United States Department of Labor
Employees' Compensation Appeals Board

H.C., Appellant	)	
and	)	**Docket No. 21-0761**
	)	**Issued: May 5, 2022**
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, PA, Employer	)	

Appearances:
Russell T. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On April 22, 2021 appellant, through counsel, filed a timely appeal from an October 30, 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.

[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*.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 12 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

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 May 5, 2005 appellant, then a 55-year-old clerk, filed a traumatic injury claim (Form CA-1) alleging that on May 3, 2005 he injured his left upper arm when he attempted to stop a tray of mail from slipping off a rack while in the performance of duty. OWCP accepted the claim for left shoulder/arm sprain/strain, left bicipital tenosynovitis, left primary osteoarthritis, and other affection of the left shoulder region.[4]

On April 4, 2007 appellant underwent OWCP-authorized left shoulder arthroscopic, subacromial decompression, distal clavicle excision, minor anterior labral debridement, and biceps tenotomy.

In a January 6, 2015 report, Dr. Nicholas P. Diamond, an osteopath specializing in pain medicine, rated appellant's left shoulder permanent impairment under the diagnosis-based impairment (DBI) method. He determined that, under Table 15-5 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[5] the combined impairments resulted in a rating of 35 percent left upper extremity permanent impairment. Dr. Diamond related that appellant's class of diagnosis (CDX) of left shoulder acromioclavicular (AC) joint arthropathy with distal clavicular excision, a Class 1 impairment which resulted in 12 percent permanent impairment of the left upper extremity, a CDX of-moderate sensory deficit from C8, a Class 1 impairment which resulted in 0 percent permanent impairment of the left upper extremity, a CDX of mild motor strength deficit of the left biceps, Class 1 impairment, which resulted in 13 percent permanent impairment of the left upper extremity, and entrapment neuropathy of the left median nerve at the wrist, which resulted in 6 percent permanent impairment of the left wrist.

On April 12, 2015 appellant filed a claim for compensation (Form CA-7) for a schedule award.

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[3] Docket No. 18-0896 (issued December 19, 2018); Docket No. 16-0323 (issued April 10, 2017).

[4] On January 4, 2008 appellant filed an occupational disease claim (Form CA-2) alleging that he sustained bilateral brachial plexus injuries causally related to factors of his federal employment. OWCP assigned OWCP File No. xxxxxx920. It denied the claim on March 13, 2008. OWCP has administratively combined the present claim, OWCP File No. xxxxxx973 and OWCP File No. xxxxxx920, with the latter designated as the master file.

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

In a June 2, 2015 report, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon serving as OWCP's district medical adviser (DMA), determined that appellant had 12 percent permanent impairment of the left upper extremity based on Dr. Diamond's January 6, 2015 findings regarding appellant's distal clavicle resection. He opined that Dr. Diamond's other permanent impairment ratings were for conditions which were not causally related to the accepted May 3, 2005 employment injury.

By decision dated June 23, 2015, OWCP granted appellant a schedule award for 12 percent permanent impairment of the left upper extremity.

Appellant, through counsel, appealed to the Board on December 8, 2015. By decision dated April 10, 2017, the Board set aside the June 23, 2015 decision.[6] The Board found that OWCP had inconsistently applied Chapter 15 of the A.M.A., *Guides* regarding the proper use of either the DBI or range of motion (ROM) methodology in assessing the extent of permanent impairment. The Board remanded the case for OWCP to issue a *de novo* decision after development of a consistent method for calculating permanent impairment of the upper extremities.

In a November 16, 2017 report, Dr. Morley Slutsky, a DMA Board-certified in occupational medicine, reviewed the medical record with the exception of Dr. Diamond's January 6, 2015 report, as it had not been provided for his review. He determined that appellant had 10 percent left upper extremity permanent impairment. Dr. Slutsky referenced Table 15-5 of the A.M.A., *Guides*, Shoulder Regional Grid, Upper Extremity Impairment, CDX of AC joint injury or disease, Class 1 impairment, for distal clavicle resection. He then utilized the adjustment grid and grade modifiers, and determined that appellant had a grade modifier for functional history (GMFH) of 1, a grade modifier for physical examination (GMPE) of 1, and a grade modifier for clinical studies (GMCS) of 1, as clinical studies confirmed lesions of rotator cuff/SLAP labral biceps tendon tear. Utilizing the adjustment formula resulted in no adjustment to the default value of grade C, resulting in 10 percent permanent impairment of the left upper extremity.

By decision dated November 28, 2017, OWCP denied appellant's claim for an increased schedule award for the left upper extremity. It found that, pursuant to FECA Bulletin No. 17-06, the evidence did not support greater than the 12 percent permanent impairment of the left upper extremity previously awarded.

Appellant, through counsel, appealed to the Board on April 16, 2018. By decision dated December 19, 2018, the Board found that the case was not in posture for decision.[7] The Board explained that, when rendering his impairment rating, Dr. Slutsky did not have all the relevant medical evidence as OWCP failed to provide the January 6, 2015 report of Dr. Diamond. The Board remanded the case to OWCP for referral of appellant to a second opinion physician.

On remand, OWCP referred appellant, a statement of accepted facts (SOAF), and the medical record to Dr. Willie Thompson, a Board-certified orthopedic surgeon, for a second

[6] Docket No. 16-0323 (issued April 10, 2017).

[7] Docket No. 18-0986 (issued December 19, 2018).

opinion examination to determine the extent of permanent impairment of appellant's left upper extremity.

In a report dated March 5, 2019, Dr. Thompson noted his review of the SOAF and medical record. On examination, he found that appellant had full ROM, normal strength, no evidence of muscle atrophy or wasting, and intact neurovascular status. Dr. Thompson observed no AC joint tenderness, negative impingement signs, 5/5/ shoulder flexion and abduction strength, normal muscle bulk and tone, and adequate radial pulse. He diagnosed status post left shoulder arthroscopic surgery with distal clavicle resection. Dr. Thompson concluded that appellant had no residuals of the accepted March 5, 2015 employment injury. Using Table 15-5 of the A.M.A., *Guides*, page 403 and CDX of distal clavicle resection, he determined that appellant was functional with normal ROM and therefore he had a Class 1, or 10 percent permanent impairment of the left upper extremity.

In a March 15, 2019 supplemental report, Dr. Thompson revised his left upper extremity permanent impairment rating from 10 to 8 percent. He reported bilateral shoulder ROM of 180 degrees flexion, 60 degrees extension, 180 degrees abduction, 60 degrees adduction, 70 degrees internal rotation, and 90 degrees external rotation. Using the DBI rating method, Dr. Thompson assigned a GMFH of 0, a GMPE of 0 and a GMCS of 0. He applied the net adjustment formula and found a net adjustment of -3, which moved the default grade of C two spaces to the left resulting in a grade A, or eight percent permanent impairment of the left shoulder. Dr. Thompson determined that appellant reached maximum medical improvement (MMI) on March 4, 2008.

On March 25, 2019 OWCP referred the medical record to Dr. Herbert White, Jr., Board-certified in preventive medicine, acting as OWCP's DMA, for a schedule award evaluation. In a March 28, 2019 report, Dr. White, reviewed the medical evidence of record, including Dr. Thompson's March 5 and 15, 2019 reports, and concurred with Dr. Thompson's left upper extremity permanent impairment rating of eight percent.

By decision dated April 29, 2019, OWCP denied appellant's claim for an increased schedule award based on the opinions of Dr. Thompson, OWCP's second opinion physician, and Dr. White, the DMA.

On May 6, 2019 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated June 24, 2019, OWCP's hearing representative vacated OWCP's April 29, 2019 decision. The hearing representative remanded the case to OWCP to obtain an addendum report from Dr. White addressing whether Dr. Thompson's reports contained a permanent impairment rating for the left upper extremity using both the DBI and ROM methodologies and to explain Dr. Thompson's different left upper extremity impairment ratings. The hearing representative also instructed OWCP to make findings regarding Dr. Diamond's July 6, 2015 impairment evaluation.

In a July 12, 2019 report, Dr. White provided clarification on the impairment ratings as instructed by the hearing representative. He utilized the ROM method in Table 15-34, page 475 of the A.M.A., *Guides* to find zero percent impairment for 180 degrees flexion, zero percent

impairment for 60 degrees extension, zero percent impairment for 170 degrees abduction, zero percent impairment for 60 degrees adduction, two percent impairment for 70 degrees internal rotation, and zero percent impairment for 90 degrees external rotation, totaling two percent left upper extremity permanent impairment. Using Table 15-5, page 403, the DMA found CDX of distal clavicle resection, a Class 1 impairment, with a default value of 10 percent impairment. Under Table 15-7, page 406, Dr. White found a GMFH of 0, under Table 15-8, page 408, he found a GMPE of 1, and under Table 15-9, page 410, he found a GMCS of 0. Utilizing the net adjustment formula calculation, the DMA found a net adjustment of -2,[8] which resulted in grade A or eight percent permanent impairment for left shoulder distal clavicle resection. The DMA advised that the DBI method should be used as it provided the higher rating percentage of permanent impairment. With respect to Dr. Thompson's differing impairment ratings, the DMA observed that Dr. Thompson did not apply the net adjustment formula when he calculated 10 percent left upper extremity permanent impairment, but did utilize the net adjustment formula in his addendum report when he calculated 8 percent left upper extremity permanent impairment. Dr. White further explained that, while he had found a GMPE of 1 and Dr. Thompson found a GMPE of 0, this difference would not change the rating. He determined the date of MMI to be March 5, 2019, the date of Dr. Thompson's examination.

By decision dated July 15, 2019, OWCP again denied appellant's claim for an increased schedule award.

On July 23, 2019 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A telephonic hearing was held on November 8, 2019.

Following the hearing, counsel submitted an October 30, 2019 addendum report from Dr. Diamond who disagreed with Dr. Thompson's impairment rating. He noted that, according to FECA, all conditions of the affected body part must be included in the permanent impairment rating. Dr. Diamond asserted that appellant's impairment rating did not take into consideration positive objective evidence of entrapment neuropathy, which should have been included in the impairment rating. He again determined that appellant had 35 percent permanent impairment of the left upper extremity.

By decision dated January 17, 2020, OWCP's hearing representative found a conflict in the medical opinion evidence between Dr. Diamond, for appellant, and Dr. Thompson, a second opinion physician, and Dr. White, a DMA, with regard to the nature and extent of appellant's permanent impairment. He remanded the case to OWCP for referral to an impartial medical examiner (IME) for resolution of the outstanding conflict.

By letter dated February 5, 2020, OWCP referred appellant, along with a SOAF and a series of questions to Dr. John Perry, a Board-certified orthopedic surgeon serving as the IME.

In a report dated March 16, 2020, Dr. Perry reviewed appellant's history of injury and left shoulder surgery in May 2012. He diagnosed left shoulder distal clavicle resection and biceps tenotomy, left shoulder AC degenerative joint disease, inconsistent presentation, and minimal

[8] (GMFH - CDX)(0-1) + (GMPE - CDX)(1-1) + (GMCS - CDX)(0-1) = -2.

evidence of brachial plexus neuropathy with bilateral cubital tunnel and carpal tunnel syndrome. Dr. Perry concluded that the brachial neuropathy with bilateral cubital tunnel and carpal tunnel syndrome were unrelated to the accepted May 3, 2005 employment injury as they were late onset. He related that appellant's left shoulder ROM findings included 80 degrees abduction, 90 degrees elevation, 45 degrees external rotation, and internal rotation to the iliac crest. Appellant's physical examination of the left shoulder showed no crepitus, swelling or joint effusion, stable anterior glenohumeral joint, and posterior and inferior stress testing. Dr. Perry noted that people who have distal clavicle surgery usually perform very well. He noted that, at the time of Dr. Thompson's evaluation, he found full left shoulder ROM. Thus, Dr. Perry concluded that appellant's current ROM restriction was unrelated to the accepted May 3, 2005 work injury. He also concluded that it was possible that appellant had left glenohumeral joint progressive arthritis, which was the cause of the restricted ROM. Alternatively, Dr. Perry suggested that appellant's restricted ROM was due to other nonemployment-related conditions based on appellant's having full ROM several years after the work injury.

In an April 22, 2020 addendum report, Dr. Perry indicated that appellant had full ROM when examined by Dr. Thompson, but did not have full ROM during his examination. Thus, he explained that he could not link appellant's left shoulder ROM restrictions with his accepted employment injury-related functional impairment using the A.M.A., *Guides*. Dr. Perry found that Dr. Thompson's evaluation should be relied upon to rate appellant's ROM.

By decision dated May 26, 2020, OWCP denied appellant's claim for an increased schedule award. It accorded the special weight of the medical evidence to Dr. Perry's impartial medical opinion.

On June 2, 2020 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review. A telephonic hearing was held on September 9, 2020.

In an August 12, 2020 report, Dr. David Weiss, an osteopath Board-certified in orthopedic surgery, noted that Dr. Perry found significant ROM deficits, which the physician opined that were unrelated to the May 3, 2005 employment injury as the restricted ROM became evident after the evaluation by Dr. Thompson. He also noted that, while Dr. Perry found that appellant had evidence of brachial plexus neuropathy, cubital and carpal tunnel syndrome, these late-onset conditions were not related to his employment injury. Dr. Weiss noted that impairment ratings under FECA must include all conditions of the affected body part at the time of the rating. He concluded that appellant had 35 percent permanent impairment of the left upper extremity.[9]

By decision dated October 30, 2020, OWCP's hearing representative affirmed OWCP's May 26, 2020 decision, finding that the thorough, well-rationalized opinion of Dr. Perry was entitled to the special weight of the medical evidence.

[9] Dr. Weiss related that he stood by his findings and report of January 6, 2015, however, the record indicates that, his partner, Dr. Diamond signed the report dated January 6, 2015.

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.[10] 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.[11] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[12]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment CDX condition, which is then adjusted by GMFH, GMPE, and GMCS.[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14]

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.[15] 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 [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.*"[16] (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

[10] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[11] *Id*. at § 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).

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

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

[14] *Id*. at 411.

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

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

should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE [claims examiner]."[17]

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.[18]

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.[19] 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.[20] 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.[21]

When OWCP obtains an opinion from an IME for the purpose of resolving a conflict in the medical opinion evidence and the specialist's opinion requires clarification or elaboration, it must secure a supplemental report from the specialist to correct the defect in the original report.[22] If the IME fails to respond or does not provide an adequate response, it should refer appellant for a new impartial medical examination.[23]

ANALYSIS

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

OWCP properly found a conflict in medical opinion between Dr. Diamond an attending physician, and Drs. Thompson and White, for the government, regarding appellant's permanent

[17] *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 (May 8, 2017).

[18] *See supra* note 12, Chapter 2.808.6(f) (March 2017).

[19] 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).

[20] 20 C.F.R. § 10.321.

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

[22] *See J.K.*, Docket No. 21-0007 (issued July 30, 2021); *M.M.*, Docket No. 20-1524 (issued April 20, 2021); *S.R.*, Docket No. 17-1118 (issued April 5, 2018); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988).

[23] *See J.K.*; *id.*; *M.M.*, *id.*; *W.H.*, Docket No. 16-0806 (issued December 15, 2016); *Talmadge Miller*, 47 ECAB 673 (1996); *Harold Travis*, 30 ECAB 1071, 1078 (1979).

impairment.[24] In order to resolve the conflict of medical opinion, it properly referred appellant to Dr. Perry for an impartial medical examination, pursuant to 5 U.S.C. § 8123(a).[25]

In his March 16 and April 22, 2020 reports, Dr. Perry diagnosed left shoulder distal clavicle resection and biceps tenotomy, left shoulder AC degenerative joint disease, inconsistent presentation, and minimal evidence of brachial plexus neuropathy with bilateral cubital tunnel and carpal tunnel syndrome. He reviewed the medical reports and concluded appellant's current restricted ROM was unrelated to the accepted May 3, 2005 work injury. Dr. Perry recommended using Dr. Thompson's evaluation when considering appellant's ROM and any impairment rating. He did not provide an impairment rating under the tables of the A.M.A., *Guides* for the left upper extremity using the ROM methodology, nor did he rate appellant's left upper extremity permanent impairment under the DBI methodology for the left shoulder diagnoses he provided. As such, Dr. Perry's opinion does not conform to the A.M.A., *Guides* and is of diminished probative value.[26]

When OWCP obtains an opinion from an IME for the purpose of resolving a conflict in the medical evidence, and the IME's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[27] Accordingly, the Board finds that OWCP should have referred the case back to Dr. Perry for another supplemental report for clarification, or to a new IME. Consequently, the case is remanded for further medical development with regard to appellant's entitlement to a greater schedule award for permanent impairment of his left extremity. After this and other such further development as necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[24] Upper extremity impairments due to brachial plexus impairment are rated under Table 15-20 of the A.M.A., *Guides* 434.

[25] *L.Y.*, Docket No. 20-0398 (issued February 9, 2021); *B.S.*, Docket No. 19-1717 (issued August 11, 2020); *Darlene R. Kennedy*, 57 ECAB 414 (2006).

[26] *L.Y.*, *id.*; *see Paul R. Evans, Jr.*, 44 ECAB 646, 651 (1993).

[27] *L.Y.*, *id.*; *W.H.*, Docket No. 16-0806 (issued December 15, 2016); *supra* note 12 at Chapter 2.810.11(e) (September 2010); *April Ann Erickson*, 28 ECAB 336, 341-42 (1977).

ORDER

IT IS HEREBY ORDERED THAT the October 30, 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: May 5, 2022
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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