

developmental dislocation of the right shoulder joint, due to pushing and pulling mail containers on and off trailers.²

Dr. Raymond R. Gibbons, an attending Board-certified general surgeon, diagnosed a right rotator cuff tear on October 29, 2014. Appellant participated in physical therapy through January 2015. On February 5, 2015 x-rays of the right shoulder showed a suspected inferior subluxation of the humerus without frank dislocation.

Dr. Gregg T. Podleski, an attending Board-certified orthopedic surgeon, diagnosed a complete right rotator cuff rupture on March 4, 2015. On April 10, 2015 he performed an arthroscopic repair of a full-thickness right rotator cuff tear, anterior Bankart repair with anchor fixation, and repair of a superior labral tear from anterior to posterior tear. OWCP authorized the procedure. Appellant received wage-loss compensation for temporary total disability. Dr. Podleski released him to full-time light-duty employment effective August 17, 2015. Appellant participated in physical therapy through March 2016.

On April 6, 2016 appellant filed a claim for a schedule award (Form CA-7). In an April 25, 2016 letter, OWCP notified appellant of the additional evidence needed to establish his schedule award claim, including a report from his attending physician supporting that he had attained maximum medical improvement, 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*).³ Appellant was afforded 30 days to submit such evidence.

In response, appellant submitted an April 1, 2016 impairment evaluation by Dr. Mike Shah, an attending Board-certified physiatrist. Dr. Shah reviewed a history of injury and treatment, noting that appellant had attained maximum medical improvement. He observed restricted ranges of motion (ROM) using the ROM methodology and calculated corresponding percentages of upper extremity impairment according to Table 15-34⁴ of the A.M.A., *Guides*: three percent for flexion at 140 degrees; one percent for extension at 30 degrees; two percent for internal rotation 60 degrees; two percent for external rotation at 50 degrees; three percent for abduction at 135 degrees; and one percent for adduction at 28 degrees. Dr. Shah added these percentages to equal 12 percent permanent impairment of the right arm.

An OWCP medical adviser reviewed Dr. Shah's impairment rating on May 3, 2016 and opined that it should be disregarded as it was based on the ROM loss in the shoulder. He instead recommended a diagnosis-based impairment rating of seven percent according to Table 15-5

² A September 15, 2014 magnetic resonance imaging (MRI) scan of the right shoulder showed a near full-thickness tear of the anterior supraspinatus tendon, subscapularis tendinosis with partial tearing of insertional fibers, and degenerative tearing of the superior labrum.

³ A.M.A., *Guides* (6th ed.).

⁴ Table 15-34, page 475 of the sixth edition of the A.M.A., *Guides* is titled "Shoulder Range of Motion."

resulting from a full-thickness rotator cuff tear with residuals and the grade 2 modifiers for physical examination and clinical studies.⁵

Dr. Shah responded by June 10, 2016 letter, contending that the diagnosis-based method of calculating permanent impairment was inappropriate as it required a normal ROM. He also noted that OWCP's medical adviser did not rate appellant's right shoulder dislocation, which equaled 13 percent permanent upper extremity impairment according to Table 15-5.

OWCP's medical adviser responded with a July 29, 2016 letter, contending that Dr. Shah's methodology was incorrect. He reiterated that appellant had seven percent permanent impairment of the right upper extremity using the diagnosis-based impairment method.

By decision dated August 16, 2016, OWCP issued a schedule award for seven percent permanent impairment of the right upper extremity, based on OWCP's medical adviser's review of Dr. Shah's clinical findings.

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.⁶ 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.⁷ 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.⁸

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.

⁵ Table 15-5, page 403 of the sixth edition of the A.M.A., *Guides* is titled "Shoulder Regional Grid: Upper Extremity Impairments."

⁶ See 20 C.F.R. §§ 1.1-1.4.

⁷ For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

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

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

ANALYSIS

The issue on appeal is whether appellant had more than seven percent permanent impairment of the right upper extremity, for which he previously received a schedule award. Dr. Shah, an attending Board-certified physiatrist, opined that according to the ROM rating method of the A.M.A., *Guides*, the accepted injuries caused 13 percent permanent impairment of the right arm. In contrast, an OWCP medical adviser found that appellant had seven percent permanent impairment of the right upper extremity, using the diagnosis-based impairment rating method. OWCP issued its August 16, 2016 schedule award for seven percent permanent impairment of the right arm, relying on the OWCP medical adviser's use of the diagnosis-based impairment rating method.

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 diagnosis-based impairment or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.¹¹ The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.¹² 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 diagnosis-based impairment 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 diagnosis-based impairment 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.¹³

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

⁹ 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).

¹⁰ *Isidoro Rivera*, 12 ECAB 348 (1961).

¹¹ *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

¹² *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

¹³ *Supra* note 11.

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 August 16, 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 August 16, 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 13, 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