United States Department of Labor
Employees' Compensation Appeals Board

ROBERT L. COLLIER, Appellant	)	
and	)	**Docket No. 05-1125**
	)	**Issued: July 20, 2006**
U.S. POSTAL SERVICE, POST OFFICE, Indianapolis, IN, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On April 25, 2005 appellant filed a timely appeal from the March 30, 2005 merit decision of the Office of Workers' Compensation Programs, which denied his claim for an increased schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review this schedule award claim.[1]

ISSUE

The issue is whether appellant has more than a 41 percent permanent impairment of his left upper extremity or more than a 6 percent permanent impairment of his left or right lower extremity, thereby entitling him to an increased schedule award.

[1] Appellant does not appeal the Office's November 24, 2004 nonmerit decision denying reconsideration of his claim that he sustained a recurrence of disability from April 26 through June 16, 2002.

FACTUAL HISTORY

On May 27, 1987 appellant, then a 48-year-old mail handler, sustained an injury in the performance of duty when he pulled a tub from a group of tubs and felt a sharp pain in the left side of his back. The Office initially accepted his claim for low back strain, then expanded its acceptance to include chronic pain syndrome and aggravation of arachnoiditis radiating into both lower extremities. On November 25, 1992 the Office issued a schedule award for a six percent permanent impairment of each lower extremity.[2]

On May 21, 1996 appellant filed a claim alleging that his cervical and lumbar stenosis with radiculopathy was a result of his federal employment. The Office accepted this claim for aggravation of cervical and lumbar stenosis and approved an anterior cervical discectomy and fusion. The Office also approved a decompressive laminectomy at L3-5. On December 8, 1999 the Office issued a schedule award for a 41 percent permanent impairment of the left upper extremity.[3]

On February 7, 2003 appellant filed a claim for an increased schedule award. On July 30, 2003 the Office denied the claim because there was no competent, reliable medical evidence that appellant sustained additional impairment of his upper or lower extremities. The Office subsequently denied modification of this decision.

Appellant submitted, among other things, an October 27, 2004 report from Dr. Daniel F. Cooper, Jr., a Board-certified neurosurgeon, who stated:

> "I will give the PPI [permanent partial impairment] as best that I can from the New Guide to the Evaluation of Permanent Impairment, Fifth Edition. It will be done from the spine part 15.12 on page 423, which is nerve root and/or spinal cord. From the Tables 15-17, there is objective evidence of a C6 sensory abnormality and this would give an 8 percent loss of function due to the sensory deficits of the upper extremity. There is weakness of the C7 nerve root of 20 percent and impairment of the left upper extremity. It is a total 28 percent of the left upper extremity. The patient, according to the Table 15-18, has a 15 percent weakness of the L4 nerve root, maximum percent loss due to strength. So a 30 percent impairment rating of the left lower extremity. (sic) I could not define specific sensory abnormalities. According to a page 423, number 5, determining the whole person impairment by multiplying the upper extremity impairment by .6 and the lower extremity by .4, gives a PPI of 16.8 percent of the left upper extremity, 12 percent of the left lower extremity, which according to the conversion charts on page 604, gives a PPI rating of 26 percent for [appellant]."

On December 16, 2004 Dr. Nabil F. Angley, a Board-certified orthopedic surgeon and Office medical adviser, reviewed Dr. Cooper's October 27, 2004 report. Using Table 15-17, page 424, of the American Medical Association, *Guides to the Evaluation of Permanent*

[2] OWCP File No. 09-0311584.

[3] OWCP File No. 09-0445451. The Office combined these cases under File No. 09-0311584.

Impairment (5th ed. 2001), Dr. Angley found that appellant had a 100 percent sensory deficit of the C6 nerve root, causing an 8 percent impairment of the left upper extremity. Using Table 15-16, page 424, he reported that appellant had a Grade 2 or 57 percent motor deficit of the C7 nerve root, which can affect the upper extremity by as much as 35 percent. Multiplying 57 percent by 35 percent, Dr. Angley determined that appellant had a 20 percent impairment of the left upper extremity due to loss of strength. Using the Combined Values Chart on page 604, he concluded that appellant had a total left upper extremity impairment of 26 percent due to sensory and motor deficits.

As to the left lower extremity, using Table 15-18, page 424, he found that appellant had Grade 3 or 44 percent motor deficit of the L4 nerve root, which can affect the lower extremity by as much as 34 percent. Multiplying 44 percent by 34 percent, he determined that appellant had a 15 percent impairment of the left lower extremity due to motor deficit of the L4 nerve root. Using the same procedure, Dr. Angley reported that appellant had a Grade 3 or 44 percent motor deficit of the L5 nerve root, which he stated can affect the lower extremity by as much as 36 percent.[4] Multiplying 44 percent by 36 percent, he determined that appellant had a 15 percent impairment of the left lower extremity due to motor deficit of the L5 nerve root. Applying the Combined Values Chart, Dr. Angley concluded that appellant had a total left lower extremity impairment of 28 percent due to motor deficits. He noted that Dr. Cooper found no sensory deficit and reported no ratings for the right upper or right lower extremities.

Following the submission of a December 13, 2004 impairment rating from Dr. Francesca D. Tekula, appellant's orthopedic surgeon, the Office referred the case to Dr. Michael J. Lee, another of its medical advisers, for review and to advise whether the rating given by Dr. Tekula was consistent with her earlier chart notes and with the rating given by Dr. Cooper.

On March 15, 2005 Dr. Lee observed that Dr. Tekula's ratings[5] were inconsistent with her previous findings on physical examination: Her last chart note in April 2004 documented a normal lower extremity examination, yet she reported impairment in December 2004. Dr. Lee reported that Dr. Cooper's October 2004 rating was less inconsistent with his examination in September 2004 and was likely to be more accurate. "The difficulty with his documentation," Dr. Lee observed, "is that specific documentation on what muscle groups are weak and what grade of weakness are absent in his report. However, his assessment is well explained. Dr. Tekula's report is inconsistent. Dr. Cooper's report is less than ideally documented." Dr. Lee determined that there was insufficient evidence and documentation of physical examination findings in both reports: "What is required is a detailed physical exam[ination] on neurological status. Dermatomal sensory distributions, Grades 1 to 5 muscle testing for nerve root groups. These are not present in the chart at this time."

[4] Table 15-18, page 424, states that the maximum impairment due to motor deficit of the L5 nerve root is 37 percent of the lower extremity.

[5] She reported a three percent impairment of the left upper extremity and a nine percent impairment of each lower extremity, all due to sensory deficits.

In a decision dated March 30, 2005, the Office denied modification of its prior schedule awards. The Office found that appellant failed to meet his burden of proof to provide well written, probative evidence of an increase in the previously established impairments.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[6] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[7]

An employee seeking benefits under the Act has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence.[8] If a claimant's employment-related impairment worsens, he may apply for an additional schedule award for any increased impairment. A claimant may be entitled to an award for increased impairment, even after exposure has ceased, if causal relationship is supported by the medical evidence of record.[9]

ANALYSIS

Appellant received schedule awards for a 41 percent permanent impairment of his left upper extremity and for a 6 percent impairment of each lower extremity. He has the burden of proof to establish that his impairment has increased and that the increase is causally related to his accepted employment injury in 1987 or 1996.

In an October 27, 2004 report, Dr. Cooper, determined that appellant had a total 28 percent impairment of the left upper extremity due to a C6 sensory abnormality and weakness of the C7 nerve root. Regardless of whether his findings on September 24, 2004 support such a rating, Dr. Cooper's rating for the left upper extremity does not support appellant's claim for an increased award.[10] The rating indicates that impairment of the left upper extremity has improved

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[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001 the Office began using the A.M.A., *Guides* (5th ed. 2001). FECA Bulletin No. 01-05 (issued January 29, 2001).

[8] *Richard F. Kastan*, 48 ECAB 651 (1997) (finding that the claimant did not meet his burden of proof to establish that he had more than a 27 percent permanent impairment of his right leg, for which he previously received a schedule award). *See generally Elaine Pendleton*, 40 ECAB 1143, 1145 (1989) (burden of proof).

[9] *Paul R. Reedy*, 45 ECAB 488, 490 (1994) (claimant was not seeking reconsideration of the previous determination that his hearing loss was nonratable, but rather was claiming that he had an increased hearing loss). If the claimant sustains increased impairment at a later date which is due to work-related factors, an additional award will be payable if supported by the medical evidence. In this case, the original award is undisturbed and the new award has its own date of maximum medical improvement, percent and period. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.0808.7.b (November 1998) (claims for increased schedule awards).

[10] A.M.A., *Guides* 423 (also Tables 15-15 and 15-16, page 424).

significantly from 41 percent to 28 percent. This evidence does not form a basis for the payment of additional compensation.[11]

On September 24, 2004 Dr. Cooper reported spotty hypalgesia (decreased ability to feel pain) throughout the extremity with no specific dermatome pattern. He reported no tenderness in the left arm but stated that appellant complained of pain with movement of the left shoulder. The A.M.A., *Guides* requires the physician to identify the area of involvement using the dermatome charts and to identify the nerves that innervate the area.[12] Even if his October 27, 2004 identification of a C6 sensory abnormality is consistent with the reported hypalgesia and shoulder pain, Dr. Cooper did not explain how he determined an eight percent loss of function due to sensory deficits of the upper extremity. As Dr. Lee, the Office medical adviser, correctly noted, Dr. Cooper did not grade the severity of the sensory deficit under Table 15-15, page 424.[13]

Dr. Cooper also reported weakness of the C7 nerve root of 20 percent. His September 24, 2004 findings indicated definite weakness in both the biceps and triceps on the left side, but no major atrophy. Once again, however, he neglected to grade the severity of the motor deficit according to the classification scheme in Table 15-16, page 424.[14]

Because Dr. Cooper did not follow the procedure and grading schemes set out in the A.M.A., *Guides* for determining impairment due to sensory and motor deficits, the Board finds that appellant has not met his burden of proof to establish impairment of his left upper extremity greater than the 41 percent previously determined. The Board will affirm the Office's March 30, 2005 decision denying an increased schedule award for the left upper extremity.

Dr. Cooper's rating for the left lower extremity is based solely on motor deficits; he did not define specific sensory abnormalities. On September 24, 2004 he noted "generalized" weakness of the left lower extremity and, on October 27, 2004, reported a 15 percent weakness of the L4 nerve root and a 15 percent weakness of the L5 nerve root, which he added to arrive at

[11] Dr. Tekula, appellant's orthopedist, reported on December 13, 2004 that impairment of the left upper extremity was only three percent.

[12] *Id.*

[13] Dr. Angley, the other medical adviser, attempted to work backward from Dr. Cooper's rating to justify an eight percent sensory impairment of the left upper extremity under the A.M.A., *Guides*. But this required an assumption that appellant either had no ability whatsoever to feel pain in the C6 nerve distribution or had shoulder pain so severe that it prevented absolutely all activity, assumptions not supported by Dr. Cooper's September 24, 2004 report. When Dr. Tekula examined appellant's upper extremities on April 23, 2004, she reported only decreased sensation to light touch over the entire left hand and arm.

[14] Here as well, Dr. Angley attempted to work backward from Dr. Cooper's rating to justify a 20 percent motor impairment of the left upper extremity under the A.M.A., *Guides*. This required an assumption on his part that appellant could achieve active movement only when gravity was eliminated, something Dr. Cooper did not report. When Dr. Tekula examined appellant's upper extremities on April 23, 2004, she reported 5/5 or full muscle strength in all distributions tested, including deltoid, biceps, triceps, grip, hand intrinsics and wrist extensors.

a final rating of 30 percent. But as with the left upper extremity, he did not grade the severity of the motor deficits according to the classification scheme in Table 15-16, page 424.[15]

The Board notes that Dr. Cooper's September 24, 2004 finding of generalized weakness in the left lower extremity, together with his October 27, 2004 impairment rating of 30 percent, is not consistent with Dr. Tekula's April 23, 2004 physical examination of appellant. Dr. Tekula reported that appellant had 5/5 or full muscle strength in all distributions tested, including iliopsoas, knee extensors, dorsiflexors and plantar flexors bilaterally. Two physicians following the methods of the A.M.A., *Guides* to evaluate the same patient should report similar results and reach similar conclusions.[16] Measurements should be consistent between two trained observers or by one observer on two separate occasions, assuming the individual's condition is stable.[17] In this regard, Dr. Tekula reported on April 23, 2004 that appellant's symptoms "appear to change somewhat every time I see him."

Dr. Cooper did not follow the procedure and grading schemes set out in the A.M.A., *Guides* for determining impairment due to motor deficits. His finding of generalized weakness and rating of 30 percent are inconsistent with Dr. Tekula's finding of full muscle strength bilaterally in the lower extremities. The Board finds that appellant has not met his burden of proof to establish that the impairment of his left lower extremity has increased from the six percent previously determined. The Board will affirm the Office's March 30, 2005 decision denying an increased schedule award for the left lower extremity.

In his October 27, 2004 report, Dr. Cooper offered no impairment rating for appellant's right upper or right lower extremity. His clinical findings on September 24, 2004 were entirely normal for the right lower extremity. Examination of the right upper extremity found only an unspecified restriction of right shoulder movement. Dr. Tekula's examination on April 23, 2004 found full muscle strength in all distributions with no sensory deficit in the right upper and right lower extremities. The Board therefore finds that appellant has not submitted medical evidence sufficient to support that the impairment of his right lower extremity has increased from the six percent previously determined. The Board will therefore affirm the Office's March 30, 2005 decision denying an increased schedule award for the right lower extremity.

Page 423 of the A.M.A., *Guides* sets out the procedure an evaluating physician must follow to evaluate permanent impairment due to sensory or motor deficit of a spinal nerve root. This procedure is repeated in Tables 15-15 and 15-16 on page 424. Appellant's evaluating physicians did not follow this procedure.[18] The evaluating physician must report a clinical

[15] Dr. Angley, working backward to fill in the voids left by Dr. Cooper, simply assumed that appellant could achieve active movement only against gravity and without resistance.

[16] A.M.A., *Guides* 17.

[17] *Id*. at 20.

[18] Neither the Act nor Office regulations provide for the payment of a schedule award for the permanent loss of use of the back, so no claimant is entitled to an award for impairment of the cervical or lumbar spine. *E.g., Timothy J. McGuire*, 34 ECAB 189 (1982); *see* 5 U.S.C. § 8101(19) (excluding the back from the definition of "organ"). The Act also does not authorize the payment of schedule awards for the permanent impairment of "the whole person." *Ernest P. Govednick*, 27 ECAB 77 (1975).

description of the impairment in sufficient detail for the adjudicator to visualize the character and degree of impairment,[19] a description that permits a reliable application of the A.M.A., *Guides*. The physician must explain any inconsistency with previous clinical findings. And the physician must provide sound medical rationale explaining, if possible, how any established increase in impairment since appellant's previous schedule awards is causally related to his 1987 or 1996 employment injuries.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he has more than a 41 percent permanent impairment of his left upper extremity or more than a 6 percent permanent impairment of his left or right lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the March 30, 2005 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 20, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

[19] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.b(2) (August 2002).