United States Department of Labor
Employees' Compensation Appeals Board

C.M., Appellant	)	
and	)	**Docket No. 22-1260**
	)	**Issued: February 27, 2024**
U.S. POSTAL SERVICE, EDGEWOOD POST OFFICE, Columbia, SC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On August 29, 2022 appellant filed a timely appeal from an April 12, 2022 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 15 percent permanent impairment of the right upper extremity, 3 percent permanent impairment of the left hand, 7 percent impairment of the left thumb, 37 percent permanent impairment of the right lower extremity, and 21 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 on a different issue.[2] 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 June 13, 1996 appellant, then a 51-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on June 12, 1996 he twisted his right knee and lower back when dirt gave way and he fell while in the performance of duty.[3] He was placed on modified duty. OWCP accepted appellant's claim for right knee sprain and lumbar sprain. On January 24, 2002 appellant stopped work. OWCP paid him wage-loss compensation on the supplemental rolls, effective that date, and on the periodic rolls, effective October 6, 2002.

On July 16, 2002 appellant underwent OWCP-authorized right total knee replacement surgery.

By decision dated June 2, 2003, OWCP expanded the acceptance of appellant's claim to include right shoulder bicipital tenosynovitis and right shoulder strain.

On November 3, 2003 appellant underwent OWCP-authorized right shoulder arthroscopic surgery.

By decision dated May 18, 2004, OWCP granted appellant a schedule award for 37 percent permanent impairment of the right lower extremity and 15 percent permanent impairment of the right upper extremity based on the fifth edition of the American Medical Association, *Guides to the Evaluation of the Permanent Impairment*.[4] The period of the award ran for 153.36 weeks from May 16, 2004 through April 24, 2007.

On August 13, 2009 appellant underwent OWCP-authorized right shoulder arthroscopic, debridement and decompression surgery.

On December 10, 2010 appellant filed a claim for compensation (Form CA-7) for an increased schedule award.

By decision dated February 25, 2011, OWCP denied his claim for an increased schedule award.

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[2] Docket No. 12-1259 (issued October 10, 2012).

[3] OWCP assigned the present claim OWCP File No. xxxxxx286. It subsequently accepted a May 1, 1991 occupational disease claim (Form CA-2) for left thumb flexor tendon synovitis due to factors of his federal employment. OWCP assigned that claim OWCP File No. xxxxxx345. By decision dated April 17, 2002, it granted appellant a schedule award for three percent permanent impairment of the left hand. By decision dated January 7, 2003, OWCP granted him a schedule award for 7 percent permanent impairment of the left thumb. It has administratively combined OWCP File No. xxxxxx286 with OWCP File No. xxxxxx345, with the latter serving as the master file.

[4] A.M.A., *Guides* (5th ed. 2001).

On March 2, 2012 appellant requested reconsideration.

By decision dated March 12, 2012, OWCP denied his reconsideration request, finding that it was untimely filed and failed to demonstrate clear evidence of error. Appellant appealed to the Board. By decision dated October 10, 2012, the Board affirmed the March 12, 2012 OWCP decision.

By decision dated October 31, 2012, OWCP expanded the acceptance of appellant's claim to include aggravation of lumbar radiculopathy.

An electromyogram and nerve conduction velocity (EMG/NCV) study dated March 29, 2019 showed evidence of sensory motor polyperipheral neuropathy of the lower extremities and evidence of right L5-S1 radiculopathy.

By decision dated October 20, 2020, OWCP expanded the acceptance of appellant's claim to include right knee arthritis and right knee medial meniscus tear.

On May 18, 2021 appellant filed a Form CA-7 for an increased schedule award.

OWCP subsequently referred appellant's claim, along with a statement of accepted facts (SOAF), the case record, and a series of questions, to Dr. John B. Bieltz, an osteopathic physician Board-certified in orthopedic surgery, for a second opinion evaluation regarding permanent impairment of his bilateral upper and lower extremities due to his accepted June 12, 1996 employment injury in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] and *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*). The October 22, 2020 SOAF provided to Dr. Bieltz did not mention appellant's previous schedule awards.

In a report dated August 11, 2021, Dr. Bieltz noted his review of the case record, including the SOAF, and recounted appellant's complaints of pain in his right knee, low back, right elbow, right shoulder, and left thumb. On examination of appellant's bilateral knees, he noted well-healed surgical scars and observed pain with direct palpation over the medial and lateral joint spaces. Active range of motion was from 0 to 120 degrees. On examination of appellant's low back, Dr. Bieltz observed very limited forward flexion and very limited side-bending and rotation with pain. Straight leg raise testing was negative on sitting examination. Dr. Bieltz reported diminished sensation in both lower extremities. On examination of appellant's right shoulder, he observed very positive impingement sign. Range of motion testing of the right shoulder revealed forward flexion to 120 degrees with pain, passive range of motion to 160 degrees with pain, and decreased internal and external rotation. On examination of appellant's left thumb, Dr. Bieltz noted decreased grip strength at both the right and left thumb and no obvious thenar atrophy or intrinsic wasting. He diagnosed status-post right total knee replacement surgery, status-post left knee replacement surgery, chronic low back pain secondary to lumbar fusion, right shoulder

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

impingement (status post three prior surgeries), and basilar joint arthritis status-post ligament reconstruction and tendon interposition of the left thumb.

In response to OWCP's questions, Dr. Bieltz indicated that appellant's injuries to his shoulder, neck, and low back should be added as accepted conditions to his claim. Regarding the permanent impairment rating for appellant's bilateral knee conditions, he reported that appellant had 20 percent permanent impairment of each lower extremity due to good result for range of motion. Dr. Bieltz also opined that appellant had 33 percent whole person impairment for his low back fusion. Regarding appellant's cervical spine, he determined that appellant had 30 percent permanent impairment due to prior cervical spine fusion. Dr. Bieltz completed a work capacity evaluation form (Form OWCP-5c), which indicated that appellant was unable to work.

By decision dated September 10, 2021, OWCP expanded the acceptance of appellant's claim to include left and right post-traumatic shoulder arthritis, cervical and lumbar spine degenerative disc disease, facet arthrosis, cervical and lumbar stenosis, and left knee osteoarthritis.

On September 16, 2021 OWCP referred Dr. Bieltz' August 11, 2021 report, along with an updated SOAF, to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as the district medical adviser (DMA), for his review.

In a September 21, 2021 report, Dr. Harris reviewed appellant's history and discussed Dr. Bieltz' examination findings. He indicated that the evidence of record supported the diagnoses of status-post right total knee replacement, status-post right shoulder arthroscopic debridement, status-post right shoulder arthroscopic chondroplasty, biceps debridement, and subacromial decompression with partial acromioplasty, status-post posterior lumbar interbody fusion at L3-4-5, status-post percutaneous implantation of neurostimulator electrode ray and electrode leads, and status-post left total knee arthroplasty.

Dr. Harris applied the sixth edition of the A.M.A., *Guides* and Table 1 of *The Guides Newsletter* and determined that appellant had no bilateral upper extremity permanent impairment for his cervical condition. For appellant's lumbar radiculopathy condition, Dr. Harris referenced the sixth edition of the A.M.A., *Guides* and Table 2 of *The Guides Newsletter* to determine that appellant was a Class 0 impairment for no neurologic deficit in the lower extremities, which resulted in zero percent permanent impairment for each lower extremity due to radiculopathy. For appellant's right shoulder condition, he indicated that under the diagnosis-based impairment (DBI) rating method, the appropriate class of diagnosis (CDX) for rotator cuff tendinitis under Table 15-5 (Shoulder Regional Grid), page 401, was a class 1E impairment, which resulted in five percent permanent impairment of the right upper extremity. Dr. Harris explained that there was insufficient medical evidence to calculate impairment rating utilizing the range of motion (ROM) rating method. For appellant's left thumb condition, he utilized the DBI-rating method and determined that appellant had zero percent permanent impairment. Dr. Harris noted that there was insufficient medical evidence to calculate impairment rating utilizing the ROM rating method. For appellant's bilateral knee conditions, he indicated that under the DBI-rating method, the appropriate CDX for having a good result following knee replacement arthroplasty under Table 16-3 (Knee Regional Grid), page 511, was 2A, which resulted in 21 percent permanent impairment of each lower extremity.

In an October 25, 2021 statement, appellant indicated that he received notification on September 10, 2021 that his accepted conditions were expanded. He requested that OWCP issue a schedule award based on his expanded accepted conditions.

On November 17, 2021 OWCP requested that the DMA clarify whether appellant's current impairment rating included his prior impairment ratings or whether it was in addition to his previous impairment rating of 37 percent of the right lower extremity, 15 percent of the right upper extremity, 3 percent of the left hand, and 7 percent of the left thumb.

In a report dated November 22, 2021, Dr. Harris explained that there has been no increase in appellant's right and left upper extremity permanent impairment and no increase in appellant's right lower extremity permanent impairment. He reported that appellant's left lower extremity permanent impairment had increased to a total of 21 percent permanent impairment.

By decision dated April 12, 2022, OWCP granted appellant a schedule award for 21 percent permanent impairment of the left lower extremity. The period of the award ran for 60.48 weeks from August 11, 2021 through October 8, 2022. The award was based on the August 11, 2021 report of Dr. Bieltz and the September 21 and November 22, 2021 reports of Dr. Harris, the DMA.

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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such adoption.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides,* published in 2009, is used to calculate schedule awards.[9]

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.[10] However, a schedule award is permissible where the employment-related condition affects the upper and/or

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

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

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

[10] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see N.D.,* 59 ECAB 344 (2008); *Tania R. Keka,* 55 ECAB 354 (2004).

lower extremities.[11] The sixth edition of the A.M.A., *Guides* provides a specific methodology for rating spinal nerve extremity impairment using *The Guides Newsletter*, which is a supplemental publication of the sixth edition of the A.M.A., *Guides*. It offers an approach to rating spinal nerve impairments based on evidence of radiculopathy affecting the upper and/or lower extremities.[12]

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, the relevant portion of the leg for the present case, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[13] After the CDX is determined from the Knee Regional Grid (including identification of a default grade value), the Net Adjustment Formula is applied using a grade modifier for functional history (GMFH), a grade modifier for physical examination (GMPE), and/or a grade modifier for clinical studies (GMCS). The Net Adjustment Formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[15]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401. After the CDX is determined from the Shoulder Regional Grid (including identification of the default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS.[16] The net adjustment formula is (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX).[17] The appropriate table with respect to the digits is Table 15-2 (Digit Regional Grid) beginning on page 391.[18] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[19]

The A.M.A., *Guides* also provide that the ROM impairment is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[20] If ROM is used as a stand-alone approach, the total of motion

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[11] *Supra* note 9 at Chapter 2.808.5(c)(3) (March 2017).

[12] *Supra* note 9 at Chapter 3.700, Exhibit 4 (January 2010).

[13] *See* A.M.A., *Guides* (6th ed. 2009) 509-11.

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

[15] *Id.* at 23-28.

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

[17] *Id.* at 411.

[18] *Id.* at 391.

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

[20] A.M.A., *Guides* 461.

impairment for all units of function must be calculated. All values for the joint are measured and added.[21] 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.[22]

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).
>
> "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.)[23]

The Bulletin further advises:

> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allows for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[24]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[25]

It is well established that benefits payable under 5 U.S.C. § 8107(c) are reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or

[21] *Id.* at 473.

[22] *Id.* at 474.

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

[24] *Id.*

[25] *See supra* note 9 at Chapter 2.808.6f (March 2017). *R.M.*, Docket No. 18-1313 (issued April 11, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010).

function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[26]

ANALYSIS

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

OWCP referred appellant to Dr. Bieltz for a second opinion evaluation regarding permanent impairment of his bilateral upper and lower extremities due to his accepted June 12, 1996 employment injury in accordance with the sixth edition of the A.M.A., *Guides*. In an August 11, 2021 report, Dr. Bieltz noted his review of the October 22, 2020 SOAF and conducted an examination. He diagnosed status-post right total knee replacement surgery, status-post left knee replacement surgery, chronic low back pain secondary to lumbar fusion, right shoulder impingement, and basilar joint arthritis status-post ligament reconstruction and tendon interposition of the left thumb.

The Board finds that the October 22, 2020 SOAF provided to Dr. Bieltz was deficient, as it failed to note appellant's previous schedule awards of 37 percent right lower extremity permanent impairment, 15 percent right upper extremity permanent impairment, 3 percent left hand permanent impairment, and 7 percent left thumb permanent impairment. OWCP's procedures dictate that, when a DMA, second opinion specialist, or referee physician renders a medical opinion based on a SOAF, which is incomplete or inaccurate, or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[27] OWCP did not provide the second opinion specialist, Dr. Bieltz, with an accurate SOAF as it failed to mention appellant's previous schedule awards for his accepted injuries.[28] As Dr. Bieltz based his August 11, 2021 report on an inaccurate SOAF, the probative value of his opinion is diminished.[29]

Furthermore, with regard to appellant's upper extremity conditions, Dr. Bieltz did not obtain triplicate ROM measurements as required under FECA Bulletin No. 17-06.[30] As such, his report does not comply with the A.M.A., *Guides* and is of limited probative value.[31]

[26] 20 C.F.R. § 10.404(d); *see S.M.*, Docket No. 17-1826 (issued February 26, 2018); *T.S.*, Docket No. 16-1406 (issued August 9, 2017); *T.S.*, Docket No. 09-1308 (issued December 22, 2009).

[27] *R.W.*, Docket No. 19-1109 (issued January 2, 2020); *supra* note 9 at Chapter 3.600.3 (October 1990).

[28] *C.E.*, Docket No. 19-1923 (issued March 30, 2021); *M.B.*, Docket No. 19-0525 (issued March 20, 2020); *J.N.*, Docket No. 19-0215 (issued July 15, 2019); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

[29] *C.F., (S.F.)*, Docket No. 20-0430 (issued March 6, 2023); *L.F.*, Docket No. 22-0754 (issued October 14, 2022); *G.C.*, Docket No. 18-0842 (issued December 20, 2018).

[30] *Supra* notes 18 & 23.

[31] *See M.C.*, Docket No. 22-1160 (issued May 9, 2023); *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).

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.[32] Once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[33] It must do a complete job in securing from its referral physician an opinion, which adequately addresses the relevant issues.[34]

Accordingly, the case must be remanded for further development. On remand, OWCP shall refer appellant, along with the case record and an updated SOAF to a new second opinion physician in the appropriate field of medicine for a rationalized medical opinion regarding permanent impairment. After this and other such 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.

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

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

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

ORDER

IT IS HEREBY ORDERED THAT the April 12, 2022 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: February 27, 2024
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board