United States Department of Labor
Employees' Compensation Appeals Board

T.R., Appellant	)	
and	)	**Docket No. 12-988**
	)	**Issued: February 22, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Miami, FL, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 4, 2012 appellant, through his attorney, filed a timely appeal from a January 4, 2012 decision of the Office of Workers' Compensation Programs (OWCP) which affirmed a June 9, 2011 decision denying an additional schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant has more than five percent impairment of the right and left arms and two percent impairment of the left leg for which he received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board. In an October 29, 2004 order, the Board remanded appellant's case to OWCP to combine file number xxxxxx924 and file number

[1] 5 U.S.C. §§ 8101-8193.

xxxxxx539 pertaining to his request for a schedule award.[2] In a September 16, 2005 decision,[3] the Board affirmed OWCP's decision dated December 6, 2004 which found that appellant had a five percent impairment of the right arm.[4] Appellant appealed his claim to the Board and the Board issued a February 27, 2008 order noting OWCP failed to consolidated file number xxxxxx924 and file number xxxxxx539 and issue a schedule award determination for the upper and lower extremities. The Board remanded the matter and instructed OWCP to combine the files and issue a merit decision on appellant's request for a schedule award. The facts and circumstances of the case as set forth in the Board's prior decisions are incorporated herein by reference.

OWCP referred appellant to a second opinion physician for a determination as to his impairment to the upper and lower extremities. In an April 8, 2008 report, Dr. William Dinenberg, a Board-certified orthopedic surgeon, diagnosed bilateral carpal tunnel syndrome and cervical, thoracic and lumbar spine sprain. Dr. Dinenberg opined that, under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), appellant had 21 percent impairment of the right and left arms and 2 percent impairment of the right and left legs. In a May 28, 2008 report, OWCP's medical adviser reviewed the medical evidence and Dr. Dinenberg's April 8, 2008 report and opined that appellant had five percent impairment of the right and left upper extremity due to bilateral carpal tunnel syndrome release surgery.

In a June 17, 2008 decision, OWCP granted appellant a schedule award for five percent impairment of the left arm. Appellant requested an oral hearing and submitted additional medical evidence. In a decision dated October 21, 2008, OWCP's hearing representative set aside the June 17, 2008 decision and remanded the matter for further medical development. The hearing representative determined that OWCP failed to issue a schedule award decision addressing the upper and lower extremity impairment. In a report dated December 12, 2008, OWCP's medical adviser opined that appellant sustained five percent impairment to the right and left arms and no impairment of the legs.

In a decision dated February 13, 2009, OWCP found that appellant had no impairment of the legs and five percent impairment to each arm for which he was previously granted schedule awards. Appellant requested an oral hearing. In a May 1, 2009 decision, OWCP's hearing representative set aside the February 13, 2009 decision and remanded the matter for further medical development. The hearing representative instructed OWCP to refer appellant for a

[2] Docket No. 04-1346 (issued October 29, 2004).

[3] Docket No. 05-1184 (issued September 16, 2005).

[4] OWCP accepted appellant's 1998 occupational disease claim for bilateral carpal tunnel syndrome and authorized surgical releases which were performed on June 21 and October 5, 1999. File number xxxxxx539. Appellant filed a separate claim for a February 28, 1996 traumatic injury which was accepted for sprain of the cervical, thoracic and lumbar spine, file number xxxxxx924. In a February 27, 2008 order, the Board found that OWCP failed to consolidated file number xxxxxx924 and file number xxxxxx539 and issue a schedule award determination for the upper and lower extremities. The Board instructed it to combine the files and issue a merit decision on appellant's request for a schedule award. Docket No. 07-1889 (issued February 27, 2008).

second opinion to determine if he developed radiculopathy as a result of his work duties and to provide an impairment rating for impairment due to accepted work-related conditions.

OWCP referred appellant to Dr. Daryl Miller, a Board-certified orthopedic surgeon. On June 25, 2009 Dr. Miller noted findings and opined that, under the sixth edition of the A.M.A., *Guides*,[5] appellant had sensory deficit of uncertain etiology bilaterally at C5-6 for 7 percent impairment of the right and left arms, 15 percent impairment bilaterally for motor impairment for the right and left arms due to C5-6 deficit[6] and 1 percent impairment for loss of function due to L5-S1 deficit on the left side.[7] On August 27, 2009 OWCP's medical adviser opined that appellant had five percent impairment of the right and left upper extremity due to bilateral carpal tunnel syndrome release surgery. However, he indicated that Dr. Miller incorrectly found impairment for C5-6 and L5-S1 conditions that were not accepted conditions. The medical adviser opined that appellant no additional permanent impairment. OWCP requested Dr. Miller to provide a supplemental report addressing whether the 1996 injury aggravated the accepted cervical, thoracic and lumbar strains and whether appellant had residuals of the accepted condition. In response, Dr. Miller opined that he was unable to determine if appellant had residuals attributable to the work injury.

OWCP determined that another opinion was necessary as Dr. Miller did not properly resolve the issue before him. On December 15, 2009 it referred appellant to Dr. Robin Simon, a Board-certified orthopedic surgeon, to determine if appellant sustained permanent impairment as a result of the accepted work-related injuries. In a December 30, 2009 report, Dr. Simon opined that appellant sustained an aggravation of the preexisting cervical and lumbar conditions and continued to have residuals of his bilateral carpal tunnel syndrome. She noted that he sustained a sensory deficit with seven percent impairment for the arms from carpal tunnel syndrome pursuant to Table 15-4 and Table 15-2 page 425 of the A.M.A., *Guides.* Dr. Simon further noted that appellant had 15 percent impairment to the lower extremities pursuant to Table 16-2, page 534 of the A.M.A., *Guides* for L5-S1 deficit in the left lower extremity.

On February 12, 2010 OWCP's medical adviser reviewed Dr. Simon's report and noted appellant's conditions. He opined that Dr. Simon determined that appellant had 7 percent impairment of the upper extremity and 15 percent impairment for the lower extremities using the peripheral nerve impairment grids which was incorrect. The medical adviser utilized Table 15-23, Entrapment/Compression Neuropathy Impairment, page 449 of the A.M.A., *Guides*. He found the grade modifiers for Physical Examination (GMPE), Clinical Studies (GMCS) and Functional History (GMFH) totaled 4. The grades were averaged at 1.33 and rounded down to 1; therefore, appellant fell under grade modifier 1 with a default rating value of two percent for each arm. The medical adviser noted that the upper and lower extremity nerve root impairment was based on *The Guides Newsletter*, July to August 2009, Proposed Table 1 Spinal Nerve Impairment: Upper Extremity Impairments. He noted sensory deficit for bilateral C5 and C6 nerve root was mild, with a default value of one percent for C5 and C6, for two percent

[5] A.M.A., *Guides* (6th ed. 2008).

[6] *Id.* at 564, Table 17-2.

[7] *Id.* at 571, Table 17-4.

impairment of the right and left upper extremity. The medical adviser referenced Proposed Table 2 Spinal Nerve Impairment: Lower Extremity Impairment. With regards to the left L5 nerve root sensory deficit yielded two percent impairment of the left leg. The medical adviser noted that appellant previously received a schedule award for five percent of each arm for the same problems and was not entitled to an additional award for the upper extremities. He indicated that appellant had two percent impairment to the left leg.

In a decision dated March 5, 2010, OWCP granted appellant a schedule award for two percent impairment of the left leg. Appellant requested an oral hearing. In a December 13, 2010 decision, OWCP's hearing representative vacated the March 5, 2010 decision. The hearing representative found that there was a medical conflict between the medical adviser, who opined that appellant had four percent impairment to the upper extremities due to bilateral carpal tunnel syndrome and OWCP's referral physician, Dr. Simon, who opined that appellant had seven percent impairment to the upper extremities due to carpal tunnel syndrome. The hearing representative instructed OWCP to refer appellant to a specialist to address appellant's permanent impairment.

On February 16, 2011 OWCP referred appellant to Dr. Brad Cohen, a Board-certified orthopedic surgeon, for a second opinion, to determine appellant's permanent impairment. In a March 2, 2011 report, Dr. Cohen indicated that he reviewed the records provided and examined appellant. He diagnosed bilateral carpal tunnel syndrome status post carpal tunnel release, cervical, thoracic and lumbar strain, aggravation of degeneration of cervical degenerative disc disease at L4-5, C5-6 and C6-7, aggravation of multilevel lumbar degenerative disc disease including L5-S1. Dr. Cohen noted appellant's bilateral carpal tunnel syndrome was confirmed electrodiagnostically on January 2, 1999 and that he had releases on each wrist from which he had reached maximum medical improvement. He noted that, pursuant to Table 15-23, Entrapment/Compression Neuropathy Impairment, clinical studies were a grade modifier 2 for electromyography (EMG) findings, functional history was a grade modifier 2 for significant intermittent symptoms, physical examination was a grade modifier 2 for the left arm for decreased sensation and a grade modifier 3 for the right arm with mild right thenar atrophy. Dr. Cohen noted that the grade modifiers were six on the left and seven on the right and when averaged and rounded to the nearest integer equaled two. He noted that grade modifier 2 had a default value of five percent right and left upper extremity impairment. For cervical spine impairment, Dr. Cohen referenced Table 17-2, Cervical Spine Regional Grid and noted grade modifiers 3 for functional history, grade modifiers 0 for physical examination and grade modifiers 0 for clinical studies. He noted net adjustment was -1, for a class 1, grade B for one percent whole person impairment for the cervical spine. For the thoracic spine, Dr. Cohen referenced Table 17-3, Thoracic Spine Regional Grid, Spine Impairments and noted that appellant was a class zero for a zero whole person impairment for the thoracic spine. For the lumbar spine, he referenced Table 17-4, Lumbar Spine Regional Grid: Spine Impairments and noted grade modifiers 2 for functional history, grade modifiers 0 for physical examination and grade modifiers 0 for clinical studies. Net adjustment formula was -1 for a class 1, grade B for one percent whole person impairment for the lumbar spine. Dr. Cohen opined that appellant had eight percent whole person impairment pursuant to the A.M.A., *Guides*.

In an April 26, 2011 report, OWCP's medical adviser reviewed Dr. Cohen's report. He utilized Table 15-23, Entrapment/Compression Neuropathy Impairment, page 449 of the A.M.A.,

Guides. The medical adviser found that appellant had a grade modifier 1 for functional history, grade modifier 2 for physical examination and grade modifier (motor conduction studies) for clinical studies. The grades were averaged at 1.6, which he rounded down to 1, noting appellant fell under grade modifier 1 with a default rating value of two percent for each arm. The medical adviser noted no change in the net adjustment formula for a final impairment of two percent for the right and left arms for bilateral carpal tunnel syndrome. For cervical radiculopathy, he noted that OWCP recognized extremity impairment resulting from spinal nerve root deficit based on *The Guides Newsletter*, July to August 2009. The medical adviser used Proposed Table 1, Spinal Nerve Impairment: Upper Extremity Impairments. In rating the C6 injury, appellant had a class 1, default value C, mild sensory impairment for two percent impairment of the right arm (functional history grade modifier was one and clinical studies grade modifier was one for net adjustment of zero). For the left arm, he was a class 1, default value C, mild sensory impairment for two percent impairment (functional history grade modifier was one and clinical studies grade modifier was one for net adjustment of zero). The medical adviser noted a final rating for C6 sensory deficit of two percent impairment for the right and left upper extremities. He combined the impairment due to bilateral carpal tunnel syndrome with impairment due to cervical radiculopathy for four percent impairment of the right and left arms. Regarding impairment for the left L4 nerve root, Dr. Cohen noted mild decreased sensation at the first webspace of the left foot, mild antalgic gait with normal motor function. The medical adviser referenced *The Guides Newsletter*, July to August 2009 and utilized Table 2, Spinal Nerve Impairment, Lower Extremity Impairment. In rating the L4 injury, appellant was a class 1, mild sensory deficit of one percent of the left lower extremity (functional history grade modifier was one and clinical studies grade modifier was one for net adjustment of zero). The medical adviser noted a final impairment of one percent for the left leg for L4 injury and zero for the right leg.

In a June 9, 2011 decision, OWCP denied appellant's claim for an additional schedule award. It noted that OWCP's medical adviser calculated a four percent impairment of the right and left arms, one percent impairment of the left leg and no impairment of the right leg. Because appellant was previously granted five percent impairment of the right and left arms and two percent for the left leg, he was not entitled to an additional schedule award.

Counsel requested a hearing which was held on October 13, 2011. Appellant indicated that, in the December 13, 2010 decision, OWCP's hearing representative found that there was a conflict between OWCP's medical adviser and OWCP's referral physician, Dr. Simon, regarding permanent impairment. He asserted that OWCP failed to refer him to a referee physician but instead improperly referred him to Dr. Cohen for a second opinion.

In a decision dated January 4, 2012, OWCP's hearing representative affirmed the June 9, 2011 decision. The hearing representative found that there was no medical conflict between OWCP's medical adviser and Dr. Simon, OWCP's referral physician, meriting referral of appellant to an impartial medical specialist. The hearing representative determined that the weight of the medical evidence, as constituted by the medical adviser on April 26, 2011, failed to support that appellant had greater impairment of the upper or lower extremities previously granted by OWCP.

LEGAL PRECEDENT

Section 8107 of FECA[8] and its implementing federal regulations[9] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[10] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[11]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.[12] In 1960, amendments to FECA 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. Therefore, as the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[13]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. The A.M.A., *Guides* for decades has offered an alternative approach to rating spinal nerve impairments.[14] OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures which memorializes proposed tables outlined in the July to August 2009 *The Guides Newsletter*.[15]

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17]

---

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id.* at § 10.404(a).

[11] FECA Bulletin No. 09-03 (issued March 15, 2009).

[12] *Pamela J. Darling*, 49 ECAB 286 (1998).

[13] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[14] *Rozella L. Skinner*, 37 ECAB 398 (1986).

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

[16] *P.M.*, Docket No. 12-472 (issued December 27, 2012).

[17] A.M.A., *Guides* 411, 521.

ANALYSIS

Appellant's claim was accepted by OWCP for bilateral carpal tunnel syndrome and authorized surgical releases which were performed on June 21 and October 5, 1999, in file number xxxxxx539. He also had a traumatic injury which occurred on February 28, 1996 which was accepted for sprain of the cervical, thoracic and lumbar spine, file number xxxxxx924. Appellant filed claims for schedule awards and was previously awarded schedule awards totaling five percent impairment of each arm and two percent impairment of the left leg. The Board finds that the current medical evidence of record establishes six percent impairment to his left and right arms and one percent impairment to the left leg.

To further develop appellant's claim, OWCP referred appellant to Dr. Cohen for a second opinion regarding permanent impairment. In a March 2, 2011 report, Dr. Cohen, in calculating impairment for appellant's bilateral carpal tunnel syndrome, referenced Table 15-23, Entrapment/Compression Neuropathy Impairment, page 449 of the A.M.A., *Guides.* He noted clinical studies were a grade modifier 2, functional history was a grade modifier 2, physical examination was a grade modifier 2 for the left arm, for decreased sensation, but grade modifier 3 for the right arm for mild right thenar atrophy. Dr. Cohen noted that the grade modifiers totaled 6 on the left and 7 on the right and averaged 2 on the left and 2.33 on the right. He rounded both averages to the nearest integer, two. Dr. Cohen properly noted the grade modifier 2 had a default value of five percent for the right and left upper extremity impairment.

OWCP's medical adviser applied the A.M.A., *Guides* to the information provided in Dr. Cohen's report and noted pursuant to Table 15-23, Entrapment/Compression Neuropathy Impairment, of the A.M.A., *Guides* appellant had grade modifier 1 for functional history, grade modifier 2 for physical examination and grade modifier (motor conduction studies) 2 for clinical studies. The grades were averaged at 1.6; however, he improperly rounded the average down to 1, contrary to page 448, rating process of the A.M.A., *Guides,* which provides that after determining the average value for the modifiers "Round that average value to the nearest integer to determine the average grade." In this instance, the nearest integer to the average value for the modifier of 1.6 is 2. The grade modifier 2 has a default value of five percent impairment and therefore appellant has five percent impairment of each arm due to carpal tunnel syndrome.

For the spine, Dr. Cohen referenced Table 17-2, Cervical Spine Regional Grid, 17-3, Thoracic Spine Grid and 17-4 Lumbar Spine Regional Grid and determined whole person impairment. However, whole person impairment is not permitted under FECA.[18] Also, as noted, spinal nerve extremity impairments are to be rated as provided in Exhibit 4 of section 3.700 of OWCP's procedures. This identifies *The Guides Newsletter*, July to August 2009 which is to be used in rating extremity impairments caused by spinal nerve injury.[19] Thus, the medical adviser properly found that Dr. Cohen improperly used tables in Chapter 17 to determine impairment. In rating the C6 injury, he utilized Proposed Table 1, Spinal Nerve Impairment: Upper Extremity

[18] *See N.D.*, 59 ECAB 344 (2008) (FECA does not authorize schedule awards for permanent impairment of the whole person or the spine).

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

Impairments. The medical adviser opined that appellant was a class 1, mild sensory impairment with a default value of C for both the right and left upper extremities which equates to two percent impairment. However, he incorrectly noted that class 1, default value C, mild sensory impairment was two percent impairment. Instead, the A.M.A., *Guides* Proposed Table 1, Spinal Nerve Impairment: Upper Extremity Impairments, for a class 1, default value C, mild sensory impairment provides for a one percent impairment rating. Therefore, the final rating for C6 sensory deficit one percent impairment for the right and left arms. The combined impairment due to bilateral carpal tunnel syndrome and due to cervical radiculopathy yields six percent impairment of the right and left arms.

With regards to impairment for the left L4 nerve root, Dr. Cohen noted mild decreased sensation at the first webspace of the left foot, mild antalgic gait with normal motor function. OWCP's medical adviser referenced *The Guides Newsletter*, and utilized Table 2, Spinal Nerve Impairment, Lower Extremity Impairment. In rating the L4 injury, appellant was a class 1, mild sensory deficit, for one percent impairment of the left leg. The medical adviser noted a final impairment of one percent for the left lower extremity for L4 injury. He also found that there was no ratable impairment of the right lower extremity.

The Board finds that appellant has a total of six percent impairment to the right and left arms and one percent impairment to the left leg in accordance with the A.M.A., *Guides.* There is no current medical evidence in conformance with the A.M.A., *Guides* showing a greater impairment.[20] Since appellant was previously granted five percent impairment of the right and left arms and two percent impairment to the left lower extremity he is only entitled to an additional one percent impairment to the right arm and also for the left arm.

On appeal, appellant argues that there exists an unresolved conflict in opinion between OWCP referral physician, Dr. Simon, and OWCP's medical adviser with regards to whether appellant sustained permanent impairment to the upper and lower extremities and that the matter should have been sent to a referee physician. However, the Board finds this argument to be without merit. Although the hearing representative incorrectly characterized the difference between the district medical adviser and the most recent referral physician, Dr. Simon, section 8123(a) of FECA provides that when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict.[21] A conflict under 5 U.S.C. § 8123 cannot exist unless there is a conflict between an attending physician and an OWCP physician. Here, Dr. Simon, an OWCP referral physician, and OWCP's medical were both physicians of OWCP and are insufficient to create a conflict under 5 U.S.C. § 8123.[22]

[20] *See Bobby L. Jackson*, 40 ECAB 593, 601 (1989).

[21] *Robert W. Blaine*, 42 ECAB 474 (1991); 5 U.S.C. § 8123(a).

[22] *See Delphia Y. Jackson*, 55 ECAB 373, 376-77 (2004). While the hearing representative, on December 16, 2010, improperly found a medical conflict, the record indicates that OWCP's subsequent referral of appellant to Dr. Cohen was for purposes of a second opinion examination.

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

CONCLUSION

The Board finds that appellant is entitled to schedule award compensation for an additional one percent impairment to each of the right and left upper extremities. Appellant has no impairment of the right leg and no additional impairment of the left leg.

ORDER

IT IS HEREBY ORDERED THAT the January 4, 2012 decision of the Office of Workers' Compensation Programs is affirmed as modified.

Issued: February 22, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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