United States Department of Labor
Employees' Compensation Appeals Board

S.P., Appellant	)	
and	)	**Docket No. 17-1308**
	)	**Issued: January 2, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Dallas, TX, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 30, 2017 appellant filed a timely appeal from a December 5, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant met her burden of proof to establish more than two percent permanent impairment of her right lower extremity, for which she previously received a schedule award; and (2) whether appellant met her burden of proof to establish more than five percent permanent impairment of her left upper extremity, for which she previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On March 16, 2014 appellant, then a 65-year-old city letter carrier, filed an occupational disease claim (Form CA-2) alleging that over a period of time she sustained injury to her neck, shoulders, arms, wrists, and knees due to the lifting, pushing, twisting, walking, and climbing required by her work duties. She indicated that she first became aware of her claimed condition on February 11, 2014 and first realized on February 18, 2014 that it was caused or aggravated by factors of her federal employment. Appellant did not stop work around the time she filed her claim.

OWCP accepted that appellant sustained a sprain of her left shoulder/upper arm (rotator cuff), bilateral sprains of her shoulders/arms (unspecified sites), bilateral sprains of her knees (lateral collateral ligament), traumatic arthropathy of her lower right leg, and developmental dislocation of her right lower leg joint.

Beginning in February 2014, appellant participated in periodic physical therapy sessions targeting both her left shoulder and right knee.

On June 24, 2014 appellant stopped work and, on June 27, 2014, Dr. John L. McConnell, an attending Board-certified orthopedic surgeon, performed OWCP-authorized left shoulder surgery, including rotator cuff repair, arthroscopic capsulorraphy and repair of superior glenoid labrum tear, arthroscopic acromioplasty, and diagnostic arthroscopy of subacromial space with debridement.[2] She received disability compensation on the daily rolls beginning June 24, 2014 and on the periodic rolls beginning July 27, 2014.

On November 10, 2014 Dr. McConnell performed OWCP-approved right knee surgery, including arthroscopic partial medial meniscectomy, anterior cruciate ligament repair, arthroscopic retinacular/capsular ligament release, quadriceps tendon repair, and arthroscopic synovectomy of multiple compartments.

Beginning in mid-2015, Dr. Charles E. Willis, II, an attending Board-certified anesthesiologist, administered steroid injections to appellant's right knee.

On February 26, 2016 appellant filed a claim for a schedule award (Form CA-7). She submitted a February 1, 2016 report from Dr. Robert A. Helsten, an attending Board-certified family practitioner, who discussed her factual and medical history and reported the findings of the physical examination he conducted on that date.[3] Dr. Helsten noted that appellant walked with a noticeable limp and used a cane when she walked. He diagnosed left rotator cuff sprain, left shoulder sprain, and traumatic arthropathy of the right knee, and indicated that appellant had reached maximum medical improvement with respect to these conditions. Dr. Helsten rated the permanent impairment of appellant's left upper extremity and right lower extremity under the

[2] In the surgical report, Dr. McConnell described appellant's left rotator cuff tear as an "extensive/complete cuff tear."

[3] At the top of Dr. Helsten's report, the date of visit is listed as November 6, 2014, but other portions of the report show that Dr. Helsten conducted his examination on February 1, 2016.

standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

Dr. Helsten indicated that, per Table 15-5 (Shoulder Regional Grid) on page 403 of the A.M.A., *Guides*, he had selected appellant's left rotator cuff injury (full-thickness tear) to evaluate her left upper extremity permanent impairment. He found that this diagnosis fell under class 1 due to appellant's residual loss and noted that the condition had a default value of five percent impairment. Dr. Helsten determined that appellant had a functional history grade modifier of 2 (based on a *Quick*DASH score of 60) and a physical examination grade modifier of 1 (based on his findings for left shoulder motion).[5] He found that the clinical studies grade modifier was not applicable because he used clinical studies to make the diagnosis. Dr. Helsten noted that application of the net adjustment formula to the applicable grade modifiers required movement from the default value of five percent impairment on Table 15-5 to the six percent impairment value (one space to the right). Therefore, he concluded that appellant had six percent permanent impairment of her left upper extremity.

With respect to appellant's right lower extremity, Dr. Helsten determined that, under Table 16-3 (Knee Regional Grid) on page 509, appellant's diagnosis of right meniscal injury fell under class 1 due to her partial right medial meniscectomy and he noted that this condition had a default value of two percent impairment. He determined that appellant had a functional history grade modifier of 3 (based on a *Quick*DASH score of 32) and a physical examination grade modifier of 1 (based on his findings for right knee motion).[6] Dr. Helsten found that the clinical studies grade modifier was not applicable because he used clinical studies to make the diagnosis. He indicated that application of the net adjustment formula to the grade modifiers required movement from the default value of two percent impairment on Table 16-3 to the three percent impairment value (two spaces to the right). Therefore, appellant had three percent permanent impairment of her right lower extremity.

In a May 24, 2016 letter, OWCP requested that appellant submit additional factual and medical evidence in support of her schedule award claim. It indicated that Dr. Helsten impermissibly based his permanent impairment ratings on the range of motion (ROM) rating method rather than the diagnosis-based impairment (DBI) rating method.

Appellant submitted a June 6, 2016 report from Dr. Helsten who again provided an assessment of the permanent impairment of her left upper extremity and right lower extremity. Dr. Helsten provided the findings of a new physical examination of appellant that he performed on June 6, 2016.[7] He indicated that, under Table 15-5 of the sixth edition of the A.M.A., *Guides*, appellant's left rotator cuff injury (full-thickness tear) fell under class 1 due to her residual loss

[4] A.M.A., *Guides* (6th ed. 2009).

[5] Dr. Helsten indicated that appellant had 80 degrees of internal rotation, 30 degrees of external rotation, 80 degrees of flexion, 30 degrees of extension, 20 degrees of adduction, and 90 degrees of abduction.

[6] Dr. Helsten indicated that appellant had 80 degrees of flexion and -10 degrees of extension.

[7] At the top of Dr. Helsten's report, the date of visit is listed as November 6, 2014, but other portions of the report show that he conducted his examination on June 6, 2016. He again noted that appellant walked with a noticeable limp and used a cane when she walked.

and noted that this condition had a default value of five percent impairment. Dr. Helsten determined that appellant had a functional history grade modifier of 3 (based on a *Quick*DASH score of 80) and a physical examination grade modifier of 1 (based on his findings for left shoulder motion).[8] He found that the clinical studies grade modifier was not applicable because he used clinical studies to make the diagnosis. Dr. Helsten indicated that application of the net adjustment formula required movement from the default value of five percent impairment on Table 15-5 to the seven percent impairment value (two spaces to the right). Therefore, appellant had seven percent permanent impairment of her left upper extremity.

With respect to appellant's right lower extremity, Dr. Helsten determined that her right meniscal injury fell under class 1 due to her right partial medial meniscectomy and that the condition had a default value of two percent impairment under Table 16-3 (Knee Regional Grid) on page 509. He determined that appellant had a functional history grade modifier of 3 (based on a *Quick*DASH score of 32) and a physical examination grade modifier of 0 (based on his findings of normal right knee motion under Table 16-23 on page 549).[9] Dr. Helsten found that the clinical studies grade modifier was not applicable because he used clinical studies to make the diagnosis. Application of the net adjustment formula required movement from the default value of two percent impairment on Table 16-3 to the impairment value one space to the right, which also was two percent. Therefore, appellant had two percent permanent impairment of her right lower extremity.

In June 2016 OWCP referred appellant's case to Dr. Jovito Estaris, a Board-certified occupational medicine physician, for review in his capacity as an OWCP medical adviser. It requested that he review Dr. Helsten's reports and provide an opinion on the permanent impairment of appellant's left upper extremity and right lower extremity.

In an August 22, 2016 report, Dr. Estaris indicated that he reviewed Dr. Helsten's February 1 and June 6, 2016 impairment ratings. With respect to Dr. Helsten's February 1, 2016 impairment rating, Dr. Estaris provided a left upper extremity permanent impairment rating in accord with that provided by Dr. Helsten (six percent). He noted that, per Table 15-5 of the sixth edition of the A.M.A., *Guides,* appellant's left rotator cuff injury (full-thickness tear) fell under class 1 due to her residual loss and that the condition had a default value of five percent impairment. Dr. Estaris determined that appellant had a functional history grade modifier of 2 (based on a *Quick*DASH score of 60) and a physical examination grade modifier of 1 (based on the findings for left shoulder motion), and found that the clinical studies grade modifier was not applicable because clinical studies were used to make the diagnosis. Application of the net adjustment formula to the applicable grade modifiers required movement from the default value of five percent impairment on Table 15-5 to the six percent impairment value (one space to the right) and, therefore, appellant had six percent permanent impairment of her left upper extremity.

With respect to Dr. Helsten's February 1, 2016 impairment rating, Dr. Estaris provided an assessment of the permanent impairment of appellant's right lower extremity which differed from that of Dr. Helsten. Although Dr. Estaris also determined that appellant's partial right

[8] Dr. Helsten indicated that appellant had 70 degrees of internal rotation, 40 degrees of external rotation, 120 degrees of flexion, 40 degrees of extension, 40 degrees of adduction, and 80 degrees of abduction.

[9] Dr. Helsten indicated that appellant had 110 degrees of flexion and 0 degrees of extension.

medial meniscectomy fell under class 1 per Table 16-3, he opined that appellant had a functional history grade modifier of 2, rather than the value of 3 provided by Dr. Helsten.[10] He also found that the clinical studies grade modifier was not applicable because clinical studies were used to make the diagnosis. Application of the net adjustment formula required movement from the default value of two percent impairment on Table 16-3 to the impairment value one space to the right, which also was two percent. Therefore, appellant had two percent permanent impairment of her right lower extremity.

Dr. Estaris next evaluated Dr. Helsten's June 6, 2016 impairment rating. He provided an assessment of the permanent impairment of appellant's left upper extremity which differed from that provided by Dr. Helsten. Dr. Estaris agreed with Dr. Helsten that, per Table 15-5 of the sixth edition of the A.M.A., *Guides,* appellant's left rotator cuff injury (full-thickness tear) fell under class 1 due to her residual loss and that the condition had a default value of five percent impairment. He also agreed with Dr. Helsten's assessment that appellant had a physical examination grade modifier of 1 (based on the findings for left shoulder motion). However, Dr. Estaris found that the functional history grade modifier of 3 found by Dr. Helsten (based on a *Quick*DASH score of 80) was unreliable because it differed by two grades from the physical examination grade modifier.[11] He excluded the functional history grade modifier from the net adjustment formula calculation.[12] Application of the net adjustment formula to the applicable grade modifiers resulted in no movement from the default value of five percent impairment on Table 15-5 and, therefore, appellant had five percent permanent impairment of her left upper extremity.

Although Dr. Estaris provided a different calculation of the permanent impairment of appellant's left upper extremity than Dr. Helsten did on June 6, 2016, he concurred with the two percent permanent impairment of her right lower extremity based on the June 6, 2016 findings. He agreed with Dr. Helsten that appellant's partial right medial meniscectomy fell under class 1 per Table 16-3. Dr. Estaris indicated that he also agreed with Dr. Helsten that, on June 6, 2016, appellant had a physical examination grade modifier of 0 because her right knee motion had improved to the point that it was normal. However, he found that the functional history grade modifier of 3 found by Dr. Helsten (based on a *Quick*DASH score of 34) was unreliable because it differed by three grades from the physical examination grade modifier. Dr. Estaris excluded the functional history grade modifier from the net adjustment formula calculation.[13] Application of the net adjustment formula required movement from the default value of two percent impairment on Table 16-3 to the impairment value one space to the left, which also was two

[10] Dr. Estaris referenced Table 16-6 (Functional History Adjustment -- Lower Extremities) on page 516 and noted that appellant had an antalgic gait and used a cane.

[11] Dr. Estaris indicated that the text on pages 406 and 407 of the sixth edition of the A.M.A., *Guides* provides that, if the grade for functional history differs by two or more grades from that described by physical examination or clinical studies, the functional history should be assumed to be unreliable. If the functional history is determined to be unreliable or inconsistent with other documentation, it is excluded from the grading process. *See* A.M.A., *Guides* 406-07.

[12] Dr. Estaris also found that the clinical studies grade modifier was not applicable because clinical studies were used to make the diagnosis.

[13] Dr. Estaris again found that the clinical studies grade modifier was not applicable because clinical studies were used to make the diagnosis.

percent. Therefore, appellant had two percent permanent impairment of her right lower extremity.[14]

In a December 5, 2016 decision, OWCP granted appellant a schedule award for five percent permanent impairment of her left upper extremity and two percent permanent impairment of her right lower extremity. The award ran from June 6 to November 2, 2016 and was based on Dr. Estaris' August 22, 2016 evaluation of the June 6, 2016 findings of Dr. Helsten.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA[15] and its implementing regulation[16] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[17] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[18]

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the knee, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[19] After the Class of Diagnosis (CDX) is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for Functional History (GMFH), grade modifier for Physical Examination (GMPE), and grade modifier for Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[20] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[21]

[14] Dr. Estaris indicated that appellant reached maximum medical improvement on June 6, 2016.

[15] 5 U.S.C. § 8107.

[16] 20 C.F.R. § 10.404.

[17] *Id*. *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (January 2010).

[18] *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).

[19] *See* A.M.A., *Guides* 509-11 (6th ed. 2009).

[20] *Id.* at 515-22.

[21] *Id.* at 23-28.

In some instances, OWCP's medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides*. In this instance, a detailed opinion by the medical adviser may constitute the weight of the medical evidence. As long as the medical adviser explains his or her opinion, shows values and computation of impairment based on the A.M.A., *Guides*, and considers each of the reported findings of impairment, his or her opinion may constitute the weight. If the attending physician misapplied the A.M.A., *Guides*, no conflict would exist because the attending physician's report would have diminished probative value and the opinion of the medical adviser would constitute the weight of medical opinion.[22]

ANALYSIS -- ISSUE 1

The Board will first consider whether appellant met her burden of proof to establish more than two percent permanent impairment of her right lower extremity, for which she previously received a schedule award.

OWCP accepted that appellant sustained bilateral sprains of her knees (lateral collateral ligament), traumatic arthropathy of her lower right leg, and developmental dislocation of her right lower leg joint. On February 26, 2016 appellant filed a claim for a schedule award (Form CA-7) due to her accepted work conditions. In a December 5, 2016 decision, OWCP granted appellant a schedule award for two percent permanent impairment of her right lower extremity.[23] The award was based on an August 22, 2016 evaluation by Dr. Estaris, an OWCP medical adviser.[24]

In an August 22, 2016 report, Dr. Estaris properly evaluated the findings contained in Dr. Helsten's June 6, 2016 report to find that appellant had two percent permanent impairment of her right lower extremity. He noted that appellant's partial right medial meniscectomy fell under class 1 per Table 16-3.[25] Dr. Estaris indicated that he agreed with Dr. Helsten that, on June 6, 2016, appellant had a physical examination grade modifier of 0 because her right knee motion had improved to the point that it was normal. He then properly found that the functional history grade modifier of 3 found by Dr. Helsten (based on a *Quick*DASH score of 34) was unreliable because it differed by three grades from the physical examination grade modifier of 0.[26] Dr. Estaris excluded the functional history grade modifier from the net adjustment formula

[22] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8j (September 2010); *M.P.*, Docket No. 14-1602 (issued January 13, 2015).

[23] In the same decision, OWCP also granted appellant a schedule award for five percent permanent impairment of her left upper extremity.

[24] OWCP relied on Dr. Estaris' impairment rating that was based on Dr. Helsten's latest June 6, 2016 findings.

[25] A.M.A., *Guides* 509, Table 16-3.

[26] *See* A.M.A., *Guides* 406-07. As properly noted by Dr. Estaris, the A.M.A., *Guides* provides that, if the grade for functional history differs by two or more grades from that described by physical examination or clinical studies, the functional history should be assumed to be unreliable. If the functional history is determined to be unreliable or inconsistent with other documentation, it is excluded from the grading process. *Id.*

calculation.[27] He properly noted that application of the net adjustment formula required movement from the default value of two percent impairment on Table 16-3 to the impairment value one space to the left, which also was two percent.[28] Therefore, Dr. Estaris found that appellant had two percent permanent impairment of her right lower extremity. OWCP properly found that the weight of the medical opinion evidence regarding the permanent impairment of appellant's right lower extremity rests with the opinion of Dr. Estaris.[29]

On appeal appellant argues that the schedule award she received for two percent permanent impairment of her right lower extremity did not adequately compensate her for her continuing right knee problems. However, the Board has explained why she received appropriate schedule award compensation for her right lower extremity permanent impairment. Appellant has not submitted any medical evidence showing that she has more than two percent permanent impairment of her right lower extremity.[30]

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

LEGAL PRECEDENT -- ISSUE 2

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 Director of OWCP.[31] 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.[32] 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

[27] Dr. Estaris again found that the clinical studies grade modifier was not applicable because clinical studies were used to make the diagnosis. *See supra* note 13 regarding application of the net adjustment formula.

[28] *Id.*

[29] Acting within his role as OWCP medical adviser, Dr. Estaris explained that Dr. Helsten had not properly applied the A.M.A., *Guides* in his June 6, 2016 impairment rating. *See supra* note 22 regarding the role of the OWCP medical adviser in schedule award cases. The Board notes that, although Dr. Helsten and Dr. Estaris provided different calculations of appellant's right lower extremity impairment, Dr. Helsten also found, in his June 6, 2016 report, that appellant had two percent permanent impairment of her right lower extremity.

[30] The record contains a February 1, 2016 report in which Dr. Estaris found that appellant had three percent permanent impairment of her right lower extremity. In addition to the fact that this assessment was based on examination findings which were older than those obtained on June 6, 2016, Dr. Estaris properly noted in his August 22, 2016 report that the functional history grade modifier of 3 found on February 1, 2016 was unreliable because it differed by two grades from the physical examination grade modifier of 1 found on that date. In evaluating the February 1, 2016 findings, he properly excluded the functional history grade modifier from the net adjustment calculation and found that appellant also had two percent permanent impairment of her right lower extremity at that time.

[31] *See* 20 C.F.R. §§ 1.1-1.4.

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

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.[33]

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).[34] 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.[35]

ANALYSIS -- ISSUE 2

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

The Board finds that this issue 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 had been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[36] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[37] 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 cited to language in the first printing or the second printing when justifying use of either the ROM or DBI methodology. Because OWCP's own physicians were 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.[38]

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[33] 20 C.F.R. § 10.404; *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[34] *See supra* note 18.

[35] *Isidoro Rivera*, 12 ECAB 348 (1961).

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

[37] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[38] *Supra* note 36.

In order to ensure a consistent result and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the December 5, 2016 decision with respect to the permanent impairment of appellant's left upper extremity. 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.[39]

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish more than two percent permanent impairment of her right lower extremity, for which she previously received a schedule award. The Board further finds that this case is not in posture for decision with respect to the permanent impairment of appellant's left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the December 5, 2016 decision of the Office of Workers' Compensation Programs is affirmed with respect to the permanent impairment of appellant's right lower extremity. The December 5, 2016 decision is set aside with respect to the permanent impairment of appellant's left upper extremity, and the case is remanded to OWCP for action consistent with this decision.

Issued: January 2, 2018
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

[39] *See* FECA Bulletin No. 17-06 (issued May 8, 2017).