

**United States Department of Labor
Employees' Compensation Appeals Board**

M.J., Appellant)	
)	
and)	Docket No. 17-1403
)	Issued: April 6, 2018
U.S. POSTAL SERVICE, POST OFFICE,)	
Bedford Park, IL, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 12, 2017 appellant filed a timely appeal from a May 4, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish more than 31 percent permanent impairment of the left leg, for which he previously received schedule awards; and (2) whether appellant has met his burden of proof to establish more than eight percent permanent impairment of the left arm, for which he previously received a schedule award.

¹ 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.² The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On December 18, 1990 appellant, then a 32-year-old tool and parts clerk, injured his left shoulder, left hip, and lower back when he was pinned between a cabinet and a desk. OWCP assigned File No. xxxxxx090 and accepted his claim for lumbar strain and left shoulder contusion on February 7, 1991. It later expanded the acceptance of appellant's claim to include left shoulder capsulitis and permanent aggravation of degenerative disc disease at L4-5. By decision dated May 18, 1994, OWCP granted him a schedule award for eight percent permanent impairment of his left upper extremity. On January 22, 1998 OWCP granted appellant a schedule award for 29 percent permanent impairment of his left lower extremity. Appellant was released to return to light-duty work on May 21, 2002.³

On February 6, 2003 appellant filed a traumatic injury claim (Form CA-1) alleging that on February 4, 2003 he sustained additional injuries to his back and left shoulder when his chair broke while he was sitting in it in the performance of his federal job duties. OWCP assigned File No. xxxxxx830 and accepted this claim for left shoulder contusion and lumbar strain on March 5, 2003. OWCP administratively combined both claims with File No. xxxxxx830 serving as the master file.

On November 26, 2012 appellant retired from the employing establishment through a 2013 special incentive offer. He elected to receive retirement benefits from the Office of Personnel Management effective June 2, 2014, rather than wage-loss compensation benefits under FECA.

Appellant filed a claim for a schedule award (Form CA-7) on June 27, 2014. In an August 14, 2014 report, Dr. Charlotte H. Mitchell, an internist, recounted appellant's multiple work injuries. She diagnosed chronic low back pain due to spinal stenosis with left-sided radiculopathy, severe claudication of the left leg and left shoulder pain due to posterior scapula. Dr. Mitchell found that appellant had reached maximum medical improvement (MMI). She provided a whole person impairment of 33 percent permanent impairment. Dr. Mitchell reported that appellant's left shoulder traumatic degenerative joint disease was 9 percent permanent impairment and that his multidirectional left shoulder was 13 percent permanent impairment. OWCP's medical adviser reviewed this report on September 22, 2014 and found that Dr. Mitchell's report did not establish additional permanent impairment beyond the 8 percent

² Docket No. 03-2140 (issued March 25, 2004).

³ The employing establishment offered appellant a job which OWCP found suitable on August 29, 2002. In a November 29, 2002 decision, OWCP terminated appellant's wage-loss compensation and schedule award benefits finding he refused suitable work under 5 U.S.C. § 8106(c)(3). After a reconsideration request, OWCP denied modification of the November 29, 2002 decision on July 2, 2003. Appellant appealed this decision to the Board. In a March 25, 2004 decision, the Board found that OWCP did not meet its burden of proof to terminate appellant's compensation benefits effective November 25, 2002. Docket No. 03-2140 (issued March 25, 2004). Following the Board's decision, OWCP paid further wage-loss compensation benefits.

permanent impairment in the left arm and 29 percent permanent impairment in the left leg for which he had previously received schedule awards.

By decision dated October 7, 2014, OWCP denied appellant's claim for additional schedule awards. Appellant requested an oral hearing before an OWCP hearing representative on October 31, 2014.

On January 13, 2015 Dr. David Fardon, a Board-certified orthopedic surgeon, evaluated appellant for schedule award purposes. He evaluated appellant's permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.⁴ Specifically, Dr. Fardon provided appellant's impairment to his lumbar spine due to intervertebral disc herniations at multiple levels with radiculopathy. He concluded that appellant had 19 percent permanent impairment of the whole person as a result of his low back disorder.

In a report dated April 16, 2015, Dr. Neil Allen, a Board-certified neurologist, examined appellant for the purpose of a schedule award. In applying the sixth edition of the A.M.A., *Guides*, he determined that appellant had 24 percent permanent impairment of the left leg. In regard to appellant's left shoulder, Dr. Allen determined that appellant had five percent permanent impairment of his left arm.

Appellant testified at the oral hearing before an OWCP hearing representative on June 18, 2015. Following the oral hearing, he submitted a report from Dr. Mitchell dated June 26, 2015. Dr. Mitchell diagnosed chronic low back pain due to spinal stenosis with radiculopathy and chronic paraspinal spasm, bilateral lumbosacral facet arthropathy, left-sided sciatica, as well as chronic left shoulder pain due to rotator cuff tendinopathy and pericapsulitis with resultant muscular atrophy and post-traumatic degenerative joint disability. She evaluated appellant's left shoulder condition based on range of motion (ROM)⁵ and reported 90 degree of flexion which is 3 percent permanent impairment; 30 degrees of extension which she found was 2 percent permanent impairment;⁶ 75 degrees of abduction which is 6 percent permanent impairment; and 50 degrees of adduction which 10 percent permanent impairment.⁷ Dr. Mitchell totaled appellant's left upper extremity loss of ROM and found 25 percent permanent impairment under the A.M.A., *Guides*. She further found that appellant had 31 percent permanent impairment of his lumbar spine. Dr. Mitchell opined that appellant had reached MMI in August 2014.

By decision dated August 11, 2015, OWCP's hearing representative affirmed the October 7, 2014 decision.

On October 19, 2015 appellant requested reconsideration of the August 11, 2015 decision. He submitted additional medical evidence. Dr. Joseph R. Mejia, a specialist in occupational medicine and ophthalmology, completed a report on October 1, 2015 and performed an evaluation

⁴ A.M.A., *Guides* (6th ed. 2009).

⁵ *Id.* at 475, Table 15-34.

⁶ The A.M.A., *Guides* list this as one percent permanent impairment. *Id.*

⁷ *Id.*

for schedule award purposes. He reported decreased motor strength on the left, and constant thigh to knee left leg paresthesia to light touch. Dr. Mejia determined that appellant had 12 percent permanent impairment of his left lower extremity.

In a report dated October 27, 2015, Dr. Mejia addressed the percentage of permanent impairment of appellant's left upper extremity. He determined that appellant reached MMI on August 14, 2014. Dr. Mejia found that appellant's left upper extremity had pain restricted rotator cuff motion, with 90 degrees of flexion, 75 degrees of abduction, 90 degrees of internal rotation, and 45 degrees of abduction. He also reported tenderness at the acromioclavicular joint and upper trapezius muscle in the left shoulder. Dr. Mejia applied the diagnosis-based impairment (DBI) methodology and determined that appellant had four percent permanent impairment of his left upper extremity due to acromioclavicular joint injury.⁸

By decision dated January 7, 2016, OWCP denied modification of the August 11, 2015 decision. It found that appellant had not submitted medical evidence which showed more than 29 percent permanent impairment of the left lower extremity and 8 percent permanent impairment of the left upper extremity for which he previously received schedule award.⁹

Dr. Kern Sinh, a Board-certified orthopedic surgeon, examined appellant on April 27, 2016 for schedule award purposes. He reviewed appellant's history of injury and diagnosed lumbar muscular strain and L4 through S1 degenerative disc disease.

On November 15, 2016 appellant requested reconsideration and submitted additional medical evidence. Dr. Thomas Pontinen, Board-certified in pain management, examined appellant on July 26, 2016. He described appellant's history of injury and noted that appellant's back pain radiated to his left lower extremity in the L4-S1 distribution to the foot. Dr. Pontinen also found that appellant's back pain radiated in the left upper arm to the forearm and hand with no associated neurological deficit. He found 42 percent permanent impairment in the left lower extremity due to moderate motor and sensory deficits in L4, L5, and S1 with impairments of 16 percent permanent impairment for L4, 16 percent permanent impairment for L5, and 10 percent permanent impairment for L1. In regard to appellant's left upper extremity, Dr. Pontinen attributed appellant's permanent impairment to moderate deficits in the C6 and C7 dermatomes and reached 15 percent permanent impairment.

OWCP's medical adviser reviewed Dr. Pontinen's July 26, 2016 report on December 11, 2016. He found appellant had three percent permanent impairment of the left upper extremity based on the DBI method in accordance with Dr. Allen's rating. OWCP's medical adviser further noted that the major finding in appellant's left shoulder was loss of shoulder motion, and utilized the diagnosis of tendinitis as the most impairing condition in the left shoulder region. He noted that Dr. Pontinen's impairment rating of the left upper extremity was based on cervical

⁸ A.M.A., *Guides* 403, Table 15-5.

⁹ On May 9, 2016 appellant appealed a January 7, 2016 OWCP decision. On September 22, 2016 he requested that the Board dismiss his appeal. In a December 1, 2016 *Order Dismissing Appeal*, the Board granted appellant's request. Docket No. 16-1210 (issued December 1, 2016).

spine nerve conditions, which were not accepted in appellant's claim and therefore could not be considered as a basis for a schedule award.

OWCP's medical adviser applied *The Guides Newsletter* July/August 2009 to Dr. Pontinen's findings as Dr. Pontinen had failed to provide discussion of the tables, figures, and chapters from the A.M.A., *Guides*. He noted that appellant's lower extremity impairment was based on combining the motor and sensory deficits in L4, L5, and S1, not merely adding these impairments.¹⁰ For sensory deficits of the left L4 nerve root, the medical adviser determined that appellant had decreased light touch and sharp/dull sensitivities or a moderate impairment.¹¹ He applied *The Guides Newsletter* to this finding resulting in a class 1, grade C or three percent permanent impairment of the left lower extremity. The medical adviser then determined appellant's motor deficit of the left L4 nerve root based on a decreased strength of grade 3/5 or moderate strength loss of two percent permanent impairment.¹² Applying *The Guides Newsletter* to this finding resulted in class 1, grade C or 13 percent permanent impairment of the left lower extremity. He then completed the net adjustment formula noting that appellant's functional history grade modifier was 1 and that his clinical studies grade modifier was zero as there were no findings of left-sided L4 involvement on EMG resulting in a net adjustment of -1 or grade B, 11 percent permanent impairment. Appellant's total L4 impairment based on the Combined Values Chart for his sensory impairment of three and his motor impairment of 11 was 14 percent permanent impairment.

For appellant's L5 nerve root impairments to the left leg, OWCP's medical adviser repeated a similar process and sensory impairment of three percent permanent impairment. For L5 nerve root motor impairment, he found clinical studies supporting evidence of lumbar radiculopathy. The medical adviser found that the net adjustment was 0 and that appellant's motor final grade was C or 13 percent impairment. He combined the motor and sensory deficits to reach 16 percent permanent impairment due to the L5 nerve root. Regarding S1 nerve root impairment,¹³ the medical adviser found a moderate motor deficit with a grade C value of eight percent permanent impairment, and net adjustment of zero resulting in eight percent permanent impairment due to loss of strength. A moderate sensory deficit of the S1 nerve root was 2 percent impairment which he combined with appellant's motor strength loss of 8 percent impairment to reach 16 percent permanent impairment.¹⁴ In combining appellant's three nerve root impairments, OWCP's medical adviser utilized the values of 16 percent permanent impairment for the L5 nerve root, 11

¹⁰ A.M.A., *Guides* 604, Combined Values Chart.

¹¹ *Id.* at 533, Table 16-11.

¹² *Id.*

¹³ OWCP's medical adviser's report again mentions the left L4 nerve root, but the impairment ratings provided correspond to those for the S1 nerve root.

¹⁴ The medical adviser indicated that combining 8 and 2 yielded 10 percent permanent impairment.

percent permanent impairment for the L4 nerve root, and 8 percent permanent impairment for the S1 nerve root¹⁵ to reach 31 percent permanent impairment of the left lower extremity.

By decision dated January 9, 2017, OWCP modified the January 7, 2016 decision as appellant had established an additional two percent permanent impairment of the left lower extremity. However, it further found that he had not established increased impairment of his left upper extremity warranting an additional schedule award.

By decision dated January 19, 2017, OWCP granted appellant a schedule award for an additional 2 percent permanent impairment of his left lower extremity for a total permanent impairment rating of 31 percent.

On February 10, 2017 appellant requested reconsideration. He provided a January 24, 2017 note from Dr. Pontinen. Dr. Pontinen addressed appellant's left arm and found mild subacromial crepitus, positive Neers test indicating shoulder impingement, positive Hawkins test, and two centimeters of atrophy in the left arm circumference relative to the right arm. He listed appellant's left shoulder ROM as 80 degrees of flexion, 20 degrees of extension, 35 degrees of abduction, 50 degrees of adduction, 55 degrees of internal rotation, and 105 degrees of external rotation. Dr. Pontinen further found that appellant had moderate sensory deficits in the C6-7 dermatomes. He found that appellant's left shoulder Disabilities of the Arm, Shoulder, and Hand (*QuickDASH*) score was 82 as he reported pain with normal activity and could perform self-care activities with modifications, and noted this was grade modifier 2 for functional history.¹⁶ Dr. Pontinen noted that appellant's DBE was tendinitis¹⁷ with a grade C impairment of one percent permanent impairment. He further noted that appellant's physical examination grade modifier would be two considering appellant's loss of ROM. Dr. Pontinen reported that appellant had moderate sensory deficits and mild motor deficits in both the C6 and C7 dermatomes. He concluded that appellant's total left arm impairment was 15 percent. Dr. Pontinen opined that appellant's left upper extremity motor and sensory deficits should be considered when evaluating his left upper extremity for schedule award purposes.

OWCP's medical adviser resubmitted his December 11, 2016 report on April 11, 2017 without reviewing Dr. Pontinen's January 24, 2017 report with the additional correlation of upper extremity findings to the A.M.A., *Guides*.

By decision dated May 4, 2017, OWCP denied modification of its prior decisions finding that the medical evidence of record did not establish more than 31 percent permanent impairment of the left lower extremity and 8 percent permanent impairment of the left upper extremity for which he received schedule awards.

¹⁵ The Board notes that these percentages do not correlate with the impairment ratings he reached of 16 percent permanent impairment of the L5 nerve root, 14 percent permanent impairment of the L4 nerve root, and 10 percent permanent impairment of the S1 nerve root.

¹⁶ A.M.A., *Guides* 406, Table 15-7.

¹⁷ *Id.* at 402, Table 15-5.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA¹⁸ and its implementing regulations¹⁹ set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of use of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.²⁰

No schedule award is payable for a member, function or organ of the body not specified in FECA or in the regulations.²¹ Because neither FECA nor the regulations provide for the payment of a schedule award for impairment of the whole person²² or the permanent loss of use of the back or spine,²³ no claimant is entitled to such an award.²⁴

Amendments to FECA, however, modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. As the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to a limb even though the cause of the impairment originated in the spine.²⁵

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. Recognizing that certain jurisdictions, such as federal claims under FECA, mandate ratings for extremities and preclude ratings for the spine, the A.M.A., *Guides* has offered an approach to rating spinal nerve impairments consistent with sixth edition methodology.²⁶ OWCP has adopted this approach for rating impairment of the upper or

¹⁸ 5 U.S.C. §§ 8101-8193, 8107.

¹⁹ 20 C.F.R. § 10.404.

²⁰ For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

²¹ *W.D.*, Docket No. 10-0274 (issued September 3, 2010); *William Edwin Muir*, 27 ECAB 579 (1976).

²² *Tania R. Keka*, 55 ECAB 354 (2004); *G.S.*, Docket No. 17-1318 (issued October 11, 2017).

²³ FECA itself specifically excludes the back from the definition of organ. 5 U.S.C. § 8101(19).

²⁴ *W.D.*, *supra* note 21. *Timothy J. McGuire*, 34 ECAB 189 (1982).

²⁵ *W.D.*, *supra* note 21. *Rozella L. Skinner*, 37 ECAB 398 (1986).

²⁶ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5c(3) (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 Exhibit 4 (January 2010).

lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures which memorializes proposed tables outlined in a July/August 2009, *The Guides Newsletter*.²⁷

A schedule award can be paid only for a condition related to an employment injury. The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.²⁸ However, the Board has long held that preexisting impairments to the scheduled member are to be included when determining entitlement to a schedule award.²⁹

ANALYSIS -- ISSUE 1

The issue is whether appellant has met his burden of proof to establish more than 31 percent permanent impairment of the left lower extremity for which he has previously received schedule awards.

The Board finds this case not in posture for a decision.

Appellant has submitted several reports from his physicians addressing his impairment for schedule award purposes. In her August 14, 2014 report, Dr. Mitchell did not find that appellant's current lower extremity impairment exceeded his previous schedule award for 29 percent permanent impairment of the left lower extremity. She also expressed his impairment in terms of whole person impairment which is not allowed under FECA as noted above.³⁰ On January 13, 2015 Dr. Fardon also expressed his impairment rating in terms of the whole person, which again is not valid for schedule award purposes under FECA.³¹ On April 16, 2015 Dr. Allen determined that appellant had 24 percent permanent impairment of the left lower extremity, less than the 29 percent permanent impairment for which he had previously received a schedule award, such that appellant was not entitled to an additional schedule award based on this report. In her June 26, 2016 report, Dr. Mitchell provided a permanent impairment rating of appellant's spine. As noted above, FECA does not provide schedule awards for permanent impairment of the spine, and this report cannot, therefore, establish a schedule award in this regard.³² In his October 1, 2015 report, Dr. Mejia found 12 percent permanent impairment of the left lower extremity, less than the 29 percent permanent impairment for which appellant had previously received a schedule award, such that this impairment did not warrant an additional schedule award. The Board finds that these reports lack probative value and as such were insufficient to establish appellant's claim for an additional left lower extremity permanent impairment.

²⁷ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 (January 2010) (Exhibits 1, 4).

²⁸ *Veronica Williams*, 56 ECAB 367 (2005).

²⁹ *Carol A Smart*, 57 ECAB 340 (2006).

³⁰ *G.S. supra* note 22.

³¹ *Id.*

³² *F.S.*, Docket No. 16-0783 (issued September 26, 2017).

In his July 26, 2016 report, Dr. Pontinen examined appellant for schedule award purposes and provided findings addressing impairments from his lower back at the L4-S1 nerve roots which impacted appellant's left lower extremity. He reported moderate motor and sensory deficits in L4, L5, and S1 with impairments of 16 percent permanent impairment for L4, 16 percent permanent impairment for L5, and 10 percent permanent impairment for S1 totaling 42 percent permanent impairment in the left lower extremity. However, Dr. Pontinen did not provide citations to the A.M.A., *Guides* or fully explain how he reached his impairment ratings.

It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment and OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings of the attending physician.³³

OWCP's medical adviser reviewed Dr. Pontinen's July 26, 2016 report and addressed impairments of the L4, L5, and S1 nerve roots under the A.M.A., *Guides*. He properly applied the A.M.A., *Guides* and *The Guides Newsletter* and properly calculated appellant's impairment of the L4 nerve root due to sensory and motor impairments as 14 percent permanent impairment. OWCP's medical adviser then found that appellant had 16 percent permanent impairment of the L5 nerve root due to sensory and motor impairments. However, with regard to appellant's S1 nerve root impairment, the report submitted by OWCP's medical adviser contains what appears to be typographical errors attributing relisting the left L4 nerve root and reaching an impairment rating of 10. The Board further notes that OWCP's medical adviser did not properly combine his findings of impairment of 16, 14, and 10 percent permanent impairment. OWCP's medical adviser found a total impairment rating of 31 percent permanent impairment by substituting 8 rather than 10 percent permanent impairment for a nerve root without explanation.³⁴

Due to these errors in OWCP's medical adviser's report and calculations, the Board finds that the case is not in posture for decision regarding the extent of appellant's left lower extremity permanent impairment for schedule award purposes. On remand OWCP should request a supplemental report correctly detailing the impairments reached and the combined values calculations in accordance with the Combined Values Chart of the A.M.A., *Guides*.

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 the Director of OWCP.³⁵ Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use

³³ *Linda Beale*, 57 ECAB 429 (2006); *L.T.*, Docket No. 13-1290 (issued December 18, 2013).

³⁴ The Board notes that the combination of 16, 14, and 10 results in 35 percent permanent impairment of the left lower extremity rather than 31 percent permanent impairment found by the medical adviser. A.M.A., *Guides* 604, Combined Values Chart.

³⁵ See 20 C.F.R. §§ 1.1-1.4.

of specified members, functions, and organs of the body.³⁶ 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.³⁷

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).³⁸ 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.³⁹

ANALYSIS -- ISSUE 2

The issue on appeal is whether appellant has more than eight percent permanent impairment of his left upper extremity for which he received a schedule award.

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

Appellant’s physician, Dr. Mitchell provided an impairment rating of 25 percent of the left upper extremity based on appellant’s loss of ROM in his left shoulder. OWCP’s medical adviser did not review this impairment rating or otherwise address these findings. In his December 11, 2016 report, he found that appellant had three percent impairment of his left upper extremity using the DBI methodology and confirmed that this was the appropriate method of evaluation under the A.M.A., *Guides*.

The Board has found that OWCP had 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.⁴⁰ The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the

³⁶ For a complete loss of use of an arm, an employee shall receive 312 weeks’ compensation. 5 U.S.C. § 8107(c)(1).

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

³⁸ *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).

³⁹ *Isidoro Rivera*, 12 ECAB 348 (1961).

⁴⁰ *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

law to all claimants.⁴¹ 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 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.⁴²

The Board further notes that Dr. Pontinen attributed a portion of appellant's left upper extremity impairment to cervical radiculopathy. OWCP's medical adviser discounted this diagnosis and resulting impairment without discussion or investigation of whether cervical radiculopathy was a preexisting condition predating appellant's accepted employment injuries. OWCP's procedures provide that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.⁴³

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 May 4, 2017 decision as it relates to appellant's left upper extremity impairment rating. Utilizing 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.⁴⁴

CONCLUSION

The Board finds that the case is not in posture for decision on the issues of the extent of appellant's left upper and left lower extremity impairments for schedule award purposes and remands the case for further development consistent with this decision of the Board.

⁴¹ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

⁴² *Supra* note 40.

⁴³ See *Dale B. Larson*, 41 ECAB 481, 490 (1990); *J.S.*, Docket No. 17-0541 (issued October 17, 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a.3 (January 2010).

⁴⁴ FECA Bulletin No. 17-06 (issued May 8, 2017).

ORDER

IT IS HEREBY ORDERED THAT the May 4, 2017 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this decision of the Board.

Issued: April 6, 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