

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

C.U., Appellant)

and)

DEPARTMENT OF VETERANS AFFAIRS,)
ZABLOCKI MEDICAL CENTER,)
Milwaukee, WI, Employer)

Docket No. 07-1221
Issued: September 25, 2007

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

Case Submitted on the Record

DECISION AND ORDER

Before:

DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 29, 2007 appellant filed a timely appeal from the merit decisions of the Office of Workers' Compensation Programs dated April 7 and June 16, 2006, affirming a schedule award for six percent impairment to her right upper extremity. She also filed a timely appeal of a January 17, 2007 nonmerit decision which denied her request for a review of the written record. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3 the Board has jurisdiction over the merits of this claim.

ISSUES

The issues are: (1) whether appellant has more than a six percent impairment of the right upper extremity for which she received a schedule award; and (2) whether the Office properly denied appellant's request for a written review of the record.

FACTUAL HISTORY

On May 27, 2003 appellant, then a 59-year-old medical support assistant, sustained an injury to her neck and right shoulder when the elevator she was riding stopped abruptly. She stopped work as of the date of the accident and did not return. Appellant retired effective December 8, 2003. On November 25, 2003 the Office accepted her claim for a cervical fracture. Appropriate medical and compensation benefits were paid.

A magnetic resonance imaging (MRI) scan conducted on June 25, 2003 revealed a thin line of bone marrow edema just below the superior endplate of C7, which most likely represented a subacute, minimal superior endplate compression fracture of C7. Mild degenerative spondylosis at C5-6 and C6-7 with mild-to-moderate right-sided neural foraminal narrowing were also diagnosed.

On February 11, 2004 appellant was referred for a second opinion evaluation. In a medical report dated May 28, 2004, Dr. James P. Foydel, a Board-certified physiatrist, noted that he saw appellant on March 16, 2004. He noted that appellant sustained a C7 compression fracture but that it was unclear whether she sustained any neurological deficits due to this injury. Dr. Foydel recommended an electromyogram (EMG). He recommended that appellant be off work for a month or so and, upon return to work, she should perform modified duty with restrictions. Dr. Foydel noted that no permanent disability could be concluded at this time. He noted that significant issues of disability followed the accident and that partial disability could extend from 6 to 12 months. In a September 15, 2004 report, Dr. Foydel noted that an EMG failed to reveal any significant nerve damage in the upper extremities and that all nerves were within normal limits. There was nothing substantial insofar as neurological deficient or nerve damage from the accident that caused her fracture and that the fracture had stabilized, if not fully healed. Dr. Foydel noted that appellant guarded her neck in a defensive posture since the accident and, therefore, had a very limited range of motion with muscle spasms. Appellant did not have any other medical conditions or any preexisting conditions made worse by this condition. He noted that appellant had not reached maximum medical improvement, but that there was no permanent nerve damage, no permanent disability and her prognosis for recovery was excellent.

By letter dated June 23, 2005, the Office asked Dr. Subbanna Jayaprakash, appellant's Board certified physiatrist, to evaluate her with regard to any permanent impairment. In a medical disability certification dated July 21, 2005, Dr. Jayaprakash listed appellant's diagnosis as C7 fracture with C5-6 disc protrusion and right C6 radiculopathy. He opined that appellant had an 18 percent impairment of the whole person based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.¹

¹ Dr. Jayaprakash based his impairment rating on appellant having a diagnosis-related estimate category three pursuant to A.M.A., *Guides* 392, Table 15-5. He listed his reason for disability recommendations as spasm C5-7 posterior paraspinals plus loss of range of motion passive neck forward flexion of 20 degrees and right lateral rotation and flexion of 20 degrees.

In an October 2, 2005 report, an Office medical adviser opined that appellant had a three percent impairment of her right upper extremity.²

On November 1, 2005 the Office issued a schedule award for a three percent impairment of appellant's right upper extremity.

On November 12, 2005 appellant requested reconsideration.

In a medical report dated March 10, 2006, Dr. Jayaprakash noted that appellant had residual weakness of the C6 root affecting the right biceps and supinator and hand grip at 3+/4- (30 percent) loss as well as supraspinatus (30 percent) and residual numbness in the C6 distribution at 50 percent especially forearm and right index finger. Then, utilizing the A.M.A., *Guides*,³ Dr. Jayaprakash found that, pursuant to the A.M.A., *Guides*, appellant had a 16 percent impairment of the right upper extremity. He based this finding on a 4 percent sensory deficit at C6 (8 percent multiplied by 50 percent equals 4 percent) and a motor deficit of 12 percent at C6 (33 percent multiplied by 30 percent equals 12 percent). Dr. Jayaprakash concluded that 12 percent plus 4 percent equaled 16 percent right upper extremity impairment.

In a report dated March 27, 2006, the Office medical adviser determined that no additional award was merited. He noted that there was no new documentation of appellant's current subjective complaints. The Office medical adviser noted that Dr. Foydel had previously documented no residual impairment, whereas Dr. Jayaprakash recommended 16 percent right upper extremity impairment based on C6 nerve root deficiencies. He stated that the etiology of the C6 nerve root impairment was unclear. The Office medical adviser indicated that appellant's MRI scan indicated no neural compression with and a normal EMG, so there was no objective evidence of injury. Secondly, he noted that no award should be given for C6 nerve root motor or sensory impairment due to the likelihood that this impairment, if existent, stemmed from an underlying osteoarthritic degenerative process and unlikely due to the accepted injury.

By decision dated April 7, 2006, the Office denied an additional schedule award.

On April 27, 2006 appellant requested reconsideration. She submitted an April 27, 2006 report from Dr. Jayaprakash. He reviewed the report of the Office medical adviser and stated that appellant's work trauma had two components: a direct trauma to her vertebrae with fracture as well as an aggravated trauma to the adjacent spinal segment (C6-7) intervertebra level which may have been arthritic however asymptomatic until the force of her trauma permanently aggravated the underlying degenerative condition. He noted that the consequences were worsening of instability at C6-7 with pain and C6 nerve root irritation and some numbness and residual disability. Dr. Jayaprakash stated that the MRI scan clearly showed changes at the C6-7 level, but that a computerized tomography scan would have been better suited to look at

² The Office medical adviser utilized the A.M.A., *Guides* 424, Tables 15-15, 15-16 and 15-17. Appellant had one percent impairment of her right upper extremity for Grade 4 pain/sensory deficit in the C7 distribution and a two percent right upper extremity based on a Grade 4 motor deficit in the right C7 distribution. Utilizing the Combined Values Chart of the A.M.A., *Guides*, he concluded that appellant was entitled to a schedule award for a three percent impairment to her right upper extremity.

³ A.M.A., *Guides* 488, 489.

foraminal changes than an MRI scan. He further noted that sensory changes alone do not alter nerve conduction studies or EMG studies, hence none were found.

In a report dated June 5, 2006, the Office medical adviser concluded:

“Therefore, at this time, the only additional upper extremity [permanent partial impairment] awarded at this time is for a [G]rade 4 pain/sensory deficit in the C6 nerve distribution on the right. One percent [right upper extremity permanent partial impairment] is awarded based on [T]ables 15-15 combined with [T]able 15-17, p. 424 of the [A.M.A., *Guides*]. An additional [two] [percent right upper extremity permanent partial impairment] is awarded for a [G]rade 4 motor deficit in the right C6 nerve distribution according to [T]ables 15-16 and 15-17 on the same page.

“Use of the [C]ombined [V]alues [Chart] on 604 awards a total of [six percent right upper extremity permanent partial impairment.] There is no objective evidence to support any [left upper extremity permanent partial impairment] at this time.”

In a decision dated June 16, 2006, the Office granted a schedule award for an additional three percent impairment to the right upper extremity, or a total of six percent impairment.

On June 22, 2006 appellant requested review of the written record. In a June 7, 2006 report, Dr. Jayaprakash reiterated that her degenerative changes were clearly aggravated as a result of her work-related injury and trauma. Appellant continued to have considerable amounts of problems involving the shoulder area and the scapular area on the right.

In a decision dated September 13, 2006, the hearing representative set aside the June 16, 2006 decision and remanded the case because the record did not include the Office medical adviser’s June 5, 2006 report. In a November 16, 2006 decision, the Office reissued the schedule award for six percent to her right upper extremity.

On January 17, 2007 appellant requested a review of the written record of the November 16, 2006 decision. She alleged that she was not informed of the November 16, 2006 decision until December 28, 2006 and that she did not receive the decision until January 5, 2007.

By decision dated February 21, 2007, appellant’s request was denied as it was filed more than 30 days after the September 13, 2006 decision. The Office reviewed appellant’s request and denied it for the reason that the case could be equally well addressed by requesting reconsideration.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees Compensation Act⁴ and its implementing regulation⁵ 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, the Act does not specify the manner in which the percentage 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* have been adopted by the implementing regulation as the appropriate standards for evaluating schedule losses.⁶

ANALYSIS

The Office medical adviser, in determining appellant's schedule award, relied on the findings of Dr. Foydel, the second opinion physician, and his conclusion that there was no residual impairment. The Office medical adviser disagreed with appellant's treating physician, Dr. Jayaprakash, on whether the schedule award should include appellant's C6 condition, interpretation of the MRI scan and the appropriate tables of the A.M.A., *Guides* to be applied. The doctors also disagreed as to the amount of permanent impairment, with Dr. Jayaprakash finding that she had a 16 percent impairment of the right upper extremity and the Office medical adviser finding that she had no more than a six percent impairment of the right upper extremity. Both physicians addressed how they utilized the A.M.A., *Guides*, in arriving at their respective impairment rating.

Section 8123(a) of the Act provides, in pertinent part: If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.⁷ When there are opposing reports of virtually equal weight and rationale the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.⁸ The Board finds that the Office should have referred appellant to an impartial medical specialist to resolve the medical conflict regarding the extent of permanent impairment arising from appellant's accepted employment injury.

The case will be remanded to the Office for referral of appellant to an impartial medical specialist for a determination regarding the extent of impairment to her right upper extremity.⁹

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404 (1999).

⁶ *See id.*; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

⁷ 5 U.S.C. § 8123(a).

⁸ *William C. Bush*, 40 ECAB 1064 (1989).

⁹ *See Harold Travis*, 30 ECAB 1071, 1078-79 (1979).

After such further development as the Office deems necessary, a *de novo* decision should be issued regarding the extent of appellant's right upper extremity impairment.¹⁰

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated January 17, 2007 and June 16 and April 7 2006 are set aside and the case is remanded for further action consistent with this decision.

Issued: September 25, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

¹⁰ In light of the disposition of this issue, the issue with regard to whether the Office properly denied appellant's request for written review of the record is moot.