United States Department of Labor
Employees' Compensation Appeals Board

D.S., Appellant	)	
and	)	**Docket No. 25-0131**
	)	**Issued: July 25, 2025**
U.S. POSTAL SERVICE, DALLAS NETWORK DISTRIBUTION CENTER, Dallas, TX, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 20, 2024 appellant filed a timely appeal from an October 2, 2024 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 13 percent permanent impairment of the right upper extremity, 28 percent permanent impairment of the right lower extremity, and/or 10 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

On February 20, 2014 appellant, then a 55-year-old distribution clerk, filed an occupational disease claim (Form CA-2) alleging that he developed a lumbar herniated nucleus pulposus (HNP), lumbar facet disease and strain, right rotator cuff impingement syndrome, and internal derangement syndrome due to factors of his federal employment. He noted that he first became aware of his claimed conditions and realized their relation to his federal employment on September 30, 2013. Appellant did not stop work. OWCP accepted the claim for lumbar sprain, displacement of lumbar intervertebral disc without myelopathy, derangement of the right medial meniscus, traumatic arthropathy of the right lower leg, rotator cuff syndrome of the right shoulder and allied disorders, and other affections of the right shoulder region.

Appellant stopped work on September 22, 2014 and, on November 4, 2014, he underwent OWCP-authorized right knee surgery, including arthroscopy with anterior cruciate ligament augmentation and partial medial and lateral meniscectomy. He subsequently underwent an additional OWCP-authorized right knee surgery on March 31, 2016, including arthroscopy with partial medial meniscectomy; chondroplasty of the medial femoral condyle and tibial plateau; and partial synovectomy. Appellant returned to full-time light-duty work on August 23, 2016, but retired on November 1, 2017.

On October 21, 2016 appellant filed a claim for compensation (Form CA-7) for a schedule award.

By decision dated April 28, 2017, OWCP granted appellant a schedule award for 9 percent permanent impairment of the right upper extremity and 10 percent permanent impairment of the right lower extremity in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] The award was based on September 1, 2016 and February 21, 2017 reports of Dr. Charles E. Willis, a Board-certified orthopedic surgeon, and a January 19, 2017 report of Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, serving as an OWCP district medical adviser (DMA). The award ran for 56.88 weeks from September 1, 2016 through October 4, 2017.

On June 14, 2018 appellant filed a Form CA-7 claim for an additional schedule award.

In a February 28, 2018 report, Dr. Rory L. Allen, an osteopath and Board-certified occupational disease physician, applied the standards of *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 A.M.A., *Guides*. He determined that, under the standards of Proposed Table 2 of *The Guides Newsletter*, appellant had 10 percent permanent impairment of each lower extremity due to motor and sensory deficits associated with the L5 and S1 nerve distributions bilaterally.

In a July 10, 2018 report, Dr. Harris, serving as a DMA, determined that appellant had 9 percent permanent impairment of the right upper extremity due to right shoulder range of motion (ROM) deficits, 10 percent permanent impairment of the left lower extremity due to motor and sensory deficits associated with the left L5 and S1 nerve distributions, and 20 percent permanent

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

impairment of the right lower extremity comprised of 10 percent impairment due to the right knee medial and lateral meniscectomy and 10 percent impairment due to motor and sensory deficits associated with the right L5 and S1 nerve distributions.

By decision dated October 15, 2018, OWCP granted appellant a schedule award for an additional 10 percent permanent impairment of the right lower extremity, for a total of 20 percent permanent impairment. The award was based on the February 28, 2018 report of Dr. Allen and the July 10, 2018 report of Dr. Harris, and ran for 28.6 weeks from February 28 through September 17, 2018.

Appellant continued to claim an additional schedule award.

By decision dated November 27, 2018, OWCP granted appellant a schedule award for 10 percent permanent impairment of the left lower extremity (spinal impairment). The award was based on the February 28, 2018 report of Dr. Allen and an October 23, 2018 report wherein Dr. Harris restated the findings of his July 10, 2018 report. It ran for 28.8 weeks from September 18, 2018 through April 7, 2019.

In an undated report received by OWCP on January 15, 2020, Dr. Allen reported the findings of a September 27, 2019 physical examination. He utilized the diagnosis-based impairment (DBI) rating method to find that appellant had 13 percent permanent impairment of the right upper extremity due to right shoulder ROM deficits, and the DBI rating method to find that he had 18 percent permanent impairment of the right lower extremity due to a two-millimeter cartilage interval associated with right knee arthritis.

On January 15 and February 10, 2020 appellant filed CA-7 claims for an additional schedule award.

In May 15, 2020 report, Dr. Harris, serving as DMA, determined that appellant had 13 percent permanent impairment of the right upper extremity due to right shoulder ROM deficits. In a November 24, 2020 report, he found that appellant had 28 percent permanent impairment of the right lower extremity comprised of 10 percent impairment due to his medial and lateral meniscectomy and 18 percent impairment due to the two-millimeter cartilage interval associated with right knee arthritis.

By decision dated July 29, 2020, OWCP granted appellant an additional schedule award for four percent permanent impairment of the right upper extremity, for a total of 13 percent. The award was based on the undated report of Dr. Allen received by OWCP on January 15, 2020, and the May 15, 2020 report of Dr. Harris. It ran for 28.8 weeks from September 27 through December 23, 2019.

On November 17, 2020 appellant filed a Form CA-7 claim for an additional schedule award.

By decision dated February 5, 2021, OWCP granted appellant a schedule award for an additional eight percent permanent impairment of the right lower extremity (knee), for a total of 28 percent. The award was based on the November 24, 2020 report of Dr. Harris and ran for 23.04 weeks from December 24, 2019 through June 2, 2020.

In an August 6, 2021 report of a July 16, 2021 examination, Dr. Brett B. Belvin, a Board-certified pain management physician, applied the standards of *The Guides Newsletter* and calculated that appellant had additional lower extremity permanent impairment comprised of seven percent impairment of the right lower extremity and three percent impairment of the left lower extremity based on deficits associated with the L3 and L4 nerves bilaterally.

On September 21 and December 13, 2021 appellant filed Form CA-7 claims for an additional schedule award.

In a February 17, 2022 report, Dr. Belvin maintained that the seven percent permanent impairment rating for appellant's right lower extremity based on deficits associated with the L3 and L4 nerves was in addition to the 28 percent permanent impairment of the right lower extremity for which appellant had already been compensated.

In an April 1, 2022 report, Dr. Harris, the DMA, opined that appellant was not entitled to additional schedule award compensation for permanent impairment of either extremity based on nerve deficits calculated by utilizing *The Guides Newsletter*. However, he found that additional development of the medical evidence regarding the right knee was necessary to determine the total permanent impairment of the right lower extremity.

By decision dated May 6, 2022, OWCP denied appellant's claim for an additional schedule award.

On June 3, 2022 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on September 13, 2022.

By decision dated November 29, 2022, OWCP's hearing representative vacated OWCP's May 6, 2022 decision and remanded the case for OWCP to refer appellant to a second opinion physician to determine whether he had reached maximum medical improvement (MMI) and whether he was entitled to an increased schedule award, to be followed by a *de novo* decision.

On December 15, 2022 OWCP referred appellant, along with the medical record, a statement of accepted facts (SOAF), and a series of questions to Dr. Thomas M. Deberardino, a Board-certified orthopedic surgeon, for a second opinion examination and permanent impairment evaluation, which considered all of appellant's accepted conditions.

In a February 24, 2023 report, Dr. Deberardino discussed appellant's factual and medical history and reported the findings of his physical examination. He diagnosed lumbar sprain, displacement of lumbar intervertebral disc without myelopathy, derangement of the right medial meniscus, traumatic arthropathy of the right lower leg, rotator cuff syndrome of the right shoulder and allied disorders, and other affections of the right shoulder region. Dr. Deberardino applied the standards of the sixth edition of the A.M.A., *Guides* and determined that appellant had 6 percent permanent impairment of the right upper extremity due to right shoulder ROM deficits under Table 15-5 (Shoulder Regional Grid) beginning on page 401, and 10 percent permanent impairment of the right lower extremity due to his medial and lateral meniscectomy under Table 16-3 (Knee Regional Grid) beginning on page 509. He found that appellant reached MMI as of the date of his February 24, 2023 examination.

On May 23, 2023 OWCP again referred appellant's case to Dr. Harris in his capacity as a DMA. In a May 31, 2023 report, Dr. Harris concluded that appellant had 6 percent permanent impairment of the right upper extremity due to right shoulder ROM deficits and 10 percent permanent impairment of the right lower extremity due to his medial and lateral meniscectomy. He further found that appellant had zero percent permanent impairment of the left lower extremity. In assessing impairment of the lower extremities, Dr. Harris applied the standards of *The Guides Newsletter* and found no impairment in either lower extremity due to nerve deficits.

By *de novo* decision dated June 13, 2023, OWCP denied appellant's claim for an additional schedule award.

On June 26, 2023 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated September 27, 2023, OWCP's hearing representative vacated the June 13, 2023 OWCP decision and remanded the case to OWCP for further development, to be followed by a *de novo* decision. The hearing representative directed OWCP to request a supplemental report from Dr. Deberardino, which evaluated permanent impairment of the right lower extremity due to right knee arthritis.

On October 5, 2023 OWCP requested that Dr. Deberardino provide a supplemental report. In a supplemental report dated December 10, 2023, Dr. Deberardino indicated that the case record contained evidence of a two-millimeter cartilage interval in appellant's right knee. He performed a DBI rating utilizing Table 16-3 of the sixth edition of the A.M.A., *Guides* and determined that appellant had 16 percent permanent impairment of the right lower extremity due to right knee arthritis. Dr. Deberardino advised that appellant was not entitled to additional schedule award compensation for the right lower extremity as he had previously been compensated for 28 percent permanent impairment of that extremity.

By *de novo* decision dated December 28, 2023, OWCP denied appellant's claim for an additional schedule award.

On January 24, 2024 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated March 18, 2024, OWCP's hearing representative vacated the December 28, 2023 OWCP decision, finding a conflict in the medical opinion evidence between Dr. Belvin and Dr. Deberardino regarding appellant's permanent impairment. The hearing representative remanded the case for OWCP to refer appellant to a specialist in the appropriate field of medicine for an impartial medical evaluation to resolve the conflict in the medical opinion evidence, to be followed by a *de novo* decision.

On April 25, 2024 OWCP referred appellant, along with the medical record, a SOAF, and a series of questions to Dr. George Cole, an osteopath and Board-certified orthopedic surgeon, for an impartial medical examination and permanent impairment rating.

In a July 23, 2024 report, Dr. Cole, serving as the impartial medical examiner (IME), discussed appellant's factual and medical history, noting that appellant presently complained of occasional right shoulder and low back pain, numbness in the right leg, and pain in both legs. He

reported the findings of his physical examination, including a cervical spine examination, which revealed mild pain upon palpation of the right trapezius, no muscle spasm, and a negative Spurling's test bilaterally for paresthesia or radiculopathy in the upper extremities. Examination of the thoracolumbar spine showed no tenderness to palpation in the midline or paraspinal musculature bilaterally, no muscle spasm, negative straight leg raise test bilaterally, and no radicular signs bilaterally. Dr. Cole found no tenderness to palpation at the acromioclavicular joint or biceps tendon of the right shoulder and 5/5 strength of all the right rotator cuff muscles. Examination of the knees revealed crepitus with motion and negative McMurray test for internal derangement bilaterally. Dr. Cole noted that appellant had 5/5 strength and intact sensation in the upper and lower extremities. He diagnosed lumbar sprain, displacement of lumbar intervertebral disc without myelopathy, derangement of the right medial meniscus, traumatic arthropathy of the right lower leg, idiopathic degenerative osteoarthritis of the left knee, rotator cuff syndrome of the right shoulder and allied disorders, and other affections of the right shoulder region.

Dr. Cole referred to the sixth edition of the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 15-5, on page 402, the class of diagnosis (CDX) for appellant's right shoulder rotator cuff injury resulted in a Class 1 impairment with a default value of three percent. He assigned a grade modifier for functional history (GMFH) of 1 and a grade modifier for physical examination (GMPE) of 1. Dr. Cole found that a grade modifier for clinical studies (GMCS) was not applicable as no clinical studies were available. He utilized the net adjustment formula to find no movement from the default value, which resulted in a grade C or three percent permanent impairment of the right upper extremity. Dr. Cole also utilized the ROM rating method for the right shoulder and referenced Table 15-34 (Shoulder ROM), page 475, to find permanent impairment of three percent for flexion of 120 degrees, one percent for extension of 40 degrees, three percent for abduction of 90 degrees, four percent for internal rotation of 20 degrees, and two percent for external rotation of 50 degrees. He added these values to equal 13 percent and applied Table 15-35, on page 477, to find that appellant's GMFH of 1 did not increase the permanent impairment of the right upper extremity due to ROM deficits from the 13 percent figure. Dr. Cole noted that 13 percent permanent impairment was the "final rating" for the right upper extremity. With respect to both lower extremities, he applied the standards of *The Guides Newsletter*. Dr. Cole noted that there were no significant findings of the lumbar spine, and that there were no neurological/sensory, or motor deficits in either lower extremity. He found that appellant's condition fell under Class 0 and he had zero percent lower extremity impairment bilaterally when Proposed Table 2 of *The Guides Newsletter* was utilized as appellant "had no nerve injury involved."

Dr. Cole also referred to the sixth edition of the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 16-3, page 509, the CDX for appellant's right knee meniscal injury (partial medial or lateral meniscectomy) resulted in a Class 1 impairment with a default value of two. He assigned a GMFH of 1 and a GMPE of 1. Dr. Cole found that a GMCS was not applicable as no clinical studies were available. He utilized the net adjustment formula to find no movement from the default value, which resulted in a grade C or two percent permanent impairment of the right lower extremity. Dr. Cole also utilized the ROM rating method and referenced Table 16-23 (Knee Motion Impairments), page 549, to find 10 percent permanent impairment for flexion of 100 degrees. He found that appellant's GMFH of 1 did not increase the permanent impairment of the right lower extremity due to ROM deficits from the 10 percent figure. With respect to a DBI rating for the left lower extremity, Dr. Cole noted that appellant was diagnosed with idiopathic degenerative osteoarthritis of the left knee but that he did not have an

accepted condition of the left knee or leg. He indicated that appellant had left knee flexion of 100 degrees, but that ROM of the left knee was limited by his body habitus and stated, "Hence, not an accurate functional loss and should not be calculated.

On August 21, 2024 OWCP again referred the case to Dr. Harris in his capacity as a DMA, and requested that he review Dr. Cole's July 23, 2024 report and provide a permanent impairment rating.

In an August 26, 2024 report, Dr. Harris advised that he had reviewed Dr. Cole's July 23, 2024 report. He indicated that appellant did not have neurologic deficit in either lower extremity consistent with lumbar radiculopathy and thus noted that, under Proposed Table 2 of *The Guides Newsletter,* appellant's accepted lumbar injury fell under Class 0 for both lower extremities. Dr. Harris found, as did Dr. Cole, that appellant had zero permanent impairment in each lower extremity when utilizing *The Guides Newsletter*. Dr. Harris agreed with Dr. Cole's assessment that application of the sixth edition of the A.M.A., *Guides* demonstrated that appellant had 4 percent permanent impairment of the right upper extremity under the DBI rating method and 13 percent permanent impairment of the right upper extremity under the ROM rating method. He referenced Table 2-1 of the A.M.A., *Guides* and concluded that appellant had 13 percent permanent impairment of the right upper extremity given that he had a higher rating for permanent impairment under the ROM rating method than the three percent rating calculated under the DBI rating method.[3]

Dr. Harris utilized the DBI rating method to find that, under Table 16-3, page 509, the CDX for appellant's right knee meniscal injury (partial medial and lateral meniscectomy) resulted in a Class 1 impairment. He concluded that appellant had a grade C or 10 percent permanent impairment of the right lower extremity. Dr. Harris referenced Section 16.7 on page 543 of the sixth edition of the A.M.A., *Guides* regarding application of the ROM rating method. He found the ROM rating method was not appropriate as appellant's right knee diagnosis allowed for a DBI rating, there was no asterisk associated with the right knee condition on Table 16-3, which provided for use of the ROM rating method, and appellant did not otherwise meet the standards of application of the ROM rating method as discussed in Section 16.7. Dr. Harris indicated that appellant had previously been compensated for 12 percent permanent impairment of the right upper extremity. However, this appears to be a typographical error as the case record supports that appellant was in fact compensated for 13 percent permanent impairment.

Dr. Harris determined that appellant reached MMI on the date of Dr. Cole's physical examination, *i.e.*, July 23, 2024. He concluded that appellant had 13 percent permanent impairment of the right upper extremity,[4] 10 percent permanent impairment of the right lower extremity, and 0 percent permanent impairment of the left lower extremity.

On September 12, 2024 OWCP requested that Dr. Harris clarify his August 24, 2024 report with respect to appellant's entitlement to additional schedule award compensation.

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[3] *Id.* at 20, Table 2-1. *See also infra* note 12.

[4] Dr. Harris indicated that appellant had previously been compensated for 12 percent permanent impairment of the right upper extremity. However, this appears to be a typographical error as the case record supports that appellant was in fact compensated for 13 percent permanent impairment.

In a September 18, 2024 report, Dr. Harris repeated the impairment rating contained in his August 24, 2024 report. He acknowledged that appellant had previously been compensated for 13 percent permanent impairment of the right upper extremity, 28 percent permanent impairment of the right lower extremity, and 10 percent permanent impairment of the left lower extremity. Dr. Harris concluded that there was no increase in appellant's permanent impairment given his assessment that appellant presently had 13 percent permanent impairment of the right upper extremity, 10 percent permanent impairment of the right lower extremity, and 0 percent permanent impairment of the left lower extremity.

By *de novo* decision dated October 2, 2024, OWCP denied appellant's claim for an additional schedule award. It accorded the weight of the medical evidence to the reports of Dr. Cole, the IME, and Dr. Harris, the DMA. in finding no greater than 13 percent permanent impairment of the right upper extremity, 28 percent permanent impairment of the right lower extremity, and 10 percent permanent impairment of the left lower extremity, previously awarded.

LEGAL PRECEDENT

The schedule award provisions of FECA,[5] and its implementing federal regulation,[6] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

In determining impairment for the upper or lower extremities under the DBI rating method of the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the extremity to be rated. With respect to the shoulder, reference is made to Table 15-5 (Shoulder Regional Grid).[9] After the CDX is determined from the Shoulder Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) +

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id. See also T.T.,* Docket No. 18-1622 (issued May 14, 2019).

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

[9] A.M.A., *Guides* (6th ed. 2009) 401-05, Table 15-5.

(GMCS - CDX).[10] With respect to the knee, reference is made to Table 16-3 (Knee Regional Grid).[11] 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 GMFH, GMPE, and/or GMCS.[12] 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.[13]

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.[14] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[15] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. 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.[16]

ANALYSIS

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

The Board finds that OWCP found a conflict in the medical opinion evidence between Dr. Belvin and Dr. Deberardino regarding appellant's permanent impairment and properly referred appellant to Dr. Cole for an impartial medical examination, pursuant to 5. U.S.C. § 8123(a).

[10] *See id.* at 411. Table 15-5 also provides that, if motion loss is present for a claimant with certain diagnosed conditions, permanent impairment may alternatively be assessed using Section 15.7 (ROM impairment). Such a ROM rating stands alone and is not combined with a DBI rating. *Id.* at 401-05, 475-78. 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 that 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. *See* FECA Bulletin No. 17-06 (issued May 8, 2017).

[11] A.M.A., *Guides* 509-11.

[12] *See id.* at 521. Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that DBI is the primary method of calculation for the lower limb and that range of motion is primarily used as a physical examination adjustment factor. *Id.* at 497, section 16.2. The A.M.A., *Guides* also explains that some of the diagnosis-based grids refer to the ROM section when that is the most appropriate mechanism for grading the impairment. This section is to be used as a stand-alone rating when other grids refer to this section or no other diagnosis-based sections of the chapter are applicable for impairment rating of a condition. *Id.* at 543.

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

[14] 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).

[15] *Supra* note 8 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5c(3) (March 2017).

[16] *Supra* note 8 at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

In a July 23, 2024 report, Dr. Cole referred to the sixth edition of the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 15-5, the CDX for appellant's right shoulder rotator cuff injury resulted in a Class 1 impairment with a default value of three percent.[17] He assigned grade modifiers and applied the net adjustment formula to calculate that appellant had three percent permanent impairment of the right upper extremity under the DBI rating method. Dr. Cole also utilized the ROM rating method for the right shoulder and referenced Table 15-34, to find 13 percent permanent impairment of the right upper extremity.[18] He noted that 13 percent permanent impairment was the "final rating" for the right upper extremity. With respect to both lower extremities, Dr. Cole applied the standards of *The Guides Newsletter* and found that, under Proposed Table 2, appellant had no impairment of either lower extremity due to nerve deficits. He also performed a DBI rating utilizing Table 16-3, noting that appellant's right knee meniscal injury (partial medial or lateral meniscectomy) resulted in two percent permanent impairment of the right lower extremity.[19] Dr. Cole also utilized the ROM rating method and referenced Table 16-23 to find 10 percent permanent impairment for flexion of 100 degrees.[20] With respect to a DBI rating for the left lower extremity, he found no permanent impairment, noting that appellant did not have an accepted condition of the left knee or leg.

For the right lower extremity, Dr. Cole performed a DBI rating utilizing a portion of Table 16-3 for rating an individual who has undergone either a medial meniscectomy or a lateral meniscectomy. However, the case record reflects that appellant underwent both a medial meniscectomy and a lateral meniscectomy of the right knee and Table 16-3 contains different standards for rating an individual who has undergone both knee procedures.[21] In addition, OWCP previously compensated appellant for 18 percent permanent impairment of the right lower extremity due to a two-millimeter cartilage interval associated with right knee arthritis.[22] However, Dr. Cole did not provide an evaluation of whether appellant is entitled to an increased schedule award for permanent impairment of the right lower extremity due to right knee arthritis deficits. Moreover, Dr. Cole performed both DBI and ROM ratings for the right upper extremity but did not fully explain why he determined that appellant had 13 percent permanent impairment of that extremity. He also performed ROM ratings for both knees but did not explain the basis for undertaking such ratings.[23]

Therefore, in order to resolve the conflict in the medical opinion evidence, the case must be remanded to OWCP for referral of the case record, a SOAF, and, if necessary, appellant, to

[17] A.M.A., *Guides* 402, Table 15-5.

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

[19] *Id.* at 509, Table 16-3.

[20] *Id.* at 549, Table 16-23.

[21] *Id.* at 509. In August 24 and September 18, 2024 reports, Dr. Harris, the DMA, performed a DBI rating utilizing the diagnosis of medial and lateral medial meniscectomy, but he did not fully explain his rating calculations.

[22] *Id.* at 511. The 28 percent permanent impairment of the right lower extremity for which OWCP compensated appellant was comprised of 18 percent permanent impairment due to right knee arthritis and 10 percent permanent impairment due to deficits associated with the L5 and S1 nerve distributions.

[23] *See supra* notes 10 and 12.

Dr. Cole for a supplemental opinion regarding the extent of appellant's permanent impairment. If Dr. Cole is unable to clarify his original report or if his supplemental report is also vague, speculative, or lacking in rationale, OWCP must submit the case record and a detailed SOAF to a new IME for the purpose of obtaining his or her rationalized medical opinion on the issue.[24] 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.

ORDER

IT IS HEREBY ORDERED THAT the October 2, 2024 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: July 25, 2025
Washington, DC

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

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

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

[24] *See M.C.,* Docket No. 22-1160 (issued May 9, 2023); *Talmadge Miller*, 47 ECAB 673 (1996); *Harold Travis*, 30 ECAB 1071, 1078 (1979).