

2008 he underwent a magnetic resonance imaging (MRI) scan of the cervical spine, which demonstrated advanced multilevel degenerative joint and disc disease as well as spondylosis. The MRI scan demonstrated severe central canal stenosis and early cord compression.

OWCP authorized surgery for a C3-4, C4-5 and C5-6 anterior cervical decompression and instrument fusions on November 18, 2008. Appellant underwent an MRI scan on November 19, 2008, which demonstrated multilevel spinal stenosis created by disc and osteophytic changes between C3 and C6-7. On that day he underwent a computed tomography of the cervical spine, which demonstrated a C3-6 anterior cervical fusion with moderate left neuroforaminal narrowing and C3-4, C4-5 and C5-6 with right neuroforaminal narrowing at C5-6.

On February 18, 2010 Dr. Jane M. Stark, Board-certified in public health and general preventive medicine, examined appellant and noted that he had improvement in his symptoms. Appellant had some mild neck aching with no radicular symptoms in his left upper extremity. Dr. Stark found some occasional soreness in the neck with no tingling into the left upper extremity or weakness. She diagnosed status post anterior cervical fusion and cervical spondylosis without myelopathy. Dr. Stark determined that appellant reached maximum medical improvement on November 18, 2008 and accorded a five percent impairment of the cervical spine under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*² (A.M.A., *Guides*) based on the cervical spine regional grid.³

On December 13, 2010 Dr. Stark examined appellant, who noticed discomfort in his right shoulder and arm for the past year. Since December 2, 2010 appellant had numbness and tingling into the wrist and fingers of his right hand. He reported that the grip strength in his right hand had decreased. Dr. Stark noted the cervical fusion and right carpal tunnel release surgery in 2000. She diagnosed right wrist pain.

Appellant underwent a cervical MRI scan on January 7, 2011 which demonstrated cervical disc fusion C3-6 with lucent area in the posterior aspects of the graft at C5-6. He also underwent an electromyogram (EMG) and nerve conduction studies on January 17, 2011 which demonstrated electrophysiological evidence for a chronic active right C7 and C8 radiculopathies.

Appellant requested a schedule award on February 22, 2011. OWCP referred his claim to an OWCP medical adviser on March 7, 2011. On March 16, 2011 Dr. Neil Ghodadra, a medical adviser, stated that appellant had no residual pain and no symptoms of radiculopathy in accordance with Dr. Stark's evaluation. He stated, "I disagree with the rating given by Dr. Stark as she used the cervical region grid although the claimant has had excellent results with no ongoing pain symptoms." Dr. Ghodadra found zero percent impairment.

By decision dated April 6, 2011, OWCP denied appellant's claim for a schedule award on the grounds that he had no ratable impairment of a scheduled member.

² A.M.A., *Guides*, 6th ed. (2009).

³ *Id.* at 564.

Appellant requested reconsideration on January 13, 2012. He asked that OWCP consider recent medical evidence and submitted an x-ray of his left shoulder. Dr. Sanjai Shukla, a medical adviser, reviewed the record on March 25, 2012. He found that, as appellant did not have an accepted left shoulder condition, there was no basis for a schedule award for this member. Dr. Shukla stated, "If the claimant is arguing that his left shoulder acromioclavicle joint degenerative changes are work-related[,] documentation from an examining physician must be provided."

By decision dated April 4, 2012, OWCP denied modification of its April 6, 2011 decision.

LEGAL PRECEDENT

The schedule award provision of FECA⁴ and its implementing regulations⁵ 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*.⁶

FECA does not authorize the payment of schedule awards for the permanent impairment of the whole person.⁷ Payment is authorized only for the permanent impairment of specified members, organs or functions of the body. No schedule award is payable for a member, function or organ of the body not specified in FECA or in the regulations.⁸ FECA and the implementing federal regulations do not provide for schedule award for the permanent loss of use of the back or spine.⁹ A claimant is not entitled to such an award.¹⁰

The schedule award regulations 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 the scheduled or nonscheduled member. As the schedule award provisions of

⁴ 5 U.S.C. §§ 8101-8193, 8107.

⁵ 20 C.F.R. § 10.404.

⁶ 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 2.808.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

⁷ *W.D.*, Docket No. 10-274 (issued September 3, 2010); *Ernest P. Govednick*, 27 ECAB 77 (1975).

⁸ *W.D.*, *supra* note 7; *William Edwin Muir*, 27 ECAB 579 (1976).

⁹ FECA itself specifically excludes the back from the definition of organ. 5 U.S.C. § 8101(19).

¹⁰ *W.D.*, *supra* note 7. *Timothy J. McGuire*, 34 ECAB 189 (1982).

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.¹¹

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.¹² 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.¹³ Specifically, it will address lower extremity impairments originating in the spine through Table 16-11¹⁴ and upper extremity impairment originating in the spine through Table 15-14.¹⁵

In addressing upper extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).¹⁶

ANALYSIS

OWCP accepted appellant's claim for temporary aggravation of preexisting cervical radiculopathy at C5-6, preexisting left arm radiculopathy and temporary aggravation of preexisting arthritis in the neck with cervical spondylosis. Appellant underwent a C3-4, C4-5 and C5-6 anterior cervical decompression and instrumented fusions on November 18, 2008 which was authorized by OWCP.

Dr. Stark completed an impairment evaluation on February 18, 2010. She found that appellant had improvement in his symptoms with some mild neck aching but no radicular symptoms in his left upper extremity. Dr. Stark diagnosed status post anterior cervical fusion and cervical spondylosis without myelopathy and determined that he reached maximum medical improvement on February 18, 2003. She rated a five percent impairment of the cervical spine based on the cervical spine regional grid of the A.M.A., *Guides*.¹⁷ As noted, a schedule award is not provided for loss of use of the spine.

¹¹ *W.D., supra* note 7. *Rozella L. Skinner*, 37 ECAB 398 (1986).

¹² FECA Transmittal No. 10-04 (issued January 9, 2010); Federal (FECA) Procedure Manual, *supra* note 6, Chapter 3.700 Exhibit 4 (January 2010).

¹³ Federal (FECA) Procedure Manual, *supra* note 6, Chapter 3.700 (Exhibits 1, 4) (January 2010).

¹⁴ A.M.A., *Guides*, 533, Table 16-11.

¹⁵ *Id.* at 425, Table 15-14.

¹⁶ *Id.* at 411. *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

¹⁷ *Id.* at 564.

An OWCP medical adviser reviewed this report on March 16, 2011 noting that Dr. Stark found no residual pain or symptoms of radiculopathy into the upper extremities. He noted that she inappropriately used the cervical regional grid, rating impairment of cervical spine.

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 to establish the degree of permanent impairment. OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings of the attending physician.¹⁸

Dr. Ghodadra found that the medical evidence failed to establish permanent impairment of either arm. Dr. Stark's impairment rating was not appropriately correlated to the upper extremities under the A.M.A., *Guides*. As noted no claimant is entitled to a schedule award due to permanent impairment of the spine. Dr. Stark specifically stated that appellant had no ongoing impairment to his upper extremities and provided an impairment rating based solely on his cervical spine condition. Appellant has not submitted sufficient medical evidence to establish a permanent impairment to either arm.

The record also contains a diagnosis of wrist pain by Dr. Stark as well as additional test results. These medical records do not address the issue of whether appellant has permanent impairment of an upper extremity in accordance with the A.M.A., *Guides*. There is no supporting medical evidence to establish that he sustained permanent impairment. Dr. Shukla also reviewed the medical record to note that impairment to the upper extremities was not established.

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 did not establish permanent impairment of either arm to warrant a schedule award.

¹⁸ *Linda Beale, 57 ECAB 429 (2006).*

ORDER

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

Issued: March 19, 2013
Washington, DC

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

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

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