United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
and	)	**Docket No. 20-1149**
	)	**Issued: September 8, 2021**
U.S. POSTAL SERVICE, PROCESSING & DELIVERY CENTER, Macon, GA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 4, 2020 appellant filed a timely appeal from an April 21, 2020 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 appellant's claim.[2]

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that OWCP received additional evidence following the April 21, 2020 decision. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

ISSUE

The issue is whether appellant has met her burden of proof to establish more than three percent permanent impairment of her left upper extremity for which she previously received schedule award compensation.

FACTUAL HISTORY

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

On April 4, 2013 appellant, then a 51-year-old mail processing clerk, filed an occupational disease claim (Form CA-2) alleging that she sustained a left shoulder strain causally related to factors of her federal employment. In an accompanying statement, she alleged that she injured her left shoulder while lifting and using the delivery bar code sorter. Appellant did not initially stop work.

OWCP accepted appellant's claim for left shoulder impingement syndrome and partial tear of the left rotator cuff.

In a January 21, 2015 report, Dr. Jeffrey A. Fried, a Board-certified orthopedic surgeon, diagnosed impingement syndrome of left shoulder, rotator cuff syndrome not otherwise specified, and lateral epicondylitis. He opined that appellant had two percent permanent impairment of the upper extremity pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

On February 18, 2015 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a report dated February 19, 2015, Dr. James W. Dyer, a Board-certified orthopedic surgeon acting as OWCP's district medical adviser (DMA), concurred with Dr. Fried. Using the diagnosis-based impairment (DBI) method, pursuant to Table 15-5 on page 401 of the A.M.A., *Guides*, he determined that appellant had a class 1, grade C soft tissue injury to her left shoulder causing pain, which resulted in two percent permanent impairment of her left upper extremity.

On February 26, 2015 OWCP granted appellant a schedule award for two percent permanent impairment of the left upper extremity (left arm).

On March 9, 2015 appellant requested a hearing before a representative of OWCP's Branch of Hearings and Review, which was held on October 6, 2015. By decision dated December 15, 2015, OWCP's hearing representative affirmed the February 26, 2015 schedule award decision.

[3] Docket No 18-1168 (issued February 8, 2019); Docket No. 17-0502 (issued May 22, 2017).

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

On April 22, 2016 appellant filed a Form CA-7 claiming an increased schedule award.

Appellant submitted an October 13, 2015 report from Dr. Samy F. Bishai, an orthopedic surgeon, who used the range of motion (ROM) method and opined that appellant had 24 percent permanent impairment of the left upper extremity under Table 15-34 of the A.M.A., *Guides*.[5]

On May 10, 2016 OWCP referred the case record to Dr. David Garelick, a Board-certified orthopedic surgeon serving as OWCP's DMA, for an impairment rating. In a report dated May 14, 2016, the DMA concluded that appellant had already been granted a schedule award for two percent permanent impairment of her left upper extremity, which was the appropriate award.

In a June 8, 2016 report, Dr. Bishai responded that the DMA relied upon the opinion of Dr. Fried for his impairment rating, had not examined appellant, and that the DBI method did not include the marked reduction of appellant's ROM.

In a November 11, 2016 response, Dr. Garelick explained that because there was a DBI for appellant's condition, (rotator cuff syndrome which corresponded to tendinitis as noted in Table 15-5), it was clear that the DBI method was appropriate to evaluate appellant's permanent impairment.

By decision dated December 2, 2016, OWCP denied appellant's claim for an additional schedule award, finding that the weight of the medical evidence rested with the opinion of Dr. Garelick, the DMA.

On January 9, 2017 appellant, through her representative, appealed OWCP's December 2, 2016 merit decision to the Board. In a May 22, 2017 decision, the Board found the case was not in posture for decision and remanded the case for further development.[6]

On remand OWCP referred the claim to the DMA on September 27, 2017. In a September 30, 2017 report, Dr. Garelick, the DMA, noted that on May 3, 2014 appellant underwent a left shoulder arthroscopy, acromioplasty, and lysis of adhesions. He explained that Dr. Bishai recommended a 24 percent left upper extremity rating based loss of ROM in the left shoulder; however, Dr. Bishai only provided one range of motion (ROM) measurement. Dr. Garelick explained that three sets of independent measurements must be taken and because this was not done, Dr. Bishai's rating based on the ROM method could not be used. He noted that appellant had received a two percent impairment rating and opined that based on his review of the case "this award seems certainly reasonable, and I would suggest it stand."

By decision dated December 27, 2017, OWCP denied appellant's claim for an increased schedule award.

On February 13, 2018 appellant requested reconsideration.

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

[6] Docket No. 17-0502 (issued May 22, 2017).

In a January 24, 2018 report, Dr. Fried explained that, upon further examination, the two percent impairment rating was extremely low and requested reconsideration or a reevaluation of appellant's left shoulder permanent impairment.

By decision dated May 4, 2018, OWCP denied modification of the December 27, 2017 decision.

On May 22, 2018 appellant filed a timely appeal with the Board from the May 4, 2018 decision. By decision dated February 8, 2019, the Board found that the case was not in posture for decision. The Board explained that Dr. Garelick, the DMA, should have calculated appellant's permanent impairment rating using both the ROM and DBI methods and identified the higher rating.[7]

On May 3, 2019 OWCP referred appellant, a statement of accepted facts (SOAF), and the medical record to Dr. Alexander Doman, a Board-certified orthopedic surgeon, for a second opinion examination to determine the extent of permanent impairment of appellant's left upper extremity.

In a May 23, 2019 report, Dr. Doman utilized the sixth edition of the A.M.A., *Guides*, Table 15-5, page 402, and assigned a class of diagnosis (CDX) of 1 for partial thickness rotator cuff with some residual loss of function associated with arthroscopic surgical procedure. He assigned a grade modifier for physical examination (GMPE) of 1, a grade modifier for functional history (GMFH) of 1, and a grade modifier for clinical studies (GMCS) of 1, which resulted in no shift from the default position of grade C. Dr. Doman opined that a grade C resulted in three percent impairment to the left upper extremity and that appellant had an increase of one percent from the previous award of two percent. Regarding the ROM method, he noted that forward flexion was 180 degrees, extension was 50 degrees, abduction was 170 degrees, adduction was 40 degrees, internal rotation was 80 degrees, and external rotation was 70 degrees. Dr. Doman found that the ROM method resulted in zero percent impairment as there were no deficits in ROM. He advised that appellant reached maximum medical improvement (MMI) on May 23, 2019.

In a June 25, 2019 report, Dr. Michael Katz, a Board-certified orthopedic surgeon serving as the DMA, reviewed the medical evidence of record and Dr. Doman's May 23, 2019 report and concurred with Dr. Doman's findings.

In a February 16, 2020 report, Dr. Fried provided three sets of ROM measurements. He noted on the right there was elevation of 170 degrees, 170 degrees, and 170 degrees and on the left 120, 120, and 130 degrees, with 3 percent impairment. Dr. Fried noted abduction on the right was 150, 140, and 160 degrees, and on the left it was 90, 90, and 90 degrees, with 3 percent impairment. He noted external rotation on the right was 70 degrees, 70 degrees and 80 degrees, and on the left it was 70, 70, and 70 degrees, with 0 percent impairment. Dr. Fried noted internal rotation on the right was 90, 90 and 90 degrees and on the left, 70, 60 and 70 degrees, with 2 percent impairment. He noted extension on the right of 70, 70 and 70 degrees, and on the left of 40, 40, and 40 degrees, with 1 percent impairment. Dr. Fried noted adduction on the right of 30, 30, and 30 degrees, and on the left of 20, 20, and 20 degrees, with 1 percent impairment. Dr. Fried opined that adding the

[7] Docket No. 18-1168 (issued February 8, 2019).

impairments of 3, 3, 2, 1, and 1 resulted in a 10 percent impairment using the ROM method. Using the DBI method, he referred to Table 15-5[8] and selected a CDX of 1 and based on some residual loss of motion. He noted the GMFH of 1 minus the CDX 1 resulted in 0 degrees adjusted. Dr. Fried determined that the GMPE 2 minus the CDX 1 resulted in +1 adjustment. He noted that the GMCS of 1 minus CDX 1 equaled 0 adjustment. Dr. Fried found the final grade was D, CDX 1, which resulted in a 4 percent upper extremity permanent impairment. He explained that because the ROM rating was higher, appellant was entitled to a 10 percent rating based on the ROM method. Dr. Fried indicated that appellant reached MMI on February 12, 2020.

In an April 9, 2020 report, Dr. Katz, serving as the DMA, reviewed the medical evidence and Dr. Fried's February 16, 2020 report. Dr. Katz advised that there was reason to question the reliability of the impairment rating using the ROM method based upon variability of the observations. He noted that there was marked variability in the arcs of motion measured for the left shoulder ranging from normal values to Class 2 impairments. Dr. Katz opined that the rating based on the DBI method was the sole option for determining impairment, as the ROM measurements lacked reliability or consistency. He advised that the permanent impairment of the left upper extremity was three percent. Dr. Katz noted that MMI was reached on May 23, 2019 the date of Dr. Doman's report. He explained that, since appellant had received a two percent award, she was entitled to an additional one percent.

By decision dated April 21, 2020, OWCP granted appellant an additional schedule award for one percent permanent impairment of the left upper extremity. The award ran for 3.12 weeks for the period March 29 to April 19, 2020.

LEGAL PRECEDENT

The schedule award provisions of FECA and its implementing regulations 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.[9] However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[10] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[11]

[8] A.M.A., *Guides* 402.

[9] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[10] 20 C.F.R. § 10.404; *see S.S.*, Docket No. 19-0766 (issued December 23, 2019); *L.T.*, Docket No. 18-1031 (issued March 5, 2019); *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[11] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (March 2017).

In addressing upper extremity impairments, the sixth edition requires identification of the impairment CDX condition, which is then adjusted by GMFH, GMPE, and GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13]

The A.M.A., *Guides* also provide that ROM impairment methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other DBI sections are applicable.[14] 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.[15] 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.[16]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating of upper extremity impairments.[17] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the 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*."[18] (Emphasis in the original.)

The Bulletin further advises:

> "If the rating physician provided an assessment using the ROM method and the [A.M.A.] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE [claims examiner]."[19]

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

[13] *Id*. at 411.

[14] *Id*. at 461.

[15] *Id*. at 473.

[16] *Id*. at 474.

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

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

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

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[20]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[21] This is called an impartial medical examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[22] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[23]

ANALYSIS

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

Preliminarily, the Board notes that it is unnecessary for the Board to consider the evidence appellant submitted prior to the issuance of OWCP's May 4, 2018 merit decision because the Board considered that evidence in its February 8, 2019 decision. Findings made in prior Board decisions are *res judicata* absent any further review by OWCP under section 8128 of FECA.[24]

In support of her claim, appellant submitted a new permanent impairment evaluation report dated February 16, 2020 from Dr. Fried, her treating physician. Utilizing the ROM methodology, Dr. Fried opined that appellant sustained 10 percent permanent impairment of the upper left extremity. He also found that appellant had four percent permanent impairment utilizing the DBI method.

Consistent with its procedures,[25] OWCP referred the matter to a DMA for an opinion regarding appellant's permanent impairment in accordance with the A.M.A., *Guides*.

Dr. Katz, serving as the DMA, disagreed with Dr. Fried's impairment rating, explaining that there was reason to question the reliability of the ROM rating based upon the variability of ROM measurement among observers. Dr. Katz concluded that the DBI rating was appropriate and

[20] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 2.808.6(f) (March 2017).

[21] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[22] 20 C.F.R. § 10.321.

[23] *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[24] *See B.R.*, Docket No. 17-0294 (issued May 11, 2018).

[25] *See S.S., supra* note 10; *Darlene R. Kennedy, supra* note 23; *Gloria J. Godfrey, supra* note 23.

that appellant was entitled to three percent permanent impairment of the left upper extremity. However, he did not address the difference in the ratings under the DBI method.

As Dr. Fried and Dr. Katz calculated divergent permanent impairment ratings for ROM and DBI, the Board finds that there is a conflict in the medical opinion evidence requiring referral to an impartial medical specialist pursuant to 5 U.S.C. § 8123(a).[26]

The Board will, therefore, remand the case to OWCP for referral to an impartial medical specialist to resolve the conflict in the medical opinion as to the extent of appellant's left upper extremity permanent impairment. Following this and any further development as is 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 21, 2020 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: September 8, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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

[26] 5 U.S.C. § 8123(a); *see S.S., id.*; *R.S., supra* note 21; *S.T., supra* note 21.