United States Department of Labor
Employees' Compensation Appeals Board

W.S., Appellant	)	
and	)	**Docket No. 10-677**
	)	**Issued: November 17, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Plainfield, CT, 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
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 11, 2010 appellant filed a timely appeal from an Office of Workers' Compensation Programs' decision dated December 15, 2009. Under 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 sustained any permanent impairment to his left arm causally related to his accepted cervical condition.

FACTUAL HISTORY

On February 2, 2005 appellant, a 53-year-old letter carrier, alleged that he developed left shoulder and neck conditions causally related to employment factors. The Office accepted the claim for aggravation and degeneration of a cervical intervertebral disc.

On March 4, 2008 appellant filed a Form CA-7 claim for a schedule award based upon partial loss of use of his left upper extremity.

In an October 24, 2007 report, received by the Office on March 4, 2008, Dr. John W. Ellis, a Board-certified family practitioner, found that appellant had a 32 percent impairment of his left upper extremity pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (fifth edition) (A.M.A., *Guides*). He stated that based on examination appellant had decreased grip strength and diminished sensation in the left hand, with a very mild decreased sensation in the thumb and index finger. Dr. Ellis advised that appellant had a greater loss of sensation on the ulnar aspect of the forearm than on the radial aspect. He also noted decreased range of motion of the left shoulder.

Dr. Ellis found that appellant's condition was caused by repetitive trauma which caused strains to the neck, upper back and left shoulder. He asserted that the repetitive trauma to the left shoulder resulted in tendinitis of the left shoulder joint with internal derangement of the left shoulder, in addition to deranged discs in the neck with left C6, C7 and C8 nerve root impingement and mild brachial plexus impingement. Dr. Ellis derived his impairment rating based on the following calculations: a 13 percent impairment for decreased range of motion in the shoulder; a 13 percent impairment based on weakness in the hand, fingers, wrist and elbow; a 3 percent impairment for C6 spinal nerve root impingement; a 5 percent impairment for C7 spinal nerve root impingement; and a 16 percent impairment for C6 spinal nerve root impingement under Figure 16-1(b) at page 437 of the A.M.A., *Guides*.

In an April 20, 2008 impairment evaluation, an Office medical adviser reviewed Dr. Ellis' report and stated that findings of C6, C7 and C8 spinal nerve impairments and mild brachial plexus impingement were speculative in the absence of diagnostic tests such as magnetic resonance imaging (MRI) scan of the cervical spine or electromyelogram (EMG)/nerve conduction studies of the left upper extremity. He therefore instructed the Office to schedule appellant for an MRI scan and EMG/nerve conduction studies. The Office medical adviser indicated that, upon receipt of the results of these tests and a medical opinion which reviewed these test results, appellant's entitlement to a schedule award for the left upper extremity under the A.M.A., *Guides* would be reevaluated.

In diagnostic tests performed on May 22, 2008, Dr. David Zimmerman, a Board-certified radiologist, stated that an MRI scan of the cervical spine showed mild-to-moderate disc space narrowing at the C5-6 level with loss of intradiscal signal secondary to degeneration, with no compression fractures or subluxations. He also noted mild posterior disc bulge with uncovertebral joint spurring at the C5-6 level, with no central canal stenosis or significant foraminal narrowing. Dr. Zimmerman advised that the remaining disc spaces were normal in appearance; the cervical and upper thoracic cords were normal, with no paraspinal soft tissue abnormality. He diagnosed mild cervical spondylosis of the C5-6 level with a posterior disc osteophyte complex. Dr. Devika N. Jajoo, Board-certified in radiology, administered an MRI scan of the left shoulder. The results of this test showed no tear of the glenoid labrum, no evidence of rotator cuff tear, and a loss of the fat planes between the acromion and the underlying rotator cuff; she stated that this finding was nonspecific but could be associated with impingement.

The Office referred appellant for a second opinion examination with Dr. Kent Stahl, Board-certified in psychiatry and neurosurgery, who found in a June 5, 2008 report that appellant did not have a ratable impairment of his left upper extremity under the A.M.A., *Guides*.

Dr. Stahl stated on examination that there was a 25 percent limitation in flexion and extension of the cervical spine, with normal rotation and normal shoulder range of motion; appellant's lateral cervical bending from ear to shoulder was mildly decreased. He asserted that there were no impingement signs or supraspinatus test abnormalities and that appellant had normal strength in all planes.

Dr. Stahl stated that the results of EMG/nerve conduction studies appellant underwent were mildly abnormal with a mild delay in the left distal median sensory latency. He stated, however, that there was no evidence of left cervical radiculopathy, left brachial plexopathy or peripheral polyneuropathy. Dr. Stahl reviewed the May 22, 2008 MRI scan results and advised that the left shoulder MRI scan showed no tear of the glenoid labrum and no evidence of rotator cuff tear. He indicated that there was a slight subluxation of the biceps tendon, which suggested possible partial subscapularis tear, and a minor finding of loss of fat planes between the acromium and underlying rotator cuff, which is nonspecific but could be associated with impingement. Dr. Stahl asserted that the cervical MRI scan demonstrated mild cervical spondylolysis at the C5-6 level with posterior disc osteophyte complex and no evidence of foraminal narrowing.

Dr. Stahl opined that his examination, clinical findings and the objective test results contradicted some of Dr. Ellis' clinical findings. He found no evidence of radiculopathy in appellant's report of symptoms or left shoulder impairment on his examination. Contrary to Dr. Ellis' findings, his review of appellant's left upper extremity did not indicate supraspinatus atrophy or an abnormal sensory examination. Dr. Stahl did not find any evidence of impairment beyond the cervical degenerative disc and joint disease already accepted by the Office.

In a July 19, 2008 report, the Office medical adviser determined based on his review of the MRI scan results, the EMG/nerve conduction studies and Dr. Stahl's report that there was no basis for a schedule award for the left upper extremity. He also noted that appellant had full range of motion of the left shoulder, no evidence for diminished sensation in the left forearm and hand and no evidence for diminished grip strength.

By decision dated October 2, 2008, the Office found based on Dr. Stahl's opinion that appellant had no ratable impairment of the left upper extremity and therefore was not entitled to a schedule award.

In an April 13, 2009 report, Dr. Ellis reiterated his opinion that appellant had a 32 percent left upper extremity impairment under the A.M.A., *Guides*. He stated that appellant still required ongoing treatment for his accepted injuries; he opined that the mere fact that appellant had reached maximum medical improvement did not mean that his symptoms, complaints or need for treatment had dissipated. Dr. Ellis requested that the Office review his October 24, 2007 report and reconsider appellant's entitlement to a schedule award.

By letter dated September 9, 2009, appellant's attorney requested reconsideration.

In an October 17, 2009 report, an Office medical adviser found that Dr. Ellis' April 13, 2009 report provided no basis for a schedule award. He stated that this report contained no evidence to undermine Dr. Stahl's May 22, 2008 report, which constituted the weight of the

medical evidence, or his July 19, 2008 report, which found that appellant had no ratable impairment.

By decision dated December 15, 2009, the Office denied the request for modification of the October 2, 2008 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[2] However, the Act does not specify the manner in which the percentage of loss of use of a member is to be determined. For consistent results and to ensure equal justice under the law to all claimants, the Office has adopted the A.M.A., *Guides* (fifth edition) as the standard to be used for evaluating schedule losses.[3] The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.[4]

ANALYSIS

The Office accepted a condition of aggravation/degeneration of cervical intervertebral disc. Appellant filed a claim for a schedule award based on Dr. Ellis' October 24, 2007 report, which rated a 32 percent left upper extremity impairment. The Office medical adviser found that this rating was not a sufficient basis for a schedule award because Dr. Ellis' findings of C6, C7 and C8 spinal nerve impairments and mild brachial plexus impingement were not established in the absence of an MRI scan or EMG/nerve conduction studies. Appellant was referred to Dr. Stahl, who examined him and reviewed these tests in his June 5, 2008 report. Dr. Stahl found no basis for a ratable impairment of the left upper extremity. He stated that the EMG/nerve conduction studies showed no evidence of left cervical radiculopathy, left brachial plexopathy, or peripheral polyneuropathy. The MRI scan results of the left shoulder revealed no tear of the glenoid labrum or evidence of a right rotator cuff tear. The cervical MRI scan demonstrated mild cervical spondylolysis at the C5-6 level with posterior disc osteophyte complex and no evidence of foraminal narrowing. Dr. Stahl stated that his findings contradicted those of Dr. Ellis, as his review of appellant's left upper extremity did not indicate supraspinatus atrophy or an abnormal sensory examination.

On July 19, 2008 the Office medical adviser determined that there was no basis for a schedule award for the left upper extremity based on the diagnostic test studies obtained by Dr. Stahl. The Board finds that Dr. Stahl's report was thorough, well rationalized and in conformance with the applicable protocols of the A.M.A., *Guides*. The Board finds that the

[1] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[2] *Id*. at § 8107(c)(19).

[3] 20 C.F.R. § 10.404.

[4] *Phyllis F. Cundiff*, 52 ECAB 439 (2001).

Office properly denied appellant's claim for a schedule award as the weight of medical opinion does not establish permanent impairment of the left upper extremity.

Following the October 2, 2008 decision, appellant requested reconsideration and submitted an April 13, 2009 report from Dr. Ellis who reiterated his opinion that appellant had a 32 percent left upper extremity impairment. He did not comment on the MRI scan results or EMG/nerve conduction studies, which the Office medical adviser considered essential in determining whether there was objective support for impairment to the left upper extremity. Appellant has submitted no other medical evidence to establish that he has impairment to his left arm. The Board will affirm the Office's December 15, 2009 decision.

CONCLUSION

The Board finds that appellant did not sustain any permanent impairment to his left arm causally related to his accepted cervical condition.

ORDER

IT IS HEREBY ORDERED THAT the December 15, 2009 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: November 17, 2010
Washington, DC

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

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

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