

reflex sympathetic dystrophy (RSD) syndrome of the right upper extremity while pushing a wire mail cage. Appellant did not stop work at the time of injury.

In a June 13, 2013 report, Dr. Jesse E. Seidman, an attending Board-certified orthopedic surgeon, diagnosed an acromioclavicular sprain of the right shoulder with rotator cuff and biceps tendinitis.² He provided progress notes through November 4, 2013, recommending arthroscopic surgery as conservative measures had failed to improve appellant's symptoms and functioning. Dr. Seidman held appellant off work as of November 10, 2013. Appellant received wage-loss compensation benefits beginning on November 19, 2013.

On December 18, 2013 Dr. Seidman performed arthroscopic debridement of the subscapularis, arthroscopic subacromial decompression, biceps tenotomy, arthroscopic Mumford procedure, and arthroscopic double row rotator cuff repair, as approved by OWCP. Appellant remained off work and received compensation on the daily and periodic rolls. She underwent a series of stellate ganglion blocks in 2014. Dr. Seidman released appellant to light duty as of August 14, 2014. She returned to work on August 18, 2014.

On August 26, 2014 OWCP obtained a second opinion from Dr. Eric S. Furie, a Board-certified orthopedic surgeon. He reviewed the medical record and a statement of accepted facts. Dr. Furie found active residuals of accepted RSD syndrome, with limited motion of the right wrist and hand, as well as right shoulder weakness. He restricted appellant to lifting no more than 20 pounds with her right arm and limited reaching above shoulder level with the right upper extremity. Dr. Furie noted that appellant would reach maximum medical improvement as of December 18, 2014, one year after surgery.

On January 21, 2015 appellant filed a claim for a schedule award (Form CA-7). In support of her claim, she provided a January 12, 2015 report from Dr. Seidman, noting active abduction and forward flexion of the right shoulder at 140 degrees, external rotation at 40 degrees, internal rotation at 30 degrees, and extension at 50 degrees. He found good motion of the right wrist, slight atrophy in the right hand, and range of motion of the proximal interphalangeal and metacarpophalangeal joints limited to 90 degrees.

An OWCP medical adviser reviewed Dr. Seidman's report on February 4, 2015. He found that appellant had attained maximum medical improvement as of December 18, 2014, one year after arthroscopic right shoulder surgery. Referring to Table 15-34 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*),³ he found, utilizing the range of motion methodology, three percent impairment of the right upper extremity due to forward elevation limited to 140 degrees, three percent impairment due to shoulder abduction limited to 140 degrees, four percent impairment due to internal rotation limited to 30 degrees, and two percent impairment for

² An October 31, 2013 magnetic resonance imaging (MRI) scan of the right shoulder demonstrated acromioclavicular impingement, full thickness anterior supraspinatus tendon tear, full thickness superior subscapularis tear, infraspinatus tendinosis, a partial tear and dislocation of the biceps tendon, a superior labrum anterior and posterior tear of the glenoid labrum, and subacromial bursitis.

³ A.M.A., *Guides* 475, Table 15-34 (sixth edition) is entitled "Shoulder Range of Motion."

external rotation limited to 40 degrees. The medical adviser combined these percentages to equal 12 percent permanent impairment of the right upper extremity.

In a March 2, 2015 letter, Dr. Seidman found that appellant had attained maximum medical improvement as of January 12, 2015. He opined that appellant had 18 percent permanent impairment of the right upper extremity according to unspecified portions of the A.M.A., *Guides*.

An OWCP medical adviser reviewed Dr. Seidman's report on April 10, 2015 and concurred that appellant had 18 percent permanent impairment of the right upper extremity due to limited right shoulder and finger motion. She found that it was appropriate to use the range of motion rating method as opposed to a diagnosis-based impairment (DBI) methodology, because appellant's RSD syndrome manifested itself primarily through limited shoulder and hand motion.

By decision dated May 5, 2015, OWCP granted appellant a schedule award for 18 percent permanent impairment of the right upper extremity. The period of the award ran from January 12, 2015 to February 9, 2016.

In a May 18, 2015 letter, appellant requested a telephonic oral hearing, held before an OWCP hearing representative on December 15, 2015. At the hearing, she described continued limited motion in her right hand and shoulder. Appellant's husband presented information and quoted newspaper articles about RSD syndrome. Appellant submitted photographs illustrating her limited hand motion, including the inability to make a fist with her right hand. Following the hearing, she submitted a January 12, 2015 report from Dr. Seidman, releasing her to full duty, and physical therapy notes.

By decision dated March 2, 2016, OWCP's hearing representative affirmed OWCP's May 5, 2015 schedule award determination, finding that the additional evidence submitted did not establish that appellant sustained greater than 18 percent permanent impairment of the right upper extremity.

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.⁴ 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.⁵ 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

⁴ See 20 C.F.R. §§ 1.1-1.4.

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

regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.⁶

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).⁷ 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.⁸

ANALYSIS

The issue on appeal is whether appellant has established greater than 18 percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

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 range of motion methodology when assessing the extent of permanent impairment for schedule award purposes.⁹ The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.¹⁰ 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 range of motion 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 range of motion or DBI methodology. Because OWCP’s

⁶ 20 C.F.R. § 10.404. See also *Ronald R. Kraynak*, 53 ECAB 130 (2001).

⁷ 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).

⁸ *Isidoro Rivera*, 12 ECAB 348 (1961).

⁹ *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

¹⁰ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

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.¹¹

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 March 2, 2016 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.

CONCLUSION

The Board finds this case not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the March 2, 2016 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 11, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

¹¹ *Supra* note 9.