

ISSUE

The issue is whether appellant has more than a four percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On October 7, 2011 appellant, then a 48-year-old letter carrier, alleged that she sustained a left shoulder injury as a result of lifting mail while performing a delivery on October 3, 2011. By decision dated January 27, 2012, OWCP accepted the claim for adhesive capsulitis of the shoulder. Appellant sought treatment with Dr. Joel Sorger, a Board-certified orthopedic surgeon, and underwent a left shoulder arthroscopic subacromial decompression and an acromioclavicular (AC) joint resection/decompression on April 16, 2012. Dr. Sorger released appellant to return to work with restrictions on July 16, 2012 and she returned to work the following day.

On October 23, 2012 appellant filed a claim for a schedule award (Form CA-7).

In a report dated December 8, 2012, Dr. Martin Fritzhand, Board-certified in urology, noted that forward flexion of appellant's left shoulder was diminished to 110 degrees, with extension diminished to 10 degrees. He further observed that abduction of her left shoulder was diminished to 95 degrees with adduction diminished to 20 degrees, and that internal rotation was diminished to 60 degrees with external rotation also diminished to 60 degrees. Citing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Fritzhand stated, "Maximum medical improvement [MMI] was met by November 2012. I used Table 15-5 impingement syndrome to assess impairment. However, if motion loss is present, this impairment may alternatively be assessed using Section 15-7, Range of Motion Impairment." He noted that range of motion (ROM) impairment stands alone and is not combined with diagnosis-based impairment (DBI). He reported that he had used Table 15-34 to assess impairment, with a *QuickDASH* score of 41.... Dr. Fritzhand provided an opinion that appellant has sustained a permanent partial impairment to the left upper extremity of 11 percent.

In an undated report received on January 4, 2013, Dr. Sorger released appellant to work with no restrictions.

By letter dated April 1, 2013, OWCP requested that Dr. Fritzhand explain why he used the ROM method of calculating appellant's permanent impairment and address her specific diagnosis. The letter noted that DBI is the preferred method of calculating permanent partial impairment under the A.M.A., *Guides*. OWCP also attached a statement of accepted facts to its letter for Dr. Fritzhand to review.

On April 8, 2013 Dr. Fritzhand responded to OWCP's April 1, 2013 letter. He noted that his specific diagnosis used for appellant's impairment rating was adhesive capsulitis of the left shoulder. Dr. Fritzhand explained his use of the ROM methodology to calculate appellant's permanent impairment rating:

"All shoulder grids [...] allow 'if motion loss is present this impairment may alternatively be assessed using Section 15.7, Range of Motion Impairment....' Section 15.7 specifically notes 'some of the [DBI] grids refer to the [ROM] section when that is the most appropriate mechanism for grading the impairment ... other conditions not addressed in the regional grids, but having significant functional loss.' The depressed [ROM] secondary to [appellant's] allowed condition is more accurately reflected by the [ROM] rating rather than by the [DBI] rating. The A.M.A., *Guides* certainly allow an examiner to use the [ROM] rating system as a way to reflect an accurate impairment rating in the face of substantial [ROM] loss. I should add that the [ROM] impairment rating is the preferred method of evaluation in this specific case."

OWCP routed the case file and reports of Dr. Fritzhand to a district medical adviser (DMA) on June 11, 2013. On the same date the DMA rendered a report, finding that appellant's final left upper extremity impairment was four percent. He noted that appellant's most impairing diagnosis was tendinitis in the left shoulder region. The DMA explained:

"On 11/23/2011 [appellant] underwent a left shoulder MRI [magnetic resonance imaging] scan [that] demonstrated mild capsulitis with effusion, moderate tendinopathy of the supraspinatus with no tear, moderate tendinopathy at the distal arcuate segment of the biceps long head tendon, no macrotear and Mild AC arthropathy. Based upon the most applicable diagnosis found in the [A.M.A., *Guides*], shoulder grid (Table 15-5) is tendinitis. This produced the mild-to-moderate tendinopathy observed on the left shoulder MRI scan. Therefore, the most impairing diagnosis in the LEFT shoulder is tendinitis and this will be used for final impairment calculations."

The DMA noted that Dr. Fritzhand had only documented one motion per joint movement in order to measure ROM, which rendered his ROM measurements invalid according to section 15.7, page 464 of the A.M.A., *Guides*. He also noted that the final net adjustment was 1, with a grade of D, and a date of MMI of April 8, 2013. The DMA explained that Dr. Fritzhand's date of MMI was incorrect, as the date of MMI is the date of the attending physician's evaluation without evidence to the contrary. He advised:

"[L]oss of motion may be used as an alternative to the DBI ratings only when there are no DBI ratings available and when the DBI is available, the ROM measurements may be used as an adjustment factor for physical exam[ination]." The DMA noted that the A.M.A., *Guides* "[s]ection 15.2, page 387 indicates, '[ROM] is used primarily as a physical examination adjustment factor and only to determine actual impairment values in the rare case when it is not possible to otherwise define impairment; this is a significant change from prior editions. ...

Page 481 #12 indicates Only if no other approach is available to rating, calculate impairment based on [ROM], as explained in [s]ection 15.7.”

The DMA noted that the diagnosis class for appellant was 1, her functional history adjustment was 2, her physical examination adjustment was 1, and her clinical studies adjustment was not applicable.

By decision dated February 3, 2014, OWCP granted appellant four percent permanent impairment of the left upper extremity. The date of MMI was determined to be April 8, 2013. The award covered a period of 12.48 weeks from April 8, 2013 through July 4, 2013.

On May 16, 2014 appellant, through a union representative, requested reconsideration of OWCP’s February 3, 2014 schedule award decision. In the letter accompanying her request for reconsideration, the representative argued that Dr. Fritzhand’s original permanent impairment rating of 11 percent should be used as the basis for appellant’s schedule award.

By decision dated July 30, 2014, OWCP evaluated the merits of appellant’s case and affirmed its prior decision of February 3, 2014. It found that the weight of the medical evidence remained with the DMA, as Dr. Fritzhand had used the “less-preferred” ROM method and that his ROM measurements were invalid in any event, as he did not follow proper procedures for measuring ROM according to the A.M.A., *Guides*.

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 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.

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).

⁶ 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).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 sustained more than a four percent permanent impairment of the upper left extremity for which she 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 ROM 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 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.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 June 30, 2014 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.

⁷ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (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).

¹¹ *Supra* note 9.

CONCLUSION

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

ORDER

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

Issued: March 29, 2017
Washington, DC

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

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

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