United States Department of Labor
Employees' Compensation Appeals Board

D.L., Appellant	)	
and	)	**Docket No. 12-1036**
	)	**Issued: March 1, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Middletown, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On April 12, 2012 appellant filed a timely appeal from an Office of Workers' Compensation Programs' (OWCP) schedule award decision dated March 8, 2012. 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 a 12 percent impairment of the left arm, for which she received a schedule award; and (2) whether appellant sustained any permanent impairment causally related to her accepted lumbar condition, thereby entitling her to a schedule award under 5 U.S.C. § 8107.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On June 3, 2008 appellant, a 56-year-old postmaster, injured her left knee, left shoulder and low back when she fell after slipping in a puddle of water. She filed a claim for benefits on June 7, 2008, which OWCP accepted for left shoulder sprain, lumbar sprain and left knee contusion. On December 23, 2008 appellant underwent arthroscopic surgery for repair of left shoulder impingement disease, subacromial bursitis and left rotator cuff tendinitis. The surgery was authorized by OWCP.

On September 21, 2010 appellant underwent a magnetic resonance imaging (MRI) scan of the lumbar spine, which showed disc space narrowing and desiccation at L3-4, L4-5 and L5-S1. The report found no disc bulge or protrusion at L1-2 or L2-3 and a tear of the annulus fibrosis with central disc protrusion/mild left-sided disc bulge deforming the ventral thecal sac at L3-4, with no central or neural foraminal stenosis. Appellant also had a tear of the annulus fibrosis and a small broad-based central disc protrusion deforming the ventral thecal sac at L4-5, with no significant central or neural foraminal stenosis; the study demonstrated a tear of the annulus fibrosis and a minimal disc bulge at L5-S1, with no narrowing of the central canal or neural foramina and no significant facet arthropathy. The report concluded that she had lumbar spondylosis at L3-4, L4-5 and L5-S1, with no significant spinal stenosis or nerve root impingement.

On September 22, 2010 appellant underwent an electromyogram (EMG) and nerve conduction study (NCS) following numbness in the left leg from her knee to her foot. She was evaluated for lumbar radiculopathy and/or peripheral compressive neuropathy. The results of the motor nerve conduction studies showed normal distal latencies and conduction velocities of left tibial and peroneal nerves. Sensory nerve conduction studies indicated normal peak latencies and amplitudes for left sural nerves. H-reflex studies were within the normal range. The EMG of the left lower extremity also showed normal results.

On December 23, 2010 appellant filed a claim for schedule award based on a partial loss of use of her left upper extremity and left lower extremity.

In an August 25, 2011 report, Dr. Shahzad K. Jahromi, Board-certified in family practice, found that appellant had a 12 percent permanent impairment of the left upper extremity and a 7 percent whole person impairment of the lower extremities. He stated that he used the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (fifth edition). Dr. Jahromi rated impairment based on loss of range of motion in the left shoulder. On physical examination, appellant had 80 degrees of forward flexion; 80 degrees of abduction; and that the remaining range of motion measurements were within normal limits. With regard to the accepted lower back condition, Dr. Jahromi rated a seven percent whole person impairment pursuant to Table 15-3 of the fifth edition of the A.M.A., *Guides*. He stated that appellant had sustained an acute injury with a radiographically confirmed herniated disc at the level and site noted on physical examination.

In a December 19, 2011 report, Dr. Christopher R. Bingham, a specialist in internal medicine and an OWCP medical adviser, found that appellant had a 15 percent impairment of the left arm under the sixth edition of the A.M.A., *Guides* from her accepted left shoulder impingement condition. He noted that the diagnosis-based method was the preferred method for

determining impairment. Dr. Bingham also calculated impairment under the range of motion method to determine the higher degree of impairment stemming from appellant's accepted left shoulder impingement condition.

Using the diagnosis-based method of impairment calculation, Dr. Brigham utilized Table 15-5, page 402 of the A.M.A., *Guides*, the Shoulder Regional Grid, to find that appellant had a class 1 impairment for impingement syndrome of the ligament/bone/joint. He found that this yielded a three percent upper extremity impairment for residual loss, functional with normal motion. Applying the net adjustment formula at section 15.3, pages 406, 410 and 411 of the A.M.A., *Guides*,[2] Dr. Brigham found that the grade modifier at Table 15-7, page 406 for functional history was 1, for a mild problem, pain/symptoms with strenuous/vigorous activity, plus medication to control symptoms; the grade modifier for Physical Examination (GMPE) at Table 15-8, page 408 was 2, for a moderate motion loss problem; and the grade modifier for Clinical Studies (GMCS) at Table 15-9 was 1, for a mild problem, for a postoperative diagnostic study, which confirmed mild degenerative changes. Pursuant to the formula set forth at Table 15-21, page 411, Dr. Brigham then subtracted the grade modifier 1 from grade modifier 2 for both functional history at Table 15-7 and clinical studies at Table 15-9, which yielded a net adjusted grade 0 plus 1 -- a total grade of plus 1, which moved the default position to D, which represented a four percent impairment of the left upper extremity at Table 15-5, page 402.[3] This resulted in a total seven percent impairment of the left upper extremity based on the diagnosis-based method of rating impairment.

Dr. Brigham stated that the footnote to Table 15-5, Shoulder Regional Grid, indicated that "if motion loss is present, this impairment may alternatively be assessed using [s]ection 15.7, Range of Motion Impairment." Using the range of motion measurements, Dr. Brigham evaluated impairment using section 15.7g, Shoulder Motion and Table 15-34, Shoulder Range of Motion. He properly rated a 9 percent impairment based on 80 degrees of flexion and a 6 percent impairment for 80 degrees of abduction, for a total 15 percent left upper extremity impairment based on loss of range of motion. Because this method produced a higher impairment rating than the diagnosis-based method, Dr. Brigham determined that appellant had a 15 percent left arm impairment from the accepted left shoulder impingement syndrome.

With regard to appellant's lumbar spine/radiculopathy condition, Dr. Brigham advised that spinal nerve impairment evaluations pertaining to radiculopathy, which affected the extremities had been clarified in the July/August issue of *The Guides Newsletter*.[4] The new proposed tables outlined in *The Guides Newsletter* indicated that radiculopathy was ratable but must be based on clinical findings, such as sensory or motor deficits of the spinal nerves. Pursuant to the sixth edition of the A.M.A., *Guides* at page 576, a lumbar radiculopathy supported by clinical facts, such as a herniated disc shown by an imaging study, was not sufficient to constitute a ratable spinal nerve impairment. Dr. Brigham advised that, in order for

[2] A.M.A., *Guides* 406, 410-11.

[3] *Id*. at 402.

[4] Dr. Brigham stated that the statement of accepted facts indicated that lumbar radiculopathy was listed as an "accepted diagnosis."

the radiculopathy to be ratable, the clinical findings must correlate with radiographic findings such as motor weakness, loss of reflex and a positive root tension sign. He reviewed Dr. Jahromi's August 25, 2011 report and found that none of the applicable components confirmed the diagnosis of radiculopathy. Although Dr. Jahromi noted decreased sensation in the left lower extremity below the knee along the L5 nerve root, there was no evidence of a disc herniation or stenosis that impinged on the left L5 nerve root or any other lumbar nerve root based on the MRI scan results; nor were there any other findings that supported a left L5 radiculopathy. Dr. Brigham stated that appellant underwent electrodiagnostic studies of the lower extremities on September 22, 2010 which produced normal results, with no nerve root impingement.

In addition, Dr. Brigham noted that on examination appellant showed normal strength in her lower extremities and normal and equal bilateral deep tendon reflexes of the knees and ankles. He concluded that in the absence of a verifiable lumbar radiculopathy she had no ratable impairment of the lower extremities under the sixth edition of the A.M.A., *Guides* based on Dr. Jahromi's August 25, 2011 report.

By decision dated March 8, 2012, OWCP granted appellant a schedule award for a 15 percent permanent impairment of the left upper extremity for the period August 25, 2011 to July 17, 2012, for a total of 46.8 weeks of compensation.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA[5] and its implementing regulations[6] 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. A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[7] 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.[8]

ANALYSIS -- ISSUE 1

OWCP accepted the conditions of left shoulder strain and impingement syndrome of the left shoulder. Dr. Brigham reviewed Dr. Jahromi's August 25, 2011 report and found that appellant had a 15 percent left upper extremity impairment based on the range of motion method outlined in the applicable tables of the sixth edition of the A.M.A., *Guides*, which yielded a

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404. Effective May 1, 2009, OWCP began using the A.M.A., *Guides* (6th ed. 2009).

[7] *Id.*

[8] *Veronica Williams*, 56 ECAB 367, 370 (2005).

higher impairment rating than the diagnosis-based method. The Board notes that the A.M.A., *Guides* stipulate that the examiner should use the methodology with the highest impairment rating in that region that is causally related for the impairment calculation.[9] Based on this principle Dr. Brigham properly found that the loss of range of motion method for rating impairments was the appropriate method for rating appellant's accepted left shoulder conditions, as opposed to the diagnosis-based method.

The Board has reviewed Dr. Brigham's calculation of permanent impairment of appellant's left shoulder, utilizing the range of motion methodology and finds that he properly utilized Table 15-34 of the A.M.A., *Guide*s, at page 475, to conclude that she had a nine percent impairment based on 80 degrees of flexion and a six percent impairment based upon 80 degrees of abduction. Dr. Brigham properly calculated her permanent impairment of the left upper extremity to be 15 percent.

The Board notes that Dr. Jahromi's August 25, 2011 impairment rating was rendered in conformance with the fifth edition of the A.M.A., *Guides*. Therefore, while the findings on examination and measurements Dr. Jahromi calculated constituted a sufficient basis for Dr. Brigham's impairment rating, the impairment ratings Dr. Jahromi issued in his report were not in conformance with the updated edition of the A.M.A., *Guides*. Accordingly, as OWCP's medical adviser provided the only impairment rating of record rendered in accordance with the applicable protocols and tables of the A.M.A., *Guides*, it properly granted a schedule award for a 15 percent left upper extremity impairment in its March 8, 2012 decision.

LEGAL PRECEDENT -- ISSUE 2

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.[10] In 1960, amendments to FECA modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[11]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP's procedures indicate that *The Guides*

[9] A.M.A., *Guides* 387.

[10] *Pamela J. Darling*, 49 ECAB 286 (1998).

[11] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

Newsletter "Rating Spinal Nerve Extremity Impairment using the sixth edition" (July/August 2009) is to be applied.[12]

In addressing lower extremity impairments, due to peripheral or spinal nerve root involvement, the sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Factual History (GMFH) and if electrodiagnostic testing were done, GMCS.[13] The net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[14]

ANALYSIS -- ISSUE 2

OWCP accepted a lumbar sprain condition and a lumbar radiculopathy condition. The Board notes that a schedule award is not payable under FECA for injury to the spine[15] or based on whole person impairment.[16] However, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[17] Appellant must establish impairment to a scheduled member caused by the accepted condition before an impairment due to a preexisting condition can be assessed.[18] The instant record is not sufficient to establish that appellant has any impairment caused by his accepted lumbar strain or lumbar radiculopathy condition.

Dr. Brigham found that appellant had no ratable impairment for lumbar radiculopathy under the sixth edition of the A.M.A., *Guides*. He advised that although the July/August issue of *The Guides Newsletter* indicated that, radiculopathy was ratable based on motor or sensory dysfunction of the spinal nerves, Dr. Jahromi's August 25, 2011 report did not contain documentation showing that appellant had any of these findings. Dr. Brigham stated that a lumbar radiculopathy supported by clinical facts, such as a herniated disc shown by an imaging study, was not sufficient to constitute a ratable spinal nerve impairment pursuant to the sixth edition of the A.M.A., *Guides* at page 576. He noted that the September 2010 MRI scan and EMG findings showed normal results and presented none of the applicable components to confirm a diagnosis of radiculopathy. Dr. Brigham advised that, although Dr. Jahromi noted decreased sensation in the left lower extremity below the knee along the L5 nerve root, there was no evidence of a disc herniation or stenosis that impinged on the left L5 nerve root or any other nerve root based on the September 21, 2010 MRI scan results; nor were there any other findings

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[12] *See G.N.*, Docket No. 10-850 (issued November 12, 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- *Medical, Schedule Awards*, Chapter 3.700, Exhibit 1, note 5 (January 2010). The newsletter is included as Exhibit 4.

[13] A.M.A., *Guides* 533

[14] *Id.* at 521.

[15] *Pamela J. Darling*, 49 ECAB 286, n.10 (1998).

[16] *N.M.*, 58 ECAB 273, n.9 (2007).

[17] *Thomas J. Engelhart*, 50 ECAB 319, n.11 (1999).

[18] *See generally Thomas P. Lavin*, 57 ECAB 353 (2006).

that supported a left L5 radiculopathy. He stated that the September 22, 2010 EMG studies produced normal results, with no nerve root impingement. In addition, Dr. Brigham advised that on examination appellant showed normal strength in her lower extremities; normal and equal bilateral deep tendon reflexes of the knees and ankles; and normal sensation, strength and tone in the left lower extremity. Based on this objective evidence he found that she had no ratable findings of sensory or motor loss impairment related to the L5 spinal nerve root in the left lower extremity. Dr. Brigham properly concluded that in the absence of a verifiable lumbar radiculopathy appellant had no ratable impairment of the lower extremities. Dr. Jahromi's August 2011 report merely found that she had a seven percent whole person impairment stemming from the left lower extremity; the Board notes that FECA does not provide schedule awards for permanent impairment of the whole person or body as a whole.[19]

The Board finds that OWCP properly found in its March 8, 2012 decision that appellant had no permanent impairment of the left lower extremity. Dr. Brigham's December 19, 2011 report, the only impairment rating rendered in conformance with the applicable protocols of the A.M.A., *Guides*, represented the weight of the medical evidence in this case. The March 8, 2012 decision of OWCP is affirmed.

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 no more than a 15 percent permanent impairment of the left upper extremity, for which she received a schedule award. The Board finds that appellant has not sustained any permanent impairment to a scheduled member of her body causally related to her accepted lumbar condition, thereby entitling her to a schedule award under 5 U.S.C. § 8107.

[19] *See B.M.*, Docket No. 09-2231 (issued May 14, 2010); *D.J.*, 59 ECAB 620 (2008).

ORDER

IT IS HEREBY ORDERED THAT the March 8, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 1, 2013
Washington, DC

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

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

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