United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 17-0530**
	)	**Issued: July 2, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Akron, OH, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 10, 2017 appellant, through counsel, filed a timely appeal from a December 1, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met his burden of proof to establish more than one percent permanent impairment of his right upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On August 7, 2004 appellant, then a 32-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he sustained an occupational disease due to carrying a mailbag on his right shoulder while delivering mail. He did not stop work, but he began working in a limited-duty position for the employing establishment without wage loss.

On August 13, 2004 OWCP initially accepted appellant's claim for cervical strain and right trapezius strain.

A March 13, 2006 magnetic resonance imaging (MRI) scan of appellant's cervical spine contained an impression of very minimal diffuse disc bulge with no central canal stenosis at C3-4, and mild neural foraminal narrowing at C3-4 and C6-7 secondary to small uncovertebral osteophytes.

On December 6, 2006 OWCP expanded the acceptance of the claim to include the conditions of cervical herniated disc at C6-7.

A February 21, 2007 MRI scan of appellant's cervical spine contained an impression of small right disc herniation at C6-7.

The findings of June 10, 2008 electromyogram (EMG) and nerve conduction velocity (NCV) testing of appellant's right upper extremity showed negative results for cervical radiculopathy, brachial plexus injury, and focal nerve entrapment. A July 31, 2009 MRI scan of his cervical spine contained an impression of small right herniation at C6-7 with associated mild compression of the proximal right C7 nerve root.

On August 28, 2009 OWCP expanded the acceptance of the claim to include the conditions of cervical radiculopathy and cervical disc disease at C6-7.[3]

Appellant stopped work on August 29, 2009 and he began receiving disability compensation on the periodic rolls.

On January 8, 2010 Dr. Scot D. Miller, an attending Board-certified orthopedic surgeon and osteopath, performed OWCP-approved surgery, including anterior cervical discectomy, decompression, and fusion at C6-7.

An April 6, 2010 MRI scan of appellant's cervical spine contained an impression of post-surgical changes at C6 and C7, and degenerative changes of the cervical spine predominately

[3] OWCP did not specify whether appellant's cervical radiculopathy was related to any particular nerve distribution.

involving the C3-4 level. There was no significant overall central canal or neural foraminal stenosis at these levels.

On June 25, 2010 appellant returned to limited-duty work on a full-time basis, but he later stopped work for intermittent periods and received wage-loss compensation.

OWCP referred appellant for a second opinion examination to Dr. Robert J. Nickodem, Jr., a Board-certified orthopedic surgeon. It requested that Dr. Nickodem provide an opinion regarding whether appellant had any residuals from his accepted work-related conditions.

In a July 9, 2010 report, Dr. Nickodem indicated that, upon physical examination, appellant's cervical muscles were nontender to palpation and that his right trapezial muscle had tenderness to palpation with slight spasm. He found that appellant had a work-related right trapezial muscle strain, but that his herniated disc at C6-7, cervical radiculitis, and cervical disc disease at C6-7 had resolved due to his January 8, 2010 cervical surgery. Dr. Nickodem explained that he observed no objective evidence of remaining disc disease or radiculopathy related to the conditions during his physical examination.

The findings of October 1, 2010 EMG and NCV testing of appellant's right upper extremity showed no electromyographic evidence of right brachial plexopathy, median/ulnar nerve entrapment neuropathy, peripheral neuropathy, or myopathy.

A January 6, 2011 MRI scan of appellant's right shoulder contained an impression of glenohumeral articular cartilage loss anteriorly (with near full-thickness cartilage thinning, but no subchondral edema or subchondral cystic change), mild subacromial subdeltoid bursitis, os acromiale with mild downsloping of the acromion process, and mild diffuse thinning of the rotator cuff tendons. There was no evidence of tendon tear, tendinopathy, or muscular atrophy.

In July 2011 OWCP referred appellant for another second opinion examination to Dr. Manhal Ghanma, Jr., a Board-certified orthopedic surgeon. It requested that Dr. Ghanma provide an opinion regarding whether appellant had residuals of his accepted work-related conditions.

In an August 12, 2011 report, Dr. Ghanma noted that, upon physical examination, appellant had normal strength in both shoulders with no crepitation on range of motion (ROM) testing. Appellant exhibited 30 degrees of forward flexion of his neck, 30 degrees of extension, 25 degrees of lateral bending (right and left), and 50 degrees of rotation (right and left). Dr. Ghanma indicated that there currently were no objective findings to support that appellant had residuals of any of his accepted work-related conditions. He found that appellant could work as a letter carrier, but should avoid lifting more than 50 pounds.[4]

In a November 14, 2011 report, Dr. James Bressi, an attending Board-certified pain management physician and osteopath, indicated that appellant continued to have work-related conditions/symptoms, including signs of a right trapezius strain.

[4] On August 20, 2011 appellant returned to full-time work for the employing establishment without wage loss.

OWCP determined that there was a conflict in the medical opinion evidence between Dr. Ghanma and Dr. Bressi regarding the extent of appellant's work-related residuals and referred appellant and the case record to Dr. Sheldon S. Kaffen, an attending Board-certified orthopedic surgeon, for an impartial medical examination and opinion on the matter.

In a September 7, 2012 report, Dr. Kaffen noted that appellant presented complaining of pain and tightness sensation in his posterior neck which radiated to the superior aspect of his right shoulder. He indicated that, upon physical examination, appellant exhibited tenderness of his right neck, right paraspinous muscles, and the superior border of his right trapezius muscle. Dr. Kaffen advised that ROM testing of appellant's right shoulder showed flexion to 140 degrees with a painful arc of motion beginning at 90 degrees, full extension to 50 degrees with pain, abduction to 140 degrees with pain, adduction to 40 degrees, external rotation to 80 degrees, and internal rotation to 60 degrees with pain. There was no atrophy or weakness to manual testing in appellant's right shoulder but there was tenderness to palpation of his right acromioclavicular joint, anterior subacromial region, and glenohumeral joint. Dr. Kaffen also found that there was no weakness or sensory deficit in appellant's right upper extremity. He opined that appellant's accepted cervical strain and right trapezius strain were no longer active or present. Dr. Kaffen noted that appellant exhibited no objective findings on physical examination and diagnostic testing of cervical radiculopathy and found that he no longer suffered from that condition. He further determined, however, that the accepted conditions of cervical herniated disc at C6-7 and cervical disc disease at C6-7 were still active.[5]

On January 31, 2013 appellant filed a claim for compensation (Form CA-7) seeking a schedule award due to his accepted employment injuries.[6]

By decision dated April 26, 2013, OWCP denied appellant's schedule award claim, noting that he failed to submit medical evidence sufficient to establish permanent impairment of a scheduled member.

On May 1, 2013 appellant, through counsel, requested a hearing with a representative of OWCP's Branch of Hearings and Review. During the hearing held on September 16, 2013, counsel provided testimony on appellant's behalf.

Appellant submitted a February 14, 2013 report from Dr. Rohit S. Chandurkar, an attending Board-certified emergency medicine physician, who noted appellant's complaints of neck and right arm pain with some tingling sensation in his right hand. Dr. Chandurkar detailed the physical examination findings, noting that appellant had intact strength and radial/ulnar pulses in his upper extremities. He diagnosed acute cervical neck strain with pain and acute exacerbation of chronic condition (without specifying the chronic condition).

[5] Dr. Kaffen also opined that the conditions of right shoulder acromion inflammation, right biceps tenosynovitis, and right impingement tendinitis were not work related.

[6] Appellant did not submit an impairment rating report around the time he filed his schedule award claim.

By decision dated October 28, 2013, OWCP's hearing representative affirmed the April 26, 2013 decision, noting that Dr. Chandurkar's February 14, 2013 report did not establish permanent impairment of a scheduled member.

In a November 26, 2013 report, Dr. Catherine Watkins Campbell, an attending Board-certified family practitioner, indicated that appellant reported symptoms including aching in the back of his neck, burning sensation down the ulnar side of his right upper extremity, and pins and needles sensation in the ulnar aspect of his right hand/little finger. She reported the findings of the physical examination she conducted on November 19, 2013, noting that ROM testing of appellant's right shoulder showed 120 degrees of flexion, 55 degrees of extension, 100 degrees of abduction, 30 degrees of adduction, 72 degrees of external rotation, and 25 degrees of internal rotation. Impingement signs were present in the right shoulder and muscle testing in the right upper extremity revealed 4/5 strength. Dr. Watkins Campbell noted that examination of the cervical region revealed cervical lordosis with slight forward head posture as well as tenderness to palpation of the right posterior paracervical and scalene muscles. She conducted permanent impairment ratings under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[7] Dr. Watkins Campbell indicated that under Table 15-20 (Brachial Plexus Impairment: Upper Extremity Impairments), beginning on page 434, appellant had seven percent permanent impairment of his right upper extremity.[8] She found that appellant reached maximum medical improvement (MMI) by September 2010.

OWCP referred the case to Dr. Morley Slutsky, a Board-certified occupational medicine physician serving as an OWCP medical adviser. It requested that Dr. Slutsky review the medical evidence of record, including Dr. Watkins Campbell's November 26, 2013 report, and provide an opinion on appellant's permanent impairment.

In a December 20, 2013 report, Dr. Slutsky noted that he had reviewed Dr. Watkins Campbell's November 26, 2013 report and opined that there was no diagnostic evidence or consistent clinical evidence of record to support the presence of a brachial plexus lesion. He indicated that MRI scans of appellant's cervical spine, obtained on March 13, 2006, February 21, 2007, and October 1, 2010, did not show evidence of central canal stenosis or neural foramina stenosis, and that June 10, 2008 and October 1, 2010 EMG and NCV testing of his upper extremities did not show evidence of right-sided cervical radiculopathy, brachial plexus injury, or focal nerve entrapment. He further explained that the July 9, 2010 report of Dr. Nickodem, August 12, 2011 report of Dr. Ghanma, and September 7, 2012 report of Dr. Kaffen showed no motor/sensory loss in appellant's upper extremities. Dr. Slutsky indicated that, therefore, appellant's permanent impairment should be evaluated under the diagnosis-based impairment (DBI) rating method found at Table 15-5 (Shoulder Regional Grid: Upper Extremity Impairments)

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

[8] Dr. Watkins Campbell found that appellant's brachial plexus condition fell under class 2 and that he had a functional history grade modifier of 3, a physical examination grade modifier of 2, and a clinical studies grade modifier of 0. *See* A.M.A., *Guides* 405-09, Table 15-6, Table 15-7, and Table 15-8. Dr. Watkins Campbell also found that, under Table 17-2 (Cervical Spine Regional Grid: Spine Impairments), appellant had six percent permanent impairment of his whole person. *See id.* at 564-66, Table 17-2.

beginning on page 401 of the sixth edition of the A.M.A., *Guides*.[9] He determined that, under this rating method, appellant's most impairing diagnosis was his right shoulder strain and he noted that this class 1 condition had one percent default value under Table 15-5.

Dr. Slutsky found that appellant had a functional history grade modifier of 1 and a physical examination grade modifier of 1, and noted that a clinical studies grade modifier was not applicable because clinical studies were used to place appellant in the correct diagnostic class.[10] He indicated that application of the net adjustment formula required no movement from the default value under Table 15-5 and concluded that appellant had one percent permanent impairment of his right upper extremity referable to his right shoulder condition.[11] In reaching his impairment rating, Dr. Slutsky indicated that the A.M.A., *Guides* provided that the DBI rating method was preferred over the ROM rating method for evaluating permanent impairment of the upper extremities. He asserted the ROM rating method could only be used as an alternative to the DBI rating method when "there were no DBI ratings available."

In a March 23, 2016 decision, OWCP granted appellant a schedule award for one percent permanent impairment of his right upper extremity. The award ran for 3.12 weeks from September 7 to 28, 2012 and was based on the opinion of Dr. Slutsky.

On April 5, 2016 appellant, through counsel, requested a telephone hearing with a representative of OWCP's Branch of Hearings and Review. During the hearing held on October 24, 2016 counsel argued that Dr. Slutsky improperly evaluated the permanent impairment of appellant's right upper extremity.

In a December 1, 2016 decision, OWCP's hearing representative affirmed OWCP's March 23, 2016 decision, noting that appellant had not established more than one percent permanent impairment of his right upper extremity. In affirming OWCP's March 23, 2016 schedule award determination, the hearing representative first found that appellant had not established any right upper extremity permanent impairment due to his accepted cervical-related conditions -- cervical strain, cervical herniated disc at C6-7, cervical disc disease at C6-7, and cervical radiculopathy. The hearing representative then found that appellant has failed to submit evidence showing that Dr. Slutsky was incorrect when he calculated one percent permanent impairment of appellant's right upper extremity due to his accepted right shoulder condition.

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

[9] *See* A.M.A., *Guides* 401-05, Table 15-5. Dr. Slutsky noted that appellant did not have any permanent impairment of his right upper extremity due to a work-related brachial plexus condition because there was no evidence in the record of such a condition.

[10] *See id.* at 405-09, Table 15-6, Table 15-7, and Table 15-8.

[11] *See id.* at 411. Dr. Slutsky found that appellant's MMI was September 7, 2012, the date of the physical examination conducted by Dr. Kaffen.

vested the authority to implement the FECA program with the Director of OWCP.[12] 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.[13] 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.[14]

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).[15] 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.[16]

Neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[17] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[18] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment.[19] It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper

[12] *See* 20 C.F.R. §§ 1.1-1.4.

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

[14] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[15] *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).

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

[17] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[18] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5c(3) (February 2013).

[19] The methodology and applicable tables were initially published in *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*). *Id.*

and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the procedure manual.[20]

ANALYSIS

The Board finds that appellant has failed to establish permanent impairment of his right upper extremity due to his accepted cervical-related conditions, but that the case is not in posture for decision regarding the permanent impairment of his right upper extremity due to his accepted right shoulder condition.

OWCP accepted that appellant sustained a right trapezius strain, cervical strain, cervical herniated disc at C6-7, cervical disc disease at C6-7, and cervical radiculopathy. In granting appellant a schedule award for one percent permanent impairment of his right upper extremity, OWCP had adopted the reasoning of Dr. Slutsky, OWCP's medical adviser, as provided in his December 20, 2013 impairment rating report. Dr. Slutsky applied a DBI rating method under Table 15-5 of the sixth edition of the A.M.A., *Guides* to find that appellant had one percent permanent impairment of his right upper extremity due to his accepted right shoulder condition. In reaching its schedule award determination, OWCP also found that appellant has failed to establish any right upper extremity permanent impairment due to his accepted cervical-related conditions, *i.e.*, cervical strain, cervical herniated disc at C6-7, cervical disc disease at C6-7, and cervical radiculopathy. In his December 1, 2016 decision affirming OWCP's March 23, 2016 schedule award, OWCP's hearing representative noted his agreement with Dr. Slutsky's opinion in this regard, as expressed in his December 20, 2013 impairment rating report, and made a specific finding that appellant has failed to establish right upper extremity permanent impairment due to his accepted cervical-related conditions.

Preliminarily, the Board finds that OWCP properly determined that appellant has failed to establish right upper extremity permanent impairment due to his accepted cervical-related conditions because he did not submit probative medical evidence establishing such permanent impairment. Appellant submitted a November 26, 2013 report of Dr. Watkins Campbell, an attending physician, who found that he had seven percent permanent impairment of his right upper extremity due to a right brachial plexus condition. However, OWCP has not accepted a work-related brachial plexus condition and the medical evidence of record does not otherwise establish the existence of such a brachial plexus condition, whether preexisting or work related in nature.[21] Dr. Watkins Campbell provided an opinion that appellant had a work-related condition originating in a nonscheduled member, *i.e.*, the cervical spine, that caused permanent impairment in a scheduled member, *i.e.*, the right upper extremity, but she did not provide medical rationale in support of this opinion. The Board has held that a medical report is of limited probative value on a given medical matter if it contains a conclusion regarding that matter which is unsupported by

[20] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

[21] It is well established that, in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included. *D.F.*, 59 ECAB 288 (2007); *Kenneth E. Leone*, 46 ECAB 133 (1994).

medical rationale.[22] The Board further notes that Dr. Watkins Campbell did not apply the relevant standards for evaluating such conditions originating in the cervical spine.[23]

Moreover, the record contains evidence showing that appellant did not have permanent impairment of his right upper extremity due to an accepted cervical-related condition. In his December 20, 2013 impairment rating report, Dr. Slutsky provided an extensive discussion of why the medical evidence of record showed that appellant did not have permanent impairment of his right upper extremity originating in his cervical spine. He noted that the findings of June 10, 2008 and October 1, 2010 EMG and NCV testing of appellant's right upper extremity showed no electromyographic evidence of cervical radiculopathy, brachial plexus injury, or other neuropathy originating in the cervical spine. Dr. Slutsky also referenced other medical reports of record that supported his opinion.[24]

The Board further finds that the case is not in posture for decision regarding the contribution of appellant's accepted right shoulder condition to the permanent impairment of his right upper extremity. As noted above, in granting appellant a schedule award for one percent permanent impairment of his right upper extremity, OWCP had adopted the reasoning of Dr. Slutsky, who applied the DBI method of rating permanent impairment (under Chapter 15) and found that appellant's accepted right shoulder condition established one percent permanent impairment of his right upper extremity. 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 range of motion (ROM) methodology when assessing the extent of permanent impairment for schedule award purposes.[25] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[26] In *T.H.*, the

[22] *C.M.*, Docket No. 14-0088 (issued April 18, 2014).

[23] Dr. Watkins Campbell improperly applied Table 15-20 (Brachial Plexus Impairment: Upper Extremity Impairments), beginning in page 434 of the sixth edition of the A.M.A., *Guides*, rather than *The Guides Newsletter*, to evaluate any permanent impairment originating in the cervical spine. *See supra* notes 17 through 20; *see also W.S.*, Docket No. 17-0125 (issued August 10, 2017) (finding that *The Guides Newsletter* provides the standard for evaluating permanent impairment originating in a nonscheduled member and extending into a scheduled member). Dr. Watkins-Campbell also found that under Table 17-2 (Cervical Spine Regional Grid: Spine Impairments), beginning on page 564, appellant had a permanent whole person impairment of six percent. However, the Board has held that neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the body as a whole. *See supra* note 17.

[24] For example, Dr. Slutsky noted that Dr. Nickodem, an OWCP referral physician, had indicated in his July 9, 2010 report that appellant's herniated disc at C6-7, cervical disc disease at C6-7, and cervical radiculopathy had resolved due to his January 8, 2010 cervical surgery. Dr. Nickodem explained that there was no evidence of these cervical-related conditions during the physical examination he conducted on July 9, 2010. In an August 12, 2011 report, Dr. Ghanma, an OWCP referral physician, indicated that there were no objective findings to support that appellant had residuals of any of his accepted work-related conditions. In a September 7, 2012 report, Dr. Kaffen, an impartial medical specialist, determined that, although appellant still had the localized conditions of cervical herniated disc at C6-7 and cervical disc disease at C6-7, he ceased to have residuals of the accepted cervical radiculopathy as of his September 7, 2012 examination.

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

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

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 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.[27]

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 1, 2016 decision with respect to the matter of the permanent impairment of appellant's right upper extremity due to his accepted right shoulder condition. 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 a right upper extremity schedule award.[28]

CONCLUSION

The Board finds that appellant has failed to establish permanent impairment of his right upper extremity due to his accepted cervical-related conditions, but that the case is not in posture for decision regarding the permanent impairment of his right upper extremity due to his accepted right shoulder condition.

[27] *Supra* note 25.

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

ORDER

IT IS HEREBY ORDERED THAT the December 1, 2016 decision of the Office of Workers' Compensation Programs is affirmed with respect to the finding that appellant has failed to establish permanent impairment of his right upper extremity due to his accepted cervical-related conditions. The decision is set aside regarding the permanent impairment of appellant's right upper extremity due to his accepted right shoulder condition, and the case is remanded for further action consistent with this decision.

Issued: July 2, 2018
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