United States Department of Labor
Employees' Compensation Appeals Board

S.K., Appellant	)	
and	)	**Docket No. 16-0504**
	)	**Issued: June 16, 2016**
U.S. POSTAL SERVICE, POST OFFICE, CAMP WOOD POST OFFICE, Camp Wood, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 21, 2016 appellant filed a timely appeal from a November 9, 2015 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 OWCP met his burden of proof to establish greater than 17 percent permanent impairment of the left upper extremity, for which he received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts and circumstances outlined in the Board's prior decision are incorporated herein by reference. The relevant facts are set forth below.

OWCP accepted that on or before August 16, 2001 appellant, then a 45-year-old distribution clerk, sustained an aggravation of cervical degenerative disc disease. Appellant stopped work in early September 2001. OWCP placed his case on the periodic rolls effective February 25, 2002.

Beginning in August 2001, appellant was followed by Dr. Gilbert R. Meadows, an attending Board-certified neurosurgeon, who diagnosed cervical degenerative disc disease, herniated discs at C4-5, C5-6, and C6-7 and spinal stenosis at C5-6. On September 24, 2001 Dr. Meadows performed a three-level anterior cervical discectomy and fusion. In an April 24, 2002 report, he found appellant permanently and totally disabled for work due to sequelae of the cervical fusion as well as disc herniation at L3-4, L4-5, and L5-S1. A July 26, 2002 functional capacity evaluation (FCE) showed appellant could perform part-time light-duty work.

On January 21, 2003 Dr. Meadows performed an anterior C3-4 discectomy and fusion with allograft and anterior plate fixation, authorized by OWCP.[3] He submitted reports through April 2004 stating that appellant remained permanently disabled for work. Appellant retired from the employing establishment effective April 16, 2004.

Dr. Meadows submitted reports from July 2004 to January 2006 finding that appellant remained disabled. He recommended additional surgery. OWCP then obtained a second opinion from Dr. Charles W. Kennedy, Jr., a Board-certified orthopedic surgeon.[4] In an April 13, 2006 report, Dr. Kennedy opined that the proposed surgery and all past surgeries were inappropriate and that appellant had no work-related disability.

OWCP subsequently found a conflict of medical opinion between Dr. Meadows for appellant and Dr. Kennedy for the government regarding appellant's ability to work. It selected Dr. Theodore W. Parsons, III, a Board-certified orthopedic surgeon, as the impartial medical examiner. In a June 1, 2006 report, Dr. Parsons opined that any additional cervical fusions would fail. He found that according to the 2002 FCE, appellant was able to work four to six hours a day light duty, with lifting limited to 20 pounds. Dr. Parsons noted that OWCP must

[2] Docket No. 08-1334 (issued March 9, 2009).

[3] On February 27, 2004 OWCP obtained a second opinion report from Dr. Govindasamy Durairaj, a Board-certified orthopedic surgeon, who opined that appellant was totally disabled due to cervical fusions and desiccated discs at L3-4, L4-5, and L5-S1. It obtained an FCE on May 14, 2004, showing that appellant could perform light or sedentary duty with restrictions. In a May 14, 2004 work capacity evaluation, Dr. Durairaj noted that appellant was permanently and totally disabled for all work. He found appellant unable to perform the sedentary tasks demonstrated in the FCE.

[4] Appellant claimed a schedule award (Form CA-7) on May 13, 2002 and on February 18, 2005.

also consider appellant's deconditioned body habitus, chronic pain, and use of prescribed narcotics.

On August 17, 2006 Dr. David A. Roberts, a Board-certified orthopedic surgeon to whom appellant was referred by a treating physician, opined that appellant had no impairment of the extremities originating in the spine.[5]

In a January 5, 2007 report, Dr. Meadows opined that appellant could probably work four hours a day with rest breaks but could not drive to and from work due to medication side effects. He recommended additional cervical fusions. Dr. Meadows submitted February 20 and March 7, 2007 reports noting increasing symptoms in the C6-7 dermatome, correlating to March 7, 2007 magnetic resonance imaging (MRI) scan findings.[6] On July 16, 2007 Dr. Meadows performed bilateral keyhole laminotomies at C7-T1, fusions with rod placement at C3, C4, and C7 bilaterally and posterior fusions at C3-4 and C7-T1 with autologous bone graft.

Dr. David M. Hirsch, an attending osteopathic physician Board-certified in physiatry, submitted periodic reports from July 21, 2009 through 2012 diagnosing a left long thoracic nerve injury, diffuse atrophy of the supraspinatus and infraspinatus musculature, left cervical paraspinals and trapezius dystonia, and a mild C7-T1 spondylolisthesis. He administered periodic injections.[7]

Dr. John R. Hall, an attending osteopath, provided reports from 2011 through 2012 diagnosing cervical neuritis.

On January 17, 2013 appellant again claimed a schedule award. In support of his claim, he submitted a December 17, 2012 impairment rating from Dr. Robert C. Lowry, an attending Board-certified physiatrist, finding nine percent permanent impairment of the left arm due to long thoracic nerve injury, according to the peripheral neuropathy criteria under Table 15-21 of

[5] On June 22, 2006 the employing establishment offered appellant a modified clerk position for six hours a day, but appellant refused the offer. On July 17, 2006 OWCP advised appellant that the offered position was suitable work and that he had 30 days to accept the job or to provide valid reasons for refusal. On August 22, 2006 the employing establishment modified the job offer from six to four hours a day. OWCP advised appellant that he had 15 additional days in which to accept the offered job. Appellant did not accept the job. On September 6, 2006 OWCP terminated appellant's monetary compensation benefits under 5 U.S.C. § 8106(c)(2) for refusing suitable work. After initially pursuing reconsideration before OWCP, appellant appealed to the Board. In a March 9, 2009 decision, the Board found that OWCP improperly terminated appellant's compensation as the offered position was not suitable work. *See supra* note 2. OWCP paid compensation retroactively to September 3, 2006.

[6] OWCP obtained a second opinion report regarding the necessity of additional surgery from Dr. James F. Hood, a Board-certified orthopedic surgeon. In a May 8, 2007 report, Dr. Hood found appellant totally disabled for work due to an unstable cervical spine. He opined that the proposed fusions were medically necessary and appropriate. Based on Dr. Hood's opinion, OWCP approved Dr. Meadows' request for surgery.

[7] An August 19, 2009 cervical MRI scan showed postoperative changes from C3-4 through C6-7, with a mild one to two-millimeter spondylolisthesis of C7 on T1. An August 5, 2011 EMG and nerve conduction velocity study of the upper extremities showed impairment of the median motor and ulnar sensory nerves bilaterally.

the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).[8]

On September 30, 2013 appellant underwent a left L5-S1 minimally invasive tubular retraction discectomy.

In an October 2, 2013 report, Dr. Lorry Thornton, an osteopath Board-certified in family practice, found 10 percent permanent impairment of the arms due to cervicalgia, utilizing the peripheral nerve impairment criteria under Table 15-21 of the A.M.A., *Guides*.

On December 23, 2013 OWCP obtained a second opinion from Dr. Jerome O. Carter, a Board-certified physiatrist, and provided him a statement of accepted facts and a copy of the medical record. Dr. Carter agreed with Dr. Lowry that appellant had reached maximum medical improvement for the cervical spine on February 3, 2012. On examination, he found normal sensation and motor testing in the right arm, but diminished strength and sensation throughout the left arm. Dr. Carter noted that appellant's nonoccupational lumbar condition had not yet stabilized. He explained that, under the A.M.A., *Guides*, neurologic impairment originating in the spine should not be rated using peripheral or compression neuropathy criteria, but according to Proposed Table 1 of the July/August 2009 *The Guides Newsletter*, Dr. Carter found that, under Proposed Table 1, appellant had a class 1 Class of Diagnosis (CDX) based impairment for mild motor deficits in the left C5 distribution, a grade modifier for Functional History (GMFH) of 2 for pain during normal activities according to Table 15-7,[9] and a grade 1 modifier for Clinical Studies (GMCS) for motor delay confirmed by electromyogram (EMG) testing according to Table 15-9.[10] He explained that there was no applicable grade modifier for findings on Physical Examination (GMPE). Applying the net adjustment formula of (GMFH-CDX) + (GMCS-CDX), or (2-1) + (1-1) resulted in a net modifier of +1, raising the default CDX from C to D, equaling a six percent impairment of the left upper extremity. Using the same tables and calculation methods, Dr. Carter found seven percent impairment of the left arm due to mild motor deficits in the C6 distribution. Regarding the C7 distribution, he found that as there were no relevant findings on clinical studies, resulting in five percent impairment for mild motor deficits. Dr. Carter combined the 5, 6, and 7 percent impairments to equal 17 percent impairment of the left arm. He also found no impairment of the right arm as appellant had normal strength and sensation throughout the arm. In a March 7, 2014 report, an OWCP medical adviser concurred with Dr. Carter's rating and methodology.[11]

[8] Table 15-21, page 436 of the sixth edition of the A.M.A., *Guides* is titled "Peripheral Nerve Impairment: Upper Extremity Impairments."

[9] Table 15-7, page 406 of the sixth edition of the A.M.A., *Guides* is titled "Functional History Adjustment: Upper Extremities."

[10] Table 15-9, page 410 of the sixth edition of the A.M.A., *Guides* is titled "Clinical Studies Adjustment: Upper Extremities."

[11] A September 11, 2014 cervical MRI scan showed a C3-C7 osseous fusion, a C7-T1 anterior listhesis with severe bilateral neuroforaminal narrowing, and an asymmetric right facet arthrosis causing severe right neural foraminal narrowing. December 2, 2014 cervical spine x-rays showed a C3-7 fusion with fixation hardware at C3-4 and C7-T1.

By decision dated April 24, 2015, OWCP granted appellant a schedule award for 17 percent permanent impairment of the left upper extremity.[12]

In a September 11, 2015 letter, appellant requested reconsideration, contending that OWCP relied on outdated medical reports. He provided reports from Dr. Hall dated from February 2011 through January 2015, diagnosing a left long thoracic nerve injury, left suprascapular nerve injury, and severe left C6-7 radiculopathy. Dr. Hall administered periodic trigger point injections to the left cervical paraspinal and trapezius regions. Appellant also submitted a May 23, 2013 cervical MRI scan report demonstrating postsurgical changes from C3-4 and C7-T1, and facet hypertrophy from C2 to C7 with no canal stenosis. He also provided copies of medical evidence previously of record.

By decision dated November 9, 2015, OWCP affirmed the April 24, 2015 decision, finding that Dr. Hall's reports were insufficient to outweigh that of Dr. Carter.

LEGAL PRECEDENT

The schedule award provisions of FECA[13] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. It, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized 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 OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[14] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*.[15]

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).[16] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on functional history,

[12] On June 1, 2015 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review. By decision dated June 25, 2015, OWCP denied appellant's request for a hearing as it was not timely filed within 30 days of the April 24, 2015 decision. It further denied the claim as the issue involved could be addressed equally well through a request for reconsideration.

[13] 5 U.S.C. § 8107.

[14] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[15] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); *see also*, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[16] A.M.A., *Guides* at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement" (6th ed. 2009).

physical examination, and clinical studies.[17] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

Neither FECA nor its regulations provide for a schedule award for impairment to the back or to the body as a whole.[18] Furthermore, the back is specifically excluded from the definition of organ under FECA.[19] The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that FECA allows ratings for extremities and precludes ratings for the spine, *The Guides Newsletter* offers an approach to rating spinal nerve impairments consistent with sixth edition methodology. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that July/August 2009 *The Guides Newsletter* is to be applied.[20]

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 percentage of impairment using the A.M.A., *Guides*.[21]

ANALYSIS

OWCP accepted that appellant sustained an aggravation of cervical disc disease necessitating a C3-7 fusion. On January 17, 2013 appellant claimed a schedule award for impairment of the extremities originating in the spine. He provided a December 17, 2012 report from Dr. Lowry, an attending Board-certified physiatrist, finding nine percent permanent impairment of the left upper extremity according to Table 15-21 of the A.M.A., *Guides*, pertaining to peripheral nerve impairment. On September 30, 2013 Dr. Thornton, an attending Board-certified family practitioner, found 10 percent permanent impairment both upper extremities according to Table 15-21. However, under the A.M.A., *Guides*, impairment of an extremity caused by spinal nerve injury is rated according to Proposed Table 1 of the July/August 2009 *The Guides Newsletter*, and not using the criteria for peripheral neuropathy.

As appellant's physicians did not provide an impairment rating according to the appropriate portions of the A.M.A., *Guides*, OWCP obtained a second opinion from Dr. Carter, a Board-certified physiatrist. Dr. Carter provided a December 23, 2013 report utilizing Proposed Table 1 of the July/August 2009, *The Guides Newsletter*. He assessed combined 17 percent permanent impairment of the left upper extremity due to motor deficits in the C5, C6, and C7 dermatomes. Dr. Carter provided detailed clinical findings and explained how those objective elements warranted the percentages assessed. An OWCP medical adviser concurred with

[17] *Id*. at 494-531 (6th ed. 2009).

[18] *See N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

[19] *See* 5 U.S.C. § 8101(19); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

[20] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[21] *Id*. at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

Dr. Carter's rating and methodology. OWCP then issued the April 24, 2015 schedule award for 17 percent permanent impairment of the left arm.

Appellant requested reconsideration. He submitted chart notes from Dr. Hall noting periodic trigger point injections and a May 23, 2013 cervical spine MRI scan report. As these documents did not address the percentage of permanent impairment, OWCP affirmed the April 24, 2015 schedule award by decision dated November 9, 2015.

The Board finds that OWCP properly accorded Dr. Carter's impairment rating the weight of the medical evidence. Dr. Carter's opinion was based on a statement of accepted facts and the complete medical record. He provided a detailed impairment rating, utilizing the appropriate portions of the A.M.A., *Guides* and *The Guides Newsletter*. Dr. Carter described how objective clinical and electrodiagnostic findings in each affected cervical dermatome warranted the specified percentage of impairment. In contrast, appellant's physicians based their impairment ratings on an incorrect methodology. There is no probative medical evidence of record demonstrating that appellant sustained more than 17 percent permanent impairment of his left upper extremity due to the accepted cervical condition. Therefore, OWCP's November 9, 2015 decision was proper under the law and facts of this case.

On appeal, appellant asserts that OWCP has accepted a lumbar condition because it utilized the diagnosis code "7726" to accept "Aggravation of Degenerative Disc Disease," which he refers "to the entire spine unspecified." The Board notes that rather than referring to a condition of the entire spine, the diagnosis code indicates acceptance of a condition affecting an unspecified spinal region. The diagnosis code is merely a convenient, uniform method of classification, and does not constitute acceptance of a lumbar condition.

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

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish greater than 17 percent permanent impairment of the left upper extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 9, 2015 is affirmed.

Issued: June 16, 2016
Washington, DC

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board