

FACTUAL HISTORY

On April 16, 2014 appellant, then a 61-year-old shuttle van operator, filed a claim (Form CA-2) alleging that he sustained an occupational disease due to his work duties. He indicated that he experienced severe pain on the right side of his neck with pain radiating into his arms. Appellant stated that his job required him “to assist patients and wheel chairs into/out of shuttle vans over the years, aggravating upper extremities and neck.” He indicated that on August 19, 2013 he first became aware of his claimed condition and that it was caused or aggravated by his employment. Appellant did not stop work at the time he filed his occupational disease claim.²

In an August 2, 2013 report, Dr. Mary C. Spires, an attending physical medicine and rehabilitation physician, stated that appellant presented complaining of significant pain in his right elbow with edema and neuropathic pain. Appellant reported pain in his right medial epicondyle region with some puffiness and noted that range of motion of his right arm was limited. Dr. Spires diagnosed neuropathic pain and ulnar mononeuropathy status post revision of transposition.

On September 27, 2013 appellant filed a claim for an increased schedule award due to his accepted work injuries.

In a November 4, 2013 report, Dr. Walter P. Jacobsen, an attending osteopath and Board-certified neurosurgeon, stated that appellant reported having terrible pain in his right shoulder since suffering a work-related injury to his right arm in 1993. Appellant reported pain, weakness and paresthesias in his right hand and pain, numbness and tingling in his right arm. Dr. Jacobsen indicated that physical examination revealed 4/5 strength in appellant’s right biceps and triceps and significant paresthesias in his right arm. He recommended that appellant undergo additional diagnostic testing.³

In an April 14, 2014 report, Dr. Norman Mindrebo, a Board-certified orthopedic surgeon serving as an OWCP referral physician, determined that appellant had 17 percent permanent impairment of his right arm under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009). He opined that for appellant’s right ulnar nerve neuropathy, his right arm impairment was seven percent and for the diagnosis of acromioclavicular joint disease status post distal clavicle excision his right arm

² OWCP had previously accepted that appellant sustained a number of work-related conditions stemming from several traumatic work injuries. Due to an August 19, 1993 work injury appellant sustained a right elbow contusion, right ulnar neuropathy, right medial epicondylitis, right shoulder tendinitis, depressive psychosis, and the need for a right shoulder Mumford procedure; due to a March 14, 2002 work injury he sustained right rotator cuff tendinitis and post-traumatic stress disorder; and due to a May 13, 2002 work injury he sustained an exacerbation/aggravation of right chronic ulnar neuropathy. In a February 5, 1996 decision, OWCP granted appellant a schedule award for four percent permanent impairment of his right arm and, in a January 24, 2000 decision, OWCP granted him a schedule award for an additional 18 percent permanent impairment of his right arm. In a September 20, 2005 decision, OWCP granted appellant a schedule award for an additional 16 percent permanent impairment of his right arm. Appellant has been compensated for a total right arm impairment of 38 percent.

³ Appellant also submitted November 4, 21, December 30, 2013, February 14 and March 21, 2014 reports of Dr. Jacobsen. However, none of the reports addressed the question of whether appellant sustained an occupational disease in late 2013.

impairment was 10 percent. Dr. Mindrebo then added together the impairments for appellant's right arm to arrive at a total impairment of 17 percent. He further explained the rationale for his impairment rating:

“If we try and calculate the patient's impairments based on his Mumford distal clavicle resection for rotator cuff tendinopathy and for upper extremity impairment secondary to ulnar nerve issues below the elbow, we would use Table 15-21 of the A.M.A., *Guides* to address the ulnar nerve below the forearm. Since this is basically a cubital tunnel syndrome that has not significantly improved, secondary to probable scar tissue formation and constant irritation on the nerve, it would be considered a severe sensory deficit or severe chronic regional pain syndrome type II, secondary to the hyperesthesias and the atrophy involving the flexor carpi ulnaris and extensor carpi ulnaris muscles of the right forearm. This would be graded as a severe sensory deficit using Table 15-23.

“On history, the patient has constant symptoms and, on physical exam[ination] findings, he has had the atrophy as noted, which would increase his upper extremity impairment to [seven] percent, since this is a class 1 impairment with a [g]rade 3 functional history score and physical exam[ination] finding score for final grade of E or [seven] percent for that category. To address his shoulder, Table 15-5 describes acromioclavicular joint disease for rotator cuff tendinopathy as a class 1 injury. His major deficits are at the elbow and not the shoulder, so he has a functional history adjustment of 1 and a physical exam[ination] finding adjustment of 1, for a [g]rade C or 10 percent impairment of the upper extremity. Totaling the [two] impairments, this would be a 17 percent upper extremity impairment.”

In an April 24, 2014 letter, OWCP requested that appellant submit additional factual and medical evidence in support of his occupational disease claim. In an undated statement received on May 5, 2014, appellant indicated that his job required him to pick up laboratory coolers which weighed about 10 pounds each as well as other packages at least 10 to 15 times per day.

In a supplemental report dated April 30, 2014, Dr. Mindrebo stated that appellant had a severe sensory deficit involving the ulnar nerve below the mid-forearm, which was consistent with a six percent impairment rating based on Table 15-21 of the sixth edition of the A.M.A., *Guides*. He indicated that it was a typographical error when he mentioned Table 15-23. Dr. Mindrebo noted that appellant had had a severe sensory deficit and not a very severe deficit and stated, “Since the severe deficit would be graded as a 6 percent upper extremity impairment, combining the two impairments would increase [sic] his upper extremity impairment to 16 percent and not 17 percent, as previously dictated.”⁴

In a May 23, 2014 report, Dr. Morley Slutsky, a Board-certified occupational medicine physician serving as an OWCP medical adviser, stated that he had reviewed Dr. Mindrebo's impairment rating. With respect to appellant's right ulnar nerve/neuropathy, he opined that

⁴ It appears that Dr. Mindrebo inadvertently stated that the impairment rating of appellant's right arm increased from 17 percent to 16 percent when he intended to state that it decreased from 17 to 16 percent.

Dr. Mindrebo used the wrong rating table to arrive at his impairment rating, using the peripheral nerve table (Table 15-21) when he should have used the compression neuropathy table (Table 15-23). Dr. Slutsky asserted that appellant had six percent impairment for the right ulnar nerve.

Regarding the right medial epicondylitis, he noted that there was no mention of finding a medial epicondylitis/elbow contusion and no clinical findings related to this condition. Dr. Slutsky felt that Dr. Mindrebo did not document findings consistent with medial epicondylitis/contusion or properly rate appellant for these conditions. As such the final impairment was zero percent for medial epicondylitis/elbow contusion.

Regarding the right shoulder, Dr. Slutsky opined a 9 percent right upper extremity impairment which was 1 percent less than the 10 percent opined by Dr. Mindrebo. He differed in opinion on Dr. Mindrebo's physical examination grade modifier of 1, instead opining a modifier of 0, because passive range of motion was not allowed under the sixth edition of the A.M.A., *Guides* edition for rating purposes. Dr. Slutsky also assigned a grade modifier of 1 for clinical studies for mild findings whereas Dr. Mindrebo did not assign a grid modifier for clinical studies. His net adjustment for grade modifiers was -1, which resulted in a final grade of B, as compared to Dr. Mindrebo's grade C. This resulted in the one percent difference in the opined impairment for appellant's diagnosis of acromioclavicular joint disease status post distal clavicle excision. Dr. Slutsky combined the impairment ratings for appellant's right elbow and shoulder, resulting in 14 percent right arm impairment.

In a June 3, 2014 note, Dr. Jacobsen reported that he was asked to comment on the fact that appellant was a shuttle driver since 1999 and to provide an opinion regarding whether the maneuvering from this job could have caused any worsening of his stenosis and worsening neck degeneration. He stated:

“Unfortunately I can[no]t say for sure if his original injury with the increase inactivity looking back and forth from driving had any worsening of his degeneration as certainly motion can cause degeneration but with certainly with [sic] that long period of time I can[no]t find any direct correlation between the two but that is to say that it can[no]t also be ruled out. Unfortunately I do n[o]t have a direct answer for this other than I can[no]t directly correlate his worsening arthritis in his neck, spinal cord compression or nerve root compression to turning his neck in order to drive the van.”

In a June 5, 2014 decision, OWCP found that appellant did not meet his burden of proof to establish more than 38 percent permanent impairment of his right arm, for which he previously received schedule awards. It discussed the April 14 and 30, 2014 reports of Dr. Mindrebo and the May 23, 2014 report of Dr. Slutsky and noted that they did not establish more than 38 percent permanent impairment of his right arm.

In a June 27, 2014 decision, OWCP denied appellant's occupational disease claim filed in April 2014 as he had not submitted sufficient medical evidence to establish that his conditions were due to his work as a shuttle van operator. The decision noted that none of the medical evidence contained an opinion that appellant sustained such a condition.

LEGAL PRECEDENT -- ISSUE 1

An employee seeking benefits under FECA has the burden of establishing the essential elements of his or her claim including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA, that an injury was sustained in the performance of duty as alleged, and that any disability and specific condition for which compensation is claimed are causally related to the employment injury.⁵ These are the essential elements of each compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.⁶

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the claimant's diagnosed condition and the compensable employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.⁷

ANALYSIS -- ISSUE 1

On April 16, 2014 appellant filed a claim alleging that he sustained an occupational disease due to his work duties. He indicated that he experienced severe pain on the right side of his neck with pain radiating into his arms. Appellant stated that his job as shuttle van operator required him "to assist patients and wheel chairs into/out of shuttle vans over the years, aggravating upper extremities and neck." He indicated that on August 19, 2013 he first became aware of his claimed condition and that it was caused or aggravated by his employment.

⁵ *B.B.*, 59 ECAB 234 (2007); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

⁶ See *Delores C. Ellyett*, 41 ECAB 992, 994 (1990); *Ruthie M. Evans*, 41 ECAB 416, 423-25 (1990). A traumatic injury refers to injury caused by a specific event or incident or series of incidents occurring within a single workday or work shift whereas an occupational disease refers to an injury produced by employment factors which occur or are present over a period longer than a single workday or work shift. 20 C.F.R. § 10.5(ee), (q); *Brady L. Fowler*, 44 ECAB 343, 351 (1992).

⁷ See *Donna Faye Cardwell*, 41 ECAB 730, 741-42 (1990).

The Board finds that appellant failed to submit sufficient medical evidence to establish an occupational disease in late 2013 as alleged. OWCP had previously accepted that appellant sustained numerous work-related injuries to his right arm, but he did not show that he sustained a new injury to his right arm or neck in late 2013. On appeal, appellant asserted that the evidence of record showed that he sustained such an injury, but he did not identify which medical evidence of record supported this claim.

Appellant submitted an August 2, 2013 report in which Dr. Spires, an attending physical medicine and rehabilitation physician, stated that he presented complaining of significant pain in his right elbow with edema and neuropathic pain. Dr. Spires diagnosed neuropathic pain and ulnar mononeuropathy status post revision of transposition. She did not, however, provide any indication that appellant sustained an occupational disease in late 2013 as alleged. In numerous reports dated between November 2013 and June 2014, Dr. Jacobsen, an attending osteopath and Board-certified neurosurgeon, stated that appellant reported having symptoms in his right arm, such as pain, numbness, and tingling. He also failed to provide an opinion that appellant sustained an occupational disease in late 2013 as alleged. Dr. Jacobsen addressed the matter in his June 3, 2014 report but he explicitly indicated that he could not provide an opinion that appellant's job as shuttle van operator caused a new occupational disease. He stated, "Unfortunately I do n[o]t have a direct answer for this other than I can[no]t directly correlate his worsening arthritis in his neck, spinal cord compression or nerve root compression to turning his neck in order to drive the van."

The medical evidence is insufficient to establish appellant's claim for a new occupational disease and the denial is affirmed.

LEGAL PRECEDENT -- ISSUE 2

The schedule award provision of FECA⁸ and its implementing regulations⁹ 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.¹⁰ The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.¹¹

⁸ 5 U.S.C. § 8107.

⁹ 20 C.F.R. § 10.404 (1999).

¹⁰ *Id.*

¹¹ FECA Bulletin No. 09-03 (issued March 15, 2009).

ANALYSIS -- ISSUE 2

In a February 5, 1996 decision, OWCP granted appellant a schedule award for a 4 percent permanent impairment of his right arm and, in a January 24, 2000 decision, it granted him a schedule award for an additional 18 percent permanent impairment of his right arm. In a September 20, 2005 decision, it granted appellant a schedule award for an additional 16 percent permanent impairment of his right arm. Appellant now had been compensated for a total right arm impairment of 38 percent. On September 27, 2013 he filed a claim for an increased schedule award due to his accepted work injuries.

The Board finds that appellant did not submit any medical evidence showing that he has more than a 38 percent permanent impairment of his right arm, for which he received schedule awards. The record contains impairment evaluations of Dr. Mindrebo, a Board-certified orthopedic surgeon serving as an OWCP referral physician, and Dr. Slutsky, a Board-certified occupational medicine physician serving as an OWCP medical adviser, which contain ratings for permanent impairment of appellant's right arm that are well below the 38 percent impairment for which he has already been compensated. On appeal, appellant argued that the existing medical evidence of record showed that he has more than 38 percent permanent impairment of his right arm, but he did not adequately explain the basis for this argument.

In an April 14, 2014 report, Dr. Mindrebo determined that appellant had 17 percent permanent impairment of his right arm under the standards of the sixth edition of the A.M.A., *Guides*. He opined that for appellant's right ulnar nerve neuropathy his right arm impairment was 7 percent and that for the diagnosis of acromioclavicular joint disease status post distal clavicle excision his right arm impairment was 10 percent. Dr. Mindrebo then added together the impairments for appellant's right arm to arrive at a total impairment of 17 percent. In a supplemental report dated April 30, 2014, he stated that appellant had a severe sensory deficit involving the ulnar nerve below the mid-forearm, which was consistent with a six percent impairment rating based on Table 15-21 of the sixth edition of the A.M.A., *Guides*. Dr. Mindrebo indicated that it was a typographical error when he mentioned Table 15-23 and noted that he had recalculated appellant's right arm impairment to be 16 percent, rather than 17 percent.

In a May 23, 2014 report, Dr. Slutsky, a Board-certified occupational medicine physician serving as an OWCP medical adviser, stated that he had reviewed Dr. Mindrebo's impairment rating. He concluded that appellant had 14 percent permanent impairment of his right arm under the sixth edition of the A.M.A., *Guides* and discussed several instances where he disagreed with the impairment rating calculations provided by the other OWCP physician, Dr. Mindrebo. For example, regarding the right shoulder, Dr. Slutsky opined that appellant had 9 percent right upper extremity impairment which was 1 percent less than the 10 percent opined by Dr. Mindrebo. His net adjustment for grade modifiers was -1, which resulted in a final grade of B, as compared to Dr. Mindrebo's grade C. This resulted in the one percent difference in the opined impairment for appellant's diagnosis of acromioclavicular joint disease status post distal clavicle excision.

Accordingly, the Board finds appellant has failed to establish greater than 38 percent impairment of his right arm.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he sustained an occupational disease in late 2013. The Board further finds that appellant did not meet his burden of proof to establish that he has more than 38 percent permanent impairment of his right arm, for which he received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the June 27 and 5, 2014 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: January 7, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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