United States Department of Labor
Employees' Compensation Appeals Board

M.J., Appellant	)	
and	)	**Docket No. 20-1565**
	)	**Issued: January 24, 2023**
U.S. POSTAL SERVICE, POST OFFICE, Bedford Park, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On August 25, 2020 appellant filed a timely appeal from an April 21, 2020 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.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 8 percent permanent impairment of his left upper extremity and 31 percent permanent impairment of the left lower extremity for which he previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts and circumstances as presented in the prior decisions are incorporated herein by reference. The relevant facts are as follows.

On December 18, 1990 appellant, then a 32-year-old tool and parts clerk, injured his left shoulder left hip and lower back when he was pinned between a cabinet and a desk while in the performance of duty. OWCP assigned File No. xxxxxx090 and accepted his claim for lumbar strain and left shoulder contusion on February 7, 1991. It later expanded acceptance of the claim to include left shoulder capsulitis and permanent aggravation of degenerative disc disease at L4-5. By decision dated May 18, 1994, OWCP granted appellant a schedule award for eight percent permanent impairment of his left upper extremity. On January 22, 1998 OWCP granted appellant a schedule award for 29 percent permanent impairment of his left lower extremity. Appellant was released to return to light-duty work on May 21, 2002.[3]

On February 6, 2003 appellant filed a traumatic injury claim (Form CA-1) alleging that on February 4, 2003 he sustained additional injuries to his back and left shoulder when his chair broke while he was sitting in it in the performance of duty. OWCP assigned File No. xxxxxx830 and accepted that claim for left shoulder contusion and lumbar strain on March 5, 2003. Appellant stopped work on February 4, 2003. OWCP administratively combined OWCP File Nos xxxxxx090 and xxxxxx830, with the latter serving as the master file.

On November 26, 2012 appellant retired from the employing establishment through a 2013 special incentive offer. He elected to receive benefits from the Office of Personnel Management effective June 2, 2014 in lieu of wage-loss compensation benefits under FECA.

Appellant filed a claim for compensation (Form CA-7) for an increased schedule award on June 27, 2014.

In a report dated August 14, 2014, Dr. Charlotte H. Mitchell, an internist, noted appellant's multiple work injuries. She diagnosed chronic low back pain due to spinal stenosis with left side radiculopathy, severe claudication of the left leg and left shoulder pain due to posterior scapula. Dr. Mitchell found that appellant had reached maximum medical improvement (MMI). She provided a whole person impairment of 33 percent permanent impairment. Dr. Mitchell reported that appellant's left shoulder traumatic degenerative joint disease was 9 percent permanent impairment and that his multidirectional left shoulder was 13 percent permanent impairment.

On September 18, 2014 OWCP referred this report to its district medical adviser (DMA), Dr. David H. Garelick, a Board-certified orthopedic surgeon. In his September 22, 2014 report,

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[2] Docket No. 17-1403 (issued April 6, 2018); Docket No. 03-2140 (issued March 25, 2004).

[3] The employing establishment offered appellant a job which OWCP found suitable on August 29, 2002. In a November 29, 2002 decision, OWCP terminated appellant's wage-loss compensation and schedule award benefits finding he refused suitable work under 5 U.S.C. § 8106(c)(2). By decision dated July 2, 2003, it denied modification of its prior decision. Appellant appealed that decision to the Board. By decision dated March 25, 2004, the Board reversed, finding that OWCP did not meet its burden of proof to terminate appellant's compensation benefits effective November 25, 2002. Docket No. 03-2140 (issued March 25, 2004). Following the Board's decision OWCP restored appellant's wage-loss compensation benefits.

the DMA found that Dr. Mitchell had not established additional permanent impairment beyond the 8 percent permanent impairment in the left upper extremity and 29 percent permanent impairment in the left lower extremity for which he had previously received a schedule award.

By decision dated October 7, 2014, OWCP denied appellant's claim for an increased schedule award. On October 31, 2014 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

On January 13, 2015 Dr. David Fardon, a Board-certified orthopedic surgeon, evaluated appellant for schedule award purposes. He evaluated appellant's permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment.*[4] Specifically, Dr. Fardon provided appellant's impairment to his lumbar spine due to intervertebral disc herniations at multiple levels with radiculopathy. He concluded that appellant had 19 percent permanent impairment of the whole person as a result of his low back disorder.

In a report dated April 16, 2015, Dr. Neil Allen, a Board-certified neurologist, examined appellant for schedule award purposes. In applying the A.M.A., *Guides*, he determined that appellant had 24 percent impairment of the left lower extremity. In regard to appellant's left shoulder, Dr. Allen determined that appellant had five percent permanent impairment of his left upper extremity.

An oral hearing was held on June 18, 2015. OWCP subsequently received a report from Dr. Mitchell dated June 26, 2015. Dr. Mitchell diagnosed chronic low back pain due to spinal stenosis with radiculopathy and chronic paraspinal spasm, bilateral lumbosacral facet arthropathy, left-sided sciatica, as well as chronic left shoulder pain due to rotator cuff tendinopathy and pericapsulitis with resultant muscular atrophy and post-traumatic degenerative joint disability. She evaluated appellant's left shoulder condition based on range of motion (ROM)[5] and reported 90 degree of flexion which is 3 percent permanent impairment; 30 degrees of extension which she found was 2 percent permanent impairment;[6] 75 degrees of abduction which is 6 percent permanent impairment; and 50 degrees of adduction which 10 percent permanent impairment.[7] Dr. Mitchell totaled his left upper extremity loss of ROM and found 25 percent permanent impairment under the A.M.A., *Guides*. She further found that appellant had 31 percent impairment of his lumbar spine. Dr. Mitchell opined that he had reached MMI in August 2014.

By decision dated August 11, 2015, OWCP's hearing representative affirmed the October 7, 2014 decision.

On October 19, 2015 appellant requested reconsideration of the August 11, 2015 decision and submitted additional medical evidence. Dr. Joseph R. Mejia, a specialist in occupational medicine and ophthalmology, completed a report on October 1, 2015 and performed an evaluation for schedule award purposes. He reported decreased motor strength on the left, and constant thigh

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

[5] *Id*. at 475, Table 15-34.

[6] The A.M.A., *Guides* lists this as one percent permanent impairment. *Id*.

[7] *Id*.

to knee left leg paresthesia to light touch. Dr. Mejia determined that appellant had 12 percent permanent impairment of his left lower extremity.

In a report dated October 27, 2015, Dr. Mejia addressed the percentage of permanent impairment of appellant's left upper extremity. He determined that appellant reached maximum medical improvement on August 14, 2014. Dr. Mejia found that appellant's left upper extremity had pain restricted rotator cuff motion, with 90 degrees of flexion, 75 degrees of abduction, 90 degrees of internal rotation, and 45 degrees of abduction. He also reported tenderness at the acromioclavicular joint and upper trapezius muscle in the left shoulder. Dr. Mejia applied the diagnosis-based estimates (DBE) and determined that appellant had four percent permanent impairment of his left upper extremity due to acromioclavicular joint injury.[8]

In a decision dated January 7, 2016, OWCP denied modification of the August 11, 2015 decision, finding that appellant had not submitted medical evidence which showed more than 29 percent permanent impairment of the left lower extremity and 8 percent permanent impairment of the left upper extremity for which he had previously received schedule award compensation.

Dr. Kern Sinh, a Board-certified orthopedic surgeon, examined appellant on April 27, 2016 for schedule award purposes. He reviewed appellant's history of injury and diagnosed lumbar muscular strain and L4 through S1 degenerative disc disease.[9]

On November 15, 2016 appellant requested reconsideration of the January 7, 2016 decision and submitted additional medical evidence. Dr. Thomas Pontinen, a physician Board-certified in pain management, examined appellant for schedule award purposes on July 26, 2016. He described appellant's history of injury and noted that appellant's back pain radiated to his left lower extremity in the L4-S1 distribution to the foot. Dr. Pontinen also found that appellant's back pain radiated in the left upper arm to the forearm and hand with no associated neurological deficit. He found 42 percent permanent impairment in the left lower extremity due to moderate motor and sensory deficits in L4, L5, and S1 with impairments of 16 percent permanent impairment for L4, 16 percent permanent impairment for L5, and 10 percent permanent impairment for L1. In regard to appellant's left upper extremity, Dr. Pontinen attributed appellant's permanent impairment to moderate deficits in the C6 and C7 dermatomes and reached 15 percent permanent impairment.

On December 11, 2016 OWCP's DMA reviewed Dr. Pontinen's July 26, 2016 report. He found appellant had three percent permanent impairment of the left upper extremity based on the DBE in accordance with Dr. Allen's rating. The DMA further noted that the major finding in appellant's left shoulder was loss of shoulder motion, and utilized the diagnosis of tendinitis as the most impairing condition in the left shoulder region. He noted that Dr. Pontinen's impairment rating of the left upper extremity was based on cervical spine nerve conditions, which were not accepted in appellant's claim and therefore could not be considered for schedule award purposes.

[8] A.M.A., *Guides* 403, Table 15-5.

[9] On May 9, 2016 appellant appealed the January 7, 2016 OWCP decision. In a letter dated September 22, 2016, he requested that the Clerk of the Appellate Boards dismiss his appeal. In an *Order Dismissing Appeal*, issued December 1, 2016, the Board granted appellant's request for the dismissal of his appeal. Docket No. 16-1210 (issued December 1, 2016).

The DMA applied *The Guides Newsletter,* Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July /August 2009) (*The Guides Newsletter*) to Dr. Pontinen's findings as Dr. Pontinen failed to provide discussion of the tables, figures, and chapters from the A.M.A., *Guides* used. He noted that appellant's lower extremity impairment was based on combining the motor and sensory defects in L4, L5, and S1, not merely adding these impairments.[10] For sensory deficits of the left L4 nerve root, the DMA determined that appellant had decreased light touch and sharp/dull sensitivities or a moderate impairment.[11] He applied *The Guides Newsletter* to this finding resulting in a Class 1, Grade C or three percent permanent impairment of the left lower extremity. The DMA then determined appellant's motor deficit of the left L4 nerve root based on a decreased strength of grade 3/5 or moderate strength loss of two percent permanent impairment.[12] Applying *The Guides Newsletter* to this finding resulted in Class 1, Grade C or 13 percent permanent impairment of the left lower extremity. The DMA then completed the net adjustment formula noting that appellant's function history grade modifier was 1 and that his clinical studies grade modifier was 0 as there were no findings of left-sided L4 involvement on electromyogram resulting in a net adjustment of -1 or Grade B, 11 percent permanent impairment. Appellant's total L4 impairment based on the Combined Values Chart for his sensory impairment of 3 and his motor impairment of 11 was 14 percent permanent impairment.

In regard to appellant's L5 nerve root impairments to the left lower extremity, the DMA repeated a similar process and sensory impairment of three percent permanent impairment. In regard to appellant's L5 nerve root motor impairment, he found clinical studies supporting evidence of lumbar radiculopathy. The DMA found that the net adjustment was 0 and that appellant's motor final grade was C or 13 percent impairment. He combined the motor and sensory deficits to reach 16 percent permanent impairment due to the L5 nerve root.

In regard to appellant's S1 nerve root impairment,[13] the DMA found a moderate motor deficit with a Grade C value of eight percent permanent impairment, and net adjustment of 0 resulting in eight percent permanent impairment due to loss of strength. He found moderate sensory deficit of the S1 nerve root was 2 percent permanent impairment and combined this with appellant's motor strength loss of 8 percent permanent impairment to reach 16 percent permanent impairment.[14] In combining appellant's three nerve root impairments, the DMA utilized the values of 16 percent permanent impairment for the L5 nerve root, 11 percent permanent impairment for the L4 nerve root, and 8 percent permanent impairment for the S1 nerve root[15] to reach 31 percent permanent impairment of the left lower extremity.

[10] A.M.A., *Guides* 604.

[11] *Id*. at 533, Table 16-11.

[12] *Id.*

[13] OWCP's medical adviser's report again mentions the left L4 nerve root, but the impairment ratings provided correspond to those for the S1 nerve root.

[14] The Combined Values Chart combines 8 and 2 to reach 10 percent permanent impairment.

[15] The Board notes that these percentages do not correlate with the impairment ratings he reached of 16 percent permanent impairment of the L5 nerve root, 14 percent permanent impairment of the L4 nerve root, and 10 percent permanent impairment of the S1 nerve root.

By decision dated January 9, 2017, OWCP found that the January 7, 2016 decision should be modified as appellant had established an additional 2 percent permanent impairment of the left lower extremity. However, it further found that he had not established increased impairment of his left upper extremity warranting an additional schedule award.

In a decision dated January 19, 2017, OWCP granted appellant a schedule award for an additional two percent permanent impairment of his left lower extremity, for a total impairment rating of 31 percent.

On February 10, 2017 appellant requested reconsideration of the January 19, 2017 decision. He provided an additional note from Dr. Pontinen dated January 24, 2017. Dr. Pontinen addressed appellant's left upper extremity and found mild subacromial crepitus, positive Neers' test indicating shoulder impingement, positive Hawkins' test, and two centimeters of atrophy in the left arm circumference relative to the right arm. He listed appellant's left shoulder range of motion as 80 degrees of flexion, 20 degrees of extension, 35 degrees of abduction, 50 degrees of adduction, 55 degrees of internal rotation, and 105 degrees of external rotation. Dr. Pontinen further found that appellant had moderate sensory deficits in the C6-7 dermatomes. He found that appellant's left shoulder *Quick*DASH score was 82 as he reported pain with normal activity and could perform self-care activities with modifications, and noted this was Grade Modifier 2 for functional history.[16] Dr. Pontinen noted that appellant's DBE was tendinitis[17] with a Grade C impairment of one percent permanent impairment. He further noted that appellant's physical examination grade modifier would be two considering appellant's loss of range of motion. Dr. Pontinen reported that appellant had moderate deficits in sensory and mild motor deficits in both the C6 and C7 dermatomes. He concluded that appellant's total left upper extremity impairment was 15 percent permanent impairment. Dr. Pontinen opined that appellant's left upper extremity motor and sensory deficits should be considered when evaluating his left upper extremity for schedule award purposes.

The DMA resubmitted his December 11, 2016 report on April 11, 2017 without reviewing Dr. Pontinen's January 24, 2017 report with the additional correlation of upper extremity findings to the A.M.A., *Guides*.

By decision dated May 4, 2017, OWCP denied modification of its prior decisions, finding that the medical evidence did not establish greater than 31 percent permanent impairment of the left lower extremity and 8 percent permanent impairment of the left upper extremity for which he has previously received schedule award compensation.

Appellant appealed to the Board. By decision dated April 6, 2018, the Board remanded the case for further development of the medical evidence regarding permanent impairment of appellant's upper and lower extremities.[18] Specifically, the Board requested that OWCP determine whether the diagnosis-based impairment (DBI) method or ROM method was more appropriate for appellant's upper extremity impairment and whether the diagnosed condition of cervical

[16] A.M.A., *Guides* 406, Table 15-7.

[17] *Id*. at 402, Table 15-5.

[18] Docket No. 17-1403 (issued April 6, 2018).

radiculopathy preexisted his accepted employment injuries such that any impairment due to this condition should be included for schedule award purposes. In regard to appellant's left lower extremity impairment rating, the Board remanded for a supplemental report from the DMA correctly detailing the impairments reached and the combined values in accordance with the Combined Values Chart of the A.M.A., *Guides*.

On January 17, 2020 OWCP referred appellant's schedule award claim to Dr. Morley Slutsky, Board-certified in occupational medicine, and DMA, to address whether appellant had greater than 8 percent permanent impairment of his left upper extremity,[19] noting that Dr. Mitchell had found 25 percent impairment based on loss of ROM. It further noted that Dr. Pontinen's January 24, 2017 report attributed a portion of appellant's left upper extremity impairment to cervical radiculopathy and requested that the DMA discuss whether cervical radiculopathy was a preexisting condition predating appellant's accepted employment injuries.

In his February 5, 2020 report, the DMA found that Dr. Mitchell's reports did not provide sufficient findings to establish permanent impairment. He noted that the August 14, 2014 report did not provide clinical testing or impairment calculations. The DMA reviewed Dr. Mitchell's June 26, 2015 report and found that she had not provided three valid shoulder ROM measurements as required by the A.M.A., *Guides* and that she had provided no other shoulder findings. He concluded that Dr. Mitchell's reports were of no value in determining appellant's upper extremity impairment in accordance with the sixth edition of the A.M.A., *Guides*. The DMA concluded that based on the medical evidence of record, the DBI method was more appropriate for the condition of tendinitis with residual dysfunction or three percent permanent impairment.

The DMA reviewed the medical records and found no evidence that appellant demonstrated cervical spine lesions or cervical nerve root deficits prior to October 27, 2015, or after his accepted employment injuries. He further found that Dr. Pontinen failed to provide a diagnostic study supporting his findings. However, the DMA provided an impairment rating based on five percent of the left upper extremity due to left C6-7 nerve root deficits based on Dr. Pontinen's reports. He found that including C6-7 nerve root deficits, appellant was entitled to an increased schedule award for his left upper extremity totaling 13 percent permanent impairment.

By decision dated April 21, 2020, OWCP denied appellant's claim for an additional schedule award, finding that he was previously paid a schedule award for 8 percent permanent impairment of the left upper extremity and 29 percent impairment of the left lower extremity, and that the medical evidence did not support an increase in his permanent impairment.

LEGAL PRECEDENT

The schedule award provisions of FECA,[20] and its implementing federal regulations,[21] 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,

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[19] The accompanying statement of accepted facts notes both that appellant's claim was accepted for left shoulder conditions and that he received a schedule award for eight percent of the right upper extremity.

[20] 5 U.S.C. § 8107.

[21] 20 C.F.R. § 10.404.

however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[22] 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.[23]

The sixth edition of the A.M.A., *Guides* provides a DBI method of determining the percentage of permanent impairment. In addressing upper extremity impairments, the sixth edition requires identifying the impairment class of diagnosis (CDX), which is then adjusted by a grade modifier for functional history (GMFH), a grade modifier for physical examination (GMPE), and a grade modifier for clinical studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[24]

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

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (via the updated instructions noted above) to the rating physician(s).
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> "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.)[25]
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> The Bulletin further provides:
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> "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

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[22] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides* (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* Part 3 -- Medical, *Schedule Awards,* Chapter 3.700, Exhibit 1 (January 2010).

[23] *F.S.,* Docket No. 18-0383 (issued August 22, 2018); *Isidoro Rivera,* 12 ECAB 348 (1961).

[24] A.M.A., *Guides* 411. *F.S., id*.

[25] FECA Bulletin No. 17-06 (issued May 8, 2017); *see also W.H.,* Docket No. 19-0102 (issued June 21, 2019).

impairment rating using the DBI method, if possible, given the available evidence.[26]

"Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physician's evaluation, the CE should route that report to the DMA for a final determination."[27]

Neither FECA nor its implementing regulations provide for the payment of a schedule for the permanent loss of use of the back/spine or the body as a whole.[28] Furthermore, the back is specifically excluded from the definition of an organ under FECA.[29] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[30] The sixth edition of the A.M.A., *Guides,* however, does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. Recognizing that FECA, allows ratings for extremities and preclude ratings for the spine, *The Guides Newsletter* offers an approach to rating spinal nerve impairments consistent with sixth edition methodology.[31] For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures provide that *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) is to be applied as provided in section 3.700 of its procedures.[32]

ANALYSIS

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

With regard to the left upper extremity, in her June 26, 2015 report, Dr. Mitchell provided one set of passive ROM measurements for the left shoulder. OWCP referred Dr. Mitchell's report

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[26] *Id., J.L.,* Docket No. 19-1684 (issued November 20, 2020); *R.L.*, Docket No. 19-1793 (issued August 7, 2020); *E.P.,* Docket No. 19-1708 (issued April 15, 2020).

[27] *Id.*

[28] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *C.T.,* Docket No. 20-0043 (issued April 30, 2021); *Ernest P. Govednick*, 27 ECAB 77 (1975).

[29] *See id.* at § 8101(19); *C.T., id.*; *Francesco C. Veneziani,* 48 ECAB 572 (1997).

[30] *A.D.,* Docket No. 20-0553 (issued April 19, 2021); *Rozella L. Skinner*, 37 ECAB 398 (1986).

[31] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(c)(3) (March 2017).

[32] FECA Transmittal No. 10-0004 (issued January 9, 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, at Exhibit 4 (January 2010).

to Dr. Slutsky, its DMA, who opined that appellant had three percent left upper extremity impairment for tendinitis with residual dysfunction under the DBI methology. The DMA, who reviewed Dr. Mitchell's report, did not conduct any evaluation under the ROM method. Rather, he simply advised that Dr. Mitchell's report did not contain complete ROM measurements for the left shoulder. Section 15.7 of the sixth edition of the A.M.A., *Guides* provides that ROM should be measured after a warmup, in which the individual moves the joint through its maximum ROM at least three times. The ROM examination is then performed by recording the active measurements from three separate ROM efforts and all measurements should fall within 10 degrees of the mean of these three measurements. The maximum observed measurement is used to determine the ROM impairment.[33] There currently is no evidence in the case record that these requirements for evaluating permanent impairment due to ROM deficits have been met.

In order to conduct a full evaluation of appellant s right upper extremity permanent impairment, the Board finds that the case shall be remanded to OWCP in order for it to obtain the raw data from Dr. Mitchell's ROM testing for the left upper extremity. Once the data is obtained, it should be evaluated and considered under the relevant standards of the A.M.A., *Guides*, including referral to a DMA, as a possible basis for an impairment rating. If no such data is available, OWCP shall take appropriate action for further examination to obtain the necessary ROM measurements.

This case shall therefore be remanded for full application of OWCP s procedures found in FECA Bulletin No. 17-06 and the standards of the sixth edition of the A.M.A., *Guides*. After conducting this and other such further development of the medical evidence as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's schedule award claim.

With regard to the left lower extremity, in its April 6, 2018 decision, the Board remanded the case for a supplemental report from the DMA correctly detailing the left lower extremity impairment ratings and combined values in accordance with the Combined Values Chart of the A.M.A., *Guides*. OWCP, however, did not follow the Board's prior instructions in developing his claim with regard to his left lower extremity.

The Board has final authority to determine questions of fact and law. The Board's determinations are binding upon OWCP and must, of necessity be accepted and acted upon by the Director of OWCP.[34] A decision of the Board is final upon the expiration of 30 days following the date of its order and, in the absence of new review by the Director, the subject matter is *res judicata,* and is not subject to further consideration by the Board.[35]

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[33] A.M.A., *Guides* 464; *see also C.H.* Docket No. 20-0529 (issued June 16, 2021); *P.H.*, Docket No. 18-0987 (issued March 30, 2020).

[34] *A.H.,* Docket No. 19-1336 (issued April 16, 2020); *K.B.*, Docket No. 17-0969 (issued March 13, 2018); *see Paul Raymond Kuyoth,* 27 ECAB 498, 503-04 (1976); *Anthony Greco,* 3 ECAB 84 (1949). *See also Frank W. White,* 42 ECAB 693 (1991) (the Board's order in a prior appeal imposed an obligation on the Director to take particular actions as directed); *L.C.,* Docket No. 09-1816 (issued March 17, 2010) (OWCP did not follow the Board's instructions); *T.S.,* Docket No. 13-2135 (issued April 3, 2014).

[35] *See A.H., id.*; 20 C.F.R. § 501.6(d); *Clinton E. Anthony, Jr.,* 49 ECAB 476, 479 (1998).

OWCP has not issued a decision in which it followed the instructions of the Board in its April 6, 2018 decision, *i.e.*, it has not issued an appropriate merit decision correctly detailing the left lower extremity impairment ratings and combined values in accordance with the Combined Values Chart of the A.M.A., *Guides*. The case is, therefore, again remanded for OWCP to correctly detail the left lower extremity impairment ratings and combined values in accordance with the Combined Values Chart of the A.M.A., *Guides*.[36] Following this and other such further development as deemed necessary, OWCP issue a *de novo* merit decision regarding appellant's left lower extremity permanent impairment.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the April 21, 2020 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 24, 2023
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

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

[36] *See J.V.*, Docket No. 21-0226 (issued February 16, 2022).