

cervical radiculitis, C5-6 pseudarthrosis, brachial neuritis, and adhesive capsulitis of the right shoulder due to repetitive lifting while handling mail.²

On June 4, 2012 Dr. E. William Kennen, Jr., an attending osteopathic physician Board-certified in orthopedic surgery, diagnosed cervical degenerative disc disease with myelopathy. Appellant performed modified duty and participated in physical therapy.

Dr. Charles A. Wetherington, an attending Board-certified neurosurgeon, held appellant off work in November 2012. OWCP issued compensation for intermittent work absences. Appellant underwent a series of epidural steroid injections in January and March 2013.³ Dr. Wetherington held appellant off work beginning July 26, 2013 and OWCP paid him compensation for temporary total disability beginning July 27, 2013.

On September 6, 2013 Dr. Wetherington performed an anterior C5-6 discectomy and fusion with decompression of the spinal cord and nerve roots, plate fixation, and bone allograft.⁴ OWCP authorized the procedure and paid wage-loss compensation through July 29, 2014, when appellant returned to full-time modified duty.

On August 29, 2014 OWCP obtained a second opinion regarding appellant's work capacity from Dr. Robert Sciortino, a Board-certified orthopedic surgeon. Dr. Sciortino opined that appellant could perform full-time restricted duty, with lifting limited to 10 pounds using the right upper extremity. Dr. Wetherington limited appellant to lifting 15 pounds as of September 5, 2014. Appellant underwent additional epidural steroid injections. He stopped work on October 4, 2014 as the employing establishment did not have work available within his restrictions. OWCP paid wage-loss compensation.

Dr. W. Chris Kostman, an attending Board-certified orthopedic surgeon, diagnosed right shoulder adhesive capsulitis on January 1, 2015, consequential to the accepted cervical spine conditions.⁵

Appellant returned to full-time limited duty on March 17, 2015.

Dr. Kostman performed closed manipulation of the right shoulder under general anesthesia on March 30, 2015, authorized by OWCP. In a May 27, 2015 report, he opined that appellant's right shoulder had attained maximum medical improvement (MMI). Dr. Kostman observed forward flexion at 175 degrees, abduction at 90 degrees, and external rotation at 60 degrees.

² A May 17, 2012 magnetic resonance imaging (MRI) scan of the right shoulder showed acromioclavicular arthropathy and anterior supraspinatus tendinopathy. A May 30, 2012 cervical MRI scan showed mild cervical spondylosis most pronounced at C5-6. May 30, 2012 electromyography and nerve conduction velocity studies showed right-sided C5-6 cervical radiculopathy.

³ A March 29, 2013 cervical MRI scan showed mild cervical spondylosis most pronounced at C5-6.

⁴ A June 10, 2014 cervical MRI showed postoperative changes at C5-6, and increased disc bulging at C6-7.

⁵ A January 16, 2015 MRI scan of the right shoulder demonstrated mild supraspinatus tendinopathy without a rotator cuff tear.

On June 23, 2015 appellant filed a claim for a schedule award (Form CA-7). In a June 29, 2015 letter, OWCP notified him of the additional evidence needed to establish his schedule award claim, including a report from his attending physician supporting that he had attained MMI, the diagnosis on which the permanent impairment is based, a detailed description of the permanent impairment, and an impairment rating calculated according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).⁶ Appellant was afforded 30 days to submit such evidence. He did not submit the evidence within the allotted time.

On September 24, 2015 OWCP obtained a second opinion from Dr. Richard T. Katz, a Board-certified physiatrist. Dr. Katz reviewed the medical record and a statement of accepted facts, and obtained a *QuickDASH* score of appellant of 61. On examination he observed restricted cervical motion inconsistent with a one-level fusion, mild weakness in the right biceps, mildly diminished reflexes, subjective numbness in all fingers of the right hand, and a positive Phalen's maneuver on the right indicative of carpal tunnel syndrome. Dr. Katz found the following ranges of right shoulder motion after a warm-up: 120 degrees flexion; and 50 degrees extension; 90 degrees internal rotation; 90 degrees external rotation; 120 degrees abduction; 50 degrees adduction. Appellant reported pain with range of motion (ROM) testing. Dr. Katz opined using the ROM method that appellant had attained MMI regarding the cervical spine and right shoulder. Referring to Table 15-34 of the A.M.A., *Guides*,⁷ he noted three percent impairment for loss of flexion, and three percent impairment for loss of abduction. Dr. Katz assessed a grade 1 modifier for restricted motion, and assessed a 10 percent increase for a grade 3 *QuickDASH* score. He added these elements to equal seven percent permanent impairment of the right arm due to the accepted right shoulder conditions. Dr. Katz then referred to the July/August 2009, *The Guides Newsletter*, finding a grade 1 modifier for findings on physical examination due to mild weakness and reflex loss in the C5-6 nerve distribution with mild sensory loss. He found 9 percent permanent impairment of the right upper extremity due to mild motor deficit, resulting in 11 percent permanent impairment of the right upper extremity attributable to the cervical spine.

On October 8, 2015 an OWCP medical adviser reviewed Dr. Katz' impairment rating and opined that he misapplied the A.M.A., *Guides*. He found the ROM measurements were invalid as it was unclear whether Dr. Katz appropriately addressed loss of ROM. Therefore, the medical adviser used the diagnosis-based impairment (DBI) rating method, assessing a grade 1 impairment for tendinitis, with a default of three percent. He found a grade modifier for Functional History (GMFH) of 3, a Physical Examination (GMPE) of 1, and noted that there were no appropriate studies on which to base a grade modifier for Clinical Studies (GMCS). Applying the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or (3-1) + (1-1) the medical adviser found a net modifier of plus two, raising the default CDX from three to five percent. He commented that the numbness appellant reported in all five fingers of the right hand was nonanatomic and should not be included in the impairment rating. The medical adviser explained that Dr. Katz should not have applied the *QuickDASH* score to both the ratings for the right shoulder and cervical radiculopathy. He opined that there was no

⁶ A.M.A., *Guides* (6th ed. 2009).

⁷ Table 15-34, page 475 of the sixth edition of the A.M.A., *Guides* is titled "Shoulder Range of Motion."

applicable net modifier for appellant's cervical radiculopathy, leaving the default value at four percent, with an additional one percent impairment for residuals of C5 radiculopathy. The medical adviser therefore found 5 percent permanent impairment of the right arm due to cervical radiculopathy, combined with 5 percent permanent impairment due to adhesive capsulitis, for a total of 10 percent permanent impairment of the right upper extremity.

By decision dated November 24, 2015, OWCP issued a schedule award for 10 percent permanent impairment of the right arm with 5 percent due to cervical radiculopathy and 5 percent due to adhesive capsulitis. The award was based on an OWCP medical adviser's review of Dr. Katz' findings. OWCP found that because the medical adviser observed that Dr. Katz failed to properly assess loss of ROM, he properly used the DBI method.

LEGAL PRECEDENT

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to implement the FECA program with the Director of OWCP.⁸ Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.⁹ FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of 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

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment*." The document included various changes to the original text, intended to serve as an *erratum*/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

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

⁸ See 20 C.F.R. §§ 1.1-1.4.

⁹ For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

¹⁰ 20 C.F.R. § 10.404. 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 (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

¹² *Isidoro Rivera*, 12 ECAB 348 (1961).

ANALYSIS

The issue on appeal is whether OWCP properly determined that appellant had 10 percent permanent impairment of the right upper extremity, for which he previously received a schedule award. Dr. Katz, a second opinion physician and Board-certified physiatrist, opined that according to the ROM rating method of the A.M.A., *Guides*, the accepted injuries caused 7 percent permanent impairment of the right arm due to limited motion, with an additional 11 percent impairment due to cervical radiculopathy pursuant to *The Guides Newsletter*. In contrast, an OWCP medical adviser found that appellant had 10 percent permanent impairment of the right arm, combining 5 percent impairment using the DBI rating method for the shoulder, and 5 percent impairment of the right arm due to cervical radiculopathy. He excluded ROM as a rating element. OWCP issued its November 24, 2015 schedule award for 10 percent permanent impairment of the right upper extremity, relying on the medical adviser's opinion.

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

The Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation has been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.¹³ The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.¹⁴ In *T.H.*, the Board concluded that OWCP physicians are at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board has observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians are inconsistent in the application of the A.M.A., *Guides*, the Board finds that OWCP can no longer ensure consistent results and equal justice under the law for all claimants.¹⁵

In light of the conflicting interpretation by OWCP of the sixth edition with respect to upper extremity impairment ratings, it is incumbent upon OWCP, through its implementing regulations and/or internal procedures, to establish a consistent method for rating upper extremity impairment. In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the November 24, 2015 decision. Following OWCP's development of a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and such other development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an upper extremity schedule award.

¹³ *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

¹⁴ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

¹⁵ *Supra* note 13.

On appeal, appellant contends that OWCP should rely on Dr. Katz' ROM measurements as they were taken after the required warm up. As set forth above, the case is not in posture for a decision and will be remanded for additional development.

CONCLUSION

The Board finds this case not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the November 24, 2015 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: April 19, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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