United States Department of Labor
Employees' Compensation Appeals Board

W.S., Appellant	)	
and	)	**Docket No. 17-0125**
	)	**Issued: August 10, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, Employer	)	

Appearances:
Alan J. Shapiro, 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
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On October 27, 2016 appellant, through counsel, filed a timely appeal from a September 22, 2016 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.

[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.*

ISSUE

The issue is whether appellant met her burden of proof to establish more than nine percent permanent impairment of the left upper extremity, for which she previously received schedule awards.

FACTUAL HISTORY

OWCP accepted that on December 12, 2009 appellant, then a 43-year-old mail handler, sustained a neck sprain and cervical disc displacement as a result of pushing all-purpose containers off a truck at work.[3] Appellant stopped work on December 13, 2009. OWCP authorized anterior cervical discectomy and fusion (ACDF) surgery to treat her preoperative and postoperative diagnosis of left C4-5 cervical intervertebral disc herniation. The surgery was performed on December 17, 2010 by Dr. Adebukola A. Onibokun, an attending Board-certified neurosurgeon.

In a July 11, 2011 progress note, Dr. Onibokun indicated that appellant was doing well approximately six months after the cervical fusion. He reported that her left shoulder pain was about 60 percent reduced from the time of surgery. Dr. Onibokun noted that appellant had undergone a functional capacity evaluation which determined that she was unable to lift, pull, or push any object heavier than 10 pounds. He cleared her to return to work with these restrictions.

On January 9, 2012 appellant filed a claim for a schedule award (Form CA-7).

On January 16, 2012 Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA) reviewed the medical record, including Dr. Onibokun's July 11, 2011 findings. He opined that appellant's residual pain in the shoulder corresponded with the C5 dermatome and axillary nerve. Dr. Garelick, thus, determined that she had two percent permanent impairment of the left arm under Table 15-21 on page 436 of the sixth edition of the American Medical Association, *Guides to the Evaluation of permanent Impairment* (A.M.A., *Guides*). There was no change to the award with use of the net adjustment formula. Dr. Garelick found that there was no objective evidence to support any right arm permanent impairment at that time. He determined that appellant had reached maximum medical improvement (MMI) on July 11, 2011, the date of Dr. Onibokun's examination.

In a March 23, 2012 letter, Dr. Onibokun noted that appellant had a permanent disfigurement scar approximately three to four inches in length due to anterior neck surgery. He further noted that she had one disc removed at the C4-5 level.

In a May 3, 2012 attending physician's report for disfigurement, Dr. Leonard J. Cerullo, a Board-certified neurosurgeon, noted that appellant was examined on that day. He advised that she had a scar on her neck from surgery, cervical and lumbar pain with limited range of motion, and left shoulder pain with muscle spasms. Dr. Cerullo related that no significant improvement

[3] Subsequent to the instant claim, appellant filed a claim, assigned File No. xxxxxx964, for a neck injury sustained on August 13, 2010. OWCP accepted the claim for neck sprain.

in appellant's disfigurement was probable and that therapy, medical, or surgical treatment would only help with her pain.

In a May 15, 2012 decision, OWCP granted appellant a schedule award for two percent permanent impairment of the left arm based on Dr. Garelick's January 16, 2012 opinion.[4]

In a January 14, 2013 progress note signed by Christine Compisi, a physician assistant, indicated that appellant was seen and examined by Dr. Julian E. Bailes, Jr., a Board-certified neurosurgeon. She noted a history of the December 2009 employment injury and appellant's medical treatment and social background. Ms. Compisi also noted her left upper extremity and back complaints. She reported findings on examination and assessed status post ACDF surgery with residual pain and new pain in the lower back.

In a June 24, 2013 report, Dr. Onibokun noted appellant's past surgical history was significant ACDF surgery and that she presented with intractable cervical spinal pain. Appellant reported to him that her pain was constant, 9 out of 10 in intensity, burning in nature, and aggravated by activity. She complained about occasional numbness and tingling in the left upper extremity. Appellant also complained about left hand weakness. On physical examination, Dr. Onibokun found that she moved all four of her extremities with good strength in all muscle groups, with the exception of the left deltoid where her motor strength was 4+ out of 5. He also found normal muscle bulk and tone in all four extremities. There was decreased light touch and pinprick sensation in the left C5 and C6 dermatomal distributions. Biceps, triceps, and patellar Achilles deep tendon reflexes were 2+ symmetric bilaterally. Plantar responses were downgoing bilaterally. There was no clonus or Hoffmann's. There was severe tenderness to palpation in the mid to lower left-sided posterior cervical paramedian region. There was decreased cervical range of motion in all planes. A Spurling's maneuver was negative. Gait was normal. Romberg was negative. X-rays of the cervical spine revealed cervical fusion hardware in a good position. There was no evidence of hardware loosening or pseudoarthrosis.

A cervical spine magnetic resonance imaging scan revealed no evidence of significant cervical disc herniation, cervical nerve root compression, cervical anterolisthesis, or spinal cord compression. Dr. Onibokun diagnosed neck pain. He related that appellant was greater than two years status post ACDF surgery and presented with intractable cervical spinal pain. Dr. Onibokun advised that her recent cervical imaging studies were unremarkable. He believed that appellant's cervical spinal pain was most likely myofascial in origin. Dr. Onibokun concluded that the nature of her pain was likely originating from irritation of the cervical paraspinal muscular tissue. He recommended nonsurgical treatment.

On July 21, 2013 Dr. Christopher Gross, a Board-certified orthopedic surgeon and OWCP DMA, reviewed the medical record. He referenced Dr. Onibukun's finding that appellant had mild motor loss of left C5 with mild sensory loss of C5 and C6. Dr. Gross determined that she had a grade 1 diagnosis of mild sensory deficits of C5 and C6 on the left and mild motor deficit of C5 based on Table 2 of *The Guides Newsletter*, July/August 2009. He

[4] The record also contains evidence of prior development regarding whether appellant's injury warranted an award for disfigurement. As this matter is not at issue on the present appeal, this evidence will not be presented in this decision.

assigned a grade 2 modifier for Functional History (GMFH) under Table 15-7 on page 406 of the A.M.A., *Guides*, for pain with normal activity. Dr. Gross noted that appellant's physical examination under Table 15-8 on page 408 was used in the determination of clinical grades. He found that clinical studies were not applicable. Therefore, based on the net adjustment formula, Dr. Gross determined that appellant had a +1 adjustment which resulted in a rating of nine percent permanent impairment of the left upper extremity (sensory C5 one percent, sensory C6 two percent, motor C5 six percent). He found that she had no right upper extremity impairment. Dr. Gross concluded that appellant had reached MMI on January 14, 2013, the date of Dr. Bailes' examination.

By decision dated August 1, 2013, OWCP granted appellant a schedule award for an additional seven percent permanent impairment of the left upper extremity, totaling nine percent permanent impairment of the left upper extremity based on the June 24 and July 21, 2013 reports of Dr. Onibokun and Dr. Gross, respectively.

On October 22, 2013 appellant filed a claim for an additional schedule award (Form CA-7).

In an August 15, 2013 report, Dr. Neil Allen, a Board-certified internist and neurologist, noted appellant's history of injury and medical treatment. He described appellant's functional history, examination findings, and test results. Dr. Allen utilized the sixth edition of the A.M.A., *Guides*, and *The Guides Newsletter*, July/August 2009, to determine that she had 36 percent impairment due to motor deficits and 10 percent impairment due to sensory deficits involving the C5, C6, C7, and C8 nerve roots, totaling 46 percent permanent impairment of the left upper extremity.

On May 3, 2014 Dr. Gross again reviewed the medical record, including the findings of Dr. Allen. He noted that his prior finding that appellant had nine percent permanent impairment of the left upper extremity and no impairment of the right upper extremity remained unchanged. Dr. Gross noted that Dr. Allen's findings were drastically different from those found by Dr. Onibokun and reasoned that the latter physician was more reliable because he was a neurosurgeon and had specific expertise with the cervical spine.

On July 15, 2014 OWCP noted that the instant claim assigned File No. xxxxxx347 and the claim assigned File No. xxxxxx964 had been combined. It requested that a DMA review additional evidence of record and determine the extent of appellant's permanent impairment.

On July 23, 2014 Dr. Gross again reviewed the medical record. He also restated that his nine percent impairment rating for the left upper extremity and zero percent impairment rating for the right upper extremity remained unchanged.

In an August 1, 2014 decision, OWCP denied appellant's claim for an additional schedule award for the left upper extremity. It found that the medical evidence of record failed to establish that she had any greater impairment than previously awarded.

By letter dated August 13, 2014, appellant, through counsel, requested a telephone hearing with an OWCP hearing representative. She submitted a September 25, 2013 report from

Dr. Allen which reiterated the findings and 46 percent left upper extremity impairment rating set forth in his August 15, 2013 report.

In a May 27, 2015 decision, an OWCP hearing representative set aside the August 1, 2014 decision and remanded the case to OWCP for referral of appellant to a second opinion physician for an examination and opinion on the extent of her bilateral upper extremity impairment under the sixth edition of the A.M.A., *Guides*. She found that Dr. Allen's August 13, 2013 report had explained how he used the A.M.A., *Guides* to rate appellant's impairment.

By letter dated July 30, 2015, OWCP referred appellant, together with a statement of accepted facts (SOAF), the medical record, and a list of questions, to Dr. Allan Brecher, a Board-certified orthopedic surgeon, for a second opinion. In an August 25, 2015 report, Dr. Brecher reviewed the SOAF and medical record. He noted appellant's surgical, social, and family background. Dr. Brecher indicated that she used a crutch because she had recent surgery on her right knee and had trouble standing and putting weight on her knee. On examination of the extremities, he found that appellant could only flex and abduct the left shoulder to 90 degrees. Appellant reported that she had arthritis in the shoulder. Global strength was 4/5 in the left upper extremity and fine in the right arm. Dr. Brecher related that he could not judge appellant's right and left lower extremities because she could not put weight on the right as she was recovering from surgery, but sensibility was grossly intact. Appellant had a healed keloid on her neck.

Cervical motion was markedly limited. Appellant had no lateral flexion and 10 degrees right lateral flexion. Rotation was only 10 degrees, extension was 20 degrees, and flexion was 20 degrees at best. Appellant had some spasm. Dr. Brecher believed that appellant was exaggerating her symptoms. He indicated that appellant would not bend or straighten her elbow. Dr. Brecher related that he had to encourage her and repeatedly show her what to do and then she was able to do it, but not with complete strength. He advised that appellant had reached MMI on January 17, 2011, one year after her December 17, 2010 surgery. Dr. Brecher indicated that she continued to complain about problems, but the objective findings showed healing of this fusion. He advised that it appeared appellant had some C5 nerve impingement with numbness and decreased sensation on the left, but was minor. Dr. Brecher noted that Dr. Gross used Table 2 in *The Guides Newsletter*, July/August 2009 which was not available to him. He only had the sixth edition of the A.M.A., *Guides*. Dr. Brecher related that the most relevant impairment he could give was using the upper trunk impairment on Table 15-20 for brachial plexus impairment. He determined that appellant had mild sensory and motor deficits which represented a class 1 impairment. Dr. Brecher assigned grade modifiers 1 for GMFH and Physical Examination (GMPE) under Table 15-7 and Table 15-8 on pages 406 and 408, respectively. He determined that a grade modifier for Clinical Studies (GMCS) was not applicable. Dr. Brecher found that appellant had 3 percent impairment for sensory impairment and 9 percent impairment for mild motor deficit, totaling 12 percent permanent impairment of the left upper extremity. He found that she had no impairment of the right upper extremity. Dr. Brecher noted, however, that there was some exaggeration and from an orthopedic standpoint, he could not provide an impairment rating for appellant's "nervous breakdown."

On November 9, 2015 Dr. Garelick, as the DMA, reviewed the medical record, including Dr. Gross' July 23, 2014 findings and Dr. Brecher's August 25, 2015 findings. He noted that

appellant had already been given a schedule award for nine percent permanent impairment of the left upper extremity based on the July 23, 2014 findings of Dr. Gross. Dr. Garelick further noted that Dr. Brecher had not applied *The Guides Newsletter* July/August 2009 along with the A.M.A., *Guides* to rate her upper extremity impairment as utilized by Dr. Gross. Based on Dr. Brecher's failure to follow the appropriate protocol to award permanent partial impairment, he recommended that his impairment rating be disregarded. As a result, Dr. Garelick concluded that Dr. Gross' nine percent left upper extremity impairment rating should remain with no change to the date of MMI of January 14, 2013.

In a December 16, 2015 decision, OWCP denied appellant's claim for an additional schedule award. It found that Dr. Garelick's November 9, 2015 opinion represented the weight of medical evidence to establish that she had no more than nine percent permanent impairment of the left upper extremity.

By letter dated December 30, 2015, counsel requested a telephone hearing with an OWCP hearing representative. The hearing was held on August 1, 2016. He contended that there was a conflict in medical opinion between Dr. Allen's 46 percent left upper extremity impairment rating and Dr. Brecher's 12 percent left upper extremity impairment rating.

In a September 22, 2016 decision, an OWCP hearing representative affirmed the December 16, 2015 decision. She found that no conflict existed in the medical opinion evidence between Drs. Allen and Brecher regarding the extent of appellant's left upper extremity impairment. The hearing representative determined that the weight of the medical evidence rested with Dr. Garelick's November 9, 2015 opinion as he properly utilized the sixth edition of the A.M.A., *Guides* and provided a rationalized opinion that appellant had no more than nine percent permanent impairment of the left upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations[6] 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.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to rate permanent impairment.[8]

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

[8] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, under FECA a schedule award is not payable for injury to the spine.[9] 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.[10]

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. 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 as outlined in *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment (July/August 2009 edition) of the sixth edition.[11]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[12]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than nine percent impairment of the left upper extremity.

OWCP accepted appellant's claim for neck sprain. On December 17, 2010 appellant underwent an OWCP-authorized ACDF at C4-5. On May 15, 2012 OWCP awarded two percent impairment of the left upper extremity. By decision dated August 1, 2013, it granted an additional seven percent impairment, totaling nine percent permanent impairment of the left arm. In an August 1, 2014 decision, OWCP denied her claim for an additional schedule award for the left upper extremity. This decision was set aside by an OWCP hearing representative on May 27, 2015 and remanded to OWCP for referral to a second opinion physician for examination. After such development, OWCP and an OWCP hearing representative, in decisions dated December 16, 2015 and September 22, 2016, respectively, denied appellant's claim for an additional schedule award.

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

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

[11] *See supra* note 8 at Chapter 3.700, Exhibit 1, note 5 (January 2010). *The Guides Newsletter* is included as Exhibit 4; *see also E.P.*, Docket No. 16-1154 (issued October 26, 2016).

[12] *See supra* note 8 at Chapter 2.808.6(f) (February 2013).

Following remand of the case by OWCP's hearing representative on May 27, 2015, OWCP referred appellant to Dr. Brecher, a Board-certified orthopedic surgeon, for a second opinion. In his August 25, 2015 report, Dr. Brecher found that she had 12 percent impairment of the left upper extremity based on a brachial plexus impairment due to sensory and motor deficits under the sixth edition of the A.M.A., *Guides*. The Board finds that he failed to rate appellant's impairment using *The Guides Newsletter* standard for spinal nerve root injuries involving the extremities. OWCP procedures provide that *The Guides Newsletter* Rating Spinal Nerve Extremity Impairment is the appropriate method of determining impairment in this case.[13] *The Guides Newsletter* provides a specific method for determining impairments for conditions such as radiculopathy from a spinal nerve injury. It explains that, in the sixth edition, impairment for radiculopathy is reflected in the diagnosis-based impairment for the spinal region. In developing an alternative approach to rating isolated radiculopathy, it is important to provide consistency in impairment ratings between the chapters.[14] Dr. Brecher acknowledged that he did not use *The Guides Newsletter*, July/August 2009, and sought to make a rating based on Table 15-20 for Brachial Plexus impairment. However, he did not sufficiently explain how this rating applied under the standards of the A.M.A., *Guides* or why it was more appropriate than using *The Guides Newsletter*.[15] Furthermore, Dr. Brecher cautioned that there was exaggeration on examination. The Board finds, therefore, that his impairment rating is of diminished probative value and insufficient to establish permanent impairment to appellant's left upper extremity causally related to the accepted injury.

Dr. Garelick, an OWCP DMA, reviewed the clinical findings and reports of Drs. Brecher and Gross, a prior OWCP DMA. He properly advised that Dr. Brecher's opinion should be disregarded because he had not utilized *The Guides Newsletter*, together with the A.M.A., *Guides*, to rate appellant's left upper extremity impairment. Dr. Garelick noted that she had already been awarded nine percent permanent impairment of the left upper extremity based on the July 23, 2014 findings of Dr. Gross, a prior OWCP DMA. He agreed with Dr. Gross' impairment rating as Dr. Brecher did not follow appropriate protocol in rating appellant's impairment.

OWCP may rely on the opinion of a DMA to apply the A.M.A., *Guides*.[16] The Board finds that Dr. Garelick's rating properly utilized the A.M.A., *Guides* and represents the weight of medical opinion evidence.

In his August 15, 2013 report, Dr. Allen, a Board-certified internist and neurologist, found 36 percent permanent impairment due to motor deficits and 10 percent permanent impairment due to sensory deficits involving the C5, C6, C7, and C8 nerve roots, totaling 46 percent permanent impairment of the left upper extremity based on the sixth edition of the

[13] *See supra* note 11; *G.N.*, Docket No. 10-0850 (issued November 12, 2010).

[14] *L.J.*, Docket No. 10-1263 (issued March 3, 2011); *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[15] *See I.F.*, Docket No. 08-2321 (issued May 21, 2009) (an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of diminished probative value in determining the extent of permanent impairment).

[16] *See J.G.*, Docket No. 09-1714 (issued April 7, 2010).

A.M.A., *Guides*, and *The Guides Newsletter*, July/August 2009. The Board notes that appellant had undergone an authorized ACDF surgery at C4-5 on December 17, 2010 to repair a compression fracture at C5. While Dr. Allen provided a greater impairment rating, he did not explain how surgery at the C4-5 level caused or contributed to impairment at the C6, C7, and C8 levels. He also provided ratings that were greater than the maximum allowed under *The Guides Newsletter*.[17] The Board finds, therefore, that his opinion is of diminished probative value and insufficient to establish greater impairment.

The Board finds that appellant has not demonstrated greater permanent impairment than the prior left upper extremity schedule awards totaling nine percent and is not entitled to an additional schedule award for this extremity.

Appellant may request an 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 increased permanent impairment.

CONCLUSION

The Board finds that appellant has failed to meet her burden of proof to establish more than nine percent permanent impairment of the left upper extremity, for which she previously received schedule awards.

[17] Page 3 of the *The Guides Newsletter* provides that the combined sensory and motor impairment cannot exceed 9 percent of the arm and the combined impairment for multiple-level or bilateral level radiculopathy cannot exceed 37 percent for the arm.

ORDER

IT IS HEREBY ORDERED THAT the September 22, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 10, 2017
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board