

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

C.G., Appellant)

and)

U.S. POSTAL SERVICE, POST OFFICE,)
Fort Worth, TX, Employer)

Docket No. 09-445
Issued: November 20, 2009

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

Case Submitted on the Record

DECISION AND ORDER

Before:

COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 2, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs' March 19, May 5 and September 5, 2008 merit decisions concerning his schedule award compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has more than an 11 percent impairment of his right arm, for which he received a schedule award.

FACTUAL HISTORY

The Office accepted that on March 5, 2004 appellant, then a 45-year-old mail processor, sustained cervical and thoracic region sprains/strains, displaced lumbar disc, brachial neuritis/radiculitis and other affections of the right shoulder region due to writing with a pen for an extended period at work on that date. It subsequently accepted degeneration of the lumbar spine and a C4 disc.

On June 18, 2004 Dr. Michael LaGrone, an attending Board-certified orthopedic surgeon, performed discectomy, decompression and fusion surgery at C5-6 with instrumentation. The procedure was authorized by the Office.

In a February 4, 2005 report, Dr. Neil Veggeberg, an attending Board-certified physical medicine and rehabilitation physician, noted that appellant complained of pain, tingling and mild weakness in his right arm. He stated that examination of the cervical area and right arm revealed pain upon cervical extension and rotation to the right side that was not severe. Appellant had over 45 degrees of extension of his cervical spine, 45 degrees of flexion, 80 degrees of rotation and 30 degrees of lateral deviation bilaterally. His right shoulder showed good strength and range of motion. Dr. Veggeberg indicated that appellant had normal biceps strength, but there was a slight weakness of his right elbow extension which was felt to be due to neurological deficits in his right triceps. There was a decreased sensation in his right C7 nerve distribution.

Dr. Veggeberg advised that, applying the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001), appellant had decreased superficial cutaneous pain and tactile sensibility in the right C7 nerve distribution, which represented an 80 percent sensory deficit (Grade 2) under Table 16-10. As the maximum for sensory loss associated with the C7 nerve distribution is five percent under Table 16-13, multiplying these two values yielded four percent impairment for sensory loss in this nerve distribution. With respect to loss of motor function, appellant had active movement, against gravity with some resistance, which represented a 20 percent strength deficit (Grade 4) under Table 16-11. Dr. Veggeberg noted that the involved muscle had a 35 percent maximum value for strength loss under Table 16-13. Multiplying the two values yielded a seven percent impairment of the right arm due to strength loss. Combining the values for sensory loss and strength loss totaled 11 percent impairment of appellant's right arm.

In a November 20, 2006 decision, the Office granted appellant a schedule award for an 11 percent permanent impairment of his right arm. The award ran for 34.32 weeks from February 4 to October 2, 2005.

On January 9, 2007 Dr. Gabriel Pitman, an attending osteopath and Board-certified neurologist, stated that electromyogram (EMG) and nerve conduction velocity (NCV) studies performed on that date showed acute right radial neuropathy, mild bilateral ulnar neuropathies at the elbows, moderate right median neuropathy at the wrist, mild left median neuropathy and left radial neuropathies. There was no electrodiagnostic evidence of a cervical radiculopathy in either arm, but Dr. Pitman stated, "I wonder if [appellant] has a chronic cervical myelopathy contributing to his pain."

In a September 12, 2007 report, Dr. John W. Ellis, an attending Board-certified family practitioner, reviewed appellant's factual and medical history, including the March 5, 2004 employment injury. He indicated that appellant complained of increased cervical pain and stiffness with a shooting pain in his upper neck area, shoulder girdles and arms. Appellant described increased pain and numbness in his right middle, ring and little fingers. Dr. Ellis advised that July 13, 2006 magnetic resonance imaging (MRI) scan testing of the cervical spine revealed postsurgical changes with anterior fusion at C5-6, a central disc herniation at C3-4 with minimal compression deformity on the cervical cord; and a central disc herniation at C4-5 which

resulted in a minimal compression deformity on the cervical cord. The findings of a July 16, 2007 computerized tomography (CT) scan showed moderate disc bulges at C3-4 and C4-5 and the previous cervical fusion at C5-6. The cerebrospinal fluid space ventral to the cord was reduced at C3-4 and C4-5.

Dr. Ellis found that there was crepitation with movement of the neck and that range of neck motion was decreased. The decreased range of motion of appellant's right shoulder was due to neck, thoracic spine and shoulder girdle tightness and was not due to the shoulder joints themselves. Gentle pressure on the trapezius muscles and axilla caused a very slight change in his arm symptoms and brachial plexus impingement had improved from previous examinations. Dr. Ellis diagnosed muscle tendon unit strain of the neck with deranged and fused disc at C5-6 and deranged discs at C3-4, C4-5 and C5-6; bilateral C7 and C8 nerve root impingement; strains and tightness of the neck, thoracic region and shoulder girdles resulting in decreased range of motion of the shoulders; and brachial plexus impingement, improved. He asserted that these conditions were all related to the March 5, 2004 employment injury. Dr. Ellis posited that appellant's June 18, 2004 fusion surgery caused increased pressure in the levels above and below the fusion and caused increased C7 nerve root impingement and new C8 nerve root impingement. The C8 nerve root impingement was different from the impingement from the ulnar nerves in his elbows that went into his ring and little fingers.

Dr. Ellis provided an impairment rating for appellant's right arm based solely on the effects of the March 5, 2004 injury. Appellant had a 13 percent impairment for decreased right shoulder motion caused by C7 and C8 nerve root compression and a 25 percent impairment due to peripheral nerve sensory loss. The 25 percent impairment was comprised of a 20 percent impairment for sensory loss associated with the C7 nerve root combined with a 6 percent impairment for sensory loss associated with the C8 nerve root.¹ Dr. Ellis combined the 13 and 25 percent values to equal a 35 percent impairment of the right arm. He also provided an impairment rating for appellant's left arm based solely on the effects of the March 5, 2004 injury. Appellant had a 12 percent impairment for decreased right shoulder motion caused by C7 and C8 nerve root compression and a 14 percent impairment due to peripheral nerve sensory loss. The 14 percent impairment was comprised of an 8 percent impairment for sensory loss associated with the C7 nerve root combined with a 7 percent impairment for sensory loss associated with the C8 nerve root. Dr. Ellis combined the 12 and 14 percent values to equal a 24 percent impairment of the right arm.

On October 15, 2007 appellant filed a claim for an additional schedule award.

In a February 21, 2008 report, Dr. Shawn Smith, a Board-certified physical medicine and rehabilitation physician serving as an Office referral physician, provided a description of appellant's factual and medical history. He noted that the July 13, 2006 MRI scan showed central disc herniations at C3-4 and C4-5 with minimal compression deformities and the July 16, 2007 CT scan showed mild to moderate disc bulging at C3-4 and C4-5 and previous surgical fusion at C5-6. The findings of January 9, 2007 EMG and NCV studies showed acute right radial neuropathy, mild bilateral ulnar neuropathies at the elbows, moderate right median

¹ Dr. Ellis used the Combined Values Chart of the A.M.A., *Guides* to combine values. See A.M.A., *Guides* 604, Combined Values Chart.

neuropathy at the wrist, mild left median neuropathy and left radial neuropathies. The findings did not show any evidence of bilateral cervical radiculopathy. Dr. Smith stated that “There was some mention of the possibility of hypothec process involvement, but this was not based on the EMG nerve studies.” He noted that appellant denied any new or chronic rictuler symptoms in his arms, but reported numbness in the last two digits of his left hand and numbness and tingling in the first three digits of his right hand. On examination appellant exhibited some limitation with neck flexion and extension with passive movement. There might have been some give way weakness in the right triceps with repetitive testing, but in general he had good strength and had no problems extending his arms indirectly multiple times. Dr. Smith indicated that there was some weakness with wrist extension on the right greater than left and noted that sensation in the hands and arms was haphazard in that pinprick testing was not reliable. The hands showed some evidence of tenor and hyposthenia atrophy which was only mild in appearance.

Dr. Smith diagnosed cervical disc herniation with cervical fusion and multi-level disc disease now above the level of fusion with no frank radicular symptoms and symptoms of ulnar radial, ulnar and median nerve symptoms with EMG and NCV studies documenting compressive neuropathies. He indicated that these arm symptoms could be overlapping a diabetic neuropathy. Dr. Smith indicated that he was not assigning any impairment rating for cervical disc pathology or surgery. With regard to focal weakness and sensory changes, he found no consistent evidence of a radicular pattern of sensory loss or muscle loss that could be assigned to the cervical condition. Dr. Smith stated:

“Given the EMG nerve conduction studies performed this past year that show the new compression neuropathies and the continued treatment that is ongoing, it is my opinion that no additional impairment above and below impairment provided for by Dr. Veggeberg should he considered for the cervical spine. In comparing the reports from Dr. Veggeberg and Dr. Ellis, it appears that Dr. Ellis’ report does not include reports of the documented compressive neuropathies found by EMG, which are consistent with his physical examination. It is my opinion that current neurological symptoms he is experiencing are based on these nerve problems which [appellant] reports are either pending acceptance of claim or are assigned under different claims. Since I have been asked to provide an impairment on the cervical spine, I can only conclude that no additional impairment, based on provisions provided by the Department of Labor and the A.M.A., *Guides* can be assigned at this time.”

In March 7, 2008 an Office medical adviser noted that Dr. Smith determined that the medical evidence did not show a right ongoing cervical radiculopathy. He agreed with Dr. Smith that appellant did not have greater impairment than previously awarded.

In a March 19, 2008 decision, the Office found that appellant did not establish that he had more than an 11 percent permanent impairment of his right arm. It found that the February 21, 2008 report of Dr. Smith showed that appellant had no impairment stemming from a work-related cervical radiculopathy. The Office determined that the opinion of Dr. Ellis that appellant

had impairment based on cervical radiculopathies was not in accordance with the diagnostic testing of record.²

Appellant submitted additional medical reports concerning the treatment of his medical conditions, but none of the reports provide any assessment of the impairment to his arms.³ In a May 5, 2008 decision, the Office affirmed its March 19, 2008 decision indicating that the weight of the medical evidence continued to rest with the opinion of Dr. Smith regarding appellant's right arm impairment.

In a June 30, 2008 report, Dr. Ellis stated that his September 12, 2007 impairment rating was performed in accordance with the standards of the A.M.A., *Guides*; however, he did not provide any further description of that assessment. The findings of May 13, 2008 EMG and NCV studies showed no evidence of intracervical neural pathology. In a September 5, 2008 decision, the Office affirmed its May 5, 2008 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act⁴ and its implementing regulations⁵ 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 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.⁶

An employee seeking compensation under the Act has the burden of establishing the essential elements of his claim, including that he sustained an injury in the performance of duty as alleged and that an employment injury contributed to the permanent impairment for which schedule award compensation is alleged.⁷

The medical evidence required to establish a causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the

² The Office indicated that Dr. Ellis did not reference recent EMG and NCV testing.

³ Appellant submitted an April 15, 2008 report of Dr. Ellis but the report did not contain an impairment rating.

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404 (1999).

⁶ *Id.*

⁷ See *Bobbie F. Cowart*, 55 ECAB 476 (2004). In *Cowart*, the employee claimed entitlement to a schedule award for permanent impairment of her left ear due to employment-related hearing loss. The Board determined that appellant did not establish that an employment-related condition contributed to her hearing loss and, therefore, it denied her claim for entitlement to a schedule award for the left ear.

claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.⁸

ANALYSIS

The Office accepted that on March 5, 2004 appellant sustained cervical and thoracic region sprains/strains, displaced lumbar disc, brachial neuritis/radiculitis and other affections of the right shoulder region due to writing with a pen for an extended period at work on that date. It later upgraded the accepted conditions to include degeneration of the lumbar spine and the C4 disc. On June 18, 2004 appellant underwent discectomy, decompression and fusion surgery at C5-6 with instrumentation. On November 20, 2006 the Office granted him a schedule award for an 11 percent permanent impairment of his right arm. On October 15, 2007 appellant filed a claim alleging entitlement to additional schedule award compensation.

In a September 12, 2007 report, Dr. Ellis, an attending Board-certified family practitioner, provided an impairment rating for appellant's right arm based solely on the effects of the March 5, 2004 injury. Appellant had a 13 percent impairment for decreased right shoulder motion caused by C7 and C8 nerve root compression and a 25 percent impairment due to peripheral nerve sensory loss (associated with the C7 and C8 nerve roots). Dr. Ellis combined the 13 and 25 percent values to equal a 35 percent impairment of the right arm.⁹ He also provided an impairment rating for appellant's left arm based solely on the effects of the March 5, 2004 injury. Appellant had a 12 percent impairment for decreased right shoulder motion caused by C7 and C8 nerve root compression and a 14 percent impairment due to peripheral nerve sensory loss (associated with the C7 and C8 nerve roots). Dr. Ellis combined the 12 and 14 percent values to equal a 24 impairment of the right arm.

The Board finds, however, that Dr. Ellis' impairment rating is of limited probative value because he did not provide a rationalized medical opinion explaining why the observed deficits were related to the March 5, 2004 employment injury. Dr. Ellis posited that appellant's June 18, 2004 fusion surgery caused increased pressure in the levels above and below the fusion and caused increased C7 nerve root impingement and new C8 nerve root impingement. However, he did not adequately explain how surgery at the C5-6 level caused or contributed to impairment at the C7 and C8 levels. Dr. Ellis did not explain his opinion in light of the fact that the diagnostic testing of record did not show significant bulging at the C7 or C8 disc. Moreover, his opinion is of limited probative value for the further reason that it is not based on a complete and accurate factual and medical history.¹⁰ Dr. Ellis did not discuss the findings of January 9, 2007 EMG and NCV studies which showed no electrodiagnostic evidence of a cervical radiculopathy in either

⁸ *Victor J. Woodhams*, 41 ECAB 345, 351-52 (1989).

⁹ *Supra* note 1.

¹⁰ *See William Nimitz, Jr.*, 30 ECAB 567, 570 (1979) (finding that a medical opinion on causal relationship must be based on a complete and accurate factual and medical history).

arm. The studies did show acute right radial neuropathy, mild bilateral ulnar neuropathies at the elbows, moderate right median neuropathy at the wrist, mild left median neuropathy and left radial neuropathies. Dr. Ellis did not address whether these other neuropathies, which were not accepted as related to the March 5, 2004 employment injury, caused appellant's continuing symptoms. His opinion is therefore of dismissed probative value.

In a February 21, 2008 report, Dr. Smith, Board-certified in physical medicine and rehabilitation and serving as an Office referral physician, indicated that he was not assigning any impairment rating for cervical disc pathology or surgery. He stated that given the January 9, 2007 EMG and NCV studies that showed no cervical radiculopathies, there was no basis to find that appellant had cervical radiculopathies, related to the March 5, 2004 employment injury. Dr. Smith posited that appellant's current neurological symptoms could be explained by neuropathies of the median, ulnar and radial nerves unrelated to the March 5, 2004 employment injury. The Board notes that the Office properly relied on the opinion of Dr. Smith in reaching its determination that appellant had not shown that he had more than an 11 percent permanent impairment of his right arm.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he has more than an 11 percent permanent impairment of his right arm, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' September 5, May 5 and March 19, 2008 decisions are affirmed.

Issued: November 20, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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