



tailbone, left wrist, and chest as a result of jumping on top of an empty case with the intention to crush a box. He received continuation of pay for a brief period of time, and then returned to work in a limited-duty position. The record does not reflect that appellant received wage-loss compensation following this injury. OWCP accepted the claim for left wrist strain and contusion of the tailbone on July 11, 2005.

On January 22, 2009 appellant filed a claim for a schedule award.

By letter dated September 22, 2010, OWCP informed appellant of the medical evidence needed to support his claim for a schedule award. It requested a current medical report from his physician containing a detailed description of the permanent impairment caused by the accepted, work-related conditions. The letter also requested a detailed description of any preexisting permanent impairment of the same part or parts of the body and the date of maximum medical improvement. Finally, OWCP requested a final impairment rating according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). It allowed appellant 30 days to submit this evidence.

In a report dated October 20, 2010, Dr. Cornelia E. Schmidt<sup>2</sup> stated that appellant had leg cramps, right hip pain, and numbness of the right leg. She stated these symptoms had been caused by a tailbone contusion. Dr. Schmidt stated that appellant had a small fracture in his left hand bones, noting, “the blood flow seems to be disturbed in his left hand since the injury and the left hand is cold most of the time.”

On March 14, 2011 appellant’s counsel requested a status update regarding appellant’s claim for a schedule award.

On March 22, 2011 OWCP afforded appellant 30 days to submit additional medical evidence in support of his claim for a schedule award.

By decision dated May 12, 2011, OWCP denied appellant’s claim for a schedule award. It found that he had not submitted sufficient medical evidence to support a permanent impairment.

On May 17, 2011 appellant, through counsel, requested a telephonic hearing. The hearing was held on September 13, 2011. Appellant did not attend the hearing. The hearing representative suggested that, if appellant submitted a report from a German physician, it should be translated; but that, if it were not, OWCP should obtain a translation. Appellant’s counsel noted that she had a report from a physician in English, but that it did not meet the guidelines of the sixth edition of the A.M.A., *Guides*. The hearing representative held the record open for 30 days for submission of additional evidence.

By decision dated December 5, 2011, the Branch of Hearings and Review affirmed OWCP’s May 12, 2011 decision. The hearing representative noted that no additional evidence

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<sup>2</sup> Dr. Schmidt’s Board certification in a medical specialty could not be confirmed with the American Board of Medical Specialties or the American Osteopathic Association. The Board notes that Dr. Schmidt appears to be a doctor of medicine in Germany.

had been submitted subsequent to the telephonic hearing. She stated that the October 20, 2010 medical report from Dr. Schmidt did not adequately detail the injury and did not contain objective findings supporting a permanent impairment to any extremity as a result of the May 22, 2005 injury.

On December 13, 2012 appellant, through counsel, filed a second claim for a schedule award. With this claim, he included a report from Dr. John L. Dunne, Board-certified in occupational and preventative medicine, dated November 19, 2012. Dr. Dunne noted that appellant stated that he was working in a defense department commissary in Germany when he slipped off a box and fell onto his tailbone, left side, and left wrist. Appellant stated that he had some abrasions and a fracture of the left distal ulna and radius at the wrist. He was treated only with a splint and did not have surgery. Dr. Dunne examined appellant and calculated that he had a 22 percent impairment of the left upper extremity based upon an open fracture of the distal ulna, a closed fracture of the radius shaft with ulna, a closed fracture of the distal ulna, nonunion of fracture, and causalgia of the left upper limb. He noted that appellant had a zero percent impairment of the right upper extremity, chest wall, bilateral hips and thighs, and shoulders. Dr. Dunne stated that the date of maximum medical improvement was November 19, 2012.

By letter dated January 30, 2013, OWCP informed appellant that no action would be taken on his new claim for a schedule award because it had been previously denied by the Branch of Hearings and Review on December 15, 2011.

On February 5, 2013 appellant's counsel sent a letter to OWCP contending that appellant had a right to submit a new application for a schedule award with new evidence.

By letter dated February 27, 2013, OWCP responded that it would either forward the case file to a district medical adviser or issue a formal decision after holding the record open for 30 days for the submission of new medical evidence. It noted that appellant's claim had been accepted for a left wrist sprain and contusion of the back. OWCP asked that he submit additional medical records to establish a more serious injury due to the incident of May 22, 2005.

By decision dated April 5, 2013, OWCP denied appellant's claim for a schedule award. It noted that it had not received additional medical evidence after its letter of February 27, 2013. OWCP stated that it had only accepted a left wrist sprain and contusion of the back.

On April 9, 2013 appellant, through counsel, requested a telephonic hearing. At the hearing, he testified that his hand hurt constantly and that it was always shaped like a claw. Appellant noted that it was possible to see the bones from the fractures in his hand. He stated that OWCP had misjudged the severity of his injury and that after the incident on May 22, 2005. A clinic at the employing establishment treated his hand by wrapping it in a bandage and giving him light duty for one week. Appellant stated that he went to four different hand specialists in Germany, but that they wanted to sever nerves in his hand and that he refused this treatment. He alleged that his manager had mistreated him and that he had been homeless in Europe for several years. Appellant stated that he had difficulty getting a German physician to accept payment from OWCP. He also noted that he had recently gotten a magnetic resonance imaging (MRI) scan of his hand and elbow at a Veterans Affairs medical center. The hearing representative stated that she would hold the record open for 30 days for the submission of additional evidence.

In a report of a plastic surgery consultation dated May 31, 2013, Dr. Kia M. Washington, a Board-certified plastic surgeon, stated that appellant arrived with a complaint that he could not move his left hand. Appellant stated that he had this issue since May 2005 when he fell about three feet off of a box and sustained multiple injuries. He noted that his left hand was not treated at that time. Dr. Washington noted that appellant had been evaluated in Germany and returned to the United States in November 2012. She examined his hand and noted that it was held in a clawing position. Dr. Washington stated that trying to elicit active range of motion of the wrist resulted in 10 degrees of wrist extension and 10 degrees of wrist flexion, with decreased strength of the digits, wrist extensors, wrist flexion, intrinsics, and thumb abduction. She noted, "This is a gentleman with an old injury from Germany when [appellant] was working for the Department of Defense when he fell off of a box and claims that he cannot move his hand. He appears to be very weak on active range of motion. It is hard to elicit an examination from [appellant]; however, I think at this point, we should treat him with Lyrica, as he has complaints of neuropathic pain of shooting sensations and numbness and tingling." Dr. Washington also suggested an electromyogram, nerve conduction study (NCS), and an MRI scan.

In progress notes dated June 13, 2013, Dr. Fred S. Chen, Board-certified in physical medicine and rehabilitation, stated that he was evaluating appellant for carpal tunnel syndrome and ulnar neuropathy. He noted that appellant reported he had a left wrist fracture in 1980, and reinjured his left wrist in 2005. Appellant stated that he was unable to open or close his left hand. Dr. Chen performed an electromyographic study and NCS on appellant, and stated that his impression of a normal left upper extremity except for isolated changes that were compatible with mild ulnar nerve focal neuropathy about the elbow without evidence of denervation.

In a report dated August 9, 2013, Dr. Washington interpreted the results of an MRI scan. She stated that the MRI scan revealed degenerative changes in the left wrist with joint space narrowing and a degenerative subchondral cyst in the carpal bones. Dr. Washington also noted tendinosis of the flexor carp ulnaris and increased signal ulnar attachment of triangular fibrocartilage, with clinical correlation necessary. She stated that appellant was sent for an x-ray examination of his hand on the same date, but none was obtained. Dr. Washington stated that, given these findings, she did not believe that there was any surgical intervention warranted.

By decision dated October 30, 2013, the Branch of Hearings and Review affirmed OWCP's April 5, 2013 decision. The hearing representative found that Dr. Dunne's report was of no probative value in establishing that appellant sustained a permanent impairment of the left upper extremity, as there was no objective evidence demonstrating that he sustained a fracture of the ulna or radius as a result of the May 22, 2005 injury. She noted that Dr. Dunne appeared to base his rating on appellant's statement that he sustained a fracture of the ulna and radius, but that his claim was accepted for left wrist strain and tailbone strain. The hearing representative further noted that appellant received treatment in 2005, with no evidence of further treatment for over five years. She stated that Dr. Washington's report advised that appellant appeared to be weak on active range of motion, difficult to elicit on examination, noted that he "claimed" he could not move his hand, and appeared to hold it in a "clawing position."

By letter dated October 28, 2013, Dr. Nirmala Chengappa interpreted the results of an x-ray of appellant's left hand completed on August 21, 2013.<sup>3</sup> She noted no fractures or bony destructive changes. Dr. Chengappa stated that the carpal bones, carpal spaces, and joint spaces were within normal limits; that radiocarpal articulation was unremarkable; that appellant had exostosis of the right proximal phalanx; and no appreciable soft tissue swelling. She stated that her impression of probable benign exostosis of the possible phalanx of the fifth digit.

On December 30, 2013 appellant, through counsel, requested reconsideration of the decision dated October 30, 2013. With his request, he attached a report from Dr. Michael Nehrlich, dated September 19, 2011.<sup>4</sup> This report was in German.

In a memorandum to the director dated January 8, 2014, a claims examiner requested that Dr. Nehrlich's report be translated to English.

By letter dated January 28, 2014, OWCP requested that appellant provide a translated copy of Dr. Nehrlich's report within 20 days, noting that it would reimburse for the possible cost of translation as long as appellant submitted three bids and chose the lowest. It further noted that, if appellant was unable to obtain a translation within the allotted time frame, it would attempt to secure a translation through other means.

By decision dated February 24, 2014, OWCP reviewed the merits of appellant's claim and found that the evidence was insufficient to modify its decision dated October 30, 2013. It noted that he had not provided a translation of Dr. Nehrlich's report, but that, according to OWCP's translation, appellant suffered from Guyon's canal syndrome, which was not a condition OWCP had accepted as work related. OWCP further noted that it could not be ascertained whether this condition was related to appellant's accepted wrist sprain.

On July 1, 2014 appellant, through counsel, requested reconsideration of OWCP's February 24, 2014 decision. With his request for reconsideration, appellant submitted a translated version of Dr. Nehrlich's September 19, 2011 report. Dr. Nehrlich diagnosed appellant with a suspected older bony consolidated former scaphoid left fracture and a left bony consolidated middle phalanx fracture at D5; suspected left Guyon's canal syndrome; and a status post lumbar vertebra contusion with unexplained neurological symptoms. He stated that appellant came to him asking for a determination of a percentage of impairment, but that he told appellant it could not be completed during walk-in hours, in particular because there were no previous reports. Dr. Nehrlich examined appellant, which demonstrated a visually inconspicuous left wrist, no trophic failure disturbances, and no muscle atrophy. He noted an indication of pressure pain above the scapholunate-band region and the scaphoid, with a flexor contraction in the proximal interphalangeal joint region. Dr. Nehrlich stated that the mobility of the left wrist was painfully restricted, and an indication of pressure pain on the metacarpal joint of the middle

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<sup>3</sup> Dr. Chengappa's Board certification in a medical specialty could not be confirmed with the American Board of Medical Specialties or the American Osteopathic Association.

<sup>4</sup> Dr. Nehrlich's Board certification in a medical specialty could not be confirmed with the American Board of Medical Specialties or the American Osteopathic Association. The Board notes that Dr. Nehrlich appears to be a director of the department of trauma surgery at the University Clinic of Regensburg in Germany.

finger. He observed a pea-sized rounded structure that slid easily over the substrate, but which was extremely painful. On examination of an x-ray of appellant's wrist, Dr. Nehrlich noted an urgent suspicion of a previous scaphoid fracture, bony but consolidated; no evidence of scaphoid necrosis; osteophytic attachments in the region of the root of the hand; and bony attachments in the area of the middle phalanx of the little finger and proximal interphalangeal joint.

By decision dated September 29, 2014, OWCP reviewed the merits of appellant's claim and found that the evidence was insufficient to modify its prior decision of February 24, 2014. It noted that, while Dr. Nehrlich's report was comprehensive, it did not contain evidence or opinion that his diagnosed conditions were related to the May 22, 2005 injury. Dr. Nehrlich did not diagnose appellant with left wrist sprain or back contusion, which were appellant's accepted conditions. Furthermore, his report did not contain a date of maximum medical improvement, a sufficient description of appellant's impairment, or a percentage of impairment.

### **LEGAL PRECEDENT**

The schedule award provision of FECA<sup>5</sup> and its implementing federal regulations<sup>6</sup> set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions, and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.<sup>7</sup> The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.<sup>8</sup> For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.<sup>9</sup> It is well established that 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.<sup>10</sup>

### **ANALYSIS**

The Board finds that appellant has not met his burden of proof to establish a ratable impairment of the left arm or legs as a result due to his accepted left wrist strain and contusion of

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<sup>5</sup> 5 U.S.C. § 8107.

<sup>6</sup> 20 C.F.R. § 10.404.

<sup>7</sup> *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

<sup>8</sup> *Id.*

<sup>9</sup> FECA Bulletin No. 09-03 (issued March 15, 2009).

<sup>10</sup> See *Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a.3 (January 2010). 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.

the tailbone. Appellant has not submitted a report in conformity with the sixth edition A.M.A., *Guides* containing an impairment rating based on his accepted condition of left wrist sprain.

In a report dated November 19, 2012, Dr. Dunne noted that appellant stated that he was working in a defense department commissary in Germany when he slipped off a box and fell onto his tailbone, left side, and left wrist. Appellant stated that he had some abrasions and a fracture of the left distal ulna and radius at the wrist. He was treated only with a splint and did not have surgery. Dr. Dunne examined appellant and calculated that he had a 22 percent impairment of the left arm. He found this impairment to be caused by an open fracture of the distal ulna, a closed fracture of the radius shaft with ulna, a closed fracture of the distal ulna, nonunion of fracture, and causalgia of the left upper limb. Dr. Dunne noted that appellant had a zero percent impairment of the right upper extremity, chest wall, bilateral hips and thighs, and shoulders. He found that maximum medical improvement was November 19, 2012.

While Dr. Dunne's report contains an impairment rating, a date of maximum medical improvement, and a description of appellant's left wrist range of motion, his impairment rating was not based on any conditions accepted by OWCP as work related.<sup>11</sup> Appellant's claim was accepted in 2005 for left wrist sprain and contusion of the tailbone. Moreover, Dr. Dunne found that appellant had a zero percent impairment of right upper extremity, chest wall, bilateral hips and thighs, and shoulders. Injury to these body parts has never been accepted by OWCP. Dr. Dunne's report does not suffice to establish appellant's claim for a schedule award or warrant further development by OWCP due to appellant's accepted conditions.

The report of Dr. Nehrlich dated September 19, 2011, diagnosed appellant with a suspected older bony consolidated former scaphoid left fracture and a left bony consolidated middle phalanx fracture at D5; suspected left Guyon's canal syndrome; and a status post lumbar vertebra contusion with unexplained neurological symptoms. He stated that appellant came to him asking for a determination of a percentage of impairment, but that he told appellant it could not be completed during walk-in hours, in particular because there were no previous reports. Dr. Nehrlich examined appellant, which demonstrated a visually inconspicuous left wrist, no trophic failure disturbances, and no muscle atrophy. He noted an indication of pressure pain above the scapholunate-band region and the scaphoid, with a flexor contraction in the proximal interphalangeal joint region. Dr. Nehrlich stated that the mobility of the left wrist was painfully restricted, and an indication of pressure pain on the metacarpal joint of the middle finger. He observed a pea-sized rounded structure that slid easily over the substrate, but which was extremely painful. On examination of an x-ray of appellant's wrist, Dr. Nehrlich noted an urgent suspicion of a previous scaphoid fracture, bony but consolidated; no evidence of scaphoid necrosis; osteophytic attachments in the region of the root of the hand; and bony attachments in the area of the middle phalanx of the little finger and proximal interphalangeal joint.

Like Dr. Dunne's report, Dr. Nehrlich's report diagnoses appellant with conditions that have not been accepted by OWCP as work related. While Dr. Nehrlich's report is comprehensive and indicates that appellant has conditions of the left wrist, it does not provide a

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<sup>11</sup> The Board notes that should appellant seek to expand his claim to include additional conditions, he can submit upon reconsideration to OWCP rationalized medical evidence from a physician explaining how these additional conditions are related to the May 22, 2005 work injury.

rationalized medical opinion that these conditions are related to the traumatic injury of May 22, 2005. Furthermore, it does not contain a date of maximum medical improvement or a calculation of percentage of impairment according to the A.M.A., *Guides*. As such, it does not suffice to establish appellant's claim for a schedule award or warrant further development by OWCP.

While appellant also submitted reports from Drs. Schmidt, Washington, Chen, and Chengappa to the record, none of these physicians offered an evaluation of the degree of appellant's permanent impairment, pursuant to the A.M.A., *Guides*.

There are no impairment evaluations of record that find a ratable permanent impairment to either the left upper extremity or lower extremities as a result of appellant's accepted May 22, 2005 traumatic injury.

Appellant may request a schedule award or an increased schedule award based on evidence of a new exposure or medical evidence showing a progression of an employment-related condition resulting in permanent impairment or increased impairment.

### **CONCLUSION**

The Board finds that appellant has not met his burden of proof to establish entitlement to a schedule award for permanent impairment based on his accepted left wrist strain and contusion of the tailbone.

**ORDER**

**IT IS HEREBY ORDERED THAT** the September 29, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 2, 2015  
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge  
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge  
Employees' Compensation Appeals Board

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