United States Department of Labor
Employees' Compensation Appeals Board

L.R., Appellant	)	
and	)	**Docket No. 21-1312**
	)	**Issued: March 6, 2023**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, Employer	)	

Appearances:
Appellant, *pro se*
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 August 27, 2021 appellant filed a timely appeal from a May 26, 2021 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

ISSUE

The issue is whether appellant has met her burden of proof to establish more than 16 percent permanent impairment of the right upper extremity and more than 24 percent permanent

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence to OWCP following the May 26, 2021 decision. 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.*

impairment of the left upper extremity, for which she has previously received schedule award compensation.

FACTUAL HISTORY

On March 3, 2018 appellant, then a 43-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that she developed pain in her upper extremities due to factors of her federal employment which included sorting, casing, throwing, and delivering mail. She indicated that she first became aware of the condition on January 7, 2014 and realized that her condition was caused or aggravated by her federal employment on January 26, 2017. Appellant did not stop work. OWCP assigned OWCP File No. xxxxxx053.

By decision dated March 20, 2018, OWCP accepted the claim for synovitis and tenosynovitis of the shoulders; left elbow lateral epicondylitis; cervical disc displacement; joint derangement of the shoulders; and cervical disc disorder with radiculopathy, unspecified cervical region. Appellant had prior claims under OWCP File No. xxxxxx507, accepted for bilateral carpal tunnel syndrome, bilateral lesion of ulnar nerve, and right lateral epicondylitis, and OWCP File No. xxxxxx234, accepted for right shoulder sprain/strain.

On March 6, 2015 OWCP granted appellant a schedule award for 10 percent permanent impairment of the right upper extremity and 8 percent permanent impairment of the left upper extremity under OWCP File No. xxxxxx507.

Appellant subsequently filed a claim for compensation (Form CA-7) for a schedule award on May 31, 2018 under OWCP File No. xxxxxx053.

In a June 22, 2018 report, Dr. Samuel Chmell, a Board-certified orthopedic surgeon, noted appellant's history of injury and treatment and utilized the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) to rate appellant's permanent impairment.[3] He examined her, provided findings and concluded that she had 19 percent permanent impairment of the right upper extremity (7 percent for the right shoulder and 12 percent for cervical spine-related sensory and motor impairments); and 19 percent permanent impairment of the left upper extremity (2 percent for lateral epicondylitis, 5 percent for the shoulder, and 12 percent for cervical spine-related sensory and motor impairments). Dr. Chmell opined that appellant reached maximum medical improvement (MMI) on April 12, 2018.

On December 14, 2018 OWCP referred appellant to Dr. James Elmes, a Board-certified orthopedic surgeon, for a second opinion examination.

In a February 7, 2019 report, Dr. Elmes reviewed appellant's history of injury and medical treatment, as well as the statement of accepted facts (SOAF). He opined that she reached MMI on February 16, 2015. Dr. Elmes related appellant's physical examination findings and explained that she had no objective spasm, atrophy, or neurological deficit, other than some mild right thenar atrophy. He utilized the diagnosis-based impairment (DBI) methodology for rating permanent

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

impairment of the right upper extremity, and found that she had three percent permanent impairment for ulnar nerve entrapment of the wrist, and three percent permanent impairment for nerve entrapment of the elbow. Dr. Elmes also found that appellant had 6 percent permanent impairment of the shoulder, utilizing the range of motion (ROM) methodology, for a total of 12 percent permanent impairment of the right upper extremity. He noted that she previously received an award of 10 percent and was entitled to an additional award of 2 percent for the right upper extremity. Dr. Elmes determined that, for the left upper extremity, utilizing the DBI methodology, appellant had three percent permanent impairment for entrapment neuropathy at the wrist, three percent permanent impairment for entrapment at the elbow, and six percent permanent impairment. Utilizing the ROM methodology, appellant had six percent permanent impairment for the left shoulder. Dr. Elmes therefore concluded that she also had 12 percent permanent impairment of the left upper extremity. He noted that appellant previously received an award of eight percent for the left upper extremity and was entitled to an additional award of four percent for the left upper extremity.

On April 1, 2019 OWCP determined that a conflict of medical opinion existed between Dr. Chmell, appellant's treating physician, and Dr. Elmes, the second opinion physician, regarding the impairment ratings for the right and left upper extremities, and that she be referred to an impartial medical examiner (IME). It referred her, along with the case record and a SOAF, to Dr. Michael Grear, Board-certified in orthopedic surgery, serving as the IME.

In a June 27, 2019 report, Dr. Grear noted appellant's history of injury and medical treatment. He provided her physical examination findings and related that she had no sensory deficits bilaterally, and motor function within normal limits. Dr. Grear also provided appellant's ROM measurements. He utilized the DBI methodology for the diagnosis of shoulder tendinitis, under Table 15-5, page 402 of the A.M.A. *Guides*, and concurred with Dr. Chmell's permanent impairment rating of seven percent of each upper extremity. However, the IME found no basis for impairment related to the cervical spine. Dr. Grear noted that since appellant had received a schedule award for 10 percent permanent impairment of the right upper extremity and 8 percent permanent impairment of the left upper extremity, she had no additional permanent impairment.

In a July 31, 2019 report, Dr. Michael Katz, Board-certified in orthopedic surgery and serving as the district medical adviser (DMA), noted that Dr. Grear provided separate findings for ROM and it was unclear why these findings were not utilized to rate appellant's permanent impairment. He requested that the IME be contacted and afforded the opportunity to clarify his opinion.

In a letter dated August 29, 2019, OWCP requested that Dr. Grear clarify his opinion and confirm whether three independent ROM measurements had been made for each shoulder. It requested clarification on March 2 and June 1 and 2, 2020 without response. OWCP then referred appellant to Dr. Michael Cohen, Board-certified in orthopedic surgery, for an impartial medical examination to be scheduled after May 18, 2020.

In a June 3, 2020 report, Dr. Cohen, serving as an IME, opined that appellant had five percent permanent impairment of the right upper extremity based upon the diagnosis of rotator cuff, full thickness tear of the shoulder, under Table 15-5, page 403 of the A.M.A., *Guides*. He also found that, based on the diagnosis of tendinitis of the left shoulder, under Table 15-5, page

402 of the A.M.A., *Guides*, appellant had three percent permanent impairment of the left upper extremity.

By decision dated June 23, 2020, OWCP denied appellant's claim for an increased schedule award.

On July 15, 2020 appellant requested a hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated September 1, 2020 an OWCP hearing representative found the case not in posture for decision. The hearing representative found that Dr. Cohen's report could not be utilized as the record did not contain any documentation to establish that Dr. Cohen was properly selected as the IME and that appellant had been properly advised of the examination. OWCP's hearing representative explained that, if such documentation was not available, OWCP should take the proper steps to properly select an IME and advise appellant of the examination. The hearing representative also indicated that appellant's other claims involving the upper extremities (OWCP Files No. xxxxxx507 and xxxxxx234) should be combined with the present claim and that the IME should provide ratings under both the ROM and DBI methods.

On September 15, 2020 OWCP notified appellant that it had administratively combined her other claims, OWCP File Nos. xxxxxx507 and xxxxxx234, with the present claim serving as the master file. It further notified her that a new impartial medical examination would be scheduled.

On February 8, 2021 OWCP referred appellant, along with the case record and a SOAF, to Dr. John Scott Player, Board-certified in orthopedic surgery, to resolve the conflict in medical opinion between Dr. Elmes, the second opinion physician, and Dr. Chmell, the treating physician.

In a March 9, 2021 report, Dr. Player utilized the sixth edition of the A.M.A., *Guides* and rated appellant's upper extremity permanent impairments. He examined her and provided physical findings. Dr. Player found that appellant had reached MMI on April 12, 2018. He opined that she had 6 percent impairment of the right upper extremity and 16 percent impairment of the left upper extremity. Dr. Player provided both DBI and ROM based ratings for the right and left shoulders.

For the right shoulder DBI rating, Dr. Player referred to the Shoulder Regional Grid, and selected the class of diagnosis (CDX) of tendinitis, Table 15-5, page 402. He assigned a class 1 impairment for residual loss, functional with normal motion, a default position of C for three percent upper extremity impairment. For the functional history grade modifier (GMFH), Dr. Player referred to Table 15-7, page 406, and noted that appellant had pain/symptoms with less than normal activity and required assistance with self-care activities, arriving at a *Quick*DASH score of 75, resulting in a grade modifier of 3. For the physical examination grade modifier (GMPE), he referred to Table 15-8, page 408, noting observed and palpable findings of tenderness, swelling or crepitus, resulting in a grade modifier of 1. Dr. Player referred to Table 15-9, page 410, and noted that the grade modifier for clinical studies (GMCS) could not be utilized. He applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1- 1)

+ (1 - 1) + (0 - 1) = 0. Dr. Player noted that there was no net adjustment from the default value of C and determined three percent impairment for the right upper extremity using the DBI method.

For the left shoulder, using the DBI method, Dr. Player again selected the CDX of tendinitis, and related the same findings and calculations as he had for the right shoulder. He therefore again concluded that appellant had three percent permanent impairment of the left shoulder.

Utilizing the ROM method, Dr. Player explained that he made three independent measurements of each motion with a goniometer, rounded each measurement to the nearest zero-ending integer, determined each measurement within 10 degrees of the average of the three, and used the greatest measurement for the calculation of the ROM impairment rating.

For the right shoulder, Dr. Player used the ROM method and referred to Table 15-34, page 475 of the A.M.A., *Guides*. From his chart containing the three independent measurements and his narrative summary, he noted that the highest rating for flexion of 90 degrees was three percent, extension of 80 degrees was zero percent, abduction of 90 degrees was three percent, adduction of 40 degrees was zero percent, internal rotation of 80 degrees was zero percent, and external rotation of 70 degrees was zero percent. Dr. Player therefore found that appellant had six percent permanent impairment of the right upper extremity using the ROM method.

For the left shoulder, Dr. Player used the ROM method and referred to Table 15-34, page 475 of the A.M.A., *Guides*. From his chart containing the three independent measurements, he noted that the highest rating for flexion of 90 degrees was three percent, extension of 70 degrees was zero percent, abduction of 90 degrees was three percent, adduction of 30 degrees was one percent, internal rotation of 70 degrees was two percent, and external rotation of 60 degrees was zero percent, resulting in nine percent impairment of the left upper extremity under the ROM method. Dr. Player noted from his narrative summary that the highest rating for flexion of 90 degrees was three percent, extension of 80 degrees was zero percent, abduction of 90 degrees was three percent, adduction of 40 degrees was one percent, internal rotation of 80 degrees was two percent, and external rotation of 70 degrees was zero percent, resulting in nine percent impairment of the left upper extremity under the ROM method.

Dr. Player also provided an impairment rating for the left elbow. For the DBI method, he referred to the A.M.A., *Guides*, Table 15-4, page 399, Elbow Regional Grid, Table 15-7, page 406, and Table 15-8, page 408. Dr. Player determined that appellant's CDX of lateral or medial epicondylitis, was a class 1 impairment with a GMFH of 3, a GMPE of 1, and a GMCS of 0. After applying the net adjustment formula, he concluded that she had one percent impairment for the left elbow using the DBI method.

For the left elbow ROM, Dr. Player noted that the highest rating for flexion of 80 degrees was eight percent, extension of 0 degrees was zero percent, protraction of 90 degrees was zero percent, and supination of 90 degrees was zero percent, resulting in eight percent impairment of the left elbow using the ROM method.

Dr. Player used the Combined Values Chart on page 604 of the A.M.A., *Guides*, and combined the 9 percent impairment for the left shoulder and the 8 percent impairment for the left

elbow, resulting in 16 percent impairment for the left upper extremity. He also provided a whole person impairment of one percent for the cervical spine, under Table 17-2, page 564 of the A.M.A., *Guides*.

In a letter dated April 19, 2021, OWCP requested clarification from Dr. Player regarding whether his findings were in addition to appellant's prior award.

In a May 6, 2021 follow-up report, Dr. Player noted that appellant was previously awarded 10 percent permanent impairment for the right upper extremity and 8 percent for the left upper extremity. He explained that the present claim involved bilateral shoulder tendinitis and left elbow epicondylitis, whereas the prior claim involved bilateral carpal tunnel, bilateral ulnar nerves, and right lateral epicondylitis, and as such the prior impairment ratings were for different anatomical areas from the present claim. Dr. Player opined that therefore, the 6 percent right upper extremity and 16 percent left upper extremity ratings were in addition to the prior awards.

By decision dated May 26, 2021, OWCP granted appellant a schedule award for 6 percent permanent impairment of the right upper extremity and 16 percent permanent impairment of the left upper extremity. The period of the award ran for 68.64 weeks from April 12, 2018, through August 5, 2019.

LEGAL PRECEDENT

The schedule award provisions of FECA[4] and its implementing regulations[5] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7] 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.[8]

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id.* *See A.D.*, Docket No. 20-0553 (issued April 19, 2021); *see also T.T.*, Docket No. 18-1622 (issued May 14, 2019).

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

[8] *See D.C.*, Docket No. 20-1655 (issued August 9, 2021); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

In addressing upper extremity impairments, the sixth edition requires that the evaluator identify the impairment CDX, which is then adjusted by a GMFH, GMPE, and GMCS.[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10]

The A.M.A., *Guides* also provide that ROM impairment methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other DBI sections are applicable.[11] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[12] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[13]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating of upper extremity impairments.[14] 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."[15]

The Bulletin further advises: "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow 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 [claims examiner]."[16]

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[9] A.M.A., *Guides* 383-492.

[10] *Id.* at 411.

[11] *Id.* at 461.

[12] *Id.* at 473.

[13] *Id.* at 474.

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

[15] A.M.A., *Guides* 477.

[16] FECA Bulletin No. 17-06 (issued May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

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.[17] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[18] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*, *Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*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.[19]

Section 8123(a) of FECA provides that, if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or IME) who shall make an examination.[20] This is called an impartial medical examination and when there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[21]

ANALYSIS

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

On February 8, 2021 OWCP properly referred appellant for an impartial medical examination, pursuant to 5 U.S.C. § 8123(a), with Dr. Player serving as the IME, to resolve the conflict between Dr. Elmes, the second opinion physician, and Dr. Chmell, the treating physician.

In his March 9, 2021 report, Dr. Player provided an impairment rating of 6 percent to the right upper extremity and 16 percent to the left upper extremity. He provided impairment ratings using both the DBI and ROM methods and he rated both shoulders and the left elbow. However, the Board notes that the ROM measurements Dr. Player provided in the chart for the left shoulder were inconsistent with the ROM measurements he provided in the narrative summary for the left shoulder. The Board finds, therefore, that clarification is required as to which left shoulder ROM measurements are accurate.

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[17] 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).

[18] *Supra* note 7 at Chapter 2.808.5c(3) (March 2017).

[19] *Id.*, at Chapter 3.700, Exhibit 4 (January 2010).

[20] 5 U.S.C. § 8123(a); *see T.C.*, Docket No. 20-1170 (issued January 29, 2021); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[21] *See T.C.*, *id.*; *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

The Board further notes that Dr. Player concluded that appellant had one percent permanent impairment of the whole person due to her cervical condition. As previously noted, a schedule award cannot be granted for permanent loss of use of the spine or body as a whole.[22] The rating must be based on evidence of radiculopathy affecting sensory and motor deficits of the extremities.[23] However, Dr. Player did not provide a rating pursuant to *The Guides Newsletter* for spinal nerve impairment affecting the upper extremities.

The Board has held that, when OWCP obtains an opinion from an IME for the purpose of resolving a conflict in the medical evidence and the IME's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the IME to correct the defect in his original report.[24] If the IME is unable to clarify or elaborate on the original report, or if the supplemental report is also vague, speculative, or lacking in rationale, OWCP must submit the case record and a detailed SOAF to another IME for the purpose of obtaining a rationalized medical opinion on the issue.[25]

For the above-described reasons, the opinion of the IME, Dr. Player, requires clarification. Therefore, in order to address the unresolved conflict in the medical opinion evidence, the case will be remanded to OWCP for referral to Dr. Player for a supplemental opinion regarding the above-noted inconsistencies. If Dr. Player is unable to clarify his opinion, or if his requested supplemental report is lacking rationale, OWCP shall refer appellant to a new IME for the purpose of obtaining a rationalized medical opinion regarding any employment-related impairment.[26] Following this and other such further development as deemed necessary, OWCP shall issue *a de novo* decision on her schedule award claim.

CONCLUSION

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

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[22] *Supra* note 19.

[23] *Id*.

[24] *See F.H.*, Docket No. 17-1924 (issued January 25, 2019); *Talmadge Miller,* 47 ECAB 673 (1996); *Harold Travis*, 30 ECAB 1071, 1078 (1979); *see also supra* note 7 at Chapter 2.810.11e (September 2010).

[25] *Id*.

[26] *M.D.*, Docket No. 19-0510 (issued August 6, 2019); *Harold Travis*, *supra* note 24.

ORDER

IT IS HEREBY ORDERED THAT the May 26, 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: March 6, 2023
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