United States Department of Labor
Employees' Compensation Appeals Board

K.S., Appellant	)	
and	)	**Docket No. 15-1082**
	)	**Issued: April 18, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Portland, OR, Employer	)	

Appearances:
Joseph E. Allman, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On April 16, 2015 appellant, through counsel, filed a timely appeal from an October 23, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (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 has established permanent impairment of a scheduled member, warranting a schedule award.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On January 26, 2009 appellant, then a 55-year-old postal clerk, filed a traumatic injury claim (Form CA-1) alleging that on January 2, 2009 he was pushing a mail rack weighing between 800 and 1,000 pounds when he felt a pop in his neck and spasm/numbness in his left arm and hand. OWCP accepted the claim for sprain of neck, displacement of cervical intervertebral disc without myelopathy, and intervertebral disc disorder with myelopathy left cervical region. Appellant stopped work on May 13, 2009 and did not return. He received compensation benefits on the periodic roll commencing October 24, 2010. On November 9, 2010 appellant underwent anterior discectomy and artificial disc replacement at C5-6 and C6-7 performed by Dr. Glen S. O'Sullivan, a Board-certified orthopedic surgeon. The surgery was authorized by OWCP.

On July 17, 2011 appellant filed a claim for a schedule award (Form CA-7). In support of his claim he submitted a June 27, 2011 report from Dr. Thomas J. Purtzer, a Board-certified neurological surgeon, who opined that appellant was entitled to 25 percent whole person impairment due to disc herniation and residual multiple level radiculopathy.

OWCP routed Dr. Purtzer's report and the case record to Dr. William Stewart, an OWCP district medical adviser (DMA), for an opinion regarding permanent impairment. In a July 21, 2011 report, Dr. Stewart opined that appellant had no ratable lower extremity impairment as a result of his work-related injuries. He noted that because this was a cervical spine injury, there were no discrete peripheral nerve injuries to the lower extremity. In an August 11, 2011 report, Dr. Stewart reported that review of Dr. Purtzer's examination showed no upper extremity permanent impairment. He explained that there was no evidence of radiculopathy in either right or left upper extremities and no evidence of nerve root injury. Dr. Stewart opined that appellant had not yet reached maximum medical improvement (MMI) as it had not been a year since his November 9, 2010 cervical surgery.

On April 6, 2012 OWCP referred appellant, a statement of accepted facts (SOAF), and the case record to Dr. Aleksandar Curcin, a Board-certified orthopedic surgeon, for a second opinion evaluation. In reports dated June 14 and July 12, 2012, Dr. Curcin provided findings on physical examination, noting that appellant's motor examination of the upper extremities was 5/5. Based on physical examination findings and review of recent electrodiagnostic studies, he noted that pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (6th ed., 2009) (A.M.A., *Guides*) there was no ratable impairment of the upper or lower extremities due to the lack of objective findings causally related to the accepted conditions. Dr. Curcin opined that MMI had been reached one year status postsurgery on November 9, 2011.

On August 1, 2012 Dr. Kenneth D. Sawyer, an OWCP DMA, Board-certified in surgery, reviewed the case file and agreed with Dr. Curcin that there was no ratable permanent impairment of the upper or lower extremities. He noted that, while appellant continued to have complaints, his complaints were subjective. Dr. Sawyer further noted that appellant's complaints were based on inconsistencies and nonphysiologic findings on physical examination which were reported by multiple examiners. He also stated that objective findings supported the conclusion

that there was no functional impairment of either upper or lower extremity. Dr. Sawyer concluded that MMI had been reached on the date of Dr. Curcin's examination.

By decision dated August 9, 2012, OWCP denied appellant's claim for a schedule award as the evidence of record was insufficient to establish that he sustained any permanent impairment to a member or function of the body.

On October 22, 2012 appellant requested reconsideration of the schedule award determination. In support of his request, he submitted an August 15, 2012 report from Dr. Glen S. O'Sullivan, a Board-certified orthopedic surgeon. Dr. O'Sullivan related that appellant's status post two level cervical surgery, artificial discs C5-6 and C6-7, placed him in an A.M.A., *Guides* category 4, DRE cervical category 4, which equaled 25 percent whole person impairment.

By decision dated October 23, 2012, OWCP denied appellant's request for reconsideration finding that he neither raised substantive legal questions nor included relevant and pertinent new evidence. It noted that the medical evidence submitted did not pertain to impairment ratings and that Dr. O'Sullivan's August 15, 2012 medical report provided a whole person impairment rating which was improper.

On May 24, 2013 appellant, through counsel, requested reconsideration of the October 23, 2012 OWCP decision. In support of his request for reconsideration, appellant submitted an April 24, 2013 report from Dr. Mark Bernhard, Board-certified in physical medicine and rehabilitation. Dr. Bernhard reviewed appellant's medical records, noted a history of injury and current complaints, and provided findings on physical examination. He noted that an April 12, 2013 electrodiagnostic study demonstrated right carpal tunnel syndrome (CTS) and possible left cubital tunnel syndrome. Dr. Bernhard provided diagnoses of status post cervical surgery at C5-6 and C6-7, artificial disc replacements for cervical spondyloarthropathies, and cervical radiculopathy. He noted that appellant had residuals of cervical radiculopathy with left upper extremity abnormal nerve conduction study findings and right carpal tunnel findings suggestive of ongoing mild radiculopathy. Dr. Bernhard explained that he did not find evidence of symptom exaggeration as the findings were corroborated by weakness in grip and consistent with some radicular changes. He reported that appellant's work-related injury caused the subjective and objective findings.

Referring to *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment, for impairment resulting from the radiculopathy, *i.e.*, the spinal nerve injury,[3] Dr. Bernhard explained that the standardized rating for multiple level, bilateral radiculopathy. He assigned a class 4 diagnosis-based impairment and the incremental impairment based on moderate level impairment was calculated subtracting 28 percent minus 11 percent (midrange calculation) resulting in 28 percent upper extremity permanent impairment (maximum impairment rating for severe, multilevel radiculopathy 37 percent). Dr. Bernhard noted that appellant's category of impairment was based on documented signs of bilateral or multiple level radiculopathy at the clinically appropriate levels present at the time of examination consistent with the functional

[3] *The Guides Newsletter*, sixth edition (July/August 2009).

capacity evaluation and nerve conduction study. Electrodiagnostic results and a range of motion study were submitted with his report.

OWCP routed the case record, along with Dr. Bernhard's report, to Dr. William Stewart, an OWCP DMA,[4] to determine if appellant suffered a residual condition as a result of the accepted January 2, 2009 injury such as upper/lower extremity radiculopathy. It requested he determine the extent of appellant's permanent impairment and the date of MMI.

In a May 30, 2013 report, Dr. Stewart reviewed Dr. Bernhard's report and noted that electrodiagnostic studies performed by the physician only demonstrated right CTS with no evidence of a general neuropathy or radiculopathy. He further noted that computerized tomography (CT) and magnetic resonance imaging (MRI) scans revealed negative findings. Dr. Stewart noted that there was no objective evidence to support Dr. Bernhard's finding of bilateral upper extremity radiculopathy resulting in 28 percent upper extremity impairment. He explained that the objective evidence failed to show an abnormal physical examination or abnormal clinical studies. Dr. Stewart noted that limited range of motion was also untenable if not supported by some anatomical abnormality or muscle impairment. The only abnormal finding presented was the mild right carpal tunnel which was not evidence of general radiculopathy, and appellant's x-ray only evidenced his past cervical spine surgery. Dr. Stewart concluded that the 28 percent upper extremity impairment rating was unsupported by clinical or physical findings and there was nothing in the record to support the existence of any degree of permanent partial impairment.

In a July 11, 2013 supplemental report, Dr. Bernhard reviewed Dr. Stewart's May 30, 2013 report and disagreed with his findings. He noted that there was objective evidence of disease such as T1-2 intermittent cervicothoracic myelopathy, 3+ hypereflexic distal lower extremity reflexes, and the 50 percent reduction in loss range of motion consistent with the compromise of two-level disc spaces from the surgery. Dr. Bernhard further noted that there was evidence of motor impairment as there was 4/5 muscle strength consistent with radiculopathy and nerves supplying the weakened muscles affected at the appropriate level. He disagreed with Dr. Stewart's assessment that right CTS was the only abnormality on the electrodiagnostic study. Dr. Bernhard noted that the study also revealed compromise of the ulnar nerve at the left elbow which was disregarded by Dr. Stewart. He explained that appellant's claim was accepted for displacement of the intervertebral disc with myelopathy. The electrodiagnostic findings also corroborated the presence of a radiculopathy since the nerve to the carpal tunnel and ulnar nerves were supplied by the roots affected by the cervical disc replacement.

Given that there was no schedule award payable for spinal impairment under FECA, Dr. Bernhard noted that he was revising his prior impairment rating to reflect impairment resulting from radiculopathy to the spinal nerve. With regard to the right carpal tunnel, Dr. Bernhard utilized the *Quick*DASH score with the carpal tunnel entrapment compression neuropathy impairment rating listed under Table 15-23 to calculate three percent right upper

[4] Dr. Stewart's credentials could not be verified.

extremity impairment. With respect to the ulnar nerve on the left hand for cubital tunnel syndrome, he utilized Table 15-23 to calculate three percent left upper extremity impairment.[5]

OWCP routed a SOAF, the case file, and the reports of Dr. Bernhard to Dr. Kenneth Sawyer, an OWCP DMA,[6] for an opinion concerning the nature and percentage of impairment pertaining to the upper extremities.

In a July 31, 2013 report, Dr. Sawyer summarized prior medical reports, diagnostic studies, and findings made pertaining to upper extremity impairments. He noted that Dr. Bernhard's electrodiagnostic study only noted mild right CTS and "possible" left cubital tunnel syndrome. Dr. Sawyer disagreed with Dr. Bernhard's rating of three percent upper extremity impairment on the right for CTS and three percent left upper extremity impairment for cubital tunnel syndrome. He noted that, based on review of the record, there was no impairment of either upper extremity related to the conditions that were accepted under this claim. Dr. Sawyer explained that neither CTS nor cubital tunnel syndrome were accepted conditions, nor was there any reason for accepting them.

By decision dated August 7, 2013, OWCP affirmed its August 9, 2012 decision finding that the evidence of record failed to establish a permanent impairment to a member or function of the body. It noted that the new evidence submitted did not demonstrate impairment of the upper extremities caused by injury to a spinal nerve because the conditions of right CTS and left cubital tunnel syndrome were not accepted as related to the January 2, 2009 employment incident.

On July 31, 2014 appellant, through counsel, requested reconsideration of OWCP's decision. He asserted that a new July 3, 2014 report from Dr. Jacob E. Tauber, a Board-certified orthopedic surgeon, established work-related radiculopathy and bilateral CTS entitling appellant to a schedule award for both upper and lower extremities.

In a June 11, 2014 report, Dr. O'Sullivan noted that a May 28, 2014 MRI scan of the lumbar spine revealed herniated disc at L4-5.

In a June 13, 2014 diagnostic report, Dr. Zakir Ali, a Board-certified neurologist, reported that electromyography (EMG) and nerve conduction velocity (NCV) studies of the right median motor nerve showed prolonged distal onset latency and decreased conduction velocity (elbow/wrist). He noted that all remaining nerves were within normal limits and all examined muscles showed no evidence of electrical instability. Dr. Ali noted that appellant's right arm and leg revealed normal findings. Appellant's examination findings were noted as mild right CTS with no proximal median neuropathy, normal right ulnar tibial and peroneal nerves, no right sided cervical or lumbar radiculopathy, and no polyneuropathy, myopathy, or motor neuron disease.

In a June 13, 2014 addendum report, Dr. Ali reported that appellant complained of numbness in the arms and legs and had artificial disc replacement a few years ago. He noted that

[5] A.M.A., *Guides* 449.

[6] Dr. Sawyer's credentials could not be verified.

appellant's electrodiagnostic studies did not reveal any significant abnormalities. Dr. Ali noted mild right CTS. He explained that there were no peripheral neuromuscular causes of appellant's symptoms. With regard to whether there could be cervical myelopathy, Dr. Ali stated that appellant's 2012 MRI scan showed no structural abnormality in the cervical spinal cord.

In a July 3, 2014 report, Dr. Tauber reported that appellant underwent electrical studies on June 13, 2014 documenting right CTS. He also noted broad based posterior disc protrusion at L4-5. Dr. Tauber noted that a May 20, 2014 evaluation revealed decreased sensation to pinprick in both hands and positive Tinel's signs at both wrists. Appellant also had positive straight leg raising testing bilaterally and decreased sensation to pinprick along the medial aspect of both feet. Dr. Tauber diagnosed status post artificial disc replacements with residual radiculopathy, bilateral CTS, and sciatica. He opined that appellant had reached MMI. Dr. Tauber noted that appellant began working for the employing establishment in April 2007 as a mail processing clerk where he carried out extensive repetitive motion duties and worked on machines and pushed racks. In addition, appellant was pushing a mail rack which weighed 800 to 1,200 pounds when he felt a popping sensation. He was ultimately noted to have CTS as well as pathology in his cervical and lumbar spine with disc protrusions.

Dr. Tauber opined that appellant's anatomic conditions in his cervical and lumbar spine, as well as his nerve entrapments, were related to his employment duties. He noted that appellant never had complaints in his cervical or lumbar spine until the specific work injury occurred. Dr. Tauber noted that there was likely some contribution to the cervical and lumbar pathology from his repetitive and strenuous motion duties and that the January 2, 2009 work incident caused a permanent aggravation. He opined that appellant's work duties caused and contributed to the anatomic pathology in his spine, that there was a permanent aggravation as a result of the specific work injury in 2009, and that in all probability there was contribution to the anatomic pathology from his repetitive duties in the course of his employment.

Dr. Tauber noted that appellant's CTS was present bilaterally. Using the sixth edition of the A.M.A., *Guides*, he opined that appellant's sensory dysfunction for bilateral CTS amounted to five percent permanent impairment of the left upper extremity, and five percent permanent impairment of the right upper extremity.[7] Using *The Guides Newsletter*, Dr. Tauber noted that appellant had six percent permanent impairment of the left upper extremity, and six percent permanent impairment for the right upper extremity due to his bilateral C6 radiculopathy. Combining the values he concluded that appellant was entitled to 11 percent upper extremity permanent impairment on the left and 11 percent on the right.[8] With respect to the lower extremities, Dr. Tauber noted a sensory deficit in the L5 distribution which would total three percent permanent impairment of each lower extremity.

In a September 5, 2014 report, Dr. O'Sullivan reported that appellant's work duties continued and caused the anatomic pathology that was present in his spine. He opined that there was a permanent aggravation as a result of the 2009 work injury and a contribution from his repetitive employment duties. Dr. O'Sullivan diagnosed herniated disc at L4-5, shoulder

[7] *Id.*

[8] *Supra* note 3 at Table 1.

impingement syndrome, and mechanical axial neck and left radicular arm pain status post two-level disc replacement C5-6, C6-7.

By decision dated October 23, 2014, OWCP denied modification of the August 7, 2013 decision finding that the evidence of record failed to establish a permanent impairment to a member or function of the body. It further found that the evidence of record failed to establish that his lower back injury and CTS were related to the January 2, 2009 employment incident.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.[9] 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* (6th ed. 2009) has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[10]

It is the claimant's burden of proof to establish that he has sustained a permanent impairment of the scheduled member or function as a result of any employment injury.[11] OWCP procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred (date of MMI), describes the impairment in sufficient detail so that it can be visualized on review, and computes the percentage of impairment in accordance with the A.M.A., *Guides*.[12]

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.[13] 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.[14]

[9] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[10] *K.H.*, Docket No. 09-341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

[11] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (February 2013).

[13] *Pamela J. Darling*, 49 ECAB 286 (1998).

[14] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment.[15] For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment using the sixth edition (July/August 2009) is to be applied.[16] FECA approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities.[17]

For conditions not accepted by OWCP as being employment related, it is the employee's burden to provide rationalized medical evidence sufficient to establish causal relation, not OWCP's burden to disprove such relationship.[18]

ANALYSIS

OWCP accepted appellant's claim for sprain of neck, displacement of cervical intervertebral disc without myelopathy, and intervertebral disc disorder with myelopathy left cervical region. On November 9, 2010 appellant underwent anterior discectomy and artificial disc replacement at C5-6 and C6-7. The Board notes that a schedule award is not payable under FECA for injury to the spine[19] or based on whole person impairment.[20] However, 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.[21] The issue is whether appellant sustained a permanent impairment as a result of his employment-related work injuries. The Board finds that appellant has failed to submit sufficient evidence to establish that, as a result of his employment injury, he sustained any permanent impairment to a scheduled member warranting a schedule award.[22]

In a June 27, 2011 report, Dr. Purtzer opined that appellant was entitled to 25 percent whole person impairment due to his disc herniation and residual multiple level radiculopathy. Dr. Stewart, serving as an OWCP DMA, disagreed with Dr. Purtzer's report and opined that appellant had not yet reached MMI as he had neck surgery less than one year prior. He further noted that appellant had no ratable impairment of either upper or lower extremities as there was no evidence of nerve root injury or radiculopathy. The Board finds that the report of Dr. Purtzer is insufficient to establish appellant's claim for a schedule award. There is no statutory basis for

[15] *Supra* note 12 at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

[16] *See G.N.*, Docket No. 10-850 (issued November 12, 2010); *see also id.* at Chapter 3.700, Exhibit 1, note 5 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[17] *Supra* note 12 at 2.808.5c(3).

[18] *G.A.*, Docket No. 09-2153 (issued June 10, 2010); *Jaja K. Asaramo*, 55 ECAB 200 (2004); *Alice J. Tysinger*, 51 ECAB 638 (2000).

[19] *Pamela J. Darling*, 49 ECAB 286 (1998).

[20] *N.M.*, 58 ECAB 273 (2007).

[21] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[22] *W.R.*, Docket No. 13-492 (issued June 26, 2013).

the payment of a schedule award for whole body impairment under FECA. Payment is authorized only for the permanent impairment of specified members, organs, or functions of the body.[23] Similarly, Dr. O'Sullivan's August 15, 2012 report is also insufficient to establish appellant's claim as he also provided a rating of 25 percent whole person permanent impairment.[24]

In support of his schedule award claim, appellant also submitted reports dated April 24 and July 11, 2013 from Dr. Bernhard. In his April 24, 2013 report, Dr. Bernhard noted that an April 12, 2013 electrodiagnostic study demonstrated cervical radiculopathy, right CTS, and possible left cubital tunnel syndrome. He explained that these findings were corroborated by weakness in grip and consistent with some radicular changes, opining that appellant's work-related injury produced subjective and objective findings. In his July 11, 2013 supplemental report, Dr. Bernhard opined that appellant had three percent right upper extremity permanent impairment for carpal tunnel entrapment compression neuropathy and three percent left upper extremity impairment of the ulnar nerve on the left hand for cubital tunnel syndrome. He further argued that the electrodiagnostic study showed both right CTS and ulnar nerve at the left elbow which were corroborated by the presence of a radiculopathy since the nerve to the carpal tunnel and ulnar nerves were supplied by the roots affected by the cervical disc replacement. Dr. Bernhard noted that there was evidence of motor impairment as there was 4/5 muscle strength consistent with radiculopathy and the nerves supplying the weakened muscles affected at the appropriate level.

The Board finds that the reports of Dr. Bernhard are insufficient to establish that appellant sustained three percent impairment to each upper extremity. Dr. Bernhard's assessment pertaining to the spinal nerve injury utilized diagnoses of right CTS and ulnar nerve at the left elbow to determine appellant's upper extremity impairment rating. The Board notes that those conditions have not been accepted by OWCP as related to the January 2, 2009 employment incident.[25] OWCP's procedure manual provides that impairment ratings for schedule awards include those conditions accepted by OWCP as work related, and any preexisting permanent impairment of the same member or function. If the work-related injury has affected any residual usefulness in whole or in part, a schedule award may be appropriate.[26]

In reports dated May 30 and July 31, 2013, Dr. Stewart, an OWCP DMA, explained that electrodiagnostic studies performed by the physician only demonstrated right CTS with no evidence of a general neuropathy or radiculopathy. He noted that CT and MRI scan studies revealed negative findings. The only abnormal finding was the mild right carpal tunnel which was not evidence of general radiculopathy. Dr. Stewart concluded that upper extremity impairment was unsupported by clinical or physical findings and there was nothing in the record to support the existence of any degree of permanent partial impairment based on bilateral upper

[23] *Tania R. Keka*, 55 ECAB 354 (2004).

[24] *Supra* note 18.

[25] *R.W.*, Docket No. 15-1121 (issued August 12, 2015).

[26] *Supra* note 12 at Chapter 2.808.5 (d) (February 2013). *See also Raymond E. Gwynn*, 35 ECAB 247, 253 (1983).

extremity radiculopathy. The DMA disagreed with Dr. Barnhard's rating of three percent permanent impairment for each upper extremity, explaining that neither CTS nor cubital tunnel syndrome were accepted conditions, nor was there any reason for accepting them.

Dr. Stewart's assessment that appellant has no ratable impairment to the upper extremities was further supported by the medical evidence of record. In a June 2, 2012 second opinion evaluation, Dr. Curcin noted that physical examination and review of recent electrodiagnostic studies revealed no objective findings pertaining to the upper or lower extremities which would warrant an impairment rating. On August 1, 2012 Dr. Sawyer, an OWCP DMA, reviewed the case file and agreed with Dr. Curcin that there was no ratable impairment to the upper or lower extremities. He noted that continued complaints with regard to the extremities were based on subjective findings and not supported physiologically as objective findings revealed no functional impairment.

Following OWCP's August 7, 2013 denial of appellant's schedule award claim, counsel for appellant submitted Dr. Tauber's July 31, 2014 report in support of 11 percent permanent impairment to each upper extremity. The Board finds that Dr. Tauber's report is insufficient to establish appellant's claim for a schedule award.[27]

In his July 3, 2014 report, Dr. Tauber reported that appellant underwent electrodiagnostic studies on June 13, 2014 documenting right CTS. He further noted broad-based posterior disc protrusion at L4-5. Dr. Tauber noted that a May 20, 2014 evaluation revealed decreased sensation to pinprick in both hands and positive Tinel's signs at both wrists. Appellant also had positive straight leg raise testing bilaterally and decreased sensation to pinprick along the medial aspect of both feet. Dr. Tauber diagnosed status post artificial disc replacements with residual radiculopathy, bilateral CTS, and sciatica. He noted that appellant began working for the employing establishment in April 2007 as a mail processing clerk where he carried out extensive repetitive motion duties and worked on machines and pushed racks. In addition, appellant was pushing a mail rack which weighed 800 to 1,200 pounds when he felt a popping sensation. Appellant was ultimately noted to have CTS confirmed as well as pathology in his cervical and lumbar spine with disc protrusions.

The Board finds that Dr. Tauber's report is insufficient to establish that the above-listed injuries resulted from the January 2, 2009 employment incident.[28] Dr. Tauber opined that appellant's anatomic conditions in his cervical and lumbar spine, as well as his nerve entrapments, were related to his employment duties. He noted that appellant had no complaints in his cervical or lumbar spine until the specific work injury occurred. The Board has held that an opinion that a condition is causally related because the employee was asymptomatic before the injury is insufficient, without adequate rationale, to establish causal relationship.[29] Dr. Tauber also noted that there was likely some contribution to the cervical and lumbar

[27] *D.U.*, Docket No. 13-2086 (issued February 11, 2014).

[28] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

[29] *M.R.*, Docket No. 14-11 (issued August 27, 2014); *T.M.*, Docket No. 08-975 (issued February 6, 2009); *Michael S. Mina*, 57 ECAB 379 (2006).

pathology from his repetitive and strenuous motion duties and that the January 2, 2009 work incident caused a permanent aggravation. As he indicated that appellant suffered from these conditions prior to the January 2, 2009 employment incident, a well-rationalized opinion is particularly warranted in this case due to appellant's history of preexisting conditions.[30] Yet Dr. Tauber failed to discuss how the preexisting conditions had progressed beyond what might be expected from the natural progression of that condition.[31] Moreover, it appears that he is attributing appellant's conditions to an occupational injury produced by his work environment over a period longer than a single workday or shift claim.[32] Dr. Tauber's opinion pertaining to appellant's work-related duties as the cause of his injuries does not provide support for a schedule award arising from this traumatic injury claim.[33]

Dr. Tauber's opinion regarding radiculopathy is also unsupported by the medical evidence of record. Dr. Ali's electrodiagnostic study found testing of the right arm and leg revealed normal findings. He also specifically stated that the studies showed no support for any left upper extremity impairment or radiculopathy, contrary to Dr. Tauber's assessment. It is unclear how Dr. Tauber reached his conclusions as he disregarded the findings of Dr. Ali who submitted appellant for diagnostic testing on June 13, 2014 at his request. Dr. Tauber either did not review the relevant medical evidence of record or have an accurate history of injury as his opinion is unsubstantiated by objective findings. His opinion on causation is of no probative value and is unsupported by the diagnostic evidence of record. Appellant's injuries pertaining to the spinal nerve involve the cervical spine. The sensory deficit L5 distribution is unrelated to this particular cervical injury and does not warrant any impairment pertaining to the lower extremities. While Dr. Tauber made reference to the A.M.A., *Guides* and *The Guides Newsletter* when calculating appellant's impairment rating, his opinion is not supported by the medical evidence of record or the most recent diagnostic testing.[34]

Dr. O'Sullivan's September 5, 2014 report is also insufficient to establish appellant's claim as it mimics the conclusions reached in Dr. Tauber's report, finding 11 percent permanent impairment for each upper extremity.[35] The medical evidence of record fails to establish ratable impairment of the upper extremities related to the January 2, 2009 employment injury.[36]

On appeal, counsel argues that prior medical reports documented radiculopathy and left upper extremity with weakness. He references an August 19, 2010 referee opinion pertaining to

[30] *K.P.*, Docket No. 14-1330 (issued October 17, 2014).

[31] *R.E.*, Docket No. 14-868 (issued September 24, 2014).

[32] A traumatic injury means a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift. 20 C.F.R. § 10.5(ee). An occupational disease is defined as a condition produced by the work environment over a period longer than a single workday or shift. 20 C.F.R. § 10.5(q).

[33] *S.R.*, Docket No. 12-1098 (issued September 19, 2012).

[34] *E.J.*, Docket No. 12-1948 (issued June 5, 2013).

[35] *Id.*

[36] *E.W.*, Docket No. 12-772 (issued June 13, 2013).

authorization for disc replacement surgery by Dr. Gerard H. Dericks, a Board-certified orthopedic surgeon, as support for his argument. The Board notes that the issue on appeal is whether appellant is entitled to a schedule award after having reached MMI. As Dr. Dericks' opinion was provided prior to appellant's surgery on November 9, 2010, his report is of little probative value because MMI had not been reached. The older medical reports referenced by counsel are insufficient to establish appellant's claim for a schedule award. The Board has held that stale medical evidence cannot form the basis for current evaluation of residual symptomology or disability determination.[37]

Counsel also argues that OWCP erred in its procedures by not requesting a supplemental report from Dr. Purtzer who provided a rating of 25 percent whole person permanent impairment. While the physician may have determined that MMI had been reached, he failed to give a proper impairment rating in accordance with FECA.[38] OWCP properly referred the case for a second opinion evaluation with Dr. Curcin.[39] Following Dr. Curcin's second opinion evaluation, it followed its procedures by routing the case file to an OWCP DMA.[40]

It is appellant's burden of proof to establish a permanent impairment of a scheduled member as a result of an employment injury.[41] He did not submit such evidence and thus, OWCP properly denied his schedule award claim.[42]

Appellant may request a schedule award or increased schedule award at any time 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 has not established permanent impairment of a scheduled member warranting a schedule award.

[37] *See Keith Hanselman*, 42 ECAB 680 (1991); *Ellen G. Trimmer*, 32 ECAB 1878 (1981) (reports almost two years old deemed invalid basis for disability determination and loss of wage-earning capacity determination).

[38] *Supra* note 21.

[39] If the claimant does not provide an impairment evaluation from his/her physician when requested, and there is an indication of permanent impairment in the medical evidence of file, the claims examiner (CE) should refer the claimant for a second opinion evaluation. The CE may also refer the case to the DMA prior to scheduling a second opinion examination to determine if the evidence in the file is sufficient for the DMA to provide an impairment rating. *Supra* note 12 at Chapter 2.808.6(d) (February 2013).

[40] *Id.* at Chapter 2.808.6(f).

[41] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[42] *V.W.*, Docket No. 09-2026 (issued February 16, 2010); *L.F.*, Docket No. 10-343 (issued November 29, 2010).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated October 23, 2014 is affirmed.

Issued: April 18, 2017
Washington, DC

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

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

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