United States Department of Labor
Employees' Compensation Appeals Board

V.G., Appellant	)	
and	)	**Docket No. 20-0455**
	)	**Issued: June 17, 2021**
U.S. POSTAL SERVICE, SEMINOLE PROCESSING & DISTRIBUTION CENTER, Orlando, FL, Employer	)	

Appearances:
Wayne Johnson, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 28, 2019 appellant, through counsel, filed a timely appeal from two July 1, 2019 merit decisions of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to

[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] The Board notes that appellant has another appeal pending before the Board under Docket No. 20-0982 concerning an October 7, 2019 OWCP decision. That appeal is not addressed in this decision and will proceed under its own docket number.

the Federal Employees' Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[4]

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 17 percent permanent impairment of the left upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On January 23, 2011 appellant, then a 46-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that on that date she injured her left hand when she helped a coworker clear up a jam in the dolly maker while in the performance of duty. She did not stop work. OWCP accepted appellant's claim for left hand sprain and subsequently expanded the acceptance of her claim to include left carpal tunnel syndrome, left cubital tunnel syndrome, left trigger finger (long and little fingers), and other joint derangement of left shoulder and left arm. Appellant subsequently underwent various OWCP-authorized surgeries for her left upper extremity conditions.[5] OWCP paid her wage-loss compensation on the supplemental rolls for intermittent periods of disability and placed her on the periodic rolls, effective January 13, 2013.

On April 4, 2014 appellant filed a claim for a schedule award (Form CA-7).

In a January 23, 2014 report, Dr. Samy Bishai, an orthopedic surgeon, indicated that appellant's condition had stabilized since her left shoulder, left arm, and left trigger finger surgeries and noted that she had reached maximum medical improvement (MMI) as of that date, January 23, 2014. Upon examination of appellant's left shoulder, he observed tenderness overlying the anterior, lateral, and posterior aspects of the left shoulder joint. Dr. Bishai indicated that range of motion testing revealed 75 degrees forward flexion, 15 degrees extension, 75 degrees abduction, 15 degrees adduction, 45 degrees external rotation, and 20 degrees internal rotation. Examination of appellant's left forearm revealed residual numbness in the distribution of the median and ulnar nerves. Tinel's and Phalen's signs were positive on the left. Dr. Bishai reported that examination of appellant's left hand and wrist showed weakness of the grip and diminished sensation in the left thumb, middle, index, ring, and little fingers. He noted diagnoses of internal derangement of the left shoulder, left shoulder bursitis, left shoulder rotator cuff syndrome, status postoperative release of left carpal tunnel and cubital tunnel syndrome, status postoperative release

[3] 5 U.S.C. § 8101 *et seq.*

[4] The Board notes that, following the July 1, 2019 decision, appellant submitted additional evidence to OWCP. 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.*

[5] On July 1, 2011 appellant underwent OWCP-authorized left carpal tunnel, left cubital tunnel, and left trigger fingers release surgery. She stopped work and returned to full-time limited-duty work on August 10, 2011. On January 10, 2013 appellant underwent OWCP-authorized left shoulder arthroscopic surgery and stopped work again.

of trigger fingers of the left little, ring, and middle fingers, left shoulder impingement syndrome, right ulnar nerve dysfunction, C8-T1 entrapment of the upper extremities, status post-op arthroscopic surgery for left shoulder impingement syndrome, right shoulder internal derangement, right shoulder impingement syndrome, and right shoulder partial thickness tear of the supraspinatus and infraspinatus tendons.

Dr. Bishai referenced the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[6] and indicated that he would use the range of motion (ROM) method for rating appellant's accepted left shoulder condition because it was the most disabling problem. Referencing Table 15-34, *Shoulder Range of Motion*, page 475, he calculated that appellant had 9 percent permanent impairment due to 75 degrees of forward flexion, 2 percent permanent impairment due to 15 degrees extension, 6 percent permanent impairment due to 75 degrees abduction, 1 percent permanent impairment due to 15 degrees adduction, 4 percent permanent impairment due to 20 degrees internal rotation, and 2 percent permanent impairment due to 45 degrees of external rotation, for a total of 24 percent left upper extremity permanent impairment. For her left carpal tunnel syndrome condition, Dr. Bishai utilized Table 15-23, page 449, and indicated that appellant had nine percent permanent impairment for residual problems with left carpal tunnel syndrome, status post carpal tunnel release. He noted that her condition fell under grade modifier of 3 on Table 15-23. For appellant's left ulnar nerve entrapment Dr. Bishai determined that appellant had nine percent permanent impairment under Table 15-23, page 449. He reported that appellant's condition fell under grade modifier of 3. Dr. Bishai explained that 50 percent of the second nerve entrapment rating equaled 4.5 percent, which rounded up to 5 percent permanent impairment for appellant's left ulnar nerve entrapment condition.

For appellant's left middle, ring, and little trigger fingers, Dr. Bishai reported that he would apply Table 15-2, *Digit Regional Grid*, page 392, for all three fingers. He indicated that each of appellant's trigger fingers equated to a class of diagnosis (CDX) of 1 with a default value of six percent upper extremity impairment. Dr. Bishai assigned a grade modifier for functional history (GMFH) of 2[7] and a grade modifier for physical examination (GMPE) of 2.[8] He noted that a grade modifier for clinical studies (GMCS) was not useable.[9] Applying the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), Dr. Bishai calculated an adjustment of +2, which moved the default value up to eight percent permanent impairment each for the left middle, ring, and little fingers.[10] He converted the impairment ratings for each finger for a total left hand permanent impairment of four percent. Dr. Bishai explained that under the Combined Values Chart,[11] appellant's 24 percent left shoulder permanent impairment, 9 percent left carpal tunnel

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

[7] *Id.* at 406, Table 15-7.

[8] *Id.* at 408, Table 15-8.

[9] *Id.* at 410, Table 15-9.

[10] *Id.* at 411.

[11] *Id.* at 604 to 606.

permanent impairment, 5 percent left ulnar nerve entrapment permanent impairment, and 4 percent permanent hand impairment resulted in a total impairment rating of 37 percent left upper extremity permanent impairment.

OWCP forwarded Dr. Bishai's January 23, 2014 impairment rating report to Dr. James W. Dyer, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA). In an April 7, 2014 report, Dr. Dyer indicated that Dr. Bishai's impairment rating had correct methodology to determine schedule award for appellant's left upper extremity using Table 15-2, Table 15-23, and Table 15-34 of the A.M.A., *Guides.* The DMA noted that Dr. Bishai did not correctly use the Combined Values Chart and calculated that appellant had a total of 36 percent permanent impairment of the left upper extremity. He reported a date of MMI of January 23, 2014.

On March 14, 2014 OWCP referred appellant, along with a statement of accepted facts (SOAF) and the medical record, to Dr. William Dinenberg, a Board-certified orthopedic surgeon, for a second opinion evaluation regarding the status of her January 23, 2011 employment injury and extent of disability. In an April 15, 2014 report, Dr. Dinenberg reviewed appellant's history of injury and reviewed her medical records. Upon examination of appellant's left forearm, he noted positive Phalen's, Tinel's, and carpal tunnel compression tests. Dr. Dinenberg reported that examination of appellant's left shoulder revealed a well-healed surgical scar and ROM measurements of forward flexion to 80 degrees, which appellant stopped secondary to pain, extension to 40 degrees, stopping secondary to pain, abduction to 70 degrees, stopping secondary to pain, adduction to 20 degrees, stopping secondary to pain, internal rotation to 20 degrees, stopping secondary to pain, and external rotation to 70 degrees. He opined that appellant's accepted left hand sprain and left shoulder conditions had resolved, but explained that additional diagnostic testing was needed to determine whether appellant's left carpal tunnel and left elbow conditions had resolved.

On April 14, 2014 appellant underwent a nerve conduction velocity (NCV) study of the upper extremities, which was suggestive of mild carpal tunnel syndrome on the right and early or mild carpal tunnel syndrome on the left.[12]

In a development letter dated May 12, 2014, OWCP advised appellant of the type of evidence needed to establish her claim for a schedule award utilizing the appropriate portions of the sixth edition of the A.M.A., *Guides.* It afforded her 30 days to submit the necessary evidence.

A May 28, 2014 electromyography (EMG) and NCV study showed no electrodiagnostic evidence of any focal nerve entrapment, brachial plexopathy, cervical radiculopathy, or generalized peripheral neuropathy in the left upper limb.

In a June 20, 2014 addendum report, Dr. Dinenberg referenced Table 15-23, page 449, of the A.M.A., *Guides,* and indicated that appellant had zero percent permanent impairment due to her left carpal tunnel syndrome and zero percent permanent impairment due to her left cubital tunnel syndrome. He explained that test findings were normal with intermittent symptoms and objective findings. Regarding appellant's left trigger finger digits, Dr. Dinenberg determined that

[12] Appellant retired from federal employment, effective May 1, 2014, and elected to receive Civil Service Retirement Benefits.

appellant had zero percent permanent impairment due to physical examination findings of no triggering or tenderness. For appellant's left shoulder condition, he reported that he would utilize the diagnosis-based (DBI) rating method to determine appellant's permanent impairment because accurate range of motion measurements were not obtained. Utilizing Table 15-5, page 402, Dr. Dinenberg determined that appellant had CDX of 1, default 10 percent, for status-post distal clavicle resection. He noted GMFH of 2 and GMCS of 1. After applying the net adjustment formula, Dr. Dinenberg concluded that appellant had a total of 11 percent left upper extremity permanent impairment.

In an unsigned July 3, 2014 report, an unknown provider serving as a DMA answered "Yes" in response to the question of whether Dr. Dinenberg correctly applied the A.M.A., *Guides.* The DMA noted a date of MMI of June 20, 2014.[13]

In an August 19, 2014 report, Dr. Richard M. Blecha, a Board-certified orthopedic surgeon, indicated that he had reviewed Dr. Bishai's and Dr. Dinenberg's impairment rating reports and requested that OWCP consider his impairment rating. He provided examination findings and explained that he believed that appellant's shoulder ROM measurements were limited not by pain, but by actual stiffness. Regarding appellant's left shoulder, Dr. Blecha first utilized the DBI rating method and determined that under Table 15-5, page 403, appellant had 12 percent permanent impairment.[14] He also utilized the ROM method and indicated that under Table 15-34, page 475, appellant had 9 percent permanent impairment due to 80 degrees flexion, 2 percent permanent impairment due to 25 degrees extension, 6 percent permanent impairment due to 75 degrees abduction, 0 percent permanent impairment due to 40 degrees adduction, 4 percent permanent impairment due to 25 degrees internal rotation, and 4 percent permanent impairment due to 40 degrees of external rotation, for a total of 23 percent permanent impairment. Dr. Blecha explained that since the ROM method provided a higher impairment rating, appellant was entitled to 23 percent permanent impairment for her left shoulder condition. Regarding appellant's left carpal tunnel syndrome, he utilized Table 15-23, page 449, and indicated that appellant had 5 percent permanent impairment for residual problems with left carpal tunnel syndrome, status post carpal tunnel release, and zero percent permanent impairment relative to her left elbow ulnar nerve entrapment and trigger fingers due to normal physical examination findings. Dr. Blecha calculated that according to the Combined Values Chart, appellant had a total of 27 percent left upper extremity permanent impairment due to her accepted left shoulder and left carpal tunnel conditions.

No further development was taken regarding appellant's schedule award claim until June 30, 2015 when OWCP referred Dr. Dinenberg's June 20, 2014 addendum report and the medical record to another DMA for review. In a July 2, 2015 report, Dr. H.P. Hogshead, a Board-certified orthopedic surgeon serving as a DMA, responded, "Yes" that Dr. Dinenberg correctly applied the criteria and tables of the A.M.A., *Guides* in calculating appellant's impairment rating.

[13] The Board notes that it is unable to identify the DMA from the record.

[14] Dr. Blecha noted a CDX of 1, default 10 percent, for status-post distal clavicle resection. He assigned GMFH of 2 due to complaints of pain and symptoms with normal activity, GMPE of 3 due to severely limited ROM, and GMCS of 2 due to diagnostic testing that confirmed a partial thickness rotator cuff tear. Applying the net adjustment formula, Dr. Blecha calculated an adjustment of +4, which moved the default value up to 12 percent permanent impairment.

He indicated that he agreed with Dr. Dinenberg's impairment rating of 11 percent left upper extremity permanent impairment. DMA Hogshead also agreed that appellant reached MMI on June 20, 2014.

In a September 29, 2015 decision, OWCP denied appellant's schedule award claim finding that the medical evidence of record was insufficient to establish that she sustained a permanent impairment due to her accepted January 23, 2011 employment injury.

OWCP subsequently received a September 20, 2015 impairment rating evaluation report by Dr. Robert R. Reppy, an osteopathic physician who specializes in family medicine, who reviewed appellant's history of the January 23, 2011 employment injury and discussed diagnostic testing results. He provided examination findings and diagnosed status post-left rotator cuff and clavicle surgery, left carpal tunnel syndrome, stenosing tenosynovitis, right cubital tunnel syndrome, bilateral supraspinatus and infraspinatus tears, herniated C5-6 disc with radiculopathy, cervical stenosis, lumbar stenosis, and herniated L5-S1 disc with radiculopathy. Dr. Reppy reported that appellant reached MMI on September 10, 2015. Regarding appellant's left carpal tunnel syndrome, Dr. Reppy referred to Table 15-23, page 449, of the A.M.A., *Guides* and indicated that her condition fell under grade modifier 2,[15] which equated to 5 percent upper extremity permanent impairment. For appellant's right cubital tunnel syndrome, he noted that appellant's condition fell under grade modifier 2[16] in Table 15-23, which equated to 5 percent left upper extremity permanent impairment. Dr. Reppy explained that according to the A.M.A., *Guides,* the first entrapment is given full value and the second diagnosis is given only 50 percent, which totaled 8 percent upper extremity permanent impairment for carpal and right cubital tunnel syndrome.

For the right shoulder condition, Dr. Reppy referenced Table 15-5, page 403, of the A.M.A., *Guides,* and indicated that appellant had seven percent permanent impairment for the condition of right shoulder full thickness supraspinatus tear.[17] For appellant's left shoulder condition, he also utilized Table 15-5, page 402, and indicated that appellant had three percent permanent impairment for left shoulder partial-thickness supraspinatus tear, residual loss.[18] Regarding appellant's cervical conditions, Dr. Reppy determined that according to the A.M.A., *Guides* and *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), appellant had three percent upper extremity

[15] Dr. Reppy noted a grade modifier for test findings of 1 due to test findings of conduction delay. He also assigned a grade modifier for functional history of 3 due to constant symptoms and a grade modifier for physical findings of 3 due to weakness. Dr. Reppy noted that the average of the grade modifiers rounded to 2.

[16] Dr. Reppy noted a grade modifier for test findings of 1 due to test findings of conduction delay. He also assigned a grade modifier for functional history of 3 due to constant symptoms and a grade modifier for physical findings of 2 due to decreased sensation. Dr. Reppy noted that the average of the grade modifiers rounded to 2.

[17] Dr. Reppy noted a grade modifier for test findings of 4 due to diagnostic studies. He also assigned a grade modifier for functional history of 2 for symptoms with normal activity and self-care with modifications and a grade modifier for physical findings of 1 due to grade one instability.

[18] Dr. Reppy noted a grade modifier for test findings of 2 due to diagnostic studies. He also assigned a grade modifier for functional history of 2 for symptoms with normal activity and self-care with modifications and a grade modifier for physical findings of 1 due to grade one instability.

permanent impairment due to cervical C5-C6 disc herniation with radiculopathy and nine percent upper extremity permanent impairment due to lumbar L5-S1 disc herniation with radiculopathy. He concluded that appellant had a total of 13 percent bilateral upper extremity permanent impairment and, specifically, 9 percent left upper extremity permanent impairment. Dr. Reppy also noted 10 percent whole person permanent impairment.

On September 26, 2016 appellant, through counsel, requested reconsideration.

By decision dated December 19, 2016, OWCP vacated the September 29, 2015 decision. By a separate decision dated December 20, 2016, it granted appellant a schedule award for 11 percent permanent impairment of the left upper extremity. The award ran for 34.32 weeks from June 20, 2014 through February 15, 2015. OWCP found that the weight of the medical evidence rested with Dr. Dinenberg's June 20, 2014 report.

On December 20, 2017 appellant, through counsel, requested reconsideration.

Appellant submitted an August 2, 2017 report by Dr. Mark Seldes, a Board-certified family physician, who indicated that he concurred with Dr. Dyer's impairment rating of 36 percent left upper extremity permanent impairment. Dr. Seldes first utilized the ROM method to determine impairment for appellant's left shoulder condition. Referencing Table 15-34, page 475, he noted that appellant had 24 percent left upper extremity permanent impairment. For appellant's left carpal tunnel syndrome and left ulnar nerve entrapment, Dr. Seldes determined that under Table 15-23, page 449, appellant had nine percent permanent impairment and five percent permanent impairment, respectively. Lastly, for her left middle, ring, and little trigger finger conditions, he referenced Table 15-2, page 392, and determined that appellant had eight percent permanent impairment for each digit, which converted to four percent permanent impairment for her left hand.

In a January 31, 2018 report, Dr. Jovito Estaris, a Board-certified occupational medicine physician serving as an OWCP DMA, indicated that he was unable to provide an impairment rating based on the medical reports provided and recommended a second opinion examination.

OWCP subsequently referred appellant, along with a SOAF and copy of the medical record, to Dr. John Madlener, Board-certified in physical medicine and rehabilitation, for a second opinion examination. In a March 28, 2018 report, Dr. Madlener noted his review of the SOAF and that appellant's present claim was accepted for left hand sprain, left carpal tunnel syndrome, status post left carpal tunnel release, lesion of left ulnar nerve, status post left cubital tunnel release, left 3rd, 4th, & 5th trigger fingers, status post release of all three, and other derangement of the left shoulder and upper arm. He recounted appellant's current complaints of pain of the left side of the neck, left shoulder, left elbow, and first and second digits of the left hand.

Upon examination of appellant's left upper extremity, Dr. Madlener noted inconsistencies with evaluating the left upper limb for light touch and sharp sensation. He reported diminished light touch in the fingertips of the first and second digit and no sensation over the fingertips of the first and second digits. Tinel's sign over the median and ulnar nerve at the elbow were negative, but elicited complaints of pain. Upon examination of appellant's left shoulder, Dr. Madlener observed no severe pain upon palpation and light touch over the anterior, lateral, posterior, and superior aspects of the shoulder. He provided three ROM measurements each for forward flexion,

active abduction, and extension. Dr. Madlener explained that appellant would not allow him to passively abduct the shoulder to 90 degrees or attempt left shoulder adduction due to complaints of extreme pain. Upon examination of the digits of the left hand, he observed pain upon palpation over the volar surface at the first and second metacarpal (MCP) joint region. Dr. Madlener noted that appellant grimaced and noted severe pain when he attempted active grip/MCP joint flexion.

Dr. Madlener reported that appellant reached MMI on April 15, 2014. Regarding appellant's left shoulder condition, he agreed with Dr. Blecha that the ROM method was appropriate since it produced the higher impairment rating. Dr. Madlener explained that he would use Dr. Dinenberg's ROM measurements since these measurements were similar to Dr. Blecha and Dr. Bishai's measurements. Utilizing Table 15-34, page 475, he calculated that appellant had 9 percent permanent impairment due to 80 degrees of flexion, 1 percent permanent impairment due to 40 degrees extension, 6 percent permanent impairment due to 70 degrees abduction, 1 percent permanent impairment due to 20 degrees adduction, 4 percent permanent impairment due to 20 degrees internal rotation, and 0 percent permanent impairment due to 70 degrees of external rotation, for a total of 21 percent left upper extremity permanent impairment. Regarding permanent impairment for appellant's left carpal tunnel syndrome, Dr. Madlener reported that he agreed with Dr. Blecha's assessment of five percent left upper extremity permanent impairment. He indicated that according page 448, paragraphs 2 and 3, of the A.M.A., *Guides*, whether or not nerve conduction tests recover to normal after surgical or nonsurgical treatment does not influence impairment rating. Dr. Madlener noted that appellant's subjective complaints of pain along the median neuropathy was the only consistent sensory testing area. He opined that appellant had no permanent impairment of the digits, ulnar nerve, or hand sprain. Dr. Madlener explained that appellant only complained of digit pain over the first and second MCP, which were not accepted conditions. He concluded that according to the Combined Values Chart, page 604, appellant had a total of 25 percent permanent impairment of the left upper extremity, which converted to 15 percent whole person impairment.

In an April 9, 2018 supplemental report, Dr. Madlener utilized the DBI method to determine permanent impairment of appellant's left shoulder and indicated that under Table 15-5, page 403, appellant had a CDX of 1, with a default value of 10 percent, for the condition of status post distal clavicle resection. He assigned a GMFH of 3 due to appellant's history. Dr. Madlener indicated that GMCS were not used because it was used for class assignment and that GMPE was not used because it was unreliable. He applied the net adjustment formula, which resulted in a net adjustment of +2, and moved the default value up to 12 percent permanent impairment. Regarding permanent impairment for appellant's carpal tunnel syndrome, Dr. Madlener utilized Table 15-23, page 449, and noted a grade modifier 3 for appellant's complaints of numbness in the first and second digits. He reported a grade modifier of 2 due to diminished sensation in the first and second digits and no grade modifier for test findings. Dr. Madlener calculated the average of the grade modifiers, which rounded to 2, and resulted in five percent left upper extremity permanent impairment. He referenced the Combined Values Chart, page 604, and concluded that 12 percent permanent impairment for appellant's left shoulder and 5 percent permanent impairment for appellant's neuropathy impairment equaled a total of 16 percent left upper extremity permanent impairment. Dr. Madlener also noted that under Table 15-11, page 420, appellant had 10 percent whole person impairment.

In another April 30, 2018 addendum report, Dr. Madlener indicated that the ROM method could not reliably be used to determine permanent impairment for appellant's trigger fingers because ROM measurements were unreliable and limited due to appellant's intolerance and perceived lack of full effort. He utilized Table 15-2, page 392, and indicated that appellant had a CDX of 0 due to no residual findings for a final impairment rating of zero percent. For appellant's left hand sprain condition, Dr. Madlener utilized Table 15-2, and indicated that appellant had a CDX of 0 due to no significant consistent objective findings for an impairment rating of zero percent.

In a May 17, 2018 report, Dr. Estaris, the DMA, reviewed the case file and indicated that he agreed with Dr. Madlener's impairment evaluation for 12 percent permanent impairment for appellant's left shoulder condition and 5 percent permanent impairment for her left carpal tunnel syndrome for a combined total of 16 percent permanent impairment of the left upper extremity. Utilizing the DBI rating method, he referenced Table 15-5, page 403, of the A.M.A., *Guides* and assigned a CDX of 1 due to status post distal clavicle resection for a default impairment rating of 10 percent. The DMA noted a GMFH of 3 and a GMPE of 3. After applying the net adjustment formula, he calculated that appellant had a final upper extremity impairment of 12 percent permanent impairment of the left upper extremity. The DMA also noted that the diagnosis allowed for an alternative impairment evaluation under the ROM method. He related that, since appellant exhibited symptom magnification and suboptimal effort when performing ROM measurements during Dr. Madlener's examination, he would disallow the rating method. For appellant's left carpal tunnel syndrome, the DMA referenced Table 15-23, page 449, and assigned a grade modifier of 1 for test findings, 3 for history, and 2 for physical examination. He calculated the average of the grade modifiers for a total of five percent left upper extremity permanent impairment. The DMA reported a date of MMI of April 15, 2014, the date used by Dr. Dinenberg and agreed upon by Dr. Madlener. He further indicated that, since appellant was previously awarded an impairment rating for 11 percent due to her left shoulder, she was entitled to an additional 1 percent for her left shoulder and 5 percent for her left carpal tunnel syndrome for a total additional award of 6 percent left upper extremity permanent impairment.

By decision dated May 23, 2018, OWCP vacated the December 20, 2016 decision and granted appellant a schedule award for an additional 6 percent left upper extremity permanent impairment, for a total of 17 percent left upper extremity permanent impairment. The award ran for 18.72 weeks from February 16 through June 27, 2015, based on Dr. Madlener's second opinion reports and the May 17, 2018 DMA report.

On May 23, 2019 appellant, through counsel, requested reconsideration. He argued that that Dr. Seldes continued to treat appellant and had consistently documented her shoulder ROM measurements, which he used for calculating her impairment rating. Counsel reiterated that OWCP should have granted appellant a schedule award for 36 percent left upper extremity permanent impairment as previously determined by Dr. Dyer in his April 7, 2014 DMA report.

Appellant continued to receive medical treatment for her upper extremity symptoms and submitted various medical reports, including reports dated August 1, 2018 through June 19, 2019 by Dr. Seldes, a November 21, 2018 left elbow magnetic resonance imaging (MRI) scan report, reports dated January 10 through March 7, 2019 by Dr. Anup Patel, a Board-certified internist,

who diagnosed various right arm conditions, and an April 17, 2019 report by Dr. George White, a Board-certified internist.

By decision dated July 1, 2019, OWCP denied modification of the May 23, 2018 decision. It found that the medical evidence of record was insufficient to establish that appellant was entitled to greater than 17 percent left upper extremity (arm) permanent impairment. By separate decision also dated July 1, 2019, OWCP issued a formal schedule award granting appellant an additional 6 percent permanent impairment of the left arm for a total 17 percent permanent impairment of the left upper extremity. The period of the schedule award ran for 18.72 weeks for the period February 16 to June 27, 2015.

LEGAL PRECEDENT

The schedule award provisions of FECA[19] and its implementing regulations[20] 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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. 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 and the Board has concurred in such adoption.[21] As of May 1, 2009, the sixth edition of the A.M.A., *Guides,* published in 2009, is used to calculate schedule awards.[22]

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 the default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS.[23] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[24] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[25]

[19] 5 U.S.C. § 8107.

[20] 20 C.F.R. § 10.404.

[21] *Id.* at § 10.404 (a); *see also T.T.,* Docket No. 18-1622 (issued May 14, 2019); *Jacqueline S. Harris,* 54 ECAB 139 (2002).

[22] 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).

[23] A.M.A., *Guides* 405-12; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[24] *Id.* at 411.

[25] *R.R.,* Docket No. 17-1947 (issued December 19, 2018); *R.V.,* Docket No. 10-1827 (issued April 1, 2011).

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[26] In Table 15-23, grade modifier levels (ranging from zero to four) are described for the categories of 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 value may be modified up or down based on functional scale, an assessment of impact on daily living activities.[27]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.* DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. If the [A.M.A.,] *Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (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* 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. If the medical evidence of record is [in]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]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's 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 impairment specified.[30]

[26] *Id.* at 449.

[27] *Id.* at 448-449.

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

[29] *Id.*

[30] *See* FECA Procedure Manual, *supra* note 20 at Chapter 2.808.6(f) (March 2017). *R.M.*, Docket No. 18-1313 (issued April 11, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010).

ANALYSIS

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

OWCP referred appellant to Dr. Madlener for a second opinion examination and opinion regarding the permanent impairment of appellant's left upper extremity. Regarding appellant's left shoulder condition, he indicated that the ROM method for rating impairment was appropriate since it produced the higher impairment rating. Utilizing Table 15-34, page 475, Dr. Madlener applied Dr. Dinenberg's ROM measurements and calculated that appellant had 21 percent left upper extremity permanent impairment. In an April 9, 2018 supplemental report, he utilized the DBI method to determine appellant's left shoulder impairment rating and indicated that under Table 15-5, page 403, appellant had 12 percent left upper extremity permanent impairment for the condition of status post distal clavicle resection.

In a May 17, 2018 report, Dr. Estaris, a DMA, indicated that he agreed with Dr. Madlener's impairment evaluation for 12 percent permanent impairment of appellant's left shoulder condition. Utilizing the DBI rating method, he referenced Table 15-5, page 403, and assigned a CDX of 1 due to status-post distal clavicle resection for a default impairment rating of 10 percent. DMA Estaris noted a GMFH of 3 and a GMPE of 3. After applying the net adjustment formula, he calculated that appellant had a final upper extremity impairment of 12 percent permanent impairment of the left upper extremity. The DMA, Dr. Estaris, further explained that while the diagnosis allowed for an impairment evaluation under the ROM, he would not use this rating method because appellant exhibited symptom magnification and suboptimal effort when performing ROM measurements. The Board finds, however, that the DMA did not provide sufficient explanation in his May 17, 2018 report as to why he would not use the ROM method in assessing appellant's permanent impairment for her left shoulder condition, especially given the fact that Dr. Madlener, the second opinion examiner, determined that the ROM method was appropriate and had produced the higher impairment rating.[31]

Additionally, in his May 17, 2018 report, the DMA, Dr. Estaris also failed to discuss or provide any calculations for appellant's permanent impairment rating due to her accepted left trigger finger injuries. Pursuant to FECA Bulletin No. 17-06, if the ROM method of rating permanent impairment is allowed 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.[32] In this case, according to Table 15-2, the diagnosis for digital stenosing tenosynovitis (trigger digit) contains an asterisk, which allows for the alternative method of rating impairment under the ROM method.[33] However, the DMA, Dr. Estaris, did not follow the procedures outlined in FECA Bulletin No. 17-06 as he did not provide any discussion or calculations regarding

[31] *See J.O.*, Docket No. 19-1337 (issued February 2, 2021).

[32] *Supra* note 26.

[33] A.M.A., *Guides* 392.

appellant's permanent impairment under either the ROM or DBI method for appellant's accepted left trigger finger injuries.[34]

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[35] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[36] As OWCP undertook development of the evidence by referring appellant to an OWCP medical adviser, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.[37] The case will, therefore, be remanded for further clarification from the DMA, Dr. Estaris, regarding why he did not apply the ROM method for rating appellant's permanent impairment for her accepted left shoulder injury. Furthermore, because OWCP failed to follow the procedures set forth in FECA Bulletin No. 17-06, OWCP shall request that the DMA provide a supplemental report addressing appellant's impairment rating for her accepted left long and little trigger finger injuries under both the DBI and ROM rating methods. If the DMA determines that he is unable to render a rating on ROM because the ROM findings are incomplete, he should advise OWCP as to the medical evidence necessary to complete the ROM method of rating as required under FECA Bulletin No. 17-06.[38] Following this and other such development as deemed necessary, it shall issue a *de novo* decision.

CONCLUSION

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

[34] *See J.L.*, Docket No. 19-1684 (issued November 20, 2020).

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

[36] *S.S.*, Docket No. 18-0397 (issued January 15, 2019); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[37] *G.M.*, Docket No. 19-1931 (issued May 28, 2020); *W.W.*, Docket No. 18-0093 (issued October 9, 2018).

[38] *Supra* note 25; *see also R.L.*, Docket No. 19-1793 (issued August 7, 2020); *E.P.*, Docket No. 19-1708 (issued April 15, 2020).

ORDER

IT IS HEREBY ORDERED THAT the July 1, 2019 decisions of the Office of Workers' Compensation Programs are set aside, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: June 17, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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