United States Department of Labor
Employees' Compensation Appeals Board

CHARLES G. PORTWOOD, Appellant	)	
and	)	**Docket No. 05-1250**
	)	**Issued: June 13, 2006**
U.S. POSTAL SERVICE, POST OFFICE, Lexington, KY, Employer	)	

Appearances:
Matt Housch, Esq., for the appellant
Thomas G. Giblin, Esq., for the Director

Oral Argument February 21, 2006

DECISION AND ORDER

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

JURISDICTION

On May 18, 2005 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated December 28, 2004. Appellant also timely appealed the January 31 and March 28, 2005 decisions denying reconsideration. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of appellant's claim for a schedule award.

ISSUES

The issues are: (1) whether appellant met his burden of proof to establish that he sustained more than a 22 percent permanent impairment of his right upper extremity for which he received a schedule award; and (2) whether the Office properly denied appellant's request for a review of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On September 22, 2003 appellant, then a 54-year-old distribution clerk filed a traumatic injury claim alleging that something popped and he began to experience pain in his right

shoulder on that same date while lifting a full tub of water. The Office accepted the claim for brachia neuritis, cervical radiculitis and cervical stenosis and paid appropriate compensation benefits.[1] The Office also authorized an anterior cervical discectomy, fusion with allograft and instrumentation which was performed on December 1, 2003 and a posterior cervical laminectomy at C5-6, C6-7, C7-T1. Additionally, the Office authorized physical therapy beginning on April 28, 2004 and continuing to June 2004.

In a report dated May 5, 2004, appellant's treating physician, Dr. Yoshihiro Yamamoto, a Board-certified neurological surgeon, determined that appellant had limited range of motion of the neck and shoulder on the right, hypoesthesia in the C6-7 dermatomes on the right and give-away type weakness in the biceps, finger extensors and handgrip on the right side. He indicated that maximum medical improvement would be reached when the scar from appellant's second surgery had healed and indicated that appellant would have a 20-pound lifting restriction. He referred to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, 166 (A.M.A., *Guides*) (5th ed. 2001) and determined that appellant was at an 18 percent diagnostic-related estimate (DRE) cervical Category III, in accordance with Table 15-5.[2]

In June 6, 2004 report, Dr. Yamamoto noted that appellant had little improvement with regard to his pain and ability to manipulate his right arm. He noted that the pain worsened with certain positions such as elevating the right arm over his shoulder. Dr. Yamamoto conducted a neurological examination and determined that appellant had moderate weakness of the right triceps and mild weakness of the right wrist extensor. He noted that deep tendon reflexes were symmetrical and sensory examination showed dysesthesia along the C6 and 7 dermatomes. Dr. Yamamoto advised that appellant had reached maximum medical improvement.

By letter dated July 1, 2004, appellant requested a schedule award. Appellant indicated that he was scheduled for a functional capacity examination and that an impairment rating would be forwarded to the Office.

By letter dated July 19, 2004, the Office informed Dr. Yamamoto that impairments of the spine were not recognized under the Federal Employees' Compensation Act. Additionally, the Office requested that Dr. Yamamoto utilize the A.M.A., *Guides* and indicate whether appellant had reached maximum medical improvement and, if so, whether he had a permanent impairment.

In a report dated July 27, 2004, Dr. Yamamoto noted that appellant had "ongoing right-sided C6 and 7 right-sided radiculopathy" and opined that appellant reached maximum medical improvement on May 5, 2004. He referred to Table 13-22[3] and noted that he was rating impairment related to chronic pain in one upper extremity and determined that appellant fell into Class 3 with dominant extremity for 25 to 39 percent impairment of the whole person. He noted that appellant had extensive discomfort and concluded that appellant had 39 percent whole-

[1] On March 11, 2004 appellant was placed on the periodic rolls and continued to receive compensation every four weeks until December 2004, when appellant elected to receive disability retirement benefits.

[2] A.M.A., *Guides* 392.

[3] A.M.A., *Guides* 343.

person impairment. Dr. Yamamoto also indicated that he could rate appellant according to Table 13-23,[4] which related to his pain or deficit resulting from peripheral nerve disorders, which would allow him to classify the condition with the spinal nerve root. He explained that appellant was in the class of 25 to 60 percent sensory impairment and determined that appellant had 60 percent impairment.

By letter dated August 13, 2004, appellant requested a schedule award for a 60 percent permanent impairment of his right upper extremity based upon the July 27, 2004 report of Dr. Yamamoto.

By letter dated August 18, 2004, appellant submitted additional medical evidence in support of his request for a schedule award. He also requested that the Office utilize its discretion and award appellant concurrent payments for wage loss and a schedule award. The additional evidence included an August 13, 2004 medical report, from Dr. Harold H. Rutledge, Board-certified in anesthesiology, family medicine and pain medicine. He noted appellant's history of injury and treatment and conducted a physical examination. Dr. Rutledge diagnosed radicular pain syndrome, consistent with C8 or C7, chronic neck pain, which was a combination of discogenic problem, myofascial injury and "perhaps posterior ulna." He noted that appellant was unable to work and was "100 percent occupationally disabled."

On September 14, 2004 the Office referred appellant for a second opinion examination to Dr. Richard T. Sheridan, a Board-certified orthopedic surgeon, to determine appellant's current status and prospects for returning to work, his permanent work restrictions and an impairment rating.

In an October 19, 2004 report, Dr. Sheridan noted appellant's history of injury and treatment. He noted that appellant had 160 degrees of abduction and forward flexion in the right shoulder with 90 degrees of internal and external rotation and 50 degrees of adduction and extension in the right shoulder. He noted that appellant had a "power [four] function" in the right wrist and right lateral knuckle extension. Dr. Sheridan advised that the muscle groups were power five on the left and a power five function in shoulder abduction, adduction, forward flexion, shoulder in internal and external rotation, elbow flexion and extension, extension, forearm pronation and supination, wrist radial and ulnar deviation. He found that appellant had reached maximum medical improvement with respect to the accepted cervical radiculopathy and indicated that appellant could not perform the duties of the distribution clerk position, although he was capable of sedentary work. He referred to Tables 15-12, 15-13, 15-14, 15-17, 16-3 and utilized the Combined Values Chart.[5] Dr. Sheridan determined that appellant had an impairment of the whole person of 29 percent.

In a supplemental report dated October 29, 2004, Dr. Sheridan indicated that he was revising his previous impairment rating because he had utilized the "DRE" method. He explained that for motor weakness of power four, he referred to Table 16-12[6] and noted that for

[4] A.M.A., *Guides* 346.

[5] A.M.A., *Guides* 418, 420, 421, 424. 439, 604.

[6] A.M.A., *Guides* 484.

C6 or innervated wrist extension appellant warranted nine percent right upper extremity impairment. He noted that for C7 weakness in extension of lateral muscles, appellant warranted nine percent right upper extremity impairment. He utilized Table 16-15[7] to arrive at the motor value for the radial nerve, of 35. Dr. Sheridan multiplied the 35 percent from Table 16-15 by 25 percent from Table 16-12 and obtained 9 percent permanent impairment. He determined that appellant had five percent right upper extremity impairment for C5 hypesthesia. Dr. Sheridan also determined that appellant had one percent upper extremity impairment for lost motion in abduction and forward flexion and referred to Figures 16-40, 16-43 and 16-46.[8] He referred to the Combined Values Chart[9] and combined 9 percent and 9 percent for a total of 18 percent and combined this amount with the 5 percent, which was equal to 22 percent. He also combined the 22 percent with the 2 percent for a total of 24 percent right upper extremity impairment.

By letter dated November 4, 2004, appellant's representative provided an "impairment rating overview" in support of appellant's claim for a schedule award for 59 percent of the right upper extremity.

In a November 12, 2004 report, an Office medical adviser noted appellant's surgical history and noted that he had residual right C5-6 and C7 radiculopathy and Grade 4 radial nerve impairment of the right upper extremity. He determined that loss of motion of the right shoulder was secondary to arthrofibrosis and adhesions in the right shoulder joint, which were not a part of the accepted condition.[10] The Office medical adviser explained that for the C6 nerve root, appellant had a Grade 4 motor weakness, which was equal to a 20 percent motor deficit and multiplied this by 35 percent for the maximum percentage loss of function and obtained 7 percent.[11] For the C5 nerve root, the Office medical adviser indicated that appellant had a Grade 4 sensory deficit, which was equal to a 25 percent sensory deficit. He multiplied this sensory deficit by the five percent due to the maximum loss of function due to sensory deficit or pain and listed the result as two percent. For the C7 nerve root and radial nerve, the Office medical adviser indicated that appellant had a Grade 4 for motor weakness, which was equal to a 20 percent motor deficit for each and multiplied this value by 35 percent for each and determined that this was equal to 7 percent for the C7 nerve and the radial nerves. The Office medical adviser added the values for the radial nerve of 7 percent plus 7 percent, which he added for a total of 14 percent. He combined 7 percent for the C6 nerve root to the 14 percent and referred to the Combined Values Chart[12] to obtain a total of 20 percent. He combined 2 percent with 20 percent and again referred to the Combined Values Chart and obtained an impairment rating

[7] A.M.A., *Guides* 492.

[8] A.M.A., *Guides* 476, 477, 479.

[9] A.M.A., *Guides* 604.

[10] The Board notes that the Office medical adviser prepared an earlier report; however, this was prior to receipt of the impairment rating overview. In that November 9, 2004 report, the medical adviser opined that appellant was entitled to total impairment of 16 percent of the right arm.

[11] A.M.A., *Guides* 424, Tables 15-16 and 17.

[12] *Supra* note 9.

of 22 percent to the right arm. The Office medical adviser indicated that appellant had reached maximum medical improvement on October 19, 2004.

On November 29, 2004 the Office requested clarification from the Office medical adviser regarding appellant's accepted conditions. The Office explained that appellant had an approved laminectomy from C7-Tl and requested clarification with regard to whether there was any deficit to the extremities from T1. The Office specifically noted that the treating physician provided an impairment rating for both sensory and motor deficit on each nerve root while the medical adviser only gave either a motor weakness or sensory deficit for each nerve root. The Office requested an opinion as to whether the A.M.A., *Guides* were properly utilized.

In a November 30, 2004 report, the Office medical adviser explained that appellant did not have any deficit to the extremities from T1 hyperesthesia. He explained that only motor weakness was described for each nerve root. The Office medical adviser also explained that a spinal impairment was given for decreased neck motion, which would account for the difference and indicated that the Combined Values Charts were used correctly.

On December 3, 2004 the Office requested that the Office medical adviser address the date of maximum medical improvement.[13]

In a December 7, 2004 report, the Office medical adviser opined that he disagreed with Dr. Yamamoto's opinion that the date of maximum medical improvement was May 5, 2004. He explained that physical therapy notes of June 4, 2004 demonstrated continued improvement and increased strength of the right upper extremity by one grade. The Office medical adviser indicated that the improvement from a Grade 3 to Grade 4 classification in motor and sensory deficits decreased appellant's permanent impairment from Dr. Yamamoto of 60 percent of the whole person to 22 percent of the right upper extremity. He noted that this was based upon the findings in a June 4, 2004 physical therapy report and opined that the more relevant and accurate date for maximum medical improvement was June 4, 2004.[14]

On December 28, 2004 the Office granted appellant a schedule award for a 22 percent permanent impairment of the right upper extremity. The award covered a period of 68.64 weeks from December 26, 2004 to April 20, 2006.

By letter dated January 24, 2005, appellant requested reconsideration and alleged the treating physician's opinion should carry the weight of the evidence and that the Office medical adviser incorrectly relied upon the June 4, 2004 report of the physical therapist. He alleged that the physical therapist indicated that appellant was attempting to achieve a goal to be met and had not achieved this status. Appellant alleged that it was improper to utilize a goal in the calculation of appellant's schedule award as it was not reached.

[13] In a separate undated letter, the Office indicated there were conflicting reports regarding the date of maximum medical improvement.

[14] The June 4, 2004 physical therapy reports included short-term goals, which indicated appellant would have increased strength of the cervical spine in the right upper extremity by one grade.

By decision dated January 31, 2005, the Office denied appellant's request for reconsideration without a review of the merits on the grounds that his request was insufficient to warrant review of its prior decision.

By letter dated February 28, 2005, appellant requested reconsideration. In support of the request, appellant alleged that the Office medical adviser improperly relied upon the physical therapy report, which had an error. In a statement received on February 28, 2005, the physical therapist explained that an error occurred with regard to the patient goals. He noted that the second goal regarding appellant having "increased strength of the [cervical spine and right upper extremity] by one grade" were transcribed incorrectly. He indicated that "the first aspect of [the] goal pertain[ed] to the [cervical spine,] or neck, and [was] intended to state that the '[*p*]*atient to have increased* [*cervical spine range of motion*].'" He advised that specific, measurable improvements were not provided by the goal. The physical therapist also explained that appellant's "gross or general muscle testing revealed that the right upper extremity had actually decreased or remained unchanged with the exception of the right elbow flexion, which improved ½ grade."

The Office also received copies of reports that were previously received.

By decision dated March 28, 2005, the Office denied appellant's request for reconsideration without a review of the merits on the grounds that his request was insufficient to warrant review of its prior decision.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Act[15] and its implementing regulation[16] sets 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 regulation as the appropriate standard for evaluating schedule losses.[17]

ANALYSIS -- ISSUE 1

Appellant submitted a July 27, 2004 report in which Dr. Yamamoto found that appellant had "ongoing right-sided C6 and 7 right-sided radiculopathy" and opined that appellant reached maximum medical improvement on May 5, 2004. He referred to Table 13-22[18] and noted that he was rating impairment related to chronic pain in one arm and determined that appellant fell into

[15] 5 U.S.C. § 8107.

[16] 20 C.F.R. § 10.404.

[17] A.M.A., *Guides* (5th ed. 2001).

[18] *Supra* note 3.

class 3 with dominant extremity for 25 to 39 percent impairment of the whole person. The Act, however, does not provide a schedule award based on whole person impairments.[19] Furthermore, it is unclear how he determined that appellant was in Class 3 other than noting that appellant had extensive discomfort. Dr. Yamamoto also provided an alternative method for providing an impairment rating and utilized Table 13-23,[20] which related to appellant's pain or deficit resulting from peripheral nerve disorders. He indicated that appellant was in the 25 to 60 percent class for sensory impairment and determined that appellant had 60 percent impairment. However, he did not identify and grade the nerve involved in evaluating sensory deficit or in evaluating muscles and motor nerves involved in the loss of muscles power and motor function resulting from a peripheral nerve disorder as set forth in the A.M.A., *Guides*.[21] He also subsequently failed to properly explain how he calculated such impairment ratings under the respective tables as set forth in the A.M.A., *Guides*.[22] As such, Dr. Yamamoto's impairment rating does not conform to the A.M.A., *Guides.* It is well established that, when the attending physician fails to provide an estimate of impairment conforming with the protocols of the A.M.A., *Guides*, his opinion is of diminished probative value in establishing the degree of any permanent impairment. In such cases, the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[23]

In a November 12, 2004 report, the Office medical adviser applied Dr. Yamamoto's findings to the fifth edition of the A.M.A., *Guides.* Addressing the C6 nerve root, he found that appellant had Grade 4 motor weakness which was equal to 20 percent motor deficit and multiplied this value by 35 percent for maximum loss of function due to strength and obtained 7 percent.[24] For the C5 nerve root, the Office medical adviser determined that appellant was entitled to a Grade 4 sensory deficit, which was equal to a 25 percent sensory deficit. He multiplied this sensory deficit by the five percent due to the maximum loss of function due to sensory deficit or pain and obtained two percent.[25] The Board notes that the Office medical adviser relied upon the findings contained in the June 4, 2004 physical therapy report, which were described as goals and that these were not actual findings. Therefore, the appropriate value for sensory deficit should have been the 60 percent which was due to a Grade 3 sensory deficit. The Board notes that a Grade 3 sensory deficit would entitle appellant to a 60 percent motor deficit, which when multiplied by the maximum loss of function for a sensory deficit or pain or 5 percent would equate to 3 percent. For the C7 nerve root and radial nerves, the Office medical adviser indicated that appellant had a Grade 4 motor weakness which was equal to a 20 percent

[19] *See Tania R. Keka*, 55 ECAB ___ (Docket No. 04-177, issued February 27, 2004); *James E. Mills*, 43 ECAB 215 (1991) (neither the Act, nor its implementing regulations provide for a schedule award for impairment to the body as a whole).

[20] *Supra* note 4.

[21] A.M.A., *Guides*, page 346, Table 13-23 and page 348, Table 13-24.

[22] *Id.*

[23] *See John L. McClanic*, 48 ECAB 552 (1997); *see also Paul R. Evans*, 44 ECAB 646, 651 (1993).

[24] A.M.A., *Guides* 424, Tables 15-16 and 17.

[25] 5 percent of 25 percent is actually 1.25 percent, which would be rounded to 1 percent.

motor deficit for each and multiplied this value by 35 percent for each and determined that this was equal to 7 percent for the C7 nerve and 7 percent for the radial nerves. The Office medical adviser added the values for the radial nerve of 7 percent plus 7 percent, which were equal to 14 percent. He combined the 7 percent for the C6 nerve root to the 14 percent and referred to the Combined Values Chart[26] to obtain a total of 20 percent. He then combined the 2 percent for the C5 nerve root to the 20 percent and again referred to the Combined Values Chart and obtained an impairment rating of 22 percent to the right upper extremity. The Board notes however, that the percentage for the C5 nerve root was actually three percent. The 20 percent when combined with 2 percent pursuant to the Combined Values Chart equals 22 percent. The Board notes that this error is harmless error as the total percentage remains unchanged. In his November 30, 2004 report, the Office medical adviser explained that appellant did not have any deficit to the extremities from T1 hyperesthesia and that only motor weakness was described for each nerve root. He also explained that the date of maximum medical improvement was May 5, 2004 as the physical therapy notes of June 4, 2004 demonstrated continued improvement and increased strength of the right upper extremity by one grade and opined that the more relevant and accurate date for maximum medical improvement was June 4, 2004.

The Board finds that there is no other medical evidence of record, based upon a correct application of the A.M.A., *Guides*, to establish that appellant has more than a 22 percent permanent impairment of the right upper extremity. Accordingly, the Board finds that appellant has no more than a 22 percent permanent impairment of the right upper extremity.

On appeal, appellant's representative alleged that he felt he was entitled to a 60 percent schedule award based upon the report of his physician. However, as noted, the record establishes that appellant is entitled to no more than a 22 percent impairment of the right upper extremity.

LEGAL PRECEDENT -- ISSUE 2

Under section 8128(a) of the Act,[27] the Office may reopen a case for review on the merits in accordance with the guidelines set forth in section 10.606(b)(2) of the implementing federal regulations, which provides that a claimant may obtain review of the merits if the written application for reconsideration, including all supporting documents, sets forth arguments and contains evidence that:

> "(i) Shows that [the Office] erroneously applied or interpreted a specific point of law; or
>
> "(ii) Advances a relevant legal argument not previously considered by the Office; or

[26] *Supra* note 9.

[27] 5 U.S.C. § 8128(a).

"(iii) Constitutes relevant and pertinent new evidence not previously considered by [the Office]."[28]

Section 10.608(b) provides that any application for review of the merits of the claim which does not meet at least one of the requirements listed in section 10.606(b) will be denied by the Office without review of the merits of the claim.[29]

ANALYSIS -- ISSUE 2

The Board finds that the Office improperly denied appellant's request for review. In support of his January 24 and February 28, 2005 reconsideration requests, appellant alleged that the treating physician's opinion should carry the weight of the evidence and that the Office medical adviser incorrectly relied upon the June 4, 2004 report of the physical therapist. He alleged that the physical therapist indicated that appellant was attempting to achieve a goal to be met and had not achieved this status. Appellant alleged that it was improper to utilize a goal in the calculation of appellant's schedule award as it was not reached. Additionally, in a letter dated February 28, 2005, appellant's representative provided an undated statement in which the physical therapist explained that an error had occurred with regard to the patient goals.

In the instant case, appellant and his representative disagreed with the schedule award determination and asserted that the Office medical adviser's calculation was in error, as he had relied upon the report of the physical therapist. Appellant submitted a statement from the physical therapist in which he explained that an error had occurred during the transcription and that an error had been made regarding the calculations. He noted that the second goal regarding appellant having "increased strength of the [cervical spine] and [right upper extremity] by one grade" were transcribed incorrectly. He indicated that the first aspect of the goal pertained to the "[cervical spine], or neck and [was] intended to state that the '[p]atient to have increased [cervical spine range of motion]'" and indicated that specific, measurable improvements were not provided by the goal. The physical therapist also explained that appellant's "gross or general muscle testing revealed that the right upper extremity had actually decreased or remained unchanged with the exception of the right elbow flexion, which improved ½ grade." The Board finds that this evidence, which addresses errors in the physical therapist's reported findings, is relevant and pertinent new evidence to the schedule award issue because the Office medical adviser relied on the physical therapist's findings in calculating the schedule award.

The Board finds that appellant provided relevant and pertinent new evidence which satisfies the third criterion, noted above, for reopening a claim for merit review. Therefore, the Office improperly denied his request for reconsideration. The case will therefore be remanded to the Office for a decision on the merits of appellant's claim. On remand, the Office should consider this new evidence, together with the previously submitted evidence of record, to determine if appellant has established that he was entitled to a greater schedule award.

[28] 20 C.F.R. § 10.606(b).

[29] 20 C.F.R. § 10.608(b).

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he sustained more than a 22 percent permanent impairment of his right upper extremity, for which he received a schedule award. The Board finds that the Office improperly denied appellant's request for a merit review pursuant to section 8128(a) of the Act.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 28, 2004 is affirmed. The decisions of the Office dated March 28 and January 31, 2005 are hereby vacated and the case remanded to the Office for proceedings consistent with this decision of the Board.

Issued: June 13, 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