United States Department of Labor
Employees' Compensation Appeals Board

K.C., Appellant	)	
and	)	**Docket No. 14-204**
	)	**Issued: December 17, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Indianapolis, IN, Employer	)	

Appearances:
Joseph E. Allman, Esq., for the appellant
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 November 4, 2013 appellant, through his attorney, filed a timely appeal from a May 6, 2013 merit 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.

ISSUE

The issue is whether appellant sustained any permanent impairment to his left leg or left arm under 5 U.S.C. § 8107.

FACTUAL HISTORY

On May 14, 2009 appellant, a 52-year-old mail carrier injured his head, neck, back, and face when the vehicle he was driving was struck from behind by another vehicle. OWCP accepted his claim for neck sprain, lumbar sprain, thoracic sprain, and left shoulder sprain.

[1] 5 U.S.C. § 8101 *et seq.*

On May 19, 2010 appellant filed a Form CA-7 claim for a schedule award based on loss of use of his lower and upper extremities.

In a January 4, 2011 report, Dr. Scott B. Taylor, a specialist in physical medicine and rehabilitation, rated 10 percent whole person impairment based on the lumbar and cervical sprains under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) sixth edition. He advised that the May 14, 2009 work injury aggravated appellant's cervical and lumbar radiculitis, which caused a worsening of sciatic nerve irritation and cervical radiculitis, and was manifested by pain and discomfort radiating out of the neck and low back into the extremities on the left side. As a result appellant experienced weakness, muscle spasm, and decreased sensation. Dr. Taylor advised that appellant had decreased sensation in the C5-6 distribution of his left hand with slightly diminished biceps and triceps reflex and brachioradialis. Appellant also had decreased strength with gripping and elbow flexion and diffuse tenderness through the parathoracic spine, left side worse than right.

Dr. Taylor advised that in the lumbar spine appellant experienced spasm and tenderness through the left paravertebral spinal muscles and decreased sensation in the left leg in the L4-5 and S1 distribution. Appellant had decreased range of motion in both the cervical and lumbar spine. He rated 5 percent whole person impairment for the lumbar and cervical spine, which totaled 10 percent whole person impairment under the A.M.A., *Guides*.

In order to determine whether appellant had any ratable permanent impairment from his accepted conditions, OWCP referred him to Dr. Louis J. Angelicchio, Board-certified in orthopedic surgery, for a second opinion examination. In a report dated July 12, 2011, Dr. Angelicchio reviewed the history of injury and statement of accepted facts. Appellant experienced bilateral leg numbness, leg spasms, low back pain, upper back pain, left shoulder pain, and cervical pain and stiffness with limited range of motion. Dr. Angelicchio advised that appellant underwent a magnetic resonance imaging (MRI) scan on August 14, 2009 which showed a moderately large, broad-based central disc herniation at C6-7, moderate central spinal stenosis, and moderately severe bilateral neural foraminal stenosis, left greater than right. He opined that this was consistent with a preexisting MRI scan from November 13, 2007, in which the cervical spine MRI scan evidenced a C6-7 superimposed disc bulge, broad-based protrusion. Dr. Angelicchio also stated that the MRI scan was consistent with a multilevel hypertrophic facet joint osteorarthrosis of the cervical spine, most severe at C7-T1; he also identified a small, left-sided disc herniation at C5-6.

Dr. Angelicchio found that appellant had residuals from the May 14, 2009 work injury, which included complaints of neck, thoracic, and lumbar pain with left sciatic symptoms. He advised that the complaints were supported by objective symptoms, which included loss of motion in the cervical, thoracic, and lumbar spine with radicular symptoms into the left leg. Dr. Angelicchio stated that the May 14, 2009 work injury caused or aggravated appellant's spinal conditions, which resulted in cervical radiculopathy and lumbar radiculopathy with cervical, thoracic, and lumbar back pain. He rated a 10 percent left lower extremity impairment under the A.M.A., *Guides* secondary to sciatic symptoms in the left lower extremity pursuant to Table 16-12, page 535 of the A.M.A., *Guides*,[2] the table utilized to rate peripheral nerve impairments

[2] A.M.A., *Guides* 535.

of the lower extremities. Additionally, Dr. Angelicchio rated a 10 percent left upper extremity impairment for cervical radiculopathy with sensory loss pursuant to Table 15-21, page 441 of the A.M.A., *Guides*,[3] the section used for rating peripheral nerve impairments of the upper extremity.

On November 22, 2011 OWCP accepted the conditions of brachial neuritis or radiculitis, thoracic or lumbosacral neuritis, or radiculitis.

In a December 10, 2011 report, Dr. Brian M. Tonne, an OWCP medical adviser, reviewed Dr. Angelicchio's report and found that it was not in conformance with the appropriate tables of the A.M.A., *Guides*. Although Dr. Angelicchio relied on Table 16-12 and Table 15-21 to rate 10 percent impairment to the left leg and arm, he did not clearly address whether the ratings were based upon motor findings, sensory findings, or both. Dr. Tonne noted that Dr. Angelicchio did not document the appropriate grade modifiers. While the A.M.A., *Guides* did not provide a specific method for rating extremity impairment based upon spinal pathology, such impairments were to be rated using the peripheral nerve tables such as Table 16-12 or, alternatively, under *The Guides Newsletter* "Rating Spinal Nerve Extremity Impairment using the sixth edition" (July/August 2009), which rates impairment based on radiculopathies and nerve root deficits. Dr. Tonne recommended that appellant be referred for further examination by Dr. Angelicchio or another physician.

OWCP referred appellant for a second opinion examination and impairment evaluation to Dr. Norman Mindrebo, a specialist in orthopedic surgery. In a January 19, 2012 report, Dr. Mindrebo reviewed the history of injury and, on examination, found that appellant had no ratable impairment of the upper or lower extremities arising from the accepted cervical and lumbar conditions. Appellant's complaints were related to his underlying preexisting cervical and lumbar stenosis with degenerative disc disease and nerve root compression, which were not caused by the May 2009 automobile accident. Dr. Mindrebo found no evidence of nerve root impingement based on his examination; any nerve root impingement that was present three months before his May 2009 automobile accident was related to his preexisting cervical, thoracic and lumbar spine conditions that were demonstrated in his November 13, 2007 MRI scan.

By decision dated February 16, 2012, OWCP denied appellant's claim for a schedule award.

By letter dated March 6, 2012, appellant's attorney requested an oral hearing, which was held on July 17, 2012.

In a July 24, 2012 report, Dr. Taylor stated that he had reviewed a functional capacity evaluation and a May 23, 2012 electromyogram (EMG) report, which showed evidence of left lower extremity radiculopathy.[4] There was also a moderate-length dependent sensorimotor

[3] *Id*. at 441.

[4] The record reflects that appellant underwent an electromyogram study on May 23, 2012 of the left lower extremity that was reported as abnormal. It revealed evidence of a moderate length-dependent sensorimotor axonal polyneuropathy with secondary demyelination and chronic left L3 radiculopathy.

axonal polyneuropathy with secondary demyelination. Based on the diagnostic testing and physical examination, he rated a 10 percent left leg impairment, a class 1 impairment of the sciatic nerve, pursuant to Table 16-12, page 535 of the A.M.A., *Guides*; and a 10 percent left arm impairment, a class 1 impairment for proximal left, mild weakness at Table 15-21, page 441 of the A.M.A., *Guides*.

By decision dated September 28, 2012, an OWCP hearing representative set aside the February 16, 2012 decision. She found that Dr. Taylor's July 24, 2012 impairment evaluation required review by an OWCP medical adviser.

In an October 11, 2012 report, Dr. Nabil F. Angley, an OWCP medical adviser, reviewed Dr. Taylor's July 24, 2012 report. He found that the impairment ratings for the left leg and arm failed to include the grade modifiers and adjustments required under the A.M.A., *Guides* to support an appropriate impairment rating. Dr. Angley recommended that appellant be referred for a new impairment evaluation.

OWCP referred appellant to Dr. Joseph C. Duncan, a specialist in orthopedic surgery, for a second opinion examination. In a December 10, 2012 report, Dr. Duncan reviewed the history of injury and statement of accepted facts. He rated five percent cervical impairment using Table 17-2 at page 564 of the A.M.A., *Guides*[5] based on appellant's documented history of sprain/strains, along with continued complaints of axial or nonverifiable radicular complaints. Dr. Duncan also rated five percent lumbar impairment using Table 17-4, page 570,[6] for a similar documented history of sprain/strains with continued complaints of axial and/or nonverifiable radicular complaints. He stated that "in terms of the radiculopathy that may or may not be present I cannot prove or disprove that based on examination, so I would not include that in (my) impairment." Dr. Duncan rated one percent impairment to appellant's thoracic spine based on Table 17-3, page 567 of the A.M.A., *Guides* for the documented history of sprain/strains with continued complaints of axial and/or nonverifiable radicular complaints.

In a December 13, 2012 addendum report, Dr. Duncan stated that appellant had class 1 impairment for shoulder pain under Table 15-5, page 401,[7] the shoulder regional grid, of the A.M.A., *Guides*. Appellant had a functional history grade modifier 2 at Table 15-7, page 406 of the A.M.A., *Guides*[8] due to his pain and symptoms with normal activity; a physical examination grade modifier 1 at Table 15-8, page 408; and a clinical studies grade modifier zero at Table 15-9, page 410 due to the lack of imaging studies with which he was provided. Dr. Duncan found that the net adjusted impairment of zero, which placed appellant into a default impairment of grade C, which yielded a one percent impairment of the shoulder in accordance with Table 15-5. Based on his examination and lack of objective radicular findings at the thoracic and cervical spine, appellant had no ratable impairment. With regard to the lumbar spine, Dr. Duncan found that the May 23, 2012 EMG results showed an L5 radiculopathy, for mild motor and mild

[5] A.M.A., *Guides* 564.

[6] *Id*. at 570.

[7] *Id*. at 401.

[8] *Id*. at 406.

sensory deficit under class 1, under proposed Table 2 of the July/August 2009 edition of *The Guides Newsletter*.

Dr. Duncan also used Chapter 17 of the A.M.A., *Guides* to calculate a two percent mild sensory impairment for L5 radiculopathy and nine percent impairment for L5 mild motor deficit.

In a January 10, 2013 report, Dr. Angley, the medical adviser, found that Dr. Duncan's impairment ratings were not in conformance with the appropriate tables of the A.M.A., *Guides*. Dr. Duncan relied on Chapter 17 in making his impairment rating, the chapter for rating spinal impairments which was not used by OWCP. The medical adviser recommended that appellant be referred for examination by another medical examiner to determine whether he had any permanent impairment.

Appellant was referred to Dr. Brian S. Foley, a specialist in pain medicine, for a second opinion examination. In a report dated March 11, 2013, after stating findings on examination and reviewing the medical history and the statement of accepted facts, Dr. Foley found that appellant had no ratable, permanent impairment of the left arm or leg under the A.M.A., *Guides*. He noted that appellant's EMG study mentioned radiculopathy, but stated that the tables revealed no membrane instability, positive waves or fibrillation potentials to support that finding. Dr. Foley opined that motor unit changes alone are considered a "soft finding." He stated:

> "I am being asked to comment only on [appellant's] 'accepted conditions.' With regards to his spine and musculoskeletal system they are only sprain/strain (cervical, thoracic, lumbar, and left shoulder). Sprain/strain is a short-term condition and does not continue three years past injury. The soft-tissue disorders are assumed to be resolved.
>
> "[Appellant] reports persistent symptoms but they cannot be attributed to an accepted condition as described. Since any permanent partial impairment with regards to an extremity would need to be supported by an accepted condition and consistent physical exam[ination] deficit, the A.M.A., *Guides* do not support a permanent partial impairment rating."

In a supplemental report dated March 26, 2013, Dr. Foley stated that he had reviewed the June 16, 2011 statement of accepted facts and noted that no other specific diagnoses had definitively been made other than the previously accepted conditions of diplopia, depression aggravation, cervical sprain/strain, concussion (without loss of consciousness), thoracic sprain/strain, lumbar sprain/strain, and left shoulder sprain/strain.

In a May 2, 2013 report, Dr. Angley reviewed Dr. Foley's reports and found that appellant had no ratable permanent impairment of the left arm or leg. He concurred with Dr. Foley's opinion that appellant had sustained soft-tissue conditions, which had resolved and that his accepted conditions and physical examination did not provide a sufficient basis for an impairment rating under the A.M.A., *Guides*.

By decision dated May 6, 2013, OWCP denied appellant's claim for a schedule award, finding that he did not have any permanent impairment due to his May 14, 2009 employment injury.

LEGAL PRECEDENT

The schedule award provision of FECA[9] and its implementing regulations[10] 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[11] 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.[12]

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 Newsletter* "Rating Spinal Nerve Extremity Impairment using the sixth edition" (July/August 2009) is to be applied.[13]

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 Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPH), and if electrodiagnostic testing were done, Clinical Studies (GMCS).[14] The net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[15]

ANALYSIS

The Board finds that the case is not in posture for decision.

In support of his claim for a schedule award, appellant submitted the January 14, 2011 report of Dr. Taylor, an attending physician. He rated five percent whole man impairment of the lumbar spine and five percent whole man impairment of the cervical spine utilizing Chapter 17,

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404. Effective May 1, 2009, OWCP began using the A.M.A., *Guides* (6th ed. 2009).

[11] *Id.*

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

[13] *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 Guides Newsletter* is included as Exhibit 4.

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

[15] *Id.* at 521.

of the A.M.A., *Guides*. The Board notes that Dr. Taylor's impairment rating does not conform to the protocols of OWCP in rating impairment as it is well established that schedule awards are not payable for a member, function or organ not specified as compensable under section 8107 or the implementing federal regulations.[16] FECA does not provide for whole person impairments.[17] Further, the back and spine do not come under the provisions for payment of a schedule award.[18] For this reason, the 2011 impairment rating from Dr. Taylor is of diminished probative value. The Board notes that Dr. Taylor submitted a one page follow up dated July 24, 2012, assigning a class 1 left leg impairment of 10 percent and a class 1 left arm impairment of 10 percent. While Dr. Taylor stated that he relied on the A.M.A., *Guides* in making the ratings; as noted by the medical adviser, he failed to adequately explain how the ratings were derived. He provided only general reference to Chapter 15 and 16 and did not address the adjustment factors or grade modifiers for functional history, physical examination, or clinical studies. For this reason, Dr. Taylor's 2012 impairment ratings are of diminished probative value.

OWCP developed the medical evidence by referring appellant to Dr. Angelicchio for examination. In a July 12, 2011 report, Dr. Angelicchio found that appellant had residuals of his accepted cervical and lumbar conditions, which were aggravated by the accepted motor vehicle accident. He rated 10 percent impairment to both the left leg and left arm. The left leg impairment rating was based on sciatic symptoms while the left arm rating was based on cervical radiculopathy.[19] Dr. Angelicchio generally referred to the sixth edition in making the impairment ratings. As noted by Dr. Tonne, the impairment ratings of Dr. Angelicchio did not conform to the A.M.A., *Guides*, as the physician failed to adequately address the motor and sensory findings on which they were based. Further, he did not reference *The Guides Newsletter* (July/August 2009), which is accepted for rating impairment based on radiculopathies and nerve root deficits to the extremities.[20]

Appellant was then referred to Dr. Mindrebo for an impairment evaluation. The Board notes that this report was not reviewed by an OWCP medical adviser. Dr. Mindrebo noted that appellant had a significant preexisting history of cervical, thoracic, and lumbar spine disease prior to the accepted injury. In addition, there was congenital spinal stenosis of the lumbar spine unrelated to the employment injury. Dr. Mindrebo noted that he could not rate impairment to the spine but could rate impairment of the peripheral nerve roots. He stated that he referenced Chapter 16.4c of the sixth edition and Chapter 15.4, but found that appellant did not appear to have permanent impairment based on the rear-end collision alone, compared to the significant, preexisting spinal conditions prior to the accident. The Board finds that Dr. Mindrebo's report is of reduced probative value. Dr. Mindrebo did not make any specific reference to *The Guides Newsletter*, as was requested by OWCP. Further, he was not apprised that preexisting

[16] *See Lenny M. Terska*, 53 ECAB 247 (2001).

[17] *See Marilyn S. Freeland*, 57 ECAB 607 (2006).

[18] *See Francesco C. Veneziani*, 48 ECAB 572 (1997).

[19] Based on this examination, OWCP accepted brachial neuritis or radiculitis and thoracic or lumbosacral neuritis or radiculitis.

[20] *See J.S.*, Docket No. 14-774 (issued November 3, 2014); *E.D.*, Docket No. 13-2014 (issued April 24, 2014).

impairments are included when determining the extent of permanent impairment to the member under consideration.[21]

Appellant was next referred to Dr. Duncan, who stated generally that appellant was at maximum medical improvement but he was not certain of the exact date.[22] He rated impairment with reference to Chapter 17, which pertains to the spine: five percent to the cervical spine, five percent to the lumbar spine and one percent to the thoracic spine. As noted, a schedule award is not granted for permanent impairment of the back or spine; this renders the rating by Dr. Duncan of reduced probative value. His subsequent addendum did not resolve the matter, as he again made reference to Chapter 17 in describing the adjustments for functional history, physical examination, and clinical studies in rating the lumbar spine for sensory and motor deficit.

Appellant was referred by OWCP to Dr. Foley for a second opinion. Dr. Foley noted that he was asked to comment only on appellant's accepted conditions, which were sprain/strain of the cervical, thoracic, lumbar spine, and left shoulder. Since these were soft tissue injuries, they were assumed to be resolved. Dr. Foley concluded that appellant had no permanent impairment due to these conditions. He submitted an addendum which noted that appellant had a diagnosis of persistent pain, but no other specific diagnoses other than diplopia, depression aggravation, and cervical sprain/strain, concussion without loss of consciousness, thoracic sprain/strain, lumbar sprain/strain, and left shoulder sprain strain. Dr. Angley, the medical adviser, agreed with Dr. Foley's opinion that all the accepted conditions with regard to appellant's spine and musculoskeletal system were only sprain/strain and assumed to be resolved without permanent impairment.

The Board notes that included among the various condition accepted in this case are brachial neuritis or radiculitis and thoracic or lumbosacral neuritis or radiculitis. These conditions were not addressed by Dr. Foley in assessing whether appellant had any permanent impairment to his left arm or leg. Certain of the diagnostic tests of record have been positive for lumbar or cervical radiculitis. These tests were not adequately addressed by Dr. Foley in reaching his opinion on permanent impairment. It does not appear, therefore, that the physician's report was based on an accurate statement of the accepted conditions or a full review of the medical record. Further, the Board has recognized that soft-tissue injuries such as sprains/strains may give rise to permanent impairment warranting a schedule award.[23] This is primarily a medical question to be resolved by probative medical opinion.

As OWCP attempted development of the medical evidence, it has the responsibility to see that justice is done.[24] The case will be remanded for further development of the medical evidence as appropriate on the issue of permanent impairment. The examining physician should

[21] *See Carol A. Smart*, 57 ECAB 340 (2006).

[22] The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record and is usually based on the evaluation by the examining physician which is accepted by OWCP as definitive. *See Mark A. Holloway*, 55 ECAB 321 (2004).

[23] *See S.M.*, Docket No. 14-1052 (issued September 4, 2014); *A.H.*, Docket No. 13-1961 (issued April 22, 2014).

[24] *See Phillip L. Barnes*, 55 ECAB 426 (2004).

be asked to address impairment in terms of *The Guides Newsletter* "Rating Spinal Nerve Extremity Impairment using the sixth edition" (July/August 2009). After such further development of the record as it deems necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision. The case is remanded for further development of the medical evidence.

ORDER

IT IS HEREBY ORDERED THAT the May 6, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for further action consistent with this decision of the Board.

Issued: December 17, 2014
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
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