United States Department of Labor
Employees' Compensation Appeals Board

N.G., Appellant	)	
and	)	**Docket No. 25-0628**
	)	**Issued: August 1, 2025**
U.S. POSTAL SERVICE, NEW ORLEANS POST OFFICE, New Orleans, LA, 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
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 10, 2025 appellant filed a timely appeal from an April 16, 2025 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]

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the April 16, 2025 decision, appellant submitted additional evidence to OWCP and on appeal to the Board. 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*.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 40 percent permanent impairment of the right upper extremity and 13 percent permanent impairment of the left upper extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

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

On December 17, 1999 appellant, then a 45-year-old distribution clerk, filed a traumatic injury claim (Form CA-1) alleging that on that date he injured his right shoulder when casing mail while in the performance of duty. He did not stop work. OWCP assigned File No. xxxxxx279 and accepted the claim for the conditions of right shoulder strain, and right rotator cuff tear with tendinitis and subacromial bursitis. On August 22, 2000 appellant underwent OWCP-authorized right shoulder surgery, including rotator cuff repair, distal clavicle resection, and acromioplasty.

On February 21, 2001 appellant filed a claim for compensation (Form CA-7) for a schedule award. By decision dated February 11, 2002, OWCP granted a schedule award for 17 percent permanent impairment of the right upper extremity as calculated under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] The award was based on a September 26, 2001 report of Dr. Henry Mobley, a Board-certified internist serving as an OWCP district medical adviser (DMA), whose calculations were derived from April 10, 2001 examination findings of Dr. Gregg A. Bendrick, a Board-certified occupational medicine physician serving as an OWCP referral physician.

In connection with a traumatic injury claim assigned OWCP File No. xxxxxx144, OWCP accepted that appellant sustained a cervical strain due to a February 12, 2002 employment incident. In connection with an occupational disease claim assigned OWCP File No. xxxxxx160, it accepted that he sustained bilateral carpal tunnel syndrome due to repetitive work tasks performed by April 5, 2002.[5] OWCP subsequently administratively combined OWCP File Nos. xxxxxx144, xxxxxx160, and xxxxxx279, with the latter serving as the master file.

On July 10, 2006 appellant underwent OWCP-authorized cervical spine anterior interbody fusion at C3 and C4.

On March 5, 2007 appellant filed a claim for an additional schedule award. By decision dated March 6, 2008, OWCP granted him a schedule award for 13 percent permanent impairment

[3] Docket No. 02-1856 (issued November 18, 2002); *Order Remanding Case*, Docket No. 05-514 (issued July 28, 2005); Docket No. 06-1648 (issued April 20, 2007); Docket No. 08-1409 (issued December 17, 2008); Docket No. 20-0557 (issued January 5, 2021).

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

[5] On May 29, 2003 appellant underwent OWCP-authorized right carpal tunnel release surgery.

of the left upper extremity. The award was based on a February 11, 2008 report of Dr. Ronald Blum, a Board-certified orthopedic surgeon serving as a DMA, whose calculations were derived from September 25, 2007 examination findings of Dr. Donald Faust, a Board-certified orthopedic surgeon.

On February 18, 2010 appellant filed a claim for an additional schedule award. By decision dated July 14, 2011, OWCP granted him a schedule award for an additional two percent permanent impairment of the right upper extremity. The award was based on March 10 and May 27, 2011 reports of Dr. Blum, whose calculations were derived from February 7, 2011 examination findings of Dr. Douglas Lurie, a Board-certified orthopedic surgeon.

On December 8, 2016 appellant filed a claim for an additional schedule award.

In an April 25, 2017 report, Dr. Simon Finger, a Board-certified orthopedic surgeon serving as an OWCP referral physician, determined that appellant had 12 percent permanent impairment of the right upper extremity based upon a diagnosis-based impairment (DBI) rating utilizing Table 15-5 (Shoulder Regional Grid). In February 1 and May 3, 2018 supplemental reports, he found 16 percent permanent impairment of the right upper extremity due to right shoulder deficits and right carpal tunnel syndrome, and 5 percent permanent impairment of the left upper extremity due to left carpal tunnel syndrome.

On June 18, 2018 OWCP referred appellant's case to Dr. Morley Slutsky, a Board-certified occupational medicine physician serving as a DMA. In a July 3, 2018 report, Dr. Slutsky calculated 16 percent permanent impairment of the right upper extremity due to right shoulder deficits and right carpal tunnel syndrome, and 8 percent permanent impairment of the left upper extremity due to left shoulder deficits and left carpal tunnel syndrome.

On August 23, 2018 OWCP determined that there was a conflict in the medical opinion evidence between Dr. Finger and Dr. Slutsky regarding permanent impairment. On September 18, 2018 it referred appellant, along with the medical record, a statement of accepted facts (SOAF), and a series of questions to Dr. Gordon Nutik, a Board-certified orthopedic surgeon, for an impartial medical examination and impairment rating. In an October 10, 2018 report, Dr. Nutik determined that appellant had 15 percent permanent impairment of the right upper extremity due to right shoulder range of motion (ROM) deficits and two percent permanent impairment of each upper extremity due to carpal tunnel syndrome.

Due to unresolved deficiencies in Dr. Nutik's evaluation, OWCP referred appellant, along with the medical record, a SOAF, and series of questions, to Dr. Allen Johnston, a Board-certified orthopedic surgeon, for an impartial medical examination and impairment rating. In a May 14, 2019 report, Dr. Johnston advised that, under Table 17-2 beginning on page 564 of the sixth edition of the A.M.A., *Guides*, appellant's cervical condition warranted six percent permanent impairment rating, but he did not specify to which upper extremity or extremities the rating applied. He utilized Table 15-5, beginning on page 401, to determine that appellant's diagnosis of distal clavicle resection warranted 12 percent permanent impairment rating of the right upper extremity. Dr. Johnston calculated five percent permanent impairment of each upper extremity under Table 15-21, beginning on page 436, for bilateral carpal tunnel syndrome.

On July 25, 2019 OWCP referred appellant's case back to Dr. Slutsky, in his capacity as a DMA. In an August 26, 2019 report, Dr. Slutsky opined that Dr. Johnston's impairment rating was improper, noting deficiencies including misapplication of Table 15-21 and Table 17-2.

By decision dated October 18, 2019, OWCP determined that appellant did not meet his burden of proof to establish more than 19 percent permanent impairment of the right upper extremity and 13 percent permanent impairment of the left upper extremity.

Appellant appealed to the Board. By decision dated January 5, 2021,[6] the Board set aside OWCP's October 18, 2019 decision and remanded the case for further development, to be followed by a *de novo* decision. The Board found that Dr. Johnston actually served as an OWCP referral physician, rather than as an impartial medical examiner. The Board further found that Dr. Slutsky had identified deficiencies in Dr. Johnston's permanent impairment rating and directed OWCP to obtain clarification from Dr. Johnston regarding the deficiencies identified by Dr. Slutsky.

As Dr. Johnston had retired from practice, OWCP referred appellant, along with the medical record, and a series of questions, to Dr. James C. Butler, a Board-certified orthopedic surgeon, for a second opinion examination and impairment rating. In an April 26, 2021 report, Dr. Butler found that, utilizing Table 17-2 of the sixth edition of the A.M.A., *Guides*, appellant had a "combined upper extremity impairment rating" of 33 percent due to his cervical condition. In the summary portion of the report, he also advised that appellant had "30 percent combined upper extremity impairment rating with regards [sic] to the cervical spine and documented neurological deficits and residual symptoms following cervical spine surgery and untreated cervical spondylosis with stenosis of the cervical spine."

In June 2021 OWCP requested that Dr. Butler clarify his opinion by producing a report that utilized *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*. In July 18 and August 10, 2021 supplemental reports, he applied the standards of Proposed Table 2 of *The Guides Newsletter* and found that sensory and motor deficits associated with the C5, C6, and C7 nerve distributions bilaterally warranted a permanent impairment rating of 31 percent of the right upper extremity. Dr. Butler utilized Table 15-23 to find that appellant had two percent permanent impairment of the right upper extremity due to right carpal tunnel syndrome and eight percent permanent impairment of the left upper extremity due to left carpal tunnel syndrome. With respect to the right shoulder, he applied the DBI rating method under Table 15-5 to find that appellant had seven percent permanent impairment of the right upper extremity. Alternatively, Dr. Butler applied the ROM rating method to find that appellant had 20 percent permanent impairment of the right upper extremity due to right shoulder ROM deficits.

On August 12, 2021 OWCP referred appellant's case to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA. In an August 14, 2021 report, Dr. Katz determined that appellant had 38 percent permanent impairment of the right upper extremity due to deficits associated with his right rotator cuff injury, right carpal tunnel syndrome, and right-sided cervical

[6] Docket No. 20-557 (issued January 5, 2021).

injury. He also found that appellant had 8 percent permanent impairment of the left upper extremity due to deficits associated with his left carpal tunnel syndrome.

By decision dated September 7, 2021, OWCP granted appellant an additional schedule award for 21 percent permanent impairment of the right upper extremity, thereby compensating him for a total permanent impairment of the right upper extremity of 40 percent.

On January 7, 2024 appellant filed a Form CA-7 for an additional schedule award.

On April 10, 2024 OWCP again referred appellant, along with the medical record, a SOAF, and a series of questions to Dr. Finger for a second opinion examination and impairment rating of the upper extremities under the standards of the sixth edition of the A.M.A., *Guides*.

In an October 1, 2024 report, Dr. Finger detailed the findings of his physical examination, including providing one ROM measurement for each type of ROM of the right shoulder, *i.e.*, flexion (85 degrees), extension (50 degrees), abduction (80 degrees), adduction (40 degrees); internal rotation (80 degrees), and external rotation (40 degrees). He noted that appellant had intact subjective sensation in the upper extremities, including in the median nerve distribution for each hand. With respect to the right shoulder, Dr. Finger utilized the ROM rating method under Table 15-5 on page 403 of the sixth edition of the A.M.A., *Guides* to find that appellant's acromioclavicular joint injury fell under a class of diagnosis (CDX) of Class 1 with a default value of 10 percent. He assigned a grade modifier for physical examination (GMPE) of 2 and a grade modifier for functional history (GMFH) of 2 and advised that a grade modifier for clinical studies (GMCS) was not applicable as clinical studies were used to make the diagnosis. Dr. Finger applied the net adjustment formula and concluded that appellant had 12 percent permanent impairment of the right upper extremity under the DBI rating method. Alternatively, he applied the standards of Table 15-34 on page 475 to determine that appellant had 17 percent permanent impairment of the right upper extremity due to right shoulder ROM deficits, which was comprised of 9 percent impairment due to flexion of 85 degrees, 6 percent impairment due to abduction of 80 degrees, and 2 percent impairment due to external rotation of 40 degrees. Dr. Finger noted that, in terms of impairment stemming from the cervical spine condition, appellant had zero percent impairment of the upper extremities under the standards of *The Guides Newsletter*. He utilized Table 15-23 on page 449 and found that appellant had a grade modifier for test findings of 1, a grade modifier for physical findings of 1, and a grade modifier for history of 0. Dr. Finger calculated the average of the modifiers and concluded that appellant had two percent permanent impairment of the right upper extremity due to right carpal tunnel syndrome. He also stated that appellant received an identical impairment rating on the left side with two percent impairment for the left upper extremity.[7]

On October 15, 2024 OWCP referred appellant's case to Dr. Katz, serving as a DMA. In an October 19, 2024 report, he found that Dr. Finger's findings demonstrated that appellant had 19 percent permanent impairment of the right upper extremity comprised of 17 percent permanent impairment due to right shoulder ROM deficits and 2 percent permanent impairment due to right carpal tunnel syndrome. Dr. Katz applied the DBI rating method of Table 15-5 on page 403 to

[7] Dr. Finger determined that appellant reached maximum medical improvement (MMI) on April 26, 2021, the date of Dr. Butler's examination.

determine, as had Dr. Finger, that appellant had 12 percent permanent impairment of the right upper extremity due to his acromioclavicular joint injury. Dr. Katz also utilized the ROM rating method of Table 15-34 to determine, as had Dr. Finger, that appellant had 17 percent permanent impairment of the right upper extremity due to right shoulder ROM deficits, which was comprised of 9 percent impairment due to flexion of 85 degrees, 6 percent impairment due to abduction of 80 degrees, and 2 percent impairment due to external rotation of 40 degrees. Dr. Katz also applied Table 15-23 to evaluate right carpal tunnel syndrome and *The Guides Newsletter* to evaluate nerve deficits in both upper extremities stemming from the cervical spine. However, in a November 10, 2024 addendum, he determined that it was necessary for Dr. Finger to provide a detailed opinion regarding appellant's permanent impairment due to left carpal tunnel syndrome.

On December 10, 2024 OWCP requested that Dr. Finger clarify his October 1, 2024 report. In a January 7, 2025 supplemental report, Dr. Finger indicated that, with respect to the rating of appellant's left carpal tunnel syndrome, he utilized Table 15-23, page 449, and found that appellant had a grade modifier for test findings of 1, a grade modifier for physical findings of 1, and a grade modifier for history of 0. He calculated the average of the modifiers and concluded that appellant had two percent permanent impairment of the left upper extremity due to left carpal tunnel syndrome.

On February 11, 2025 OWCP referred appellant's case to Dr. Katz. In a February 15, 2025 report, Dr. Katz again provided impairment rating calculations, which were in accord with Dr. Finger's utilization of the DBI rating method under Table 15-5 and the ROM rating method under Table 15-24 for the right upper extremity. He requested that OWCP send him copies of the medical evidence supporting appellant's prior right upper extremity schedule awards so that he could determine whether his present right upper extremity permanent impairment overlapped that of the prior awards.

OWCP provided Dr. Katz with the requested medical evidence and, in a report dated March 17, 2025, he again provided impairment rating calculations, which were in accord with Dr. Finger's utilization of the DBI rating method under Table 15-5 and the ROM rating method under Table 15-24 for the right upper extremity. Dr. Katz opined that appellant was not entitled to additional schedule award compensation because his present permanent impairment of 19 percent permanent impairment of the right upper extremity and 2 percent permanent impairment of the left upper extremity overlapped the permanent impairment for which he was compensated by the prior schedule awards.

By decision dated April 16, 2025, OWCP denied appellant's claim for an additional schedule award.

LEGAL PRECEDENT

The schedule award provisions of FECA,[8] and its implementing regulations,[9] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[11]

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 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.)
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> "If the rating physician provided an assessment using the DBI 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 CE.
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> "If the medical evidence of record is not 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 impairment rating using the DBI method, if possible, given the available evidence."[12]

ANALYSIS

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

[10] *Id.*

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

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

In reports dated October 19, 2024, and February 15 and March 17, 2025, Dr. Katz, serving as a DMA, calculated the permanent impairment of appellant's right upper extremity based on October 1, 2024 physical examination findings obtained by Dr. Finger, an OWCP referral physician. He applied the DBI rating method of Table 15-5 to determine, as had Dr. Finger, that appellant had 12 percent permanent impairment of the right upper extremity due to his acromioclavicular joint injury.[13] Dr. Katz also utilized the ROM rating method of Table 15-34 to determine, as had Dr. Finger, that appellant had 17 percent permanent impairment of the right upper extremity due to right shoulder ROM deficits, which was comprised of 9 percent impairment due to flexion of 85 degrees, 6 percent impairment due to abduction of 80 degrees, and 2 percent impairment due to external rotation of 40 degrees.[14]

Since Dr. Katz provided a rating using the DBI rating method and appellant's condition provided for application of the ROM rating method, he was required to independently calculate his impairment using both the DBI and ROM rating methods and identify the higher rating for the claims examiner.[15] As noted above, FECA Bulletin No. 17-06 provides detailed instructions for obtaining sufficient evidence to conduct a complete permanent impairment evaluation.

The Board notes that, although Dr. Katz attempted to conduct an impairment calculation under the ROM rating method, the case record does not contain complete recent ROM findings of appellant's right shoulder for properly conducting a right upper extremity permanent impairment rating under the ROM rating method. Dr. Finger did not indicate that he conducted three measurements for each type of motion of the right upper extremity and the relevant instructions for conducting the ROM rating method were not fully carried out in this case. Therefore, it is necessary to further develop the medical evidence in accordance with FECA Bulletin No. 17-06.[16]

Section 15.7 of the sixth edition of the A.M.A., *Guides* provides that ROM should be measured after a "warm up," 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.[17] 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 permanent impairment, the Board finds that the case shall be remanded to OWCP. On remand, OWCP shall refer appellant, along with the SOAF, and the case record, to a new second opinion physician in the appropriate field of

[13] A.M.A., *Guides* 403, Table 15-5 (6th ed. 2009).

[14] *Id.* at 475, Table 15-34. Dr. Katz also utilized Table 15-23 on page 449 to evaluate carpal tunnel syndrome in both upper extremities, and *The Guides Newsletter* to evaluate nerve deficits in both upper extremities stemming from the cervical spine. He concluded, as had Dr. Finger, that appellant had total permanent impairment of 19 percent of the right upper extremity and 2 percent of the left upper extremity.

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

[16] *See id. See also C.J.,* Docket No. 25-0440 (issued May 12, 2025).

[17] A.M.A., *Guides* 464.

medicine. The second opinion physician shall provide an impairment rating in accordance with the sixth edition of the A.M.A., *Guides*, including three sets of ROM measurements of the upper extremities. The permanent impairment rating provided by the second opinion physician shall then be referred to a DMA for review. Following 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.

ORDER

IT IS HEREBY ORDERED THAT the April 16, 2025 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: August 1, 2025
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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