United States Department of Labor
Employees' Compensation Appeals Board

T.H., Appellant	)	
and	)	**Docket No. 20-0905**
	)	**Issued: December 9, 2022**
U.S. POSTAL SERVICE, POST OFFICE, Mahwah, NJ, Employer	)	

Appearances:
Christopher Henwood, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On March 20, 2020 appellant, through his representative, filed a timely appeal from a January 24, 2020 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that, following the January 24, 2020 decision, appellant submitted additional evidence to OWCP. 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 evidence for the first time on appeal. *Id.*

ISSUE

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

FACTUAL HISTORY

On December 8, 2016 appellant, then a 63-year-old retired letter carrier,[4] filed an occupational disease claim (Form CA-2) alleging that he sustained injuries to the right shoulder, right thumb, and right foot and ankle due to his work duties which included repetitive motions.

In support of his claim, appellant submitted a December 8, 2016 report by Dr. Robert A. Kayal, a Board-certified orthopedic surgeon. On examination, Dr. Kayal noted positive Hawkins' and Neer's tests of the right shoulder, and exquisite tenderness to palpation of the left long head of the biceps tendon, basal joint of the right hand, and the first and second metatarsals of the right foot. X-rays of the right shoulder and foot were negative, while x-rays of the right hand demonstrated severe basal joint arthritis. Dr. Kayal recounted appellant's history of treatment, noting in July and August 2015, appellant underwent a series of injections to the right second metatarsal by Dr. Chad Rappaport, a podiatrist, who also prescribed bilateral foot orthotics.

On November 20, 2015 appellant underwent right shoulder arthroscopy with glenohumeral joint synovectomy, stabilization of labral tear, decompression of the axillary nerve, and debridement/repair of a partial thickness rotator cuff tear. Dr. Kayal administered additional right shoulder injections in May and June 2016.

Appellant was subsequently treated with Dr. Edward A. Lin, a Board-certified orthopedic surgeon specializing in surgery of the hand, for right carpometacarpal (CMC) joint arthritis and diffuse arthritis of the distal interphalangeal (DIP) and proximal interphalangeal (PIP) joints. Dr. Kayal diagnosed a right shoulder labral tear, right glenoid labrum lesion, right shoulder tendinitis, unilateral primary osteoarthritis of the first right CMC joint, and tenosynovitis of the right foot and ankle. He opined that the diagnosed conditions were all causally related to repetitive motion while in the performance of duty.

On March 27, 2017 OWCP accepted appellant's claim for right shoulder labral tear, right shoulder tendinitis, primary osteoarthritis of the first CMC joint of the right hand, and tenosynovitis of the right ankle and foot.

In an April 13, 2017 report, Dr. Lin noted appellant's continued right shoulder and right CMC joint pain. He administered an injection to the right thumb CMC joint.

On June 13, 2018 appellant filed a claim for compensation (Form CA-7) for a schedule award. In support of his claim, he submitted an April 18, 2018 impairment rating by Dr. Peter Blumenthal, Board-certified in occupational medicine. Dr. Blumenthal noted a history of November 20, 2015 arthroscopic labral surgery of the right shoulder, reviewed a history of treatment, and noted findings on examination. He diagnosed status post arthroscopic labral surgery

[4] Appellant retired from the employing establishment in May 2015.

of the right shoulder, adhesive capsulitis of the right shoulder, CMC arthritis of the right hand, and first metatarsophalangeal (MTP) joint arthritis of the right great toe. Referring to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*),[5] Dr. Blumenthal found 12 percent permanent impairment of the right upper extremity according to Table 15-5 (Shoulder Regional Grid: Upper Extremity Impairments), page 403, 35 percent permanent impairment of the right thumb according to Table 15.2 (Digit Regional Grid: Digit Impairments), page 394, and 6 percent permanent impairment of the right foot according to Table 16.2 (Foot and Ankle Regional Grid -- Lower Extremity Impairments), page 507.

On December 18, 2018 OWCP referred the case record, along with a statement of accepted facts (SOAF), and Dr. Blumenthal's report to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), for a review and rating of appellant's permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.

In a January 3, 2019 report, Dr. Harris reviewed the SOAF and the medical record, including the April 18, 2018 report of Dr. Blumenthal. Regarding the right shoulder, he utilized the diagnosis-based impairment (DBI) rating method to find a three percent permanent impairment of the right upper extremity for labral tear according to Table 15-5, a two percent permanent impairment of the right upper extremity due to digit impairment for degenerative joint disease according to Table 15-2, and a one percent permanent impairment of the right lower extremity for probable early arthritis of the first MTP joint according to Table 16-2. Dr. Harris noted that there was insufficient information to rate the right shoulder and right thumb impairments utilizing the range of motion (ROM) method, and that appellant did not meet the criteria necessary to rate the foot impairment utilizing the ROM method.

OWCP found a conflict of medical opinion evidence regarding the appropriate percentage of permanent impairment of the right upper and lower extremities. To resolve the conflict, it referred appellant, the medical record, and a SOAF to Dr. Ian B. Fries, a Board-certified orthopedic surgeon.

In a June 10, 2019 report, Dr. Fries reviewed the medical record and SOAF and noted findings of a May 20, 2019 examination. He noted that appellant exhibited cognitive impairment and could not complete intake forms or pain questionnaires. Regarding the right upper extremity, Dr. Fries diagnosed adhesive capsulitis of the right shoulder, status post right shoulder arthroscopic synovectomy, and degenerative arthritis of the CMC joint of the right thumb. Referring to Figure 15-30 (Shoulder External and Internal Rotation), page 476, of the A.M.A., *Guides* and Table 15-35 (Range of Motion Grade Modifiers), page 477, he found three percent permanent impairment of the right upper extremity for flexion limited to 100 degrees, one percent permanent impairment for extension at 30 degrees, six percent permanent impairment for abduction at 35 degrees, and two percent permanent impairment for external rotation at 50 degrees. Dr. Fries calculated 13 percent permanent impairment of the right upper extremity impairment utilizing the ROM method. He used the DBI method to find that, under Table 15-5 (Shoulder Regional Grid: Upper Extremity Impairments), page 405, the class of diagnosis (CDX) for post-traumatic degenerative joint disease resulted in a class 1 impairment, with a grade modifier for functional history (GMFH) of 2, a grade

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

modifier for physical examination (GMPE) of 3, and a grade modifier for clinical studies adjustment (GMCS) of 2. Applying the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or (2-1) + (3-1) + (2-1), resulted in a net modifier of 5, raising the default CDX grade upward to equal nine percent permanent impairment of the right upper extremity. Regarding the right thumb, Dr. Fries found a Class 1 DBI impairment for post-traumatic degenerative joint disease of the right thumb according to Table 15-2, page 392. He calculated a GMFH of 2, GMPE of 2, and GMCS of 2. Application of the net adjustment formula, or (2-2) + (2-2) + (2-2), resulted in a net adjustment of zero, leaving the default CDX undisturbed, to equal six percent permanent impairment of the left upper extremity. Dr. Fries opined that appellant had a final right upper extremity permanent impairment rating of 13 percent as right shoulder permanent impairment using the ROM method is higher than using the DBI method, and higher than the right thumb impairment. He found no ratable permanent impairment of the right lower extremity. Dr. Fries opined that there were no objective findings on examination to support appellant's complaints of right forefoot pain. He noted, however, that he had not been provided contemporary medical records of treatment for the right foot although the medical record indicated that appellant had been treated by a podiatrist on three occasions.

In a July 16, 2019 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP DMA, found that the right thumb impairment should not be excluded from the right upper extremity impairment rating. He requested that OWCP obtain a supplemental report from Dr. Fries to allow him to correct the issue and include the right thumb impairment in the right upper extremity impairment rating.

OWCP obtained an August 5, 2019 supplemental report from Dr. Fries, in which he affirmed his exclusion of the right thumb impairment from the right upper extremity rating as page 387 of the A.M.A., *Guides* provided that the rating process should be repeated for "each separate diagnosis and each limb involved. In most cases, only one diagnosis would be appropriate." Dr. Fries also requested that OWCP advise him in writing if it had a different interpretation of the A.M.A., *Guides*. In that case, he would provide a calculation including permanent impairment of the right thumb. Using the Combined Values Chart at page 604 of the A.M.A., *Guides*, Dr. Fries determined that the combined 13 and 6 percent permanent impairment ratings of the right upper extremity would result in a total of 18 percent permanent impairment of the right upper extremity. He requested that, for any future ratings, OWCP provide an official methodology clarifying whether multiple impairments affecting one extremity should be combined.

In a September 3, 2019 report, Dr. Katz opined that appellant had attained maximum medical improvement (MMI) as of May 20, 2019. He noted that Dr. Fries correctly excluded the right thumb impairment based on page 387 of the A.M.A., *Guides*. Dr. Katz found 13 percent permanent impairment of the right upper extremity and 0 percent permanent impairment of the right lower extremity.

By decision dated September 25, 2019, OWCP granted appellant a schedule award for 13 percent permanent impairment of the right upper extremity. It found that he had not established permanent impairment of the right lower extremity. The period of the award ran for 40.56 weeks, from May 20, 2019 through February 27, 2020.

On October 16, 2019 appellant, through his representative, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. He later modified his request to a

request for a review of the written record. Appellant's representative asserted that neither Dr. Fries nor Dr. Katz provided adequate rationale for excluding right thumb impairment from the overall impairment rating of the right upper extremity. He noted that Dr. Katz recommended that Dr. Fries correct his opinion to include right thumb impairment as an element of the right upper extremity rating. Appellant's representative contended that page 387 of the A.M.A., *Guides* pertained to two diagnoses in the shoulder and not to two diagnoses in different regions of the upper extremity as in appellant's case. He asserted that according to Table 2-1 (Fundamental Principles of the *Guides*), page 20, of the A.M.A., *Guides*, "[a]ll regional impairments in the same organ or body system shall be combined as prescribed" by the rule. Appellant's representative also asserted that rotator cuff and thumb impairments should be combined according to Example 15-26 (Multiple Upper Extremity Impairments), page 478, and Figure 15-31 (Upper Extremity Impairment Evaluation Example), page 480, of the A.M.A., *Guides*. Additionally, he contended that OWCP's procedures at Chapter 3.0700.3.a.3[6] directed inclusion of multiple impairments of the same member or function of the body.

By decision dated January 24, 2020, OWCP's hearing representative affirmed the September 25, 2019 schedule award determination, finding that Dr. Fries' opinion represented the special weight of the medical evidence as he served as the impartial medical examiner in the case. The hearing representative further found that the arguments of appellant's representative were irrelevant as they did not constitute medical evidence.

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.[7] 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.[8] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[9] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[10]

[6] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, *Determining Schedule Awards*, Chapter 3.700.3.a.3 (January 2010).

[7] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[9] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *see also* at Chapter 2.808.5a (March 2017).

[10] *J.C.*, Docket No. 20-1071 (issued January 4, 2021); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's *International Classification of Functioning Disability and Health: A Contemporary Model of Disablement*.[11] In addressing upper extremity impairments, the sixth edition requires identification of the impairment CDX condition, which is then adjusted by grade modifiers or GMFH, GMPE, and GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[14]

The A.M.A., *Guides* also provide that the 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.[15] 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.[16] 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.[17]

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.[18] 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:

> "[A]s the [A.M.A.,] *Guides* caution that, if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (via the updated instructions noted above) to the rating physician(s).
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the A.M.A., Guides allow for the use of both the DBI and ROM methods to calculate an*

[11] *Supra* note 6 at p.3, section 1.3.

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

[13] *Id*. at 411.

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

[15] *Supra* note 6 at 461.

[16] *Id*. at 473.

[17] *Id*. at 474.

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

impairment rating for the diagnosis in question, the method producing the higher rating should be used."[19] (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."

Section 8123(a) of FECA provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[20] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical examiner (IME), pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[21] Where a case is referred to an IME for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[22]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[23]

ANALYSIS

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

In an August 5, 2019 supplemental report, Dr. Fries indicated that he was uncertain as to how to apply the A.M.A., *Guides* methodology for combining multiple impairments affecting one extremity. He offered that, if OWCP allowed inclusion of right thumb impairment, appellant would have 18 percent permanent impairment of the right upper extremity, and if not, appellant had 13 percent permanent impairment of the right upper extremity.

On September 3, 2019 Dr. Katz reviewed Dr. Fries' supplemental report and opined that Dr. Fries correctly excluded permanent impairment of the right thumb. The Board notes, however, that Dr. Fries offered two impairment rating calculations, one which included permanent impairment of the right thumb, and one that excluded permanent impairment of the right thumb.

[19] *Id*.

[20] 5 U.S.C. § 8123(a). *See R.C.*, Docket No. 18-0463 (issued February 7, 2020); *see also G.B.*, Docket No. 16-0996 (issued September 14, 2016).

[21] *See M.R.*, Docket No. 19-0526 (issued July 24, 2019); *C.R.*, Docket No. 18-1285 (issued February 12, 2019).

[22] *V.H.*, Docket No. 20-0012 (issued November 5, 2020).

[23] *Supra* note 11 at Chapter 2.808.6(f) (March 2017).

Additionally, Dr. Katz did not provide medical rationale to explain why he altered his July 16, 2019 opinion that appellant's right thumb permanent impairment must be included in rating permanent impairment of the right upper extremity.[24] OWCP subsequently issued the September 25, 2019 schedule award, affirmed on January 24, 2020, which excluded permanent impairment of the right thumb from the right upper extremity impairment rating, based on Dr. Fries' opinion as the special weight of the medical evidence, as reviewed by Dr. Katz.

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden of proof to establish entitlement to compensation. However, OWCP shares responsibility in the development of the evidence to see that justice is done.[25] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[26]

In a situation where OWCP secures an opinion from an IME for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, it has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[27]

The Board finds that Dr. Fries' opinion requires further clarification, supported by medical rationale, as to whether appellant's right thumb condition should be included in rating permanent impairment of the right upper extremity, and whether appellant has any permanent impairment of the right lower extremity. As OWCP did not obtain a sufficiently rationalized medical opinion resolving the conflict on these issues, this case must be remanded for further development of his opinion.

On remand OWCP shall refer appellant along with an updated SOAF and the medical record to a new IME for an opinion as to whether CMC arthritis of the right thumb should be included in determining the appropriate percentage of permanent impairment of the right upper extremity, and whether appellant has any permanent impairment of the right lower extremity. Following this and other such further development as deemed necessary, it shall issue a *de novo* decision.

CONCLUSION

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

[24] *Id*.

[25] *See L.B.*, Docket No. 19-0432 (issued July 23, 2019); *William J. Cantrell*, 34 ECAB 1223 (1983).

[26] *Id.*; *see also C.F.*, Docket No. 21-0003 (issued January 21, 2022); *S.A.*, Docket No. 18-1024 (issued March 12, 2020).

[27] *C.F.*, *id*.; *S.R.*, Docket No. 17-1118 (issued April 5, 2018); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232, 238 (1988).

ORDER

IT IS HEREBY ORDERED THAT the January 24, 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: December 9, 2022
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board