

bicep tendon strain, and partial tear of right rotator cuff tendon. The claim was subsequently expanded to include sprain of the shoulder and upper arm, subscapularis right.

On October 25, 2013 appellant underwent a magnetic resonance imaging (MRI) scan of his right shoulder. The results of the scan indicated that he had a partial thickness tearing of the anterior supraspinatus attachment along the articular surface, longitudinal splitting and tendinosis in the distal subscapularis attachment and a degenerative superior labral tear from anterior to posterior (SLAP) tear.

On January 30, 2014 appellant underwent right shoulder surgery for diagnostic arthroscopy and subscapular tear repair. Dr. Bruce E. Thomas, Board-certified in orthopedic surgery, performed the procedure, which had been authorized by OWCP.

On June 11, 2014 appellant filed a claim for a schedule award (Form CA-7).

In a June 12, 2014 report, Dr. William Brandt, Board-certified in orthopedic surgery, found that, under the sixth edition of the American Medical Association, *Guides to Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),² appellant had 12 percent permanent impairment of his right upper extremity using the range of motion (ROM) methodology to rate loss of ROM in the right shoulder. He relied on Table 15-34 (Shoulder ROM) on page 475 of the A.M.A., *Guides* to find that appellant had 3 percent upper extremity impairment for loss of right shoulder flexion; 3 percent upper extremity impairment for loss of right shoulder abduction; 4 percent upper extremity impairment for loss of right shoulder internal rotation; and 2 percent upper extremity impairment for loss of right shoulder external rotation, which amounted to a total of 12 percent right upper extremity permanent impairment.

In an October 24, 2014 report, an OWCP medical adviser reviewed Dr. Brandt's June 12, 2014 report and found that appellant's right shoulder impairment rating should be based on the diagnosis-based impairment (DBI) methodology, as opposed to the ROM methodology. He claimed that the A.M.A., *Guides* indicates that the DBI method is the "preferred" rating method for the upper extremities and that the ROM method should be used only as a physical adjustment factor. The medical adviser noted that the A.M.A., *Guides* further provides that an impairment rating based upon the ROM methodology is to be used "only when no other approach is available." Based upon his understanding of the A.M.A., *Guides*, the medical adviser utilized the DBI method and relied on Table 15-5, page 402 (Shoulder Regional Grid), to find that appellant had a class 1 impairment for the diagnosis which yielded the highest impairment rating, partial thickness tear, based upon the right thickness shoulder region rotator cuff tear with residual dysfunction. Applying the net adjustment formula at section 15.3, pages 406-11 of the A.M.A., *Guides*, he found that the grade modifier at Table 15-7, page 406 for functional history was 1, for a mild problem, as appellant's *QuickDASH* score of 21 did not document that he had to perform functional modifications in order to achieve self-care activities. The medical adviser noted that the grade modifier for physical examination at Table 15-8, page 408 was 2, based on mild tenderness to palpation. He further noted that the grade modifier for clinical studies at Table 15-9, page 407-11 was 2, as the October 28, 2013 MRI scan showed a partial thickness tear in the anterior supraspinatus attachment along the articular surface, with longitudinal

² A.M.A., *Guides* (6th ed. 2009).

splitting and tendinosis in the distal subscapularis attachment and degenerative SLAP tear in the superior labrum.

Pursuant to the net adjustment formula set forth at Table 15-21, pages 409-11, OWCP's medical adviser determined that appellant had an adjusted, default grade E impairment, which yielded a rating of five percent permanent impairment of the right upper extremity at Table 15-5, page 402 of the A.M.A., *Guides*.

By decision dated October 30, 2014, OWCP granted appellant a schedule award for five percent permanent impairment of his right upper extremity. The date of maximum medical improvement was noted as June 12, 2014 and the award ran from June 12 to September 29, 2014, for a total of 15.6 weeks of compensation.

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.³ 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.⁴ 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.⁵

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).⁶ 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.

³ See 20 C.F.R. §§ 1.1-1.4.

⁴ For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

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

⁶ 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 & Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

ANALYSIS

The issue on appeal is whether appellant has established more than five percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

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

OWCP accepted the conditions of right rotator cuff sprain, right bicep tendon strain, partial tear of right rotator cuff tendon, and right subscapularis tear. Following surgery to repair the tears in appellant's right shoulder, his treating physician, Dr. Brandt, found that appellant had 12 percent permanent impairment of his right upper extremity based on the ROM methodology for rating upper extremity permanent impairment. OWCP's medical adviser, however, found that appellant had five percent right upper extremity impairment, noting that the DBI method is the preferred rating method under the A.M.A., *Guides*.

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 had been followed regarding the proper use of the DBI or ROM methodology when assessing the extent of permanent impairment for schedule award purposes.⁷ The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.⁸ In *T.H.*, the Board concluded that OWCP physicians were 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 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 found that OWCP could no longer ensure consistent results and equal justice under the law for all claimants.⁹

In order to ensure a consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the October 30, 2014 decision. Utilizing a consistent method for calculating permanent impairment for upper extremities applied uniformly, and after 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.¹⁰

CONCLUSION

The Board finds this case not in posture for decision.

⁷ *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

⁸ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

⁹ *Supra* note 7.

¹⁰ *See* FECA Bulletin No. 17-0006 (issued May 8, 2017).

ORDER

IT IS HEREBY ORDERED THAT the October 30, 2014 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision.

Issued: December 20, 2017
Washington, DC

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

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board