United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	**Docket No. 23-0579**
	)	**Issued: January 30, 2024**
U.S. POSTAL SERVICE, DALLAS MAIN POST OFFICE, Dallas, TX, 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 March 16, 2023 appellant filed a timely appeal from a February 14, 2023 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.

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish greater than 15 percent permanent impairment of his left upper extremity due to his accepted left shoulder conditions, for which he previously received schedule award compensation; and (2) whether he has met his burden of proof to establish permanent impairment of his upper and lower extremities, due to his accepted spinal conditions, warranting a schedule award.

[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 March 1, 2012 appellant, then a 58-year-old tractor-trailer operator, filed a traumatic injury claim (Form CA-1) alleging that on February 29, 2012 he injured his left shoulder and neck when he was backing in a dock and a bobtail truck tried to pass him, causing a collision, while in the performance of duty. OWCP assigned the claim OWCP File No. xxxxxx752. Appellant stopped work on March 1, 2012, and was released to part-time, modified duty on April 3, 2015. OWCP accepted appellant's claim for neck sprain and paid him wage-loss compensation on the supplemental rolls for partial disability, effective April 5, 2012.

By decisions dated June 4 and September 12, 2012, OWCP expanded the acceptance of appellant's claim to include brachial neuritis or radiculitis, and sprain of the left shoulder/upper arm, including the rotator cuff.

Appellant subsequently filed an occupational disease claim (Form CA-2) on February 19, 2013 alleging that he developed neck and upper extremity injuries due to factors of his federal employment. OWCP assigned the claim OWCP File No. xxxxxx993 and accepted it for bilateral rotator cuff syndrome, bilateral lateral epicondylitis, de Quervain's tenosynovitis, bilateral carpal tunnel syndrome, and bilateral cubital tunnel syndrome. By decision dated May 14, 2015, it granted appellant schedule award compensation for 15 percent permanent impairment of the left upper extremity and 15 percent permanent impairment of the right upper extremity under OWCP File No. xxxxxx993. The period of the award ran for 93.6 weeks from April 2, 2015 through January 16, 2017. OWCP has administratively combined OWCP File Nos. xxxxxx993 and xxxxxx752, with the latter claim serving as the master file.

Attending physicians advised that, in late 2014, appellant underwent a thoracic spine laminectomy from T1 through L1. Appellant reported difficulty in walking for a period after the surgery.

On January 6, 2016 appellant filed another Form CA-2 alleging that he developed thoracic spinal epidural lipomatosis due to medication to treat his accepted upper extremity and neck injuries. OWCP initially assigned the claim OWCP File No. xxxxxx134. In a memorandum dated January 21, 2016, it determined that appellant's claim under OWCP File No. xxxxxx134 should be developed as a claim for recurrence due to a consequential condition under OWCP File No. xxxxxx752. On June 17, 2016 appellant filed another Form CA-2 alleging that he developed thoracic spinal epidural lipomatosis because of excessive steroid treatment to treat his previously accepted employment injuries. OWCP assigned the claim OWCP File No. xxxxxx338 and subsequently converted his occupational disease claim to a recurrence of disability claim under OWCP File No. xxxxxx752. It has administratively combined OWCP File Nos. xxxxxx134 and xxxxxx338 with OWCP File Nos. xxxxxx993 and xxxxxx752, with the latter claim continuing to serve as the master file.

[2] Docket No. 19-0892 (issued November 4, 2020).

Appellant retired from federal employment due to disability, effective August 7, 2017.

By decision dated May 24, 2018, OWCP expanded the acceptance of appellant's claim to include lipomatosis.

On June 1, 2021 appellant filed a claim for compensation (Form CA-7) for an increased schedule award.

In a June 14, 2021 development letter, OWCP requested that appellant's treating physician provide a medical report, which included an impairment rating utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[3] and *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*). It afforded him 30 days to submit the requested information.

By decision dated September 3, 2021, OWCP expanded the acceptance of appellant's claim to include cervical spinal stenosis, cervical intervertebral disc displacement, left shoulder partial-thickness rotator cuff tear, left shoulder superior labrum anterior and posterior (SLAP) lesion, and left shoulder impingement syndrome.

On October 21, 2021 OWCP referred the case record, a statement of accepted facts (SOAF), and a series of questions to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), and requested that he indicate whether appellant sustained work-related spinal cord/drug-induced myelopathy. In an October 26, 2021 report, Dr. Katz opined that the 2014 thoracic spine laminectomy from T1 through T11 was necessitated by the accepted condition of lipomatosis, which was located in appellant's thoracic spine. He found that lipomatosis and the resultant 2014 surgery contributed to work-related spinal cord/drug-induced myelopathy.

By decision dated November 1, 2021, OWCP expanded the acceptance of appellant's claim to include spinal cord/drug-induced myelopathy.

Appellant submitted a February 23, 2022 thoracic spine magnetic resonance imaging (MRI) scan, which revealed post-laminectomy from T1-2 to T10-11, nodular soft tissue enhancement posterior to the spinal cord from T4 through T9, and mild thoracic spondylosis.

On March 11, 2022 appellant referred, the case record, a SOAF, and series of questions, to Dr. George M. Cole, an osteopath, for a second opinion examination and permanent impairment evaluation of the upper extremities. In an April 11, 2022 report, Dr. Cole reviewed appellant's history of injury and reported appellant's accepted conditions as neck sprain, cervical spinal stenosis, cervical intervertebral disc displacement, brachial neuritis or radiculitis, left rotator cuff sprain, left shoulder partial-thickness rotator cuff tear, left shoulder SLAP lesion, left shoulder impingement syndrome, and lipomatosis. On physical examination of appellant's cervical/thoracic spine, he observed minimal tenderness in the surgical scar area from C6 through T12. Range of motion (ROM) was normal in all planes. Examination of appellant's lumbar spine demonstrated positive straight leg raise testing bilaterally and no radicular symptoms. On examination of appellant's left shoulder, Dr. Cole conducted three ROM

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

measurements, which revealed flexion and abduction to 120 degrees, extension and abduction to 60 degrees, and internal and external rotation to 80 degrees. He reported that appellant had reached maximum medical improvement (MMI) for his left upper extremity and cervical injuries on February 22, 2018.

Dr. Cole referenced Proposed Table 1 (Spinal Nerve Impairment) of *The Guides Newsletter* and indicated that appellant had zero percent permanent impairment of the upper extremity. He noted that on physical examination appellant had minimal tenderness and electrodiagnostic testing revealed no cervical radiculopathy. Dr. Cole also referenced Table 15-5 (Shoulder Regional Grid), pages 401-05, of the A.M.A., *Guides* and indicated that the applicable categories would be left shoulder sprain, rotator cuff partial tear, and SLAP lesion. He determined that, under the diagnosis-based impairment (DBI) rating method, appellant's class of diagnosis (CDX) of rotator cuff injury with a partial-thickness tear resulted in a Class 1 impairment for history of painful or acute injury with residual symptoms with a default value of grade C or one percent. Dr. Cole assigned a grade modifier for functional history (GMFH) of 1 for pain with vigorous activity, a grade modifier for physical examination (GMPE) of 1 for mild decreased ROM, and a grade modifier for clinical studies (GMCS) of 2. He applied the net adjustment formula (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX) = (1 – 1) + (1 – 1) + (2 – 1) = +1, and found two percent permanent impairment of the left shoulder. Dr. Cole utilized Table 15-34 (Shoulder Range of Motion), page 475, and determined that appellant had three percent permanent impairment due to 120 degrees flexion, three percent permanent impairment due to 120 degrees abduction, and zero percent permanent impairment due to 60 degrees adduction, 60 degrees extension, 80 degrees internal rotation, and 80 degrees external rotation for a total of six percent permanent impairment of the left upper extremity. He noted that appellant had a GMFH of 1, which resulted in no increase in impairment rating. Dr. Cole concluded that since the ROM rating method yielded the higher percentage rating, appellant had six percent permanent impairment of the left upper extremity.

In a letter dated May 25, 2022, OWCP requested clarification from Dr. Cole regarding whether appellant's current impairment rating was in addition to his previous impairment ratings. It noted that appellant had previously received an impairment rating of 15 percent permanent impairment for each upper extremity on May 14, 2015 for a total of 30 percent bilateral upper extremity permanent impairment.

In a supplemental report dated October 11, 2022, Dr. Cole reported that since the 6 percent left upper extremity permanent impairment was less than the prior percentage of 15 percent left upper extremity permanent impairment, appellant was not entitled to an additional impairment. He noted that at the time of his evaluation, appellant's injuries to the cervical spine, left shoulder, and lipomatosis had reached MMI and were considered permanent and stationary.

On October 17, 2022 OWCP requested that Dr. Cole review an updated SOAF, which included appellant's claims under OWCP File Nos. xxxxxx134, xxxxxx338, and xxxxxx993, and provide a supplemental report regarding whether appellant sustained permanent impairment of the bilateral lower extremities due to his accepted conditions of lipomatosis and spinal cord/drug-induced myelopathy.

In a supplemental report dated November 4, 2022, Dr. Cole indicated that at his April 11, 2022 examination he observed normal ROM of the hips, knees, and ankles. Reflexes, strength, and sensation were symmetrical in the bilateral lower extremities. Dr. Cole opined that appellant

had reached MMI related to the lower extremities on February 22, 2018. He concluded that examination of the bilateral lower extremities was normal in all aspects.

OWCP referred the claim and a series of questions to Dr. Katz, who again served as the DMA, to provide an opinion on permanent impairment under the standards of the A.M.A., *Guides* and *The Guides Newsletter*. In a December 23, 2022 report, Dr. Katz reviewed the SOAF and reported appellant's accepted conditions as neck sprain, brachial neuritis or radiculitis, lipomatosis, cervical spine sprain, cervical spinal stenosis, other cervical disc displacement, cervical radiculopathy, left shoulder rotator cuff sprain, left shoulder incomplete rotator cuff tear, left shoulder SLAP lesion, left shoulder impingement, and other specified diseases of the spinal cord. Regarding the left shoulder, he found three percent permanent impairment due to limited shoulder flexion according to Table 15-34 (Shoulder Range of Motion), page 475, and three percent permanent impairment due to limited abduction, for a total of six percent permanent impairment of the left upper extremity. Dr. Katz assigned a GMFH of 1, which resulted in no further adjustment. He also utilized Table 15-5 (Shoulder Regional Grid), pages 401-05, to find a Class 1 impairment for a CDX of rotator cuff injury with a default value of three. Dr. Katz assigned a GMFH of 1, a GMPE of 1 and a GMCS of 2. After applying the net adjustment formula, (1 – 1) + (1 – 1) + (2 – 1) = +1, he indicated that the impairment rating increased to four percent permanent impairment of the left shoulder. Dr. Katz reported that because the ROM impairment exceeded the DBI impairment, he opined that appellant had six percent permanent impairment of the left upper extremity.

Regarding appellant's spinal injury, Dr. Katz noted that Dr. Cole found no myotomal motor/dermatomal sensory deficits in either the upper or lower extremities. He referenced Proposed Table 1 of *The Guides Newsletter* and indicated that appellant had zero percent permanent impairment of the upper extremities due to no motor or sensory deficits. Dr. Katz also referenced Proposed Table 2 of *The Guides Newsletter* and reported that appellant had zero percent permanent impairment of the lower extremities due to no motor or sensory deficits. He concluded that the above impairment rating represented appellant's total current impairment of the affected members and included any prior percentage awarded.

By decision dated February 14, 2023, OWCP denied appellant's claim for an increased schedule award, finding that he was not entitled to greater than 15 percent permanent impairment of the left upper extremity previously awarded. It also found that the medical evidence of record was insufficient to establish permanent impairment of the upper and lower extremities due to appellant's accepted spinal injuries, warranting a schedule award.

LEGAL PRECEDENT -- ISSUES 1 &2

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. 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

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such adoption.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[7]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish that the appropriate diagnosis for each part of the upper extremity to be rated. Under the DBI rating method, the sixth edition requires identifying the class for the CDX, which is then adjusted by the GMFH, GMPE, and GMCS.[8] The net adjustment formula is (GMFH) – (CDX) + (GMPE – CDX) + (GMCS – CDX).[9] 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.[10]

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.[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]

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).
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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*

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

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

[8] A.M.A., *Guides* 494-531.

[9] *Id.* at 521.

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

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

[12] *Id.* at 473.

[13] *Id.* at 474.

> *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.)[14]
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> The Bulletin further advises:
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> "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."[15]

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.[16] Furthermore, the back is specifically excluded from the definition of an organ under FECA.[17] The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that FECA allows ratings for extremities and precludes ratings for the spine, *The Guides Newsletter* offers an approach to rating spinal nerve impairments consistent with sixth edition methodology. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that the July/August 2009 edition of *The Guides Newsletter* is to be applied.[18]

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.[19]

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 function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[20]

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

[15] *Id*.

[16] 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).

[17] *See* 5 U.S.C. § 8101(19); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

[18] *Supra* note 7 at Chapter 3.700 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[19] *See id*. 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).

[20] 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).

ANALYSIS -- ISSUES 1 &2

The Board finds that this case is not in posture for decision regarding whether appellant has met his burden of proof to establish greater than 15 percent permanent impairment of his left upper extremity due to his accepted left shoulder conditions, for which he previously received schedule award compensation.

In April 11, October 11, and November 4, 2022 reports, Dr. Cole, OWCP's second opinion examiner, reviewed appellant's history of injury and noted appellant's accepted cervical and left upper extremity conditions. He provided examination findings, including three ROM measurements for appellant's left shoulder. Dr. Cole determined that appellant had two percent permanent impairment of the left shoulder under the DBI rating method and six percent permanent impairment of the left shoulder under the ROM rating method. He found that since the ROM rating method yielded the higher percentage rating, appellant had six percent permanent impairment of the left upper extremity, which constituted his only permanent impairment.

In a December 23, 2022 report, Dr. Katz, the DMA, reviewed Dr. Cole's second opinion reports and the SOAF. Utilizing Table 15-34 (Shoulder Range of Motion), page 475, he found a three percent permanent impairment due to limited shoulder flexion and three percent permanent impairment due to limited abduction, for a total of six percent permanent impairment of the left upper extremity. Dr. Katz found a GMFH of 1, which resulted in no further adjustment. He also utilized Table 15-5 (Shoulder Regional Grid), pages 401-05, to find a Class 1 impairment for a CDX of rotator cuff injury with a default impairment of three percent. Dr. Katz assigned a GMFH of 1, a GMPE of 1, and a GMCS of 2. After applying the net adjustment formula, (1 – 1) + (1 – 1) + (2 – 1) = +1, he indicated that the impairment rating increased to four percent permanent impairment of the left shoulder. Dr. Katz reported that because the ROM impairment exceeded the DBI impairment, he opined that appellant had six percent permanent impairment of the left upper extremity. He concluded that the impairment ratings represented appellant's total current impairment and included any prior percentage awarded.

By decision dated February 14, 2023, OWCP denied appellant's claim for an additional schedule award for his left upper extremity, finding that he was not entitled to greater than 15 percent permanent impairment of the left upper extremity previously awarded.

The Board finds that Dr. Katz did not provide sufficient explanation as to why appellant was not entitled to an increased schedule award for his left upper extremity due to deficits related to his accepted left shoulder conditions. The Board has held that simply comparing the prior percentage of permanent impairment awarded to the current impairment for the same member is not always sufficient to deny an increased schedule award claim.[21] The issue is not whether the current permanent impairment rating is greater than the prior impairment ratings, but whether it duplicates in whole or in part the prior impairment rating.[22] Dr. Katz did not discuss appellant's prior impairment rating of 15 percent of the left upper extremity nor the medical condition

[21] *See D.P.*, Docket No. 19-1514 (issued October 21, 2020); *S.M.*, Docket No. 17-1826 (issued February 26, 2018).

[22] *Id*.

contained in the prior impairment rating. The case must, therefore, be remanded for clarification and development.[23]

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[24] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[25] As OWCP undertook development of the evidence by referring appellant to a DMA, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.[26] For this reason, the case must be remanded for further clarification from Dr. Katz, the DMA in this case.

The Board further finds that appellant has not met his burden of proof to establish permanent impairment of his upper and lower extremities, due to his accepted spinal conditions, warranting a schedule award.

In a December 23, 2022 report, Dr. Katz reviewed Dr. Cole's reports and noted appellant's accepted cervical and left upper extremity injuries, as well as his accepted lipomatosis of the thoracic spine. He indicated that Dr. Cole found no myotomal motor/dermatomal sensory deficits in either the lower or upper extremity on physical examination. Dr. Katz referenced Proposed Table 1 of *The Guides Newsletter* and indicated that appellant had zero percent permanent impairment of the upper extremities due to no motor or sensory deficits. He also referenced Proposed Table 2 of *The Guides Newsletter* and reported that appellant had zero percent permanent impairment of the lower extremities due to a lack of motor or sensory deficits.

The Board finds that Dr. Katz correctly applied the appropriate tables and grading schedules of the A.M.A., *Guides* and *The Guides Newsletter* to find that appellant had zero percent permanent impairment of the upper and lower extremities due to his accepted spinal injuries.[27] He utilized Table 1 and Table 2 of *The Guides Newsletter* and noted that he had no ratable impairment due to no evidence of motor or sensory deficits in the upper or lower extremities. Dr. Katz's report is detailed, well rationalized, and based on a proper factual background, and thus his opinion represents the weight of the medical evidence.[28]

The Board finds, therefore, that appellant has not met his burden of proof to establish a ratable permanent impairment of the upper and lower extremities due to his accepted spinal injuries. The case, however, will be remanded for further clarification from the DMA, Dr. Katz, to discuss the impairment rating from appellant's previous schedule award and explain how

[23] *M.F.*, Docket No. 20-1434 (issued April 26, 2021).

[24] *N.L.*, Docket No. 19-1592 (issued March 12, 2020); *M.T.*, Docket No. 19-0373 (issued August 22, 2019); *B.A.*, Docket No. 17-1360 (issued January 10, 2018).

[25] *S.S.*, Docket No. 18-0397 (issued January 15, 2019); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[26] *G.M.*, Docket No. 19-1931 (issued May 28, 2020); *W.W.*, Docket No. 18-0093 (issued October 9, 2018).

[27] *See J.C.*, Docket No. 21-0288 (issued July 1, 2021); *T.B.*, Docket No. 20-0642 (issued September 30, 2020).

[28] *See V.S.*, Docket No. 19-1679 (issued July 8, 2020); *T.F.*, Docket No. 19-157 (issued April 21, 2020).

appellant's current left upper extremity impairment rating due to work-related left shoulder deficits duplicated the prior left upper extremity impairment rating. Following this and other such further development as deemed necessary, OWCP 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 regarding whether appellant has met his burden of proof to establish greater than 15 percent permanent impairment of his left upper extremity due to his accepted left shoulder conditions, for which he previously received schedule award compensation. The Board further finds that appellant has not met his burden of proof to establish permanent impairment of his upper and lower extremities due to his accepted spinal conditions, warranting a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the February 14, 2023 decision of the Office of Workers' Compensation Programs is affirmed in part, and set aside in part. The case is remanded for further proceedings consistent with this decision of the Board.

Issued: January 30, 2024
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