeping mail while in the performance of duty. OWCP assigned File No. xxxxxx144 and accepted the claim for neck sprain/strain. On April 5, 2002 appellant filed an occupational disease claim (Form CA-2) alleging that he sustained right carpal tunnel syndrome due to factors of his federal employment including repetitive work duties. OWCP assigned File No. xxxxxx160 and accepted the claim for bilateral carpal tunnel syndrome.[3] It subsequently combined File Nos. xxxxxx144, xxxxxx160, and xxxxxx279, designating the latter as the master file.

On July 10, 2006 appellant underwent OWCP-authorized cervical spine anterior interbody fusion at C3 and C4.

On March 5, 2007 appellant filed a claim for an increased schedule award. By decision dated March 6, 2008, OWCP granted him a schedule award for 13 percent permanent impairment of his left upper extremity. The award was based on a February 11, 2008 report of Dr. Ronald Blum, a Board-certified orthopedic surgeon who served as a new DMA. The impairment calculations were derived from the September 25, 2007 examination findings of Dr. Donald Faust, a Board-certified orthopedic surgeon.

On February 18, 2010 appellant filed a claim for an increased schedule award. By decision dated July 14, 2011, OWCP granted him a schedule award for an additional two percent permanent impairment of his right upper extremity. The award was based on March 10 and May 27, 2011

[3] On May 29, 2003 appellant underwent OWCP-authorized right carpal tunnel release surgery.

reports of Dr. Blum. The impairment calculations were derived from the February 7, 2011 examination findings of Dr. Douglas Lurie, a Board-certified orthopedic surgeon.

On August 28, 2011 appellant filed a claim for an increased schedule award.

In an October 2, 2011 development letter, OWCP requested that appellant submit an impairment rating report within 30 days. Appellant failed, however, to submit the requested evidence within the afforded period. By decision dated December 1, 2011, OWCP denied appellant's claim for an increased schedule award.

On December 8, 2016 appellant again filed a claim for an increased schedule award. In a December 15, 2016 development letter, OWCP requested that he submit an impairment rating report within 30 days. However, appellant did not submit the requested evidence within the afforded period.

On April 18, 2017 OWCP referred appellant for a second opinion examination to Dr. Simon Finger, a Board-certified orthopedic surgeon. It requested that Dr. Finger provide an opinion regarding the extent of appellant's bilateral upper extremity permanent impairment under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] OWCP provided Dr. Finger with a copy of the case record, including a recent statement of accepted facts (SOAF).

In an April 25, 2017 report, Dr. Finger discussed appellant's factual and medical history and reported physical examination findings. He determined that, under the standards of the sixth edition of the A.M.A., *Guides,* appellant had 12 percent permanent impairment of his right upper extremity based upon a diagnosis-based impairment (DBI) rating by utilizing Table 15-5 (Shoulder Regional Grid) beginning on page 401. OWCP requested that Dr. Finger clarify his April 25, 2017 report and, in February 1 and May 3, 2018 supplemental reports, Dr. Finger determined that appellant had 16 percent permanent impairment of his right upper extremity due to right shoulder deficits and right carpal tunnel syndrome[5] and 5 percent permanent impairment of his left upper extremity due to left carpal tunnel syndrome. In reaching this determination, he utilized Table 15-5, as well as Table 15-23 (Entrapment/Compression Neuropathy Impairment) beginning on page 449.

On June 18, 2018 OWCP referred appellant's case to Dr. Morley Slutsky, a Board-certified occupational medicine physician serving as a new DMA, and requested that he review Dr. Finger's permanent impairment ratings. In a July 3, 2018 report, the DMA determined that appellant had 16 percent permanent impairment of his right upper extremity due to right shoulder deficits and right carpal tunnel syndrome, and 8 percent permanent impairment of his left upper extremity due to left shoulder deficits and left carpal tunnel syndrome.

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

[5] Under the Combined Values Chart on page 604, the 16 percent value was derived by combining the 12 percent permanent impairment due to right shoulder deficits with the 5 percent permanent impairment due to right carpal tunnel syndrome.

On August 23, 2018 OWCP determined that there was a conflict in the medical opinion between Dr. Finger, and the DMA regarding the extent of appellant's permanent impairment. On September 18, 2018 it referred appellant, pursuant to section 8123(a) of FECA, to Dr. Gordon Nutik, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion regarding appellant's bilateral upper extremity permanent impairment under the sixth edition of the A.M.A., *Guides.* OWCP provided Dr. Nutik with a copy of the case record, including a recent SOAF.

In an October 10, 2018 report, Dr. Nutik discussed appellant's factual and medical history and detailed the findings of his physical examination. He determined that appellant had 15 percent permanent impairment of his right upper extremity due to range of motion (ROM) deficits of the right shoulder. In reaching this determination, Dr. Nutik utilized Table 15-35 on page 477. He also found that appellant had two percent permanent impairment of each upper extremity due to carpal tunnel syndrome.

OWCP referred appellant's case back to Dr. Slutsky, in his capacity as a DMA, and requested that he review Dr. Nutik's permanent impairment rating. In a January 14, 2019 report, Dr. Slutsky noted deficiencies in Dr. Nutik's evaluation, including his failure to provide proper ROM measurements for the right shoulder and his failure to provide modifiers for his assessment of permanent impairment due to carpal tunnel syndrome.

Given the multiple deficiencies of Dr. Nutik's impairment rating, OWCP determined that referral to a new impairment medical specialist was necessary. On April 17, 2019 it referred appellant to Dr. Allen Johnston, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion regarding the extent of appellant's bilateral upper extremity permanent impairment under the sixth edition of the A.M.A., *Guides.* OWCP provided Dr. Johnston with a copy of the case record, including a recent SOAF.

In a May 14, 2019 report, Dr. Johnston discussed appellant's factual and medical history and detailed the findings of his physical examination. He noted that, with respect to appellant's neck, he applied the standards of Table 17-2 (Cervical Spine Regional Grid) beginning on page 566 of the sixth edition of the A.M.A., *Guides*. Dr. Johnston advised that appellant had a class of diagnosis (CDX) of 1 for cervical spondylosis, with one to two millimeters of subluxation at C5-6, which warranted six percent permanent impairment. With respect to the right shoulder, he utilized Table 15-5 and found that appellant's diagnosis of distal clavicle resection (with weakness in the supraspinatus and infraspinatus tendons as well as decreased mobility to 90 degrees with shoulder abduction and forward flexion) warranted a finding of 12 percent permanent impairment of the right upper extremity due to right shoulder deficits. Dr. Johnston found that appellant had eight percent permanent impairment of the left upper extremity due to five percent impairment related to left wrist deficits and three percent impairment due to left shoulder rotator cuff tendinitis/impingement (class 1). He rated appellant for bilateral carpal tunnel syndrome, noting that his CDX of 1 (below mid-forearm and median nerve involvement) equaled five percent

permanent impairment of each upper extremity under Table 15-21 (Peripheral Nerve Impairment) beginning on page 436.[6]

On July 25, 2019 OWCP referred appellant's case back to Dr. Slutsky, in his capacity as a DMA, and requested that he review Dr. Johnston's permanent impairment rating.

In an August 26, 2019 report, the DMA noted that Dr. Johnston rated appellant utilizing Chapter 17 for his cervical spinal condition despite the fact that OWCP does not use Chapter 17 to rate the cervical spine. He indicated that Dr. Johnston did not identify specific cervical nerve roots involved, but only identified decreased light touch in the median nerve of both hands, a finding which constitutes a compression neuropathy. The DMA maintained that Dr. Johnston must provide documentation of any sensory and manual muscle testing he performed in the upper extremities and, if he finds deficits under such testing, he must rate the deficits for each involved nerve under Table 15-14 on page 425. He noted that this information would then be applied to the impairment methods described in *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*) for each cervical nerve affected. The DMA indicated that Dr. Johnston must then assign grade modifiers for functional history and clinical studies and apply the net adjustment formula to derive a final grade of impairment. The sensory and motor impairments for each cervical nerve root (in each upper extremity) must then be combined.

The DMA further noted that Dr. Johnston did not provide valid ROM measurements for the upper extremities and he advised that Dr. Johnston indicated that some of the ROM measurements provided were "approximate." However, he maintained that goniometer measurements (which were required) provided exact measurements and noted that there must be three measurements for each shoulder motion and that the three measurements must each be within 10 degrees of the average of the three values. The DMA noted that Dr. Johnston did not document three measurements for each type of movement of the shoulders. He advised that, when rating appellant for right acromioclavicular joint disease (status post distal clavicle excision), there must be grade modifiers assigned with rationale from each of the tables for the numbers assigned. The DMA indicated that Dr. Johnston did not derive such modifiers and "somehow arrived" at a rating of 12 percent permanent impairment of the right upper extremity. He found that Dr. Johnston erroneously used Table 15-21 for carpal tunnel syndrome as this condition could only be rated utilizing Table 15-23. The DMA noted that the process first required review of electromyogram/nerve conduction velocity (EMG/NCV) test results to determine whether they were appropriate to use in conjunction with Table 15-23. In addition, scores for test findings, history, and physical examination values must be provided and average scores must be calculated. The DMA noted that the *Quick*DASH score must then be used to evaluate whether the average score should be adjusted and a final impairment rating would then be obtained for each upper extremity.

By decision dated October 18, 2019, OWCP determined that appellant had not met his burden of proof to establish more than 19 percent permanent impairment of his right upper

[6] Dr. Johnston noted that he utilized the combined values chart to combine the 12 percent impairment rating due to right shoulder deficits with the 5 percent impairment rating for right carpal tunnel syndrome and determined that appellant had 16 percent permanent impairment of his right upper extremity.

extremity and 13 percent permanent impairment of his left upper extremity. It found that he had not submitted medical evidence establishing a greater level of permanent impairment.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and its implementing regulation[8] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10]

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.[11] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[12] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. 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.[13]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[14] In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id. See also T.T.*, Docket No. 18-1622 (issued May 14, 2019).

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

[11] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see A.G.*, Docket No. 18-0815 (issued January 24, 2019); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[12] *Supra* note 10, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5c(3) (March 2017).

[13] *Supra* note 10, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

[14] *See* A.M.A., *Guides* 449, Table 15-23.

value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[15]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401. After the CDX is determined from the Shoulder Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for functional history (GMFH), grade modifier for physical examination (GMPE), and grade modifier for clinical studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16]

Section 8123(a) of FECA provides in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[17] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[18]

ANALYSIS

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

The Board preliminarily finds that OWCP improperly determined that there was a conflict in the medical opinion evidence between Dr. Finger, an OWCP referral physician, and Dr. Slutsky, the DMA, regarding appellant's permanent impairment as both were physicians for the government.[19] OWCP ultimately referred appellant to Dr. Johnston for an impartial medical

[15] A survey completed by a given claimant, known by the name *Quick*DASH, may be used to determine the Function Scale score. *Id.* at 448-49.

[16] *See* A.M.A., *Guides* (6th ed. 2009) 405-12. Table 15-5 also provides that, if motion loss is present for a claimant with certain diagnosed conditions, permanent impairment may alternatively be assessed using Section 15.7 (ROM impairment). Such a ROM assessment stands alone and is not combined with a DBI rating. *Id.* at 401-05, 475-78.

[17] 5 U.S.C. § 8123(a).

[18] *D.M.*, Docket No. 18-0746 (issued November 26, 2018); *R.H.*, 59 ECAB 382 (2008); *James P. Roberts*, 31 ECAB 1010 (1980).

[19] *See supra* note 17.

examination and an opinion on the matter, but the Board finds that Dr. Johnston actually served as an OWCP referral physician rather than an impartial medical specialist.[20]

In a May 14, 2019 report, Dr. Johnston advised that appellant had a CDX of 1 for the diagnosis of cervical spondylosis under Table 17-2 of the sixth edition of the A.M.A., *Guides*, with one to two millimeters of subluxation at C5-6, which warranted six percent permanent impairment. With respect to the right shoulder, he utilized Table 15-5 to find that appellant had 12 percent permanent impairment of the right upper extremity due to right shoulder deficits. Dr. Johnston found that appellant had eight percent permanent impairment of the left upper extremity due to five percent impairment related to left wrist deficits and three percent impairment due to left shoulder rotator cuff tendinitis/impingement (class 1). He rated appellant for bilateral carpal tunnel syndrome, noting that his class 1 condition (below mid-forearm and median nerve involvement) equaled five percent permanent impairment of each upper extremity under Table 15-21.

In an August 26, 2019 report, Dr. Slutsky, the DMA, identified multiple concerns he had with Dr. Johnston's permanent impairment rating and explained that it was not carried out in accordance with the sixth edition of the A.M.A., *Guides*. The Board finds that the DMA's concerns in this regard are valid and it was improper for OWCP to deny appellant's claim for an increased schedule award without addressing these concerns.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[21] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[22] Once OWCP undertakes development of the record, it has the responsibility to do so in a manner that will resolve the relevant issues in the case.[23] Accordingly, as OWCP undertook development of the evidence by referring appellant to a second opinion physician, it has a duty to secure an appropriate report addressing the relevant issues.[24]

In his August 26, 2019 report, the DMA noted numerous deficiencies in Dr. Johnston's report and provided guidance on the proper methodology to complete a rating examination for the accepted conditions in the claim.

[20] *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). The Board notes that OWCP previously referred appellant to Dr. Nutik in 2018 for an evaluation of permanent impairment. However, Dr. Slutsky, serving as a DMA, found multiple deficiencies in Dr. Nutik's October 10, 2018 rating report and OWCP determined that referral to another specialist was appropriate.

[21] *See M.T.*, Docket No. 19-0373 (issued August 22, 2019).

[22] *See S.S.*, Docket No. 18-0397 (issued January 15, 2019).

[23] *See T.C.*, Docket No. 17-1906 (issued January 10, 2018).

[24] *See B.W.*, Docket No. 19-0965 (issued December 3, 2019).

The Board thus finds that the opinion of Dr. Johnston is in need of clarification and elaboration. As Dr. Johnston failed to provide an opinion on permanent impairment in accordance with the relevant standards, the case will be remanded to OWCP to obtain clarification from Dr. Johnston that properly resolves the issue.[25] If Dr. Johnston is unavailable or unwilling to provide a supplemental opinion, OWCP shall refer appellant, together with a SOAF and a list of specific questions, to a second opinion physician in the appropriate field of medicine to resolve the issue of appellant's permanent impairment.[26] After such further development as OWCP deems necessary, a *de novo* decision shall be issued regarding appellant's permanent impairment.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the October 18, 2019 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: January 5, 2021
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

[25] *See M.N.*, Docket No. 17-1729 (issued June 22, 2018).

[26] *See F.K.*, Docket No. 19-1804 (issued April 27, 2020).