United States Department of Labor
Employees' Compensation Appeals Board

M.E., Appellant	)	
and	)	**Docket No. 21-1058**
	)	**Issued: March 2, 2022**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF PRISONS, Marion, IL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 6, 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.

[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*.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 29 percent permanent impairment of the left upper extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On September 8, 2003 appellant, then a 41-year-old senior correctional officer, filed a traumatic injury claim (Form CA-1) alleging that on September 6, 2003 he possibly fractured his left shoulder blade and experienced swelling in his arm when he hit the corner of a security cabinet door with his left shoulder while in the performance of duty. He stopped work on the date of injury. OWCP accepted the claim for complete rotator cuff tear or rupture, other joint derangement of the left shoulder, sprain of the left shoulder and upper arm, superior glenoid labrum lesion, and left exostosis, site unspecified. On December 3, 2003 appellant underwent authorized left shoulder arthroscopic surgery. He returned to full-time, modified-duty work with restrictions, effective June 8, 2004, until he stopped work on June 24, 2004.[4]

On August 2, 2004 appellant filed a claim for compensation (Form CA-7) for a schedule award.

By decision dated June 27, 2005, OWCP granted appellant a schedule award for eight percent permanent impairment of the left upper extremity. The period of the award ran for 24.96 weeks from December 3, 2004 through May 26, 2005.

In a September 26, 2007 decision, OWCP granted appellant a schedule award for an additional 10 percent permanent impairment of the left upper extremity, for a total of 18 percent permanent impairment. The period of the award ran for 31.20 weeks from April 23 through November 27, 2007.

By decision dated March 19, 2013, OWCP granted appellant a schedule award for an additional three percent permanent impairment of the left arm, for a total of 21 percent left upper extremity permanent impairment. The award ran for 9.36 weeks for the period October 26 to December 30, 2012.

By decision dated August 6, 2018, OWCP expanded the acceptance of appellant's claim to include complex regional pain syndrome (CRPS) of the left upper limb.

[3] Docket No. 06-2068 (issued April 20, 2007).

[4] Appellant retired from the employing establishment effective April 15, 2007.

OWCP subsequently received a June 12, 2019 medical report by Dr. John W. Ellis, an attending Board-certified family practitioner. Dr. Ellis determined that appellant had 16 percent permanent impairment of the left upper extremity using the diagnosis-based impairment (DBI) rating method, 45 percent permanent impairment of the left upper extremity using the range of motion (ROM) rating method, and 80 percent permanent impairment of the left upper extremity based on the accepted condition of CRPS under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] He determined that MMI was reached on the date of his evaluation.

On September 15, 2019 Dr. Herbert White, Jr., a Board-certified orthopedic surgeon serving as an OWCP DMA, reviewed the medical record, including Dr. Ellis' June 12, 2019 findings. He found that appellant had 13 percent permanent impairment of the left upper extremity based on CRPS and five percent permanent impairment of the left upper extremity based on a labral tear using the DBI method, and 36 percent permanent impairment of the left upper extremity using the ROM method in accordance with the sixth edition of the A.M.A., *Guides*. Dr. White determined that the date of MMI was June 12, 2019, the date of Dr. Ellis' impairment evaluation. He noted discrepancies in Dr. Ellis' impairment ratings.

By letter dated October 25, 2019, OWCP requested that Dr. Ellis review Dr. White's September 15, 2019 findings. In a November 14, 2019 addendum report, Dr. Ellis disagreed with the DMA's 13 percent left upper extremity impairment rating for CRPS and advised that his 80 percent left upper extremity impairment rating for the same condition remained unchanged.

On November 26, 2019 OWCP requested that DMA, Dr. White, review Dr. Ellis' November 14, 2019 report. In a December 5, 2019 addendum report, the DMA related that Dr. Ellis did not provide any additional information that would change his impairment rating.

On January 6, 2020 OWCP determined that a conflict in medical opinion existed between Dr. Ellis and the DMA regarding the extent of appellant's left upper extremity permanent impairment. On January 29, 2020 it referred appellant, along with a statement of accepted facts (SOAF) and the medical record, to Dr. Sunil Dedhia, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a March 10, 2020 report, Dr. Dedhia on examination of appellant's left shoulder noted that there was no evidence of obvious atrophy within the supraspinatus or infraspinatus fossa. There was tenderness to palpation over the coracoid process, acromioclavicular joint, long head biceps tendon, posterior capsule. ROM measurements included 90 degrees of flexion, 80 degrees of abduction, 0 degrees of external rotation, 10 degrees of internal rotation, passive forward elevation to 100 degrees, and passive adduction to 90 degrees.

Upon gross examination of appellant's left upper extremity, there was no evidence of obvious side-to-side upper extremity swelling or edema. There was no appreciable side-to-side difference in temperature changes throughout the upper arm or forearm and very minimal coolness was noted over the left hand compared to the right. There was no evidence of obvious hair changes

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

on the right and left side. There was evidence of curved dystrophic nails on the left side compared to the right. Skin turgor and texture was fairly symmetric with no evidence of glistening or nonelastic skin. There was no evidence of obvious changes in the sweat pattern of the left upper extremity compared to the right. Using Table 15-25 of the sixth edition of the A.M.A., *Guides*, Dr. Dedhia assigned a point score of 4 for CRPS, class of diagnosis (CDX), based on his examination findings. He determined the score of 4 resulted in a class 1 impairment under Table 15-26. Dr. Dedhia took into account grade modifiers for functional history (GMFH) and physical examination (GMPE) which resulted in a grade E, 13 percent permanent impairment of the left upper extremity. He noted that a grade modifier for clinical studies (GMCS) was not included in his calculations because clinical studies had not been provided to him. Dr. Dedhia related that appellant had advised that radiographic studies, including a bone scan had been performed; however, the actual reports and images were not available for his review. Utilizing Table 15-5, he found that a labrum lesion resulted in a class 1, five percent impairment, with a range adjustment to grade E based on GMPE and GMFH adjustments. Dr. Dedhia also found a grade E seven percent impairment, for a full-thickness rotator cuff tear under Table 15-5 based on GMFH and GMPE findings. He noted that his seven percent impairment rating included all diagnoses related to appellant's shoulder condition and was the greater rating based on the DBI method.

Dr. Dedhia also utilized the ROM method at Table 15-34 to rate permanent impairment of the left shoulder. He found 3 percent impairment for flexion, 6 percent impairment for abduction, 2 percent impairment for external rotation, 1 percent impairment each for extension and adduction, and 4 percent impairment for internal rotation, totaling 17 percent permanent impairment of the left upper extremity. Dr. Dedhia advised that since his 17 percent ROM permanent impairment rating was greater than the DBI permanent impairment ratings, it was the predominate rating for appellant's left shoulder conditions. He determined that appellant had reached MMI.

By letter dated July 10, 2020, OWCP requested that Dr. Dedhia clarify his calculation of the 17 percent ROM impairment rating as it calculated a 16 percent ROM impairment rating, whether his 13 percent DBI impairment rating should be added to the 17 percent ROM impairment rating for a total of 30 percent left upper extremity permanent impairment, and whether his current total impairment rating considered the 18 percent left upper extremity impairment rating for which appellant previously received schedule award compensation.

In a September 15, 2020 addendum report, Dr. Dedhia acknowledged that OWCP was correct in finding that appellant had a 16 percent left shoulder ROM impairment rating. He therefore found that appellant had 29 percent permanent impairment of the left upper extremity based on CRPS and shoulder ROM deficits. Dr. Dedhia related that, if appellant had been given a previous schedule award for 18 percent impairment, then he had an additional 11 percent permanent impairment. He advised that his 29 percent impairment rating was not in addition to the 18 percent previously awarded.

OWCP, by decision dated November 12, 2020, granted appellant a schedule award for an additional 11 percent permanent impairment of the left upper extremity, resulting in a total of 29 percent permanent impairment. The period of the award ran for 34.32 weeks from March 10 through November 5, 2020 and was based on the impartial medical opinion of Dr. Dedhia.

On November 19, 2020 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

OWCP subsequently received progress notes dated July 3 and August 22, 2018 by Dr. Alan G. Shepard, a neurologist, who diagnosed Type 1 CRPS of the left upper extremity, degeneration of the lumbar or lumbosacral intervertebral disc, and hand weakness.

OWCP issued an amended decision dated December 10, 2020, again granting appellant a schedule award for an additional 11 percent permanent impairment of the left upper extremity, for a total 29 percent permanent impairment, based on Dr. Dedhia's impairment rating.

An oral hearing was held on March 18, 2021.

By decision dated June 2, 2021, OWCP's hearing representative affirmed the December 10, 2020 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing regulations[7] 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. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[8] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[9] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[10]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the *World Health Organization's International Classification of Functioning, Disability and Health* (ICF).[11] In addressing impairment for the upper extremities, the sixth edition of the A.M.A., *Guides* requires identifying the impairment class for the diagnosed condition, which is

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id. See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[9] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (March 2017).

[10] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[11] A.M.A., *Guides* 3, section 1.3, *The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement* (6th ed. 2009).

then adjusted by GMFH, GMPE, and GMCS.[12] Evaluators are directed to provide rationale for their impairment rating choices, including the choices of diagnosis from regional grids and calculations of modifier scores.[13]

Impairment due to CRPS is evaluated under the scheme found in Table 15-26 (Complex Regional Pain syndrome (UEI)) as well as Table 15-24 and Table 15-25 and the accompanying relevant text.[14] The grade modifier level (ranging from zero to four) are described from the categories of functional history, clinical studies, and physical examination. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a class rating value. If that class number is not supported by the objective diagnostic criteria point, the highest class specified by those points is selected. The rating for CRPS is a "stand alone" approach.[15]

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

> "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)."[16]

FECA provides that, if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[17] For a conflict to arise, the opposing physicians' viewpoints must be of virtually equal weight and rationale.[18] Where OWCP has referred the case to an impartial medical examiner (IME) to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[19]

ANALYSIS

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

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[12] A.M.A., *Guides* 385-419; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[13] *D.S.*, Docket No. 19-0292 (issued June 21, 2019); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[14] A.M.A., *Guides* 450-54.

[15] *Id.*

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

[17] 5 U.S.C. § 8123(a); *A.R.*, Docket No. 18-0632 (issued October 19, 2018).

[18] *C.H.*, Docket No. 18-1065 (issued November 29, 2018.

[19] *W.M.*, Docket No. 18-0957 (issued October 15, 2018).

OWCP properly found a conflict in the medical opinion evidence between appellant's attending physician, Dr. Ellis and the DMA, Dr. White, regarding the extent of permanent impairment of the left upper extremity due to his accepted left shoulder injury. It referred appellant's case to Dr. Dedhia pursuant to 5 U.S.C. § 8123(a) for an impartial medical examination in order to resolve the conflict in medical opinion. In his March 10, 2020 report, the IME, Dr. Dedhia, reviewed appellant's history of injury and the relevant medical evidence, and provided physical examination findings. He noted appellant's accepted conditions of left shoulder, including rotator cuff tear and left arm CRPS. In evaluating appellant's permanent impairment due to CRPS, using the DBI method at Table 15-25 of the sixth edition of the A.M.A., *Guides*, Dr. Dedhia assigned a point score of 4 due to his examination findings. He determined that, under Table 15-26, the CDX for appellant's CRPS resulted in a class 1 impairment. Dr. Dedhia considered adjustments for GMFH and GMPE which resulted in a grade E impairment with a default value of 13 percent permanent impairment. He noted that an adjustment for GMCS was not applicable as clinical studies had not been provided to him.

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden of proof to establish entitlement to compensation. However, OWCP shares responsibility in the development of the evidence to see that justice is done.[20] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[21]

In a situation where OWCP secures an opinion from an IME for the purpose of resolving a conflict in the medical evidence and the opinion from such IME requires clarification or elaboration, it has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[22]

The Board finds that while Dr. Dedhia attempted to rate appellant's permanent impairment of the left shoulder for CRPS, he clearly noted that appellant's entire medical record, including all diagnostic studies, was not provided for his review. He therefore did not apply the GMCS in the net adjustment formula. OWCP should have referred the entire medical record including all diagnostic reports and/or studies to Dr. Dedhia, once he noted this discrepancy.[23] On remand it shall refer appellant's entire medical record to Dr. Dedhia and request that he provide a supplemental opinion regarding appellant's permanent impairment of the left shoulder based upon his CRPS diagnosis.

The Board also notes that Dr. Dedhia also used the ROM method under Table 15-34 to rate permanent impairment of appellant's left shoulder. Dr. Dedhia found 3 percent impairment for flexion, 6 percent impairment for abduction, 2 percent impairment for external rotation, 1 percent

[20] *See L.B.*, Docket No. 19-0432 (issued July 23, 2019); *William J. Cantrell*, 34 ECAB 1223 (1983).

[21] *Id.*; *see also S.A.*, Docket No. 18-1024 (issued March 12, 2020).

[22] *J.C.*, Docket No. 20-0064 (issued September 4, 2020); *S.R.*, Docket No. 17-1118 (issued April 5, 2018); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232, 238 (1988).

[23] *Id.*

impairment each for extension and adduction, and 4 percent impairment for internal rotation, totaling 17 percent permanent impairment of the left upper extremity. However, he did not record or otherwise report that he had taken three independent ROM measurements of appellant's left shoulder.[24] On remand, OWCP should also request that Dr. Dedhia explain whether three ROM measurements were taken to evaluate appellant's left shoulder loss of ROM. Following this and other such further development, as deemed necessary, it shall issue a *de novo* decision on appellant's schedule award claim.

CONCLUSION

The Board finds that the 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. The case is remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: March 2, 2022
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

[24] The Board also notes that the record does not substantiate that Dr. Dedhia was advised by OWCP that three independent measurements were necessary.