United States Department of Labor
Employees' Compensation Appeals Board

G.L., Appellant	)	
and	)	**Docket No. 23-0584**
	)	**Issued: April 1, 2024**
U.S. POSTAL SERVICE, WEST SACRAMENTO PROCESSING & DISTRIBUTION CENTER, West Sacramento, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On March 17, 2023 appellant filed a timely appeal from November 29, 2022 and February 16, 2023 merit decisions of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the February 16, 2023 decision, appellant submitted additional evidence to OWCP. However, the Board's *Rules of Procedures* provides: The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal. 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 11 percent permanent impairment of the left upper extremity and 16 percent permanent impairment of the right upper extremity for which he 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 decision are incorporated herein by reference. The relevant facts are as follows.

On January 21, 2003 appellant, then a 44-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that he developed numbness and pain in both hands and arms due to factors of his federal employment including squeezing a handle in order to operate a machine. He noted that he first became aware of his condition and realized its relation to his federal employment on December 3, 2003. Appellant did not immediately stop work. OWCP assigned the current claim File No. xxxxxx819 and accepted it for repetitive strain injury of both upper extremities.

On May 29, 2003 appellant filed a claim for compensation (Form CA-7) for a schedule award. By decision dated November 17, 2003, OWCP granted him a schedule award for nine percent permanent impairment of the right upper extremity and nine percent permanent impairment of the left upper extremity in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] The period of the award ran for 56.16 weeks from August 26, 2003 through September 22, 2004.

On February 28, 2008 appellant filed a traumatic injury claim (Form CA-1) alleging that on that date he severed his right finger while adjusting an oscillating fan while in the performance of duty. OWCP assigned OWCP File No. xxxxxx749. It accepted the claim for open wound of right hand, except fingers, without complications, open wound of the right finger without complications, and closed fracture of the right phalanx or phalanges. On February 28, 2008 appellant underwent a reapplication of the tip of his right finger with a full-thickness graft. On April 25, 2008 he underwent a revision amputation of the right index finger. On January 12, 2010 OWCP granted appellant a schedule award for 13 percent permanent impairment of the right upper extremity, which included the 9 percent permanent impairment award previously paid under OWCP File No. xxxxxx819 for bilateral repetitive strain injury, and an additional 4 percent permanent (hand) impairment for open wound of the right finger. The period of the award ran for 12.48 weeks from August 21 through November 16, 2009.[5]

[3] Docket No. 22-0166 (issued August 24, 2022).

[4] A.M.A., *Guides* (5th ed. 2001).

[5] OWCP administratively combined OWCP File Nos. xxxxxx819 and xxxxxx749, with OWCP File No. xxxxxx819 designated as the master file.

On July 5, 2013 appellant filed a Form CA-7 for a schedule award under OWCP File No. xxxxxx819. By decision dated September 23, 2013, OWCP denied his claim for an additional schedule award.

On August 13, 2019 Dr. Ralph D'Auria, a Board-certified physiatrist, evaluated appellant for bilateral upper extremity pain. He referred to the sixth edition of the A.M.A, *Guides*[6] and calculated impairment for each upper extremity pursuant to Table 15-34 (Shoulder Range of Motion), page 475, and determined the final upper extremity impairment of "3.45" percent permanent impairment for each upper extremity due to shoulder deficits or 7 percent permanent impairment for both combined.

On September 13, 2019 appellant filed a Form CA-7 for an additional schedule award.

OWCP received an electromyogram and nerve conduction velocity (EMG/NCV) study dated October 31, 2019, which revealed right and left median neuropathies at the wrists (bilateral carpal tunnel syndrome).

On May 28, 2020 OWCP expanded the acceptance of appellant's claim to include carpal tunnel syndrome of the left and right upper extremities, and lesion of the ulnar nerves of the right and left upper extremities.

By decision dated July 10, 2020, OWCP denied appellant's claim for an additional schedule award.

OWCP received additional evidence. In a report dated November 17, 2020, Dr. D'Auria utilized the sixth edition of the A.M.A., *Guides*, examined appellant on November 17, 2020 and provided an impairment rating. Regarding impairment of the upper extremities, he referred to Table 15-23 (Entrapment/Compression Neuropathy Impairment) on page 449. Dr. D'Auria noted the diagnosis of bilateral ulnar neuropathies at the elbows and determined that appellant had six percent permanent impairment of each upper extremity due to this diagnosed condition. Regarding impairment related to deficits of both wrists, he noted the diagnosis of bilateral carpal tunnel syndrome and determined that appellant had three percent permanent impairment of each upper extremity due to this diagnosed condition.[7] Dr. D'Auria calculated the total upper extremity impairment for nerve entrapments was 7.5 percent, which he rounded down to 7 percent permanent impairment for the right upper extremity and 7 percent permanent impairment for the left upper extremity.

On January 28, 2021 appellant filed a Form CA-7 for an additional schedule award. In a letter dated February 11, 2021, OWCP indicated that no additional action would be taken on his claim and instructed him to exercise his appeal rights associated with its July 10, 2020 decision.

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

[7] Dr. D'Auria advised that, since there were two nerve entrapments, the larger impairment of 6 percent for the elbow was given the full impairment and the second impairment of 3 percent for the wrist was given 50 percent of that rating, or 1.5 percent.

OWCP received an EMG/NCV study dated November 17, 2020 which revealed bilateral ulnar neuropathy at the elbow (cubital tunnel syndrome) with complete conduction block at three centimeters below the medial epicondyle bilaterally.

Appellant submitted a February 17, 2021 report wherein Dr. D'Auria noted range of motion (ROM) findings for both shoulders and provided three successive trials for each measurement. He recommended additional diagnostic studies prior to determining impairment. OWCP also received magnetic resonance imaging (MRI) scans of the right and left shoulders dated February 26, 2021.

In a March 4, 2021 report, Dr. D'Auria calculated the permanent impairment of appellant's upper extremities due to bilateral shoulder deficits by using the ROM method and the diagnosis-based impairment (DBI) method, and noted the ROM method provided a greater impairment. He found 8 percent permanent impairment of the right upper extremity and 11 percent permanent impairment of the left upper extremity.

On April 6, 2021 appellant requested reconsideration of the July 10, 2020 decision and submitted a March 18, 2021 report wherein Dr. D'Auria requested that appellant's claim be expanded to include partial rotator cuff tears of the bilateral shoulders.

On April 19, 2021 OWCP referred appellant's medical record, including Dr. D'Auria's November 17, 2020 impairment rating, a series of questions, and a statement of accepted facts (SOAF), to the district medical adviser (DMA) for a schedule award determination.

On April 21, 2021 Dr. Michael M. Katz, a Board-certified orthopedic surgeon, serving as a DMA, reviewed the SOAF and the medical record. Utilizing the sixth edition of the A.M.A., *Guides*, Table 15-23, page 449, he noted the diagnosis of bilateral ulnar nerve entrapment and determined that appellant had six percent permanent impairment of each upper extremity due to this diagnosed condition. With regard to the diagnosis of bilateral median nerve entrapment, Dr. Katz opined that appellant had three percent permanent impairment of each upper extremity due to this diagnosed condition. He noted that the total combined impairment was eight percent permanent impairment of each upper extremity.

By decision dated April 26, 2021, OWCP vacated the decision dated July 10, 2020. It found that the medical evidence of record supported an increase in permanent impairment of the bilateral upper extremities. OWCP advised that an additional schedule award would be issued under a separate decision.

By decision dated May 19, 2021, OWCP granted appellant a schedule award for 11 percent permanent impairment of the left upper extremity and 16 percent permanent impairment of the right upper extremity. It noted that he was previously granted a schedule award for nine percent permanent impairment of the left upper extremity and was entitled to an additional award of two percent permanent impairment of the left upper extremity. OWCP further advised that appellant was previously granted a schedule award for 13 percent permanent impairment of the right upper extremity and was entitled to an additional award of 3 percent permanent impairment of the right upper extremity. The period of the award ran for 15.6 weeks from November 17, 2020 through March 6, 2021.

On June 1, 2021 appellant requested reconsideration. He asserted that the May 19, 2021 schedule award decision did not consider the most recent medical documentation from his treating physician Dr. D'Auria, dated March 18, 2021, and requested that OWCP consider all the medical documentation prior to issuing an impairment rating.

By decision dated July 2, 2021, OWCP denied appellant's request for reconsideration of the merits of his claim, pursuant to 5 U.S.C. § 8128(a).

On November 5, 2021 appellant appealed to the Board. By decision dated August 24, 2022, the Board set aside the May 19, 2021 decision and remanded the case for further development.[8] It instructed OWCP to route the case record, including additional electrodiagnostic studies and additional reports from Dr. D'Auria, to a DMA for an opinion on permanent impairment of appellant's upper extremities, to be followed by other such development and a *de-novo* decision on appellant's claim for an increased schedule award.

OWCP referred appellant, a SOAF, the medical record, and a series of questions, to Dr. Jeffrey Fried, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine whether his work-related condition resulted in permanent impairment warranting an additional schedule award.

In a November 2, 2022 report, Dr. Fried discussed appellant's factual and medical history, reviewed the SOAF, and the medical record, and reported the findings of his physical examination of appellant. He referred to the sixth edition of the A.M.A., *Guides* and utilized the DBI method to find that, under Table 15-2 (Digit Regional Grid), page 391, for the diagnosis of healed significant soft tissue/skin injury of the right index finger, appellant had four percent permanent impairment of the right index finger, which converted to one percent permanent impairment of the right upper extremity. Utilizing the ROM method to rate the right index finger under Figure 15-13, page 462 (Upper Extremity Range of Motion Record), and Table 15-30, page 470 (Finger Range of Motion), Dr. Fried found 34 percent permanent impairment for the right digit,[9] which converted to 4 percent permanent impairment for the right index finger. He indicated that the ROM method resulted in greater impairment. With regard to the shoulders, Dr. Fried utilized the DBI method under Table 15-5 (Shoulder Regional Grid), page 401, and noted that the diagnosis of bilateral shoulder sprain, painful injury, would equate to two percent permanent impairment of each upper extremity. He indicated that the most recent ROM findings of appellant's shoulders were not consistent with those obtained by Dr. D'Auria on March 4, 2021. Therefore, Dr. Fried found that, pursuant to the A.M.A., *Guides*, the ROM method would not be used to rate appellant's shoulder impairment as there were significant inconsistencies in ROM measurements.

Dr. Fried further opined that appellant had five percent permanent impairment of each upper extremity due to bilateral median nerve entrapment by utilizing Table 15-23, page 449. However, he indicated that he could not provide an impairment rating related to deficits of the

[8] *Supra* note 3.

[9] Dr. Fried noted that the net impairment was determined by subtracting the baseline ROM impairment for the contralateral uninvolved index finger, which was 10 percent, yielding net impairment of 24 percent for the index finger.

ulnar nerve of each upper extremity. Dr. Fried referenced nerve studies from 2003, which showed some slowing of the ulnar nerve. He noted that, when testing was repeated at the proper temperature, the results did not reveal any ulnar nerve entrapment. Dr Fried further indicated that he could not find the October 31, 2019 EMG/NCV study, obtained by Dr. D'Auria, in the case record provided by OWCP. He found that appellant had reached maximum medical impairment (MMI), and calculated 7 percent permanent impairment of the left upper extremity and 11 percent permanent impairment of the right upper extremity.

On November 17, 2022 OWCP referred appellant's case to Dr. Katz, serving as a DMA. In a November 24, 2022 report, Dr. Katz discussed his review of the medical record and concurred with Dr. Fried's conclusions on the extent of appellant's permanent impairment. He noted the diagnosis of bilateral shoulder sprain, painful injury, and calculated two percent permanent impairment of each upper extremity for this diagnosed condition. Dr. Katz indicated that Dr. Fried opined that, based on the significant variability of the shoulder ROM measurements upon comparison with prior examinations, the most recent ROM examination would be considered unreliable and only the DBI method could be used. With regard to the diagnosis of bilateral median nerve entrapment, he referenced Table 15-23 of the sixth edition of the A.M.A., *Guides*, and found five percent permanent impairment of each upper extremity. With regard to the accepted right finger injury, Dr. Katz determined a higher impairment rating based on the use of the amputation grid for the right distal tuft amputation. He calculated 30 percent impairment of the right index finger which converted to 5 percent permanent impairment of the right upper extremity. Dr. Katz indicated that the DBI method resulted in greater impairment. He concluded that appellant had 7 percent permanent impairment of the left upper extremity and 12 percent permanent impairment of the right upper extremity. Dr. Katz opined that, since the present impairment rating did not exceed the prior overlapping award of 11 percent permanent impairment of the left upper extremity and 16 percent permanent impairment of the right upper extremity, there was no net additional award due to appellant for permanent impairment of the upper extremities.

By decision dated November 29, 2022, OWCP denied appellant's claim for an additional schedule award, based on the opinion of Dr. Katz, the DMA, which represented the weight of the medical opinion evidence.

On December 20, 2022 appellant requested reconsideration. In an accompanying statement, he disagreed with the November 29, 2022 decision, asserting that Dr. D'Auria's March 4, 2021 report was not properly considered by Dr. Fried. Appellant further asserted that he had tears in his shoulders, which should have been accepted by OWCP and considered in the impairment rating determination. He resubmitted February 26, 2021 MRI scans of both shoulders and Dr. D'Auria's March 4, 2021 report.

By decision dated February 16, 2023, OWCP denied modification of its November 29, 2022 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[10] and its implementing regulations[11] 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 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.[12] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[13] 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.[14]

In addressing upper extremity impairments, the sixth edition requires identification of the class of diagnosis (CDX), which is then adjusted by grade modifiers or grade modifier for functional history (GMFH), grade modifier for physical examination (GMPE), and grade modifier for clinical studies (GMCS).[15] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16] 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.[17]

The A.M.A., *Guides* also provide that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[18] 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.[19] Adjustments for functional history may be made if the evaluator

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] *Id.*, *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

[14] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

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

[16] *Id.* at 411.

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

[18] *Id.* at 461.

[19] *Id.* at 473.

determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[20]

Regarding the application of ROM or DBI methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "As the [A.M.A.,] *Guides* caution that, if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
>
> "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*."[21] (Emphasis in the original.)

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[22] In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories Test Findings, History, and Physical Findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[23]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[24]

ANALYSIS

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

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[20] *Id.* at 474.

[21] FECA Bulletin No. 17-06 (issued May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[22] A.M.A., *Guides* 449, Table 15-23. *See also L.G.*, Docket No. 18-0065 (issued June 11, 2018).

[23] *Id.* at 448-49.

[24] *See supra* note 13 at Chapter 2.808.6(f) (March 2017). *See also P.W.*, Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan*, 57 ECAB 349 (2006).

Initially, the Board notes that it is unnecessary to consider the evidence appellant submitted prior to the issuance of OWCP's May 19, 2021 decision, which was considered by the Board in its August 24, 2022 decision. Findings made in prior Board decisions are *res judicata* absent further merit review by OWCP under section 8128 of FECA.[25]

Following the Board's remand in this case, OWCP referred appellant for a second opinion evaluation with Dr. Fried on November 2, 2022. Dr. Fried provided findings on examination and determined that appellant had reached MMI. He found four percent permanent impairment of the right upper extremity due to the right index finger injury, pursuant to Figure 15-13, page 462, and Table 15-31, page 470, of the sixth edition of the A.M.A., *Guides*. With regard to the shoulders, Dr. Fried utilized the DBI method for the diagnosis of sprain, painful injury, and calculated two percent impairment of each upper extremity. He opined that appellant had five percent permanent impairment of each upper extremity for median nerve entrapment by referencing Table 15-23, page 449. However, Dr. Fried noted that he could not rate the ulnar nerves because EMG/NCV studies had not been provided to him for review. He indicated that there were nerve studies from 2003, which showed slowing of the ulnar nerve, but noted that the results did not reveal any ulnar nerve entrapment when testing was repeated at the proper temperature. Dr. Fried further noted that he could not find the EMG/NCV study dated October 31, 2019 in the documents provided by OWCP, and he failed to indicate knowledge of a November 17, 2020 EMG/NCV study, which revealed bilateral ulnar neuropathies at the elbows. He advised that complete records had not been provided to him for review.

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.[26] 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.[27]

In a situation where OWCP secures an opinion from a second opinion physician and the opinion from such second opinion physician requires clarification or elaboration, it has the responsibility to secure a supplemental report from the physician for the purpose of correcting the defect in the original opinion.[28]

The Board finds that, while Dr. Fried addressed appellant's permanent impairment rating, he clearly noted that appellant's entire medical record, including all diagnostic studies, was not

[25] *C.M.*, Docket No. 19-1211 (issued August 5, 2020); *Clinton E. Anthony, Jr.*, 49 ECAB 476, 479 (1998).

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

[27] *Id.*; *see also S.A.*, Docket No. 18-1024 (issued March 12, 2020).

[28] *See M.F.*, Docket No. 23-0881 (issued December 6, 2023); *G.T.*, Docket No. 21-0170 (issued September 29, 2021); *Ayanle A. Hashi*, 56 ECAB 234 (2004) (when OWCP refers a claimant for a second opinion evaluation and the report does not adequately address the relevant issues, OWCP should secure an appropriate report on the relevant issues).

provided for his review. OWCP should have referred the entire medical record, including all diagnostic reports and/or studies to Dr. Fried, once he noted this discrepancy.[29]

On remand, OWCP shall refer appellant's entire medical record to Dr. Fried and request that he provide a supplemental opinion regarding appellant's permanent impairment pursuant to the sixth edition of the A.M.A., *Guides*. If Dr. Fried is unable to clarify or elaborate on his original report, or if his supplemental report is also vague, speculative or lacks rationale, OWCP must submit the case record, together with a detailed SOAF to a second OWCP referral physician for a rationalized medical opinion on the issue in question.[30] After completing such development relating to obtaining a second opinion, OWCP should refer appellant's case to a DMA for an opinion on permanent impairment. After this and such other further development deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[29] *Id*.

[30] *S.F.*, Docket No. 23-0509 (issued January 24, 2024); *D.W.*, Docket No. 20-0674 (issued September 29, 2020).

ORDER

IT IS HEREBY ORDERED THAT the February 16, 2023 and November 29, 2022 decisions of the Office of Workers' Compensation Programs are set aside, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: April 1, 2024
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board