

**United States Department of Labor
Employees' Compensation Appeals Board**

E.M., Appellant)	
)	
and)	Docket No. 14-795
)	Issued: January 9, 2015
U.S. POSTAL SERVICE, POST OFFICE,)	
PROCESSING & DISTRIBUTION CENTER,)	
Palatine, IL, Employer)	
)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On February 25, 2014 appellant filed a timely appeal from a September 13, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant established more than three percent permanent impairment of the left upper extremity and four percent permanent impairment of the right upper extremity for which she received a schedule award.

FACTUAL HISTORY

On April 9, 2011 appellant, then a 52-year-old mail handler, filed an occupational disease claim asserting that work duties caused right and left upper extremity, neck, low back and left knee and ankle pain. She did not stop work. OWCP accepted tendinitis of the left shoulder,

¹ 5 U.S.C. §§ 8101-8193.

temporary aggravation of lumbar disc disease, temporary aggravation of cervical disc disease, bilateral carpal tunnel syndrome and sprain of right shoulder, upper arm, and rotator cuff. Appellant received intermittent compensation. She stopped work on February 27, 2012 and filed claims for compensation. Appellant returned to work on July 17, 2012.²

On May 14, 2013 appellant filed a schedule award claim and submitted an April 19, 2013 report in which Dr. Anatoly Rozman, a Board-certified physiatrist, advised that she had been under his care since June 29, 2011. Dr. Rozman indicated that she reached maximum medical improvement on October 26, 2012. He advised that appellant had residuals of the accepted conditions, including loss of strength, pain and crepitation of both shoulders with grossly preserved range of motion and positive empty can and lift-off tests on the right; pain and spasm in the cervical and lumbar paraspinal muscles with a positive straight leg raising test and decreased sensation at the L4-5 level; decreased cervical spine range of motion with positive Spurling's maneuver and Hoffman's test; and positive Phalen's and Tinel's tests bilaterally with decreased sensation in the median nerve distribution. Dr. Rozman indicated that upper extremity electrodiagnostic testing on May 6, 2011 demonstrated cervical radiculopathy, ulnar nerve neuropathy and bilateral carpal tunnel syndrome and that lower extremity electrodiagnostic testing on May 20 and July 22, 2011 demonstrated L4-5 lumbar radiculopathy. He further noted that magnetic resonance imaging (MRI) scan studies of the cervical and lumbar spines on May 9, 2011 and February 16, 2012 respectively, demonstrated disc disease and stenosis and that left and right shoulder MRI scan studies in May and August 2011 each demonstrated partial tears of the supraspinatus tendon.

Dr. Rozman provided an impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment (A.M.A., Guides)*.³

Regarding the accepted left shoulder tendinitis, Dr. Rozman found that, under Table 15-5, Shoulder Regional Grid, appellant had a class 1 impairment with a default value of three percent. He found modifiers of one each for functional history and physical examination and a modifier of two for clinical studies. Dr. Rozman then applied the net adjustment formula, concluding that appellant had four percent impairment due to left shoulder tendinitis.

Regarding the right upper extremity, Dr. Rozman found that under Table 15-5 she had a class 1 impairment for rotator cuff tendinitis with grade modifiers of two each for functional history and clinical studies and a modifier of one for physical examination. After applying the net adjustment formula, he concluded that appellant had seven percent impairment of the right upper extremity due to right shoulder tendinitis.

Regarding bilateral carpal tunnel syndrome, Dr. Rozman indicated that, in accordance with Table 15-23, Entrapment/Compression Neuropathy Impairment, she had a modifier of one on test findings and modifiers of two each for history and physical examination findings. He

² On July 26, 2012 OWCP denied appellant's claim for wage-loss compensation. On October 14, 2012 an OWCP hearing representative vacated the July 26, 2012 decision and directed an OWCP medical adviser to provide an opinion regarding the claimed disability. Based on a November 18, 2012 report from the medical adviser, appellant was paid wage-loss compensation for the period February 27 through July 13, 2012.

³ A.M.A., *Guides* (6th ed. 2008).

averaged these and found two percent bilateral upper extremity impairment and modified this by appellant's *QuickDASH* score, concluding that appellant had a total three percent impairment of each upper extremity due to carpal tunnel syndrome. Dr. Rozman analyzed her cervical and lumbar conditions under Chapter 17, The Spine and Pelvis, finding 16 percent whole person impairment for lumbar disc disease and 15 percent whole person impairment for cervical disc disease.

In a June 3, 2013 report, Dr. Christopher Gross, an orthopedic surgeon and an OWCP medical adviser, indicated that appellant had no impairment due to her cervical and lumbar spine conditions. Regarding bilateral carpal tunnel syndrome, he indicated that, under Table 15-23, she had a grade one modifier for testing because the electrodiagnostic study demonstrated bilateral mild to moderate carpal tunnel syndrome and a modifier of one for physical findings due to mild intermittent symptoms, for a total impairment rating of two percent for each upper extremity based on carpal tunnel syndrome. Dr. Gross found a class 1 impairment under Table 15-5 for a left partial thickness rotator cuff tear with residual symptoms. He found a functional history modifier of one and physical examination and clinical studies modifiers of two each. After applying the net adjustment formula, Dr. Gross determined that appellant had two percent left shoulder impairment. He indicated that, because she had minimal pain and functional loss of the right shoulder, she had a class 0 right shoulder impairment. Dr. Gross concluded that appellant had a right upper extremity impairment of four percent and a left upper extremity of three percent and no impairment of the lower extremities, with maximum medical improvement reached on October 26, 2012, when Dr. Rozman saw a stabilization of her problems.

On September 13, 2013 appellant was granted a schedule award for three percent impairment of the left upper extremity and four percent impairment on the right, for a total of 21.84 weeks, to run from October 26, 2012 to March 27, 2013.

LEGAL PRECEDENT

The schedule award provision of FECA⁴ and its implementing federal regulations⁵ 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.⁶ For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* was used to calculate schedule awards.⁷ For decisions issued after May 1, 2009, the sixth edition is used.⁸

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404.

⁶ *Id.* at § 10.404(a).

⁷ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

⁸ FECA Bulletin No. 09-03 (issued March 15, 2009).

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).⁹ Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).¹⁰ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹¹ Section 15.2e of the A.M.A., *Guides* provides that the evaluator should select the most significant diagnosis regarding the shoulder and to rate only that diagnosis.¹²

Although the diagnosis-based approach is the preferred method of evaluating permanent impairment under the sixth edition of the A.M.A., *Guides*,¹³ Table 15-5, Shoulder Regional Grid, provides that, if loss of motion is present, the impairment may alternatively be assessed under section 17-7, range of motion impairment.¹⁴ A range of motion impairment stands alone and is not combined with a diagnosis-based impairment.¹⁵

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.¹⁶ 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.¹⁷ The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. The A.M.A., *Guides* for decades has offered an alternative approach to rating spinal nerve impairments.¹⁸ OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures which memorializes proposed tables outlined in the July/August 2009 *The Guides Newsletter*.¹⁹ Specifically, it will address

⁹ *Supra* note 3 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

¹⁰ *Id.* at 385-419.

¹¹ *Id.* at 411.

¹² *Id.* at 390.

¹³ *Id.* at 461, section 15.7.

¹⁴ *Id.* at 401-05.

¹⁵ *Id.* at 405.

¹⁶ *Pamela J. Darling*, 49 ECAB 286 (1998).

¹⁷ *Thomas J. Engelhart*, 50 ECAB 319 (1999).

¹⁸ *Rozella L. Skinner*, 37 ECAB 398 (1986).

¹⁹ FECA Transmittal No. 10-04 (issued January 9, 2010); *see supra* note 7.

lower extremity impairments originating in the spine through Table 16-11 and upper extremity impairment originating in the spine through Table 15-14.²⁰

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.²¹ In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories test findings, history and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.²²

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.²³ In determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.²⁴

ANALYSIS

The Board finds this case is not in posture for decision. The accepted conditions are bilateral carpal tunnel syndrome, temporary aggravation of cervical and lumbar disc disease, left shoulder tendinitis and right upper extremity sprains of the shoulder, upper arm and rotator cuff. Appellant was granted a schedule award on September 13, 2013 for a three percent left upper extremity impairment and a four percent impairment on the right. OWCP found the weight of the medical opinion evidence rested with the opinion of the medical adviser, Dr. Gross.

As noted above, a schedule award is not payable under FECA for injury to the spine.²⁵ A claimant, however, may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.²⁶ Dr. Rozman, the attending physiatrist, utilized Chapter 17, The Spine and Pelvis, of the A.M.A., *Guides*, rather than following section 3.700 of OWCP's procedures, which memorializes proposed tables outlined in the July/August 2009 *The Guides Newsletter* in reaching his conclusion that appellant had 15 percent whole person impairment for aggravation of cervical disc disease.²⁷ He did not indicate that she had upper extremity findings relative to the accepted temporary aggravation of

²⁰ *Supra* note 3 at 533 and 425 respectively.

²¹ *Id.* at 449.

²² *Id.* at 448-50.

²³ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

²⁴ *Peter C. Belkind*, 56 ECAB 580 (2005).

²⁵ *Supra* note 16.

²⁶ *Supra* note 17.

²⁷ *Supra* notes 7 and 19.

cervical disc disease. Dr. Rozman's impairment ratings under Chapter 17 are of no probative value. Dr. Gross, the medical adviser, advised that, while appellant had radiculopathy as demonstrated electrodiagnostically, she had no dysfunction at C6 and therefore a class 0 impairment. As he explained why appellant did not demonstrate a ratable impairment of C6 and as Dr. Rozman's analysis of cervical radiculopathy did not comport with the A.M.A., *Guides*, the Board finds that appellant was not entitled to a schedule award for the accepted temporary aggravation of cervical disc disease.

Regarding appellant's impairment due to bilateral carpal tunnel syndrome, although both physicians utilized Table 15-23,²⁸ their analyses differed. Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.²⁹ In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities, *e.g.*, by using the *QuickDASH* questionnaire.³⁰

Dr. Rozman described physical findings in detail and indicated that, in accordance with Table 15-23, appellant had a test findings modifier of one and modifiers of two each for history and physical examination. He averaged these and concluded that appellant had two percent bilateral upper extremity impairment under Table 15-23. Dr. Rozman stated that he modified this by appellant's *QuickDASH* score, finding a total three percent impairment of each upper extremity due to carpal tunnel syndrome. The record before the Board, however, does not include a completed *QuickDASH* questionnaire, and Dr. Rozman did not provide sufficient explanation to support his conclusion that by using the *QuickDASH* score, appellant's impairment due to carpal tunnel syndrome was three percent bilaterally. There is therefore no basis on which to determine how the physician arrived at his conclusion.³¹

The Board also finds that the opinion of Dr. Gross, the medical adviser, is insufficient. Dr. Gross agreed that appellant had a grade one modifier for testing because the electrodiagnostic study demonstrated bilateral mild to moderate carpal tunnel syndrome. He, however, differed in his finding of a modifier for physical findings, stating appellant had mild intermittent symptoms. Dr. Gross did not include a modifier for history. As he did not sufficiently explain how he reached his conclusions under Table 15-23, his opinion is of insufficient rationale to establish appellant's degree of impairment due to carpal tunnel syndrome.

The physicians also disagreed in their analysis of appellant's shoulder impairments. Regarding the accepted left shoulder tendinitis, Dr. Rozman, who described physical findings for

²⁸ *Supra* note 3 at 449.

²⁹ *Id.*

³⁰ *Id.* at 448-50.

³¹ *D.N.*, 59 ECAB 576 (2008).

both shoulders, found that, under Table 15-5,³² she had a class 1 impairment with a default value of three percent. He found modifiers of one each for functional history and physical examination and a modifier of two for clinical studies but did not explain his rationale for his modifier findings. Dr. Rozman then applied the net adjustment formula, concluding that appellant had four percent impairment due to left shoulder tendinitis.

Regarding the right upper extremity, Dr. Rozman found that under Table 15-5 appellant had a class 1 impairment for right shoulder sprain and rotator cuff tendinitis for a five percent impairment with grade modifiers of two each for functional history and clinical studies and a modifier of one for physical examination. After applying the net adjustment formula, he concluded that appellant had seven percent impairment of the right upper extremity due to right shoulder tendinitis.³³ Dr. Rozman did not explain which diagnosis he used and why he chose a five percent default value, and again he did not explain how he reached his modifier findings.

Dr. Gross, the medical adviser, however, found a class 1 impairment under Table 15-5 for a left partial thickness left rotator cuff tear with residual symptoms. He found a functional history modifier of one and physical examination and clinical studies modifiers of two each. After applying the net adjustment formula, Dr. Gross determined that appellant had two percent left shoulder impairment. It is unclear on what basis he chose to use a diagnosis of left rotator cuff tear. Regarding the right shoulder, Dr. Gross indicated that, because she had minimal pain and minimal functional loss of the right shoulder, she had no right shoulder impairment.³⁴

The Board finds that neither physician sufficiently explained why a particular diagnosis was chosen on which to base appellant's bilateral shoulder impairments. The accepted conditions are tendinitis of the left shoulder, and sprain of the right shoulder, upper arm, and rotator cuff. Although appellant had MRI scan findings of partial supraspinatus tears bilaterally, these conditions had not been accepted. It is well established that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included yet neither physician indicated that he took this under consideration.³⁵

For these reasons, the Board will set aside the September 13, 2013 decision and remand the case for OWCP to return the record to the medical adviser for a supplementary opinion with sufficient rationale regarding appellant's upper extremity impairments. After such further development as it deems necessary, OWCP shall issue a *de novo* schedule award decision.

In regard to a schedule award for the accepted cervical condition, appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical

³² A.M.A., *Guides*, *supra* note 3 at 403.

³³ The Board notes that the maximum allowed for class 1 tendinitis under Table 15-5 is five percent. *Id.*

³⁴ The conclusion of the medical adviser's report states that appellant has four percent right arm impairment and three percent left arm impairment. However, within his report, he states that appellant has two percent impairment of each arm due to carpal tunnel syndrome and two percent left arm impairment due to a partial thickness left rotator cuff tear. This would yield four percent left arm impairment and two percent right arm impairment. The medical adviser did not explain this discrepancy.

³⁵ *Supra* note 24.

evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment to a scheduled member.

CONCLUSION

The Board finds this case is not in posture for decision regarding the degree of appellant's bilateral upper extremity impairments.³⁶

ORDER

IT IS HEREBY ORDERED THAT the September 13, 2013 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part and the case remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: January 9, 2015
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

³⁶ The Board also notes that appellant submitted evidence with her appeal to the Board. The Board cannot consider this evidence, however, as its review of the case is limited to the evidence that was before OWCP at the time it rendered its final decision. 20 C.F.R. § 501.2(c)(1) (2009).