United States Department of Labor
Employees' Compensation Appeals Board

J.W., Appellant	)	
	)	**Docket No. 22-0223**
and	)	**Issued: August 23, 2022**
U.S. POSTAL SERVICE, CHICAGO LAWN POST OFFICE, Chicago, IL, Employer	)	

Appearances:
Larissa A. Pardo, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On November 29, 2021 appellant, through counsel, filed a timely appeal from a June 2, 2021 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that, following the June 2, 2021 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.*

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than two percent permanent impairment of each upper extremity and two percent permanent impairment of each lower extremity for which she previously received schedule award compensation.

FACTUAL HISTORY

On September 24, 2002 appellant, then a 33-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that she sustained right leg and groin injuries due to factors of her federal employment including walking, standing, stair climbing, bending, and lifting required by her job. She asserted that she first became aware of her claimed condition and its relation to her federal employment on September 3, 2002. Appellant stopped work on September 12, 2002.[4] OWCP assigned OWCP File No. xxxxxx798.

After extensive development of the evidence, OWCP accepted appellant's claim for herniated disc at L5-S1; displacement of lumbar intervertebral disc without myelopathy; bilateral plantar fascial fibromatosis; bilateral localized secondary osteoarthrosis of the lower legs; displacement of cervical intervertebral disc without myelopathy; degeneration of cervical intervertebral disc; spinal stenosis of the lumbar region; brachial neuritis or radiculitis; adhesive capsulitis of the right shoulder; and other specified disorder of bursae and tendons in the right shoulder region. It paid appellant wage-loss compensation for disability from work on the supplemental rolls, commencing September 10, 2002.[5]

OWCP has additional accepted occupational disease claims (Form CA-2) under separate case files. Under OWCP File No. xxxxxx799 filed on October 26, 2002, It accepted temporary aggravation of cervical disc disease and cervical neuropathy. Under OWCP File No. xxxxxx213 filed on August 9, 2005, OWCP accepted disc herniation at C5-6, disc protrusion at C6-7, disc protrusion at L4-5, and disc herniation and annular tear at L5-S1. Under OWCP File No. xxxxxx214 claim filed on August 9, 2005, it accepted right rotator cuff partial tear and right shoulder tendinitis, and authorized a January 12, 2012 repair of full-thickness rotator cuff tear and lysis repair of subacromial adhesions of the right shoulder. Under OWCP File No. xxxxxx458 filed on October 21, 2005, OWCP accepted bilateral carpal tunnel syndrome and issued an April 5, 2019 decision granting appellant a schedule award for two percent permanent impairment of each upper extremity due to that condition. Under OWCP File No. xxxxxx365 filed on April 7, 2009, it accepted temporary aggravation of degeneration of lumbar intervertebral disc, temporary aggravation of displacement of lumbar intervertebral disc without myelopathy, and temporary aggravation of lumbar spinal stenosis. Under OWCP File No. xxxxxx372 filed on December 14, 2016, OWCP accepted plantar fascial fibromatosis, bilateral tarsal tunnel syndrome of the feet/ankles, bilateral tenosynovitis and synovitis of the feet/ankles, and bilateral posterior tibial tendinitis of the legs. It has administratively combined OWCP File Nos. xxxxxx799, xxxxxx213, xxxxxx214, xxxxxx365, and xxxxxx798, designating the latter file as the master file. OWCP File

[4] Appellant later returned to limited-duty work and stopped work on January 14, 2013.

[5] OWCP paid appellant wage-loss compensation for disability from work, commencing December 18, 2011 on the periodic rolls.

No. xxxxxx458 and OWCP File No. xxxxxx372 have not been administratively combined by OWCP with the master file for the present claim.

In a March 12, 2020 report, Dr. Blair Rhode, a Board-certified orthopedic surgeon, detailed physical examination findings, noting that appellant exhibited pain/tenderness to palpation of the bilateral cervical and lumbar paraspinous muscles, and the medial/lateral joints of both knees. Appellant had zero degrees of flexion motion and 125 degrees of extension motion in both knees. Dr. Rhode advised that diagnostic testing showed disc herniations at C5-6, C6-7, L4-5, and L5-S1; moderate medial compartment joint space narrowing of both knees; and a medial meniscus tear of the left knee. He indicated that he would provide a rating of permanent impairment under the standards of Table 16-3 (Knee Regional Grid), page 509, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[6] and *The Guides Newsletter*, *Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), a supplemental publication of the sixth edition of the A.M.A., *Guides*. Dr. Rhode concluded that appellant had reached maximum medical improvement (MMI) and had two percent permanent impairment of each lower extremity.[7]

On April 13, 2020 appellant filed a claim for compensation (Form CA-7) for a schedule award.

OWCP referred appellant's case to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon and OWCP district medical adviser (DMA), and requested that he review the medical evidence of record, including Dr. Rhode's March 12, 2020 report, and provide an opinion on appellant's permanent impairment under the A.M.A., *Guides*.

In an April 15, 2020 report, Dr. Harris determined that, utilizing *The Guides Newsletter*, appellant did not have permanent impairment of either upper extremity due to cervical radiculopathy or permanent impairment of either lower extremity due to lumbar radiculopathy. However, he found that, utilizing Table 16-3 (Knee Regional Grid), page 509, of the sixth edition of the A.M.A., *Guides*, appellant had two percent permanent impairment of each lower extremity due to a having a medial meniscus tear in each knee.[8]

OWCP requested clarification of Dr. Harris' April 15, 2020 report, including additional discussion of the possible effect of the April 5, 2019 schedule award, granted under OWCP File No. xxxxxx458 for two percent permanent impairment of each upper extremity, on the total schedule award compensation due appellant. In a supplemental May 23, 2020 report, Dr. Harris repeated his opinion that appellant currently had no permanent impairment of the upper extremities and noted that, therefore, she was not entitled to additional schedule award compensation for the upper extremities. He also found that appellant was entitled to schedule award compensation for two percent permanent impairment of each lower extremity.

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

[7] Dr. Rhode also found four percent permanent impairment of the "cervical spine" and four percent permanent impairment of the "lumbar spine."

[8] Dr. Harris indicated that a May 5, 2015 magnetic resonance imaging (MRI) scan showed a medial meniscus tear of the right knee and that an August 12, 2018 MRI scan showed a medial meniscus tear of the left knee.

By decision dated June 22, 2020, OWCP granted appellant a schedule award for two percent permanent impairment of each lower extremity. The award ran for 11.52 weeks from March 12 through May 31, 2020 and was based on the opinions of Dr. Rhode and Dr. Harris.

On July 15, 2020 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. Following a preliminary review, OWCP's hearing representative issued a September 3, 2020 decision setting aside the June 22, 2020 decision and remanding the case to OWCP for further development of the medical evidence. The hearing representative directed OWCP to refer appellant for a second opinion examination and impairment evaluation of the upper and lower extremities, to be followed by a *de novo* decision on permanent impairment. The hearing representative noted:

> "The specialist should be advised that impairments to the upper extremities and lower extremities should be assessed in consideration of all accepted conditions. Since [OWCP] has paid a schedule award for meniscus tears, the specialist should offer a rationalized opinion addressing whether the accepted work injuries are causally related to meniscus tears of either or both the left and right knees."[9]

On March 8, 2021 OWCP referred appellant, along with a statement of accepted facts (SOAF) and a series of questions, for a second opinion examination and impairment evaluation with Dr. Eric Orenstein, a Board-certified orthopedic surgeon. It requested that Dr. Orenstein provide an opinion on permanent impairment of appellant's upper and lower extremities.

In an April 14, 2021 report, Dr. Orenstein discussed appellant's factual and medical history, noting that a May 5, 2015 MRI scan revealed a medial meniscus tear of the right knee and an August 12, 2016 MRI scan showed a medial meniscus tear of the left knee. He detailed the findings of the physical examination he conducted on April 14, 2021. Dr. Orenstein reported that examination of the cervical and lumbar regions revealed no areas of localized tenderness/spasm and that appellant had 5/5 strength in the upper and lower extremities without sensory deficits. He noted that, utilizing *The Guides Newsletter*, appellant had no ratable impairment of the upper or lower extremities given that she had no motor or sensory deficits in any extremity despite previously having various positive electromyogram and nerve conduction velocity (EMG and NCV) studies. Dr. Orenstein advised that, with respect to the feet and ankles, appellant had accepted conditions, including bilateral plantar fibromatosis and tarsal tunnel syndrome. He indicated, however, that MRI scans of both lower extremities showed no evidence of plantar fibromatosis or tarsal tunnel syndrome. Therefore, appellant had no ratable impairment of the lower extremities referable to the feet or ankles.

For the left lower extremity, Dr. Orenstein referred to the sixth edition of the A.M.A., *Guides* and utilized the diagnosis-based impairment (DBI) rating method to find that, under Table 16-3 (Knee Regional Grid), page 509, the class of diagnosis (CDX) for the partial medial meniscus tear of appellant's left knee resulted in a class 1 impairment with a default value of two. He assigned a grade modifier for functional history (GMFH) of 0 due to normal gait and a grade modifier for physical examination (GMPE) of 1 due to mild palpatory findings. Dr. Orenstein found that a grade modifier for clinical studies (GMCS) was not applicable as the clinical studies

[9] The hearing representative also indicated that OWCP File No. xxxxx458 and OWCP File No. xxxxxx372 should be combined with OWCP File No. xxxxxx798, the master file for the present claim.

were used to establish the impairment class. He utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) = (0 - 1) + (1 - 1) = -1, which resulted in a grade B or two percent permanent impairment of the left lower extremity. However, Dr. Orenstein then noted, "[t]he claimant would have no ratable impairment of the left knee using the DBI or [range of motion] ROM method." He did not perform a DBI rating for the right lower extremity with respect to the right knee.

On May 11, 2021 OWCP requested that Dr. Harris, serving as the DMA, review the opinion of Dr. Orenstein and provide an opinion on permanent impairment.

In a May 27, 2021 report, Dr Harris found that appellant did not have any neurological deficit in the right upper extremity consistent with cervical radiculopathy and, therefore, she did not have right upper extremity permanent impairment under Table 1 of *The Guides Newsletter*. He also determined that she did not have any neurological deficit in the left upper extremity consistent with cervical radiculopathy and, therefore, she did not have left upper extremity permanent impairment under Table 1 of *The Guides Newsletter*. Dr. Harris indicated that, utilizing Table 16-3 (Knee Regional Grid), page 509, of the sixth edition of the A.M.A., *Guides*, appellant had two percent permanent impairment of each lower extremity due to bilateral medial meniscus tears. He found that, given the schedule award compensation previously granted to appellant, there was no basis for granting additional schedule award compensation.

By decision dated June 2, 2021, OWCP determined that appellant had not met her burden of proof to establish greater than two percent permanent impairment of each upper extremity and two percent permanent impairment of each lower extremity for which she previously received schedule award compensation.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA,[10] and its implementing federal regulation,[11] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[12] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[13]

Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that diagnosis-based impairment is the primary method of calculation for the lower limb and that most impairments are based on the diagnosis-based impairment where impairment class

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

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

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

is determined by the diagnosis and specific criteria as adjusted by the GMFH, GMPE, and GMCS. It further provides that alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and ROM. ROM is primarily used as a physical examination adjustment factor.[14] The A.M.A., *Guides*, however, also explain that some of the diagnosis-based grids refer to the ROM section when that is the most appropriate mechanism for grading the impairment. This section is to be used as a stand-alone rating when other grids refer to this section or no other diagnosis-based sections of the chapter are applicable for impairment rating of a condition.[15]

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the knee, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[16] After the CDX is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17]

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.[18] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[19] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*, which is a supplemental publication of the sixth edition of the A.M.A., *Guides*. 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.[20]

ANALYSIS

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

OWCP primarily based its June 2, 2021 determination that appellant had no greater than two percent permanent impairment of each of her upper and lower extremities for which she

[14] A.M.A., *Guides* (6th ed. 2009) 497, section 16.2.

[15] *Id*. at 543; *see also M.D.*, Docket No. 16-0207 (issued June 3, 2016); *D.F.*, Docket No. 15-0664 (issued January 8, 2016).

[16] *Id*. at 509-11.

[17] *Id*. at 515-22.

[18] 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).

[19] *Supra* note 13, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5c(3) (March 2017).

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

previously received schedule award compensation, on the April 14, 2021 opinion of Dr. Orenstein, the OWCP referral physician. The Board finds that Dr. Orenstein's opinion on permanent impairment is in need of clarification.

The Board has held that, while the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[21] Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[22] Once it starts to procure medical opinion evidence, it must do a complete job in securing from its referral physician an opinion, which adequately addresses the relevant issues.[23]

The Board has reviewed Dr. Orenstein's April 14, 2021 report and has identified several outstanding issues. Dr. Orenstein provided a detailed calculation, utilizing Table 16-3 (Knee Regional Grid) on page 509 of the sixth edition of the A.M.A., *Guides*, to find that appellant had two percent permanent impairment of the left lower extremity due to a left medial meniscus tear, despite the fact that no such condition has been accepted as work related by OWCP. However, Dr. Orenstein then noted without elaboration, "[t]he claimant would have no ratable impairment of the left knee using the DBI method or ROM method." In addition, he did not perform a DBI rating for the right lower extremity with respect to the right knee and did not provide an explanation for not doing so. The Board notes that the OWCP hearing representative who directed the referral for a second opinion examination/evaluation noted in the June 22, 2020 remand decision, "[s]ince [OWCP] has paid a schedule award for meniscus tears, the specialist should offer a rationalized opinion addressing whether the accepted work injuries are causally related to meniscus tears of either or both the left and right knees." Dr. Orenstein did not provide an opinion regarding whether appellant had a work-related meniscus tear in either knee and, at present, his opinion does not fully satisfy the directive of the hearing representative. The Board further notes that it was appropriate for Dr. Orenstein to utilize the standards of *The Guides Newsletter* to evaluate possible bilateral upper extremity impairment stemming from appellant's accepted cervical spine condition, and to utilize the same impairment rating standards to evaluate possible bilateral lower extremity impairment stemming from appellant's accepted lumbar spine condition.[24] However, Dr. Orenstein did not adequately explain why he did not perform a DBI rating for the upper extremities, particularly with respect to the right upper extremity given that appellant has accepted right upper extremity conditions, including adhesive capsulitis of the right shoulder and other specified disorder of bursae and tendons in the right shoulder region, which were accepted in connection with the present claim.

The case must, therefore. be remanded for clarification from Dr. Orenstein regarding the above-noted issues with his permanent impairment evaluation of appellant's upper and lower

[21] *See D.V.*, Docket No. 17-1590 (issued December 12, 2018); *Russell F. Polhemus*, 32 ECAB 1066 (1981).

[22] *See A.K.*, Docket No. 18-0462 (issued June 19, 2018); *Robert F. Hart*, 36 ECAB 186 (1984).

[23] *T.B.*, Docket No. 20-0182 (issued April 23, 2021); *L.V.*, Docket No. 17-1260 (issued August 1, 2018); *Mae Z. Hackett*, 34 ECAB 1421, 1426 (1983).

[24] *See supra* notes 18 through 20. Dr. Orenstein also found that appellant had no ratable impairment directly referable to the feet or ankles.

extremities.[25] If Dr. Orenstein is unable to clarify or elaborate on his previous reports, or if the supplemental report is also vague, speculative, or lacking rationale, OWCP must submit the case record and a detailed SOAF to a new second opinion physician for the purpose of obtaining a rationalized medical opinion on the issue.[26] After this and such other further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the June 2, 2021 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: August 23, 2022
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board

[25] The Board notes that, on remand, OWCP should administratively combine File No. xxxxxx458 and File No. xxxxxx372 with File No. xxxxxx798, the master file for the present claim. Under its procedures, OWCP has determined that cases should be administratively combined where a new injury case is reported for an employee who previously filed an injury claim for the same part of the body and where correct adjudication depends on cross-referencing between files. *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *File Maintenance and Management*, Chapter 2.400.8c(1) (February 2000); *V.G.*, Docket No. 19-0670 (issued April 30, 2020).

[26] *J.H.,* Docket No. 19-1476 (issued March 23, 2021); *R.O.,* Docket No. 19-0885 (issued November 4, 2019); *Talmadge Miller*, 47 ECAB 673 (1996).