United States Department of Labor
Employees' Compensation Appeals Board

Y.M., Appellant	)	
and	)	**Docket No. 13-1626**
	)	**Issued: November 13, 2013**
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:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 28, 2013 appellant filed a timely appeal from the May 10, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP), which issued additional schedule compensation. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of this case.

ISSUE

The issue is whether appellant has more than a 17 percent additional impairment of her right upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On August 31, 2000 appellant, a 38-year-old automated mark-up clerk, filed an occupational disease claim alleging that she sustained back and right upper extremity injuries as a result of keying, throwing mail, carrying buckets, lifting trays, labeling mail, casing mail and other activities in the course of her employment. OWCP accepted her claim for cervical strain

[1] 5 U.S.C. § 8101 *et seq.*

and bilateral shoulder sprain/strain. Under another claim,[2] it accepted that appellant sustained an occupational right carpal tunnel syndrome due to work activities prior to July 8, 1999.

On December 8, 2004 OWCP issued a schedule award for a three percent impairment of appellant's right upper extremity based on loss of shoulder abduction. Appellant had no impairment from carpal tunnel syndrome.

In 2012 appellant filed another schedule award claim. Dr. William R. Knight, a Board-certified physiatrist, evaluated her on November 8, 2012. He found that appellant's employment had caused chronic cervicalgia with cervical disc disease and herniations, right cervical brachial neuritis associated with cervical radiculopathy, carpal tunnel syndrome and plexopathy, shoulder pain associated with a tear of the right supraspinatus rotator cuff, chronic tendinitis and subdeltoid bursitis and chronic cervical myofascial pain disorder. Offering whole-person impairment ratings for a variety of conditions with references to various tables in the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009), Dr. Knight concluded that appellant had a 32 percent whole-person impairment.

An OWCP medical adviser was unable to determine how Dr. Knight arrived at his ratings. There were no supporting worksheets; Dr. Knight did not apply appropriate tables; he did not follow procedures for applying grade modifiers; he rated conditions that were not accepted by OWCP and were not payable under FECA; and he gave whole-person ratings, which OWCP did not recognize. The medical adviser recommended an evaluation from a second-opinion physician who was familiar with OWCP procedure and the proper application of the A.M.A., *Guides*.

Dr. Brett Rothaermel, a Board-certified physiatrist and OWCP referral physician, evaluated appellant's impairment on March 26, 2013. He reviewed the statement of accepted facts and appellant's medical records. Dr. Rothaermel related appellant's history and complaints. An electroneuromyographic evaluation on September 5, 2012 revealed evidence of right C5-6 cervical root radicular compromise, without acute denervation activity, and continued evidence of bilateral upper brachial plexus level nerve compromise, left greater than right, with the most recent test showing improvement on the right and deterioration on the left. Dr. Rothaermel found a 13 percent right upper extremity impairment due to cervical radiculopathy/brachial plexus impairment (Table 15-20 of the A.M.A., *Guides*, page 434). He also found an eight percent right upper extremity impairment for loss of shoulder motion, an alternative stand-alone assessment in lieu of a diagnosis-based estimate for chronic right shoulder tendinitis of the supraspinatus tendon, subacromial and subdeltoid bursitis and hypertrophic changes of the acromioclavicular joint (Table 15-5, page 401; Table 15-34, page 475). On physical examination, however, he found that appellant restricted her bilateral shoulder motion in a self-limited pattern with abrupt stops at 90 degrees flexion and abduction.

Finally, as electrodiagnostic studies showed no significant findings for carpal tunnel syndrome, Dr. Rothaermel rated appellant's right wrist pain but found no impairment because appellant had no objective physical findings on examination (Table 15-3, page 395).

[2] OWCP File No. xxxxxx725.

Dr. Rothaermel combined these three impairments using the A.M.A., *Guides*' Combined Values Chart and concluded that appellant had a 20 percent impairment of her right upper extremity.

An OWCP medical adviser reviewed Dr. Rothaermel's evaluation and concurred with the ratings given for brachial plexus nerve injury, loss of shoulder motion and wrist pain. As OWCP had previously issued a schedule award for a three percent impairment of appellant's right upper extremity, the medical adviser found that appellant was entitled to an additional schedule award of 17 percent.

On May 10, 2013 OWCP issued a schedule award for an additional 17 percent impairment of appellant's right upper extremity.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[3] and the implementing regulations[4] set forth the number of weeks of compensation payable to employees who sustain permanent impairment of a scheduled member, function or organ of the body. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[5]

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. OWCP has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

ANALYSIS

OWCP accepted appellant's claim for cervical strain and bilateral shoulder sprain/strain. Under another claim, it accepted right carpal tunnel syndrome. These are the accepted medical conditions. The issue raised by appellant's schedule award claim is whether the accepted cervical strain, bilateral shoulder sprain/strain or right carpal tunnel syndrome caused any permanent impairment to her upper extremities.

Dr. Knight, the physiatrist who evaluated appellant in 2012, based his 32 percent whole-person rating on many medical conditions that were not accepted by OWCP, including chronic cervicalgia with cervical disc disease and herniations, right cervical brachial neuritis associated with cervical radiculopathy, plexopathy, shoulder pain associated with a tear of the right

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[6] 20 C.F.R. § 10.404; *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010).

supraspinatus rotator cuff, subdeltoid bursitis and chronic cervical myofascial pain disorder. In addition to whole-person ratings,[8] he did not fully explain how he applied the A.M.A., *Guides*. The fundamental defect in his report was that he did not evaluate what impairment, if any, was caused by the accepted cervical strain and bilateral shoulder sprain/strain. He did offer a two percent whole-person rating for right carpal tunnel syndrome.

OWCP referred appellant to Dr. Rothaermel, a physiatrist, for a proper evaluation, but Dr. Rothaermel, too, evaluated impairment due to unaccepted medical conditions. In particular, he found a 13 percent impairment of the right upper extremity due to brachial plexus nerve injury with cervical radiculopathy, based in part on evidence of right C5-6 cervical root radicular compromise and continued evidence of bilateral upper brachial plexus level nerve compromise. OWCP accepted only a cervical strain. Unless the accepted cervical strain has permanently impaired one or both of appellant's upper extremities, she is not entitled to a schedule award for that diagnosis.[9]

Dr. Rothaermel also found an eight percent impairment for loss of shoulder motion as an alternative stand-alone assessment in lieu of a diagnosis-based estimate for chronic right shoulder tendinitis of the supraspinatus tendon, subacromial and subdeltoid bursitis, and hypertrophic changes of the acromioclavicular joint, but again, OWCP accepted only bilateral shoulder sprain/strain. The highest diagnosis-based impairment rating a claimant can receive for a shoulder sprain/strain is a two percent impairment of the upper extremity,[10] though the A.M.A., *Guides* indicates in this instance that the evaluator may use loss of shoulder motion as a stand-alone alternative method of evaluation not to be combined with diagnosis-based impairment.

The A.M.A., *Guides* provides, however, that the examiner is permitted to disallow the rating for loss of active range of motion if there is not a pathoanatomic or physiological correlate, and there is suboptimal effort or symptom magnification.[11] When he physically examined appellant, Dr. Rothaermel found that she restricted her bilateral shoulder motion in a self-limited pattern with abrupt stops at 90 degrees flexion and abduction. He nonetheless allowed a rating for loss of shoulder motion. Having found a 13 percent impairment due to unaccepted nerve injury, Dr. Rothaermel combined an 8 percent impairment for unreliable loss of shoulder motion to find a 20 percent impairment of the right upper extremity. The Board finds this rating of little probative value.

Dr. Rothaermel did properly evaluate impairment due to the accepted right carpal tunnel syndrome. He explained that recent electrodiagnostic studies showed no significant findings for a diagnosis of carpal tunnel syndrome; therefore, he used the alternative rating for nonspecific or wrist pain.[12] As there were no objective findings on physical examination -- no atrophy,

[8] FECA does not authorize the payment of schedule awards for the permanent impairment of "the whole person." *Ernest P. Govednick*, 27 ECAB 77 (1975).

[9] Because neither FECA nor the regulations provide a schedule award for the permanent loss of use of the back or neck, no claimant is entitled to such an award. *E.g., Timothy J. McGuire*, 34 ECAB 189 (1982). FECA specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

[10] A.M.A., *Guides* 401 (Table 15-5).

[11] *Id*. at 461.

[12] *Id*. at 446.

swelling, crepitance, loss of motion, instability malalignment -- the rating was modified from one percent to zero.[13]

The Board finds, however, that Dr. Rothaermel's evaluation as a whole is insufficient to establish a 17 percent additional impairment. Accordingly, the Board will set aside OWCP's May 10, 2013 decision and remand the case for further development of the medical evidence. OWCP shall obtain an evaluation that explains, consistent with the statement of accepted facts, whether the accepted cervical strain has caused any permanent impairment of appellant's right or left upper extremity. The evaluator shall explain, consistent with the statement of accepted facts, whether the accepted bilateral shoulder sprain/strain has caused any permanent impairment of appellant's right or left upper extremity. OWCP need not further develop the extent of any permanent impairment due to the accepted right carpal tunnel syndrome, as Dr. Rothaermel has addressed that issue satisfactorily. After such further development of the evidence as may be necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.

CONCLUSION

The Board finds that this case is not in posture for decision. Further development of the medical evidence is warranted.

ORDER

IT IS HEREBY ORDERED THAT the May 10, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action.

Issued: November 13, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

[13] The highest impairment rating a claimant can receive for nonspecific wrist pain is one percent.