United States Department of Labor
Employees' Compensation Appeals Board

R.D., Appellant	)	
and	)	**Docket No. 11-1408**
	)	**Issued: January 26, 2012**
U.S. POSTAL SERVICE, POST OFFICE, New Orleans, LA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 19, 2011 appellant filed a timely appeal from a January 20, 2011 schedule award decision of the Office of Workers' Compensation Programs (OWCP). 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 this case.

ISSUES

The issues are: (1) whether appellant has more than one percent permanent impairment of the right upper extremity for which he received a schedule award; and (2) whether appellant has a ratable impairment of the right lower extremity.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] On March 27, 2003 appellant, then a 39-year-old letter carrier, filed a traumatic injury claim alleging that on March 26, 2003 he sustained injuries to his wrists, lower right leg, neck and back when a vehicle struck his postal truck. He stopped work on March 27, 2003 and returned to light duty on April 9, 2003. Appellant stopped work again on April 15, 2003 and did not return. OWCP accepted his claim for lumbar, neck, right wrist and right ankle sprain.

On June 3, 2008 appellant filed a claim for a schedule award.[3]

In a February 18, 2008 report, Dr. Gerald Snider, a Board-certified family practitioner, examined appellant for complaints of swelling in his hands and wrist and persistent knee pain and for evaluation for permanent, partial disability relating to a March 26, 2003 employment injury. He provided an accurate history of injury regarding appellant's vehicular accident at work and reviewed medical history. Dr. Snider noted that appellant was on light duty due to a previous right knee injury and underwent arthroscopic surgery on October 5, 1999, but he continued to complain of knee pain. He observed that a magnetic resonance imaging (MRI) scan of his right wrist revealed minor degenerative changes and an MRI scan of the cervical and lumbar spine revealed evidence of disc herniation at C3-4, C4-5, C5-6, and C6-7 with disc bulge at C2-3 and mild evidence of arthritis in the cervical spine. Dr. Snider also found evidence of bulging at T3-4 in the thoracic spine and lumbar spondylosis and bulging disc at L4-5 and L5-S1 levels in the lumbosacral spine. Electromyography (EMG) and nerve conduction velocity (NCV) tests revealed right L5-S1 radiculopathy, mild carpal tunnel syndrome and left mid cervical radiculopathy. Dr. Snider opined that appellant suffered from muscle spasms, facet arthropathy, cervical spondylosis, disc bulges in C3-4 and C4-5, right carpal tunnel syndrome and right meniscal tear.

Upon examination, Dr. Snider noted significant tenderness in appellant's right shoulder and lower pericervical musculature that extended out over the supraspinatus and infraspinatus. He related appellant's complaints of pain upon adduction and abduction of the right upper extremity and in extremes of extension and flexion of the right wrist and elbow. Dr. Snider observed mild swelling of the right hand and decreased sensation in the median distribution of

[2] OWCP accepted appellant's claim for lumbar, neck, right wrist and right ankle sprains. Appellant was placed on the periodic rolls. On May 24, 2004 OWCP proposed termination of his wage-loss compensation and medical benefits pursuant to second-opinion and impartial medical examination reports that found that he had reached maximum medical improvement and no longer had residuals from his accepted employment injuries. By decision dated June 21, 2004, it finalized the termination of appellant's medical and wage-loss benefits effective June 24, 2004. On May 5, 2005 appellant requested reconsideration. In a decision dated September 20, 2005, OWCP denied modification of its June 21, 2004 decision. On September 19, 2006 appellant again requested reconsideration. By decision dated December 19, 2006, OWCP denied modification of its September 20, 2005 decision. Appellant submitted an appeal to the Board. On August 23, 2007 the Board issued a decision affirming OWCP's December 19, 2006 decision to terminate his medical and wage-loss benefits finding that the medical evidence established that he no longer had residuals or disability causally related to his accepted employment injuries.

[3] The record reflects that appellant received a previous schedule award for 20 percent impairment of the right lower extremity under case xxxxxx073.

his right hand. Appellant's Tinel's test was positive. Dr. Snider concluded that appellant had bilateral carpal tunnel syndrome, left upper extremity radiculopathy, degenerative joint disease of the right knee status post meniscectomy and right lower extremity radiculopathy due to injuries sustained while a federal employee of the U.S. Postal Service. Utilizing the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[4] (A.M.A., *Guides*) Chapter 16, Table 16-34 on page 509, he stated that appellant had an 18 percent impairment of his right upper extremity. Utilizing Chapter 17, Tables 17-10 and 17-20 to 17-23, Dr. Snider found that appellant had a 46 percent permanent impairment of his right lower extremity and pursuant to Chapter 18, an additional 3 percent impairment due to pain. Dr. Snider stated that no further treatment was necessary and that appellant had reached maximum medical improvement on February 18, 2008.

On July 1, 2009 OWCP referred Dr. Snider's report and a statement of accepted facts to a district medical adviser to determine appellant's impairment rating for right upper and lower extremity.

In a July 9, 2009 report, the district medical adviser reviewed Dr. Snider's February 18, 2008 report and noted that the impairment rating was based on the fifth edition of the A.M.A., *Guides*, not the sixth edition, which OWCP required. He stated that Dr. Snider's report did not contain sufficient information to rate impairment of the right upper or lower extremities under the sixth edition and recommended that appellant undergo an evaluation that complied with current OWCP regulations.

On July 21, 2009 appellant was referred to Dr. Justin M. Lundgren, Board-certified in physical medicine and rehabilitation, for a second-opinion evaluation regarding the permanent impairment of his right upper and lower extremities. In a September 1, 2009 report, Dr. Lundgren noted that appellant's claim was accepted for cervical, lumbar, right wrist, and right ankle sprain and right knee medial cartilage-meniscus tear. He provided an accurate history of injury regarding the 2003 motor vehicle accident at work and reviewed appellant's medical history. Dr. Lundgren noted that a January 18, 2005 EMG study revealed right L5-S1 radiculopathy, mild right-sided carpal tunnel syndrome and a left mid-cervical radiculopathy. A December 18, 2003 MRI scan of appellant's right wrist did not reveal any acute pathology but showed mild evidence of joint effusion near the capitate bone, no ligamentous tears and no musculotendinous pathology. Dr. Lundgren noted that appellant was previously awarded a 20 percent total impairment for his right knee. Appellant complained of wrist pain in both his wrists, with his right wrist more affected than the left, and numbness in his right hand, primarily digits 4 and 5. He stated that he sometimes was unable to grip objects, felt weak in the hands and lost some dexterity. Appellant also complained of some radiating leg pain on his right side with no instability and weakness. He related that his right knee had a popping sensation and occasionally locked up.

Upon examination, Dr. Lundgren did not observe any abnormal muscle tone in the upper or lower extremities. Appellant's grip strength was 5/5 bilaterally for major upper extremity muscle groups and sensation was mildly diminished in digits 4 and 5 of his right hand. His

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

reflexes were symmetric and normal at the biceps, triceps, brachioradialis, patella and Achilles' bilaterally. Appellant's Tinel's test was positive on the right side at the wrist and negative at both elbows. His digit range of motion was totally within normal limits bilaterally with no swelling, erythema or deformities of the wrists. Examination of appellant's lower extremities revealed strength of 5/5 for lower extremity muscle groups, no swelling, no instability of the right knee, and no clubbing, cyanosis or edema. He experienced pain with palpation to the medial joint line of the right knee and was mildly tender to touch with palpation. Appellant tested negative for Spurling's, Lhermitte's, Hoffmann's and straight leg raise testing. Utilizing Table 15-3 on page 395 of the A.M.A., *Guides*, sixth edition,[5] Dr. Lundgren found that appellant had a class 1 impairment due to wrist pain, which provided a default value of a one percent impairment. Utilizing Table 16-3 on page 511 of the A.M.A., *Guides,* sixth edition, he found that appellant had a class 2 impairment due to knee arthritis, which provided a default value of 20 percent impairment. Pursuant to the Combined Values Chart on page 604 of the A.M.A., *Guides,* sixth edition, Dr. Lundgren then combined the 20 percent right lower extremity impairment for knee arthritis with the 19 percent whole person impairment from his spine calculation to equal 35 percent combined impairment. He added the 35 percent impairment with the 1 percent wrist impairment to total 36 percent whole person impairment. Dr. Lundgren stated that appellant had reached maximum medical improvement.

OWCP referred Dr. Lundgren's report to OWCP's medical adviser, along with a statement of facts. The medical adviser concurred with Dr. Lundgren that, pursuant to Table 15-3, page 395 of the A.M.A., *Guides,* sixth edition, appellant had a class 1 impairment due to wrist pain, with a default value of one percent permanent impairment. He also concurred that, pursuant to Table 16-3, page 511 of the A.M.A., *Guides,* sixth edition, appellant had a class 2 impairment due to knee arthritis, with a default value of 20 percent impairment. As appellant had previously been awarded a 20 percent permanent impairment for the right lower extremity, the medical adviser subtracted this percentage from the current rating to find 0 percent (no) impairment for the right lower extremity. However, he disagreed with Dr. Lundgren's rating of a 17 percent whole percent impairment because OWCP's regulations only provided awards for specific scheduled members. Accordingly, the medical adviser did not accept the impairment rating based on the spine or whole person. He noted the date of maximum medical improvement as September 1, 2009.

By decision dated January 20, 2011, OWCP granted appellant a schedule award for one percent impairment for the right upper extremity. The period of the award ran from September 1 to 22, 2009. Appellant received compensation for one percent permanent impairment for the right upper extremity.

LEGAL PRECEDENT -- ISSUES 1&2

The schedule award provision of FECA[6] and its implementing regulations 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. FECA, however, does not

[5] A.M.A., *Guides* (6th ed. 2009).

[6] 5 U.S.C. §§ 8101-8193.

specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound 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. The A.M.A., *Guides* (6th edition 2009), has been adopted by OWCP as the appropriate standard for evaluating schedule losses and the Board has concurred in such adoption.[7]

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).[8] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

FECA and its implementing regulations provide for the reduction of compensation for subsequent injury to the same scheduled member.[9] Benefits payable under section 8107(c) shall be reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[10]

ANALYSIS -- ISSUES 1 & 2

Appellant's claim was accepted by OWCP for lumbar, neck, right wrist, and right ankle sprain. He filed a claim for a schedule award. On January 20, 2011 OWCP granted appellant a schedule award for one percent impairment of the right upper extremity and did not grant a schedule award for the right lower extremity. The Board finds that the medical evidence does not support a permanent impairment greater than one percent impairment of the right upper extremity and that he is not entitled to a ratable impairment of the right lower extremity.

In a July 21, 2009 second-opinion examination report, Dr. Lundgren opined that appellant had one percent impairment of the right upper extremity pursuant to the A.M.A., *Guides*, sixth edition, due to his right wrist pain. He referred to Table 15-3, which provided a default value of one percent impairment for a class 1 impairment due to wrist pain. OWCP requested that the medical adviser review the medical record and determine the extent of any permanent impairment of the right arm. In a July 30, 2010 report, OWCP's medical adviser reviewed the evidence and Dr. Lundgren's second-opinion report and applied the sixth edition of the A.M.A., *Guides* to Dr. Lundgren's findings. He concurred with Dr. Lundgren in identifying a class 1 impairment due to wrist pain using the wrist regional grid in Table 15-3, which yielded a default value of one percent permanent impairment. Although Dr. Lundgren nor the medical adviser identified grade modifiers for functional history, physical examination and clinical

[7] *R.D.*, 59 ECAB 127 (2007); *Bernard Babcock, Jr.*, 52 ECAB 143 (2000); *see also* 20 C.F.R. § 10.404.

[8] A.M.A., *Guides* 494-531.

[9] 5 U.S.C. § 8101; 20 C.F.R. § 10.404(c).

[10] 20 C.F.R. § 10.404(c)(1), (2).

studies pursuant to the net adjustment formula,[11] the medical adviser referenced a December 18, 2003 MRI scan of appellant's right wrist which did not reveal any acute pathology. Examination of appellant's right wrist revealed no abnormal muscle tone, swelling, erythema or deformities. His grip strength was 5/5 bilaterally and his reflexes were normal and symmetric. Thus, the medical evidence does not support an impairment rating greater than one percent.

Dr. Lundgren also calculated that appellant had a 20 percent permanent impairment of his right lower extremity due to his knee arthritis pursuant to Table 16-3 of the A.M.A., *Guides* (sixth edition). The district medical adviser agreed that, pursuant to Table 16-3 of the A.M.A., *Guides,* appellant had a 20 percent permanent impairment of the lower extremity. He noted that appellant previously received a schedule award for 20 percent total impairment for his right knee arthritis and subtracted this amount from the current award to equal 0 percent impairment for the right lower extremity. As previously noted, benefits payable under FECA shall be reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[12] Because appellant previously received a schedule award of 20 percent impairment for his right knee arthritis, he is not entitled to additional compensation for that extremity.[13] The Board finds that appellant has not demonstrated that he has a ratable impairment of the right lower extremity.

Regarding appellant's cervical condition, the Board notes that a schedule award is not payable for a member, function or organ of the body not specified in FECA or in the implementing regulations. Neither FECA nor the regulations provide for payment of a schedule award for the permanent loss of use of the back or spine; no claimant is entitled to such an award.[14] The Board has recognized that a claimant may be entitled to a schedule award for permanent impairment to an upper extremity even though the cause of the impairment originates in the neck or spine;[15] however, the medical evidence of record does not substantiate a permanent impairment of the upper extremity due to an accepted cervical condition.

On appeal, appellant contends that OWCP should have required further development of the second-opinion examination as it was not competent and probative. He noted that Dr. Lundgren provided a 36 percent whole person impairment, which is not payable under FECA. Therefore, the district medical adviser based his opinion on an inaccurate report. The district medical adviser, however, specifically stated that he did not agree with Dr. Lundgren's rating of whole person impairment because OWCP regulations provide schedule awards for impairment of scheduled members only. Dr. Lundgren's report incorrectly provided a whole person impairment rating. This was an error the district medical adviser addressed in his report.

[11] (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX); *see* A.M.A., *Guides* 411.

[12] 20 C.F.R. § 10.404(c)(1), (2).

[13] *Supra* note 11*; see also K.F.*, Docket No. 11-966 (issued November 17, 2011).

[14] *See Jay K. Tomokiyo*, 51 ECAB 361 (2000); *see also George E. Williams*, 44 ECAB 530 (1993).

[15] *M.L.*, Docket No. 10-88 (issued September 24, 2010); *see also Thomas J. Englehart*, 50 ECAB 319 (1999).

Appellant has not provided sufficient medical evidence to establish that he is entitled to an additional impairment rating for his right lower extremity.

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 has a one percent impairment of his right upper extremity and is not entitled to a ratable impairment of the right lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the January 20, 2011 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: January 26, 2012
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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

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