

glenoid labrum lesion; displacement of cervical intervertebral disc without myelopathy, left; herniated cervical disc at C5-6. It authorized several surgeries including revisions of the neck and spine. Appellant underwent two left shoulder surgeries, an arthroscopic labral repair on September 13, 2004 and an open biceps tenodesis and arthroscopic repair of rotator cuff on September 28, 2006. On April 30, 2008 he underwent an anterior C6-7 cervical discectomy and fusion with a DePuy uniplate and removal on October 8, 2008. Appellant stopped work on April 30, 2003 and received appropriate compensation benefits.

In a March 3, 2009 report, Dr. John W. Ellis, a Board-certified family physician, noted appellant's history of injury and treatment. He utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001) (A.M.A., *Guides*) and examined appellant. Dr. Ellis opined that appellant had an impairment of 20 percent to the left upper extremity due to the left shoulder. On March 17, 2009 OWCP's medical adviser reviewed the report of Dr. Ellis and utilized the A.M.A., *Guides*. He opined that appellant had a 23 percent impairment of the left arm.²

On April 17, 2009 appellant's representative requested a schedule award.

On April 20, 2009 OWCP granted appellant a schedule award for 23 permanent impairment of the left upper extremity. The award covered a period of 71.76 weeks.

A January 6, 2010 electromyography (EMG) scan read by Dr. Charles Hall, a radiologist, was abnormal for the left arm and consistent with C7 radiculopathy. There was no definite EMG evidence of radiculopathy in the right upper extremity. Median focal neuropathy findings bilaterally were severe while there was moderate ulnar focal neuropathy bilaterally at the elbows which suggested diabetic polyneuropathy.

On March 1, 2010 appellant's representative requested reconsideration and argued that appellant had several accepted conditions meriting impairment. He asserted that it was premature to provide a three percent impairment rating for the left upper extremity due to the herniated cervical disc since it had been less than one year since appellant's April 2008 surgery. The representative provided additional evidence in support of an increased schedule award.

In a January 13, 2010 report, Dr. Ellis noted appellant's history and explained that appellant reached maximum medical improvement on April 30, 2009, one year after his neck surgery. He noted that the original fall was a significant injury to the neck, left shoulder, upper back, left upper arm, left elbow and left wrist. Dr. Ellis noted that appellant's C6-7 level fusion surgery would make the next level, C7-8, more sensitive to movement and deterioration due to the fused level. He stated that once the spinal nerves were impinged in the cervical spine, the cubital tunnel syndrome, carpal tunnel syndrome and Guyon's canal syndrome would become more manifest in the rest of the arm. Dr. Ellis advised that the C6-7 surgery would impinge on the C6 and C7 nerves and sometimes the C8 nerve, which would cause spinal nerve impingement. He noted that the January 6, 2010 EMG revealed severe left upper extremity cervical radiculopathy but did not show any right cervical radiculopathy. Dr. Ellis advised that

² OWCP's medical adviser indicated that 20 percent was for the lost shoulder range of motion following surgery and 4 percent for pain and sensory loss which combined to total 23 percent.

despite the lack of findings, his physical examination revealed obvious atrophy of the right thenar eminence between the thumb and index finger, “obvious findings of residuals of cervical spinal nerve impingement, which were over and above the nerve impingement of the right elbow and right wrist.” Under the heading of “Computation of Permanent Impairment,” Dr. Ellis using the sixth edition, noted a *QuickDASH* score of 66 on the right and 95 on the left upper extremity. For the right arm due to carpal and cubital tunnel syndrome, he referred to Table 15-23³ and found 12 percent arm impairment. For the combined cervical spinal nerve roots, Dr. Ellis referred to Table 15-20 and determined that appellant had 12 percent impairment.⁴ He combined the values for 23 percent impairment of the right arm. Dr. Ellis noted that the decreased range of motion of the right wrist was a standalone measurement that was not to be combined with the peripheral nerve impairments. He explained that, while the January 6, 2010 EMG did not reveal evidence of radiculopathy, this did not mean that appellant did not have peripheral nerve impairment. Dr. Ellis noted that appellant had obvious atrophy impairment of the right thenar eminence of his thumb and residuals of the C6, C7 and C8 spinal nerve impairment.

For left arm carpal and cubital tunnel syndromes, Dr. Ellis referred to Table 15-23 and found 14 percent impairment. Regarding cervical spinal nerve roots, he referred to Table 15-20 and found that appellant had 34 percent impairment of the left arm. When added, the impairment for the peripheral nerves equated to 48 percent or 43 percent when combined. Additionally, Dr. Ellis referred to Table 15-34 and determined that appellant had 19 percent impairment for decreased range of motion.⁵ This correlated to 62 percent left arm impairment when added or 54 percent when combined. Dr. Ellis explained that the left elbow and wrist range of motion impairment could not be combined with the carpal tunnel and cubital tunnel syndromes, as it was duplicative. He noted the shoulder range of motion, while a standalone impairment, was combined with the peripheral nerves because the shoulder range of motion was due to the direct injury to the shoulder and not due to the cervical spinal nerves or the cubital tunnel syndrome in the left arm. Dr. Ellis noted that acromioclavicular (AC) joint, rotator cuff and biceps tendon repair, which were diagnosis-based impairments of 17 percent, were not to be combined with the range of motion of the left shoulder. He advised that the 19 percent impairment was higher and would be utilized in computing the combined impairment for the left arm. Dr. Ellis noted that appellant had previously received 20 percent impairment due to decreased shoulder range of motion. He opined that the 54 percent should be 55 percent to the left arm.

In a May 19, 2010 report, an OWCP medical adviser determined that appellant had 23 percent permanent impairment of his left arm and no impairment of his right arm. He noted that Dr. Ellis’ report contained many errors and misstatements. The medical adviser explained that Dr. Ellis found left and right radiculopathy at C6, C7 and C8 but he advised that this was inconsistent with previous examinations. He referred to diagnostic studies and explained that they revealed a C6-7 radiculopathy and noted that Dr. Ellis’ sensory examination was consistent with C7 radiculopathy. The medical adviser stated that the peripheral neuropathy included in the impairment rating was not an accepted condition. Additionally, he explained that the *QuickDash*

³ A.M.A., *Guides* 449.

⁴ *Id.* at 434-35.

⁵ *Id.* at 475.

scores were not consistent with the objective findings on record. The medical adviser noted that the score for the left was equal to 95 and on the right was equal to 66. He referred to page 445 and 406 of the A.M.A., *Guides* and noted that they provided that those scores should be excluded when they were inconsistent with the objective findings. The medical adviser explained that appellant's previous impairment determination on March 17, 2009 found four percent impairment for sensory deficit but that OWCP now mandated use of AMA *Guides Newsletter* (A.M.A., Chicago, IL), July/August 2009 for rating spinal nerve root impairment to the upper extremities.⁶ He noted that, using this provision, a sensory deficit of C7 root resulted in a four percent permanent impairment of the left upper extremity, the same as previously determined. The medical adviser concluded that appellant had no right arm impairment and that no additional left arm impairment was appropriate.

By decision dated May 26, 2010, OWCP denied modification of its decision finding no increased left arm impairment and no evidence to support a ratable right arm impairment.

On August 25, 2010 appellant requested reconsideration.

In an August 19, 2010 report, Dr. Ellis noted that appellant's condition to the left arm had worsened.⁷ He noted that appellant's original fall was a direct injury to the neck, left shoulder, upper back, left upper arm, left elbow and wrist. Dr. Ellis explained that appellant had surgery and fusion on his neck and the cervical spinal nerves were more impinged down the left arm. He explained that, after the surgery, there was impingement of the spinal nerves down the right arm and the impingement of spinal nerves made the cubital tunnel, radial tunnel and carpal tunnel syndrome occur in his hands. Dr. Ellis referred to this as double crush syndrome. He noted that, but for the April 29, 2003 injury, appellant would not have right shoulder problems and cubital tunnel, radial tunnel and carpal tunnel syndrome in both hands. Dr. Ellis noted that the herniated disc at C6-7 on the right continued to deteriorate causing more stresses on the injured disc as well as the discs above and below the injured disc. He opined that it was medically reasonable to add the right shoulder, right elbow, right wrist and the entrapment syndromes as accepted conditions. Dr. Ellis referred to the A.M.A., *Guides* and noted that appellant completed a pain disability questionnaire (PDQ) and received a PDQ score of 118. Appellant had a *QuickDASH* score of 86 on the right arm and 100 on the left arm. He again noted right arm findings and found 23 percent right arm impairment. For the left arm, Dr. Ellis stated that appellant had 30 percent impairment "due to change of condition for the worse." For diagnosis-based impairment, he referred to Table 15-5⁸ and found 12 percent impairment for AC joint arthritis and impingement syndrome and seven percent for left rotator cuff repair and surgery. Dr. Ellis combined these values for 18 percent impairment. He also provided a peripheral nerve impairment rating of 43 percent. Dr. Ellis referred to Table 15-23⁹ and determined that appellant had 14 percent impairment due to carpal tunnel syndrome, cubital tunnel syndrome, Guyon's

⁶ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1.5 (January 2010).

⁷ Dr. Ellis also indicated that he was an instructor with regard to teaching the A.M.A., *Guides* to physicians.

⁸ A.M.A., *Guides* 403.

⁹ *Id.* at 449.

canal syndrome and radial tunnel syndrome. He referred to Table 15-20¹⁰ and stated that appellant had 34 percent impairment due to combined left C5, 6, 7 and 8 spinal nerve impairment. Dr. Ellis combined these values and determined that appellant had 43 percent impairment due to peripheral nerve impairment. He combined the diagnosis-based impairment with the peripheral nerve impairments and arrived at 53 percent impairment. Dr. Ellis subtracted the prior 23 percent award and opined that appellant had an additional 30 percent left arm impairment. He noted that appellant reached maximum medical improvement.

On September 3, 2010 appellant's representative requested reconsideration and expansion of appellant's claim. On September 30, 2010 OWCP asked its medical adviser to address whether appellant's approved cervical disc surgery would result in right arm findings.

In a September 30, 2010 report, an OWCP medical adviser noted that appellant's claim was approved for anterior cervical disc fusion (ACDF) at C5-6 and C6-7 on November 16, 2007, August 1 and September 10, 2008. He opined that the cervical disc disease for which the surgery was performed was "totally unrelated to the shoulder derangement pathology/bursitis/tenosynovitis." The medical adviser explained that cervical disc disease causes upper extremity pain, tenderness and neurological defects by compression, irritation or impingement of the nerve roots arising from the cervical spinal cord and did not involve the tendons or bursae of the joints of the arm. He opined that it was "not feasible or possible that the approved cervical disc surgery would result in the referred joint findings of the upper extremity."

By decision dated November 1, 2010, OWCP denied modification of the prior decision.

LEGAL PRECEDENT

The schedule award provision of FECA¹¹ and its implementing regulations¹² 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. However, FECA 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. For decisions issued after May 1, 2009, the A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.¹³ It is well established that in determining the amount of a schedule award for a member of the body

¹⁰ A.M.A., *Guides* 434.

¹¹ 5 U.S.C. § 8107.

¹² 20 C.F.R. § 10.404.

¹³ FECA Bulletin No. 09-03 (issued March 15, 2009). A.M.A., *Guides* (6th ed. 2008).

that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.¹⁴

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injury as extremity impairment; radiculopathy was reflected in the spinal rating process, which FECA does not recognize. Impairment to the upper extremities caused by a spinal injury should be rated, using the sixth edition, consistent with the article Rating Spinal Nerve Extremity Impairment in the July/August 2009 edition of *AMA Guides Newsletter* published by the American Medical Association and adopted by OWCP.¹⁵

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).¹⁶ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹⁷

A schedule award can be paid only for a condition related to an employment injury. 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.¹⁸

ANALYSIS

Appellant's claim was accepted by OWCP for subacromial bursitis, left shoulder; stenosis tenosynovitis, left index finger; sprain of the left shoulder and upper arm, superior glenoid labrum lesion; displacement of cervical intervertebral disc without myelopathy, left; herniated cervical disc at C5-6.

In support of his claim for a schedule award, appellant provided January 13 and August 19, 2010 reports from Dr. Ellis who rated impairment for the right arm and generally opined that appellant had work-related right arm conditions. However, the Board notes that appellant has no accepted right arm conditions and Dr. Ellis did not sufficiently explain how the accepted herniated disc at C5-6 and accepted surgeries, or any other accepted condition, caused right arm impairment. 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.¹⁹ Dr. Ellis referred to

¹⁴ See *Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b. (June 1993). This portion of OWCP's procedure provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function

¹⁵ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1.5 (January 2010).

¹⁶ A.M.A., *Guides* 494-531; see *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

¹⁷ A.M.A., *Guides* 521.

¹⁸ *Veronica Williams*, 56 ECAB 367, 370 (2005).

¹⁹ See *id.*

several nonaccepted conditions including carpal tunnel syndrome and right shoulder tendinitis. He referenced right arm impairment under the A.M.A., *Guides* but he did not provide a reasoned explanation as to how any right arm conditions would be causally related to an accepted condition.

The medical adviser found that appellant did not have right arm impairment due to the accepted work injury. For example, in his September 30, 2010 report, he explained that the cervical disc disease was “totally unrelated to the shoulder derangement pathology/bursitis/tenosynovitis.” The medical adviser indicated that cervical disc disease causes upper extremity pain, tenderness and neurological defects by compression, irritation or impingement of the nerve roots arising from the cervical spinal cord and did not involve the tendons or bursae of the joints of the arm. He opined that it was “not feasible or possible that the approved cervical disc surgery would result in the referred joint findings of the upper extremity.” Dr. Ellis did not adequately explain why the accepted conditions or C5-6 disc surgery caused right arm impairment.²⁰ Thus appellant has not established that he has ratable right arm impairment causally related to his accepted conditions.

Regarding the left arm, the Board also finds that appellant has not established that he has any additional impairment. Dr. Ellis advised in his August 19, 2010 report that appellant’s condition had worsened. His findings for the left included ratings for AC joint arthritis, impingement syndrome, left rotator cuff repair and surgery, a peripheral nerve impairment, carpal tunnel syndrome, cubital tunnel syndrome, Guyon’s canal syndrome and radial tunnel syndrome. As noted above, in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.²¹ The record does not establish that these conditions were preexisting. 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.²² Furthermore, Dr. Ellis’ rating of left arm impairment did not conform with the A.M.A., *Guides*. He combined two different left shoulder diagnosis-based impairments with peripheral nerve impairment determined under Table 15-23 and Table 15-20. The sixth edition of the A.M.A., *Guides* provides that in most cases only one diagnosis in each limb involved will be appropriate.²³ The A.M.A., *Guides* state, “[if] a patient has two significant diagnoses, for instance, rotator cuff tear and biceps tendinitis, the examiner should use the diagnosis with the highest causally related impairment rating for the impairment calculation.” The A.M.A., *Guides* further provide: “If there are multiple diagnoses within a specific region, then the most impairing diagnosis is rated because it is probable this will incorporate the functional losses of the less impairing diagnoses. In rare cases, the examiner may combine multiple impairments within a single region if the most impairment diagnosis does

²⁰ See *George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

²¹ See *supra* note 13.

²² See *id.*

²³ A.M.A., *Guides* 387, section 15.2 Diagnosis-Based Impairment.

not adequately reflect the losses.”²⁴ Dr. Ellis did not adequately explain his justification for combining the impairments.

Dr. Ellis also did not clearly explain how he determined appellant’s peripheral nerve impairment in his August 19, 2010 report. He referred to Table 15-20 on page 434 of the A.M.A., *Guides* and found 34 percent impairment for combined C5, C6, C7, and C8 spinal nerve impingement but he did not explain how he graded and assessed appellant’s deficits, and how he applied grade modifiers for functional history and clinical studies under the procedure for such ratings under section 15.4e of the A.M.A., *Guides*.²⁵ Likewise, Dr. Ellis did not clearly explain how he determined that appellant had 14 percent impairment under Table 15-23 of the A.M.A., *Guides* for carpal tunnel, cubital tunnel, Guyon’s canal and radial tunnel syndrome. He did not explain how he used grade modifiers in the rating process for entrapment/compression neuropathy.²⁶ Furthermore, for multiple simultaneous neuropathies, the A.M.A., *Guides* provide under Table 15-23 that, if more than three diagnosable focal neuropathies are identified and supported, “this section should not be used.” In these cases, the peripheral neuropathy section of the neurology chapter should be used, “as in these cases almost always the principal problem is a generalized peripheral neuropathy (medical disease) and not related to occupational or avocational activities.”²⁷ As Dr. Ellis did not clearly explain how his impairment rating of the left arm was based on the A.M.A., *Guides*, his opinion is of diminished probative value and not sufficient to establish that appellant has any greater impairment.²⁸

The Board notes that OWCP’s medical adviser also reviewed the matter and found no basis on which to recommend any greater impairment than that for which appellant had already received a schedule award. There is no other current medical evidence, in conformance with the A.M.A., *Guides*, which supports any greater left arm impairment.

On appeal, appellant contends that his physician’s impairment rating entitled him to a greater award. However, as noted above, the medical evidence does not support a greater impairment. Additionally, appellant noted that OWCP did not address his request to expand his claim. OWCP has not accepted the right arm condition and thus any consideration of impairment is premature absent a final OWCP decision.

²⁴ *Id.* at 419, section 15.3f, Combining and Converting Impairments.

²⁵ *See id.* at 429-30. *See also* A.M.A., *Guides* 423. The A.M.A., *Guides* note that it is important to determine the anatomic distribution and severity of loss of function resulting from sensory deficits or pain and motor deficits and loss of power and that these must be accurately graded to define the potential range of impairments associated with the nerve lesion. Only unequivocal and permanent deficits are given permanent impairment ratings.

²⁶ *See id.* at 448-49 for the rating process.

²⁷ *Id.* at 448.

²⁸ *See Linda Beale, 57 ECAB 429 (2006)* (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 in establishing the degree of permanent impairment).

CONCLUSION

The Board finds that appellant not established that he has more than 23 percent impairment of the left upper extremity for which he received a schedule award. Furthermore, he has not established any ratable right arm impairment causally related to his accepted conditions.

ORDER

IT IS HEREBY ORDERED THAT the November 1, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 12, 2012
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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