United States Department of Labor
Employees' Compensation Appeals Board

J.D., Appellant	)	
and	)	**Docket No. 17-1800**
	)	**Issued: May 25, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 21, 2017 appellant filed a timely appeal from a February 27, 2017 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 the claim.

ISSUE

The issue is whether appellant has met her burden of proof to establish permanent impairment of her bilateral upper extremities, warranting a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts of the case as presented in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On November 14, 1985 appellant, then a 28-year-old distribution clerk, filed a traumatic injury claim (Form CA-1) alleging bilateral wrist injury. On March 5, 2006 OWCP accepted the claim for de Quervain's tenosynovitis of the right wrist. It subsequently expanded acceptance of the claim to include bilateral carpal tunnel syndrome.[3]

Appellant stopped work on May 11, 2005 and has not returned.

Dr. Samuel J. Chmell, an attending Board-certified orthopedic surgeon, performed a left median nerve release on April 20, 2006 and a right median nerve release on December 15, 2006.

On June 20, 2008 appellant filed a claim for a schedule award (Form CA-7). In support of her claim, she provided Dr. Chmell's July 14, 2008 impairment evaluation utilizing the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[4] (hereinafter, A.M.A., *Guides*) finding 77 percent impairment of the right upper extremity due to limited shoulder motion, weakness, and cervical radiculopathy, and 40 percent impairment of the left arm due to diminished sensation and weakness. OWCP obtained a second opinion from Dr. David H. Trotter, a Board-certified orthopedic surgeon, who found no permanent impairment of either upper extremity.

OWCP subsequently found that a conflict of medical opinion existed between Dr. Chmell, for appellant, and Dr. Trotter, for the government. To resolve the conflict, it obtained an impartial medical opinion on March 26, 2012 from Dr. Jaroslaw Dzwinyk, a Board-certified neurologist, who found no ratable permanent impairment of either upper extremity. Dr. Dzwinyk explained that appellant had no objective evidence of carpal tunnel syndrome or de Quervain's tenosynovitis, full range of motion throughout the upper extremities, and a normal neurologic examination. In a March 17, 2014 supplemental report, he opined that according to page 487 of the sixth edition of the A.M.A., *Guides*,[5] a May 20, 2013 electromyography study was within normal limits as her

[2] Docket No. 15-1286 (issued December 14, 2015).

[3] The present claim was assigned OWCP File No. xxxxxx055. This claim is a master file and has been doubled with two other accepted claims. Under OWCP File No. xxxxxx273, on September 11, 1978 appellant filed a notice of traumatic injury (Form CA-1) alleging that she had sustained a right shoulder injury on September 8, 1978 when she fell out of a chair while she was performing her federal employment duties. OWCP accepted that claim for contusion of the right shoulder and upper arm, contusion of the face, scalp, neck, and headache. Under OWCP File No. xxxxxx862, appellant filed a notice of occupational disease (Form CA-1) on August 23, 2005 alleging that she sustained a right rotator cuff tear, herniated cervical disc with degenerative disc disease, and degenerative lumbar disease. OWCP accepted this claim for herniated cervical disc at C5-7, right rotator cuff tear, and lumbar strain. OWCP subsequently expanded acceptance of the claim to include bilateral aggravation of osteoarthritis of the hips.

[4] (5th ed. 2001).

[5] (6th ed. 2009).

distal latencies were 2.75 milliseconds on the right and 3.85 milliseconds on the left, less than the 4.0 millisecond latency considered normal.

By decision dated August 14, 2014, OWCP denied appellant's claim for a schedule award, finding that Dr. Dzwinyk's opinion constituted the weight of the medical evidence.

On September 3, 2014 OWCP received appellant's request for a hearing before an OWCP hearing representative. The hearing was held on February 11, 2015. By decision dated April 17, 2015 OWCP's hearing representative affirmed the August 14, 2014 denial of appellant's schedule award claim.

On May 18, 2015 appellant appealed to the Board. By decision and order issued December 14, 2015, the Board affirmed OWCP's April 17, 2015 decision.[6]

On December 6, 2016 appellant requested reconsideration. She contended that OWCP did not fully consider medical evidence of record which demonstrated neurologic impairment of the upper extremities related to her accepted conditions. Appellant submitted February 24 and July 25, 2014, December 20, 2015, and January 9, 2017 letters which alleged a pattern of corruption, malfeasance, and retaliation by OWCP and various government officials. She also provided additional medical evidence.

In December 3, 2015 reports, Dr. Chmell, related appellant's complaints of pain throughout the cervical, thoracic, and lumbosacral spine, and bilateral hand and wrist pain, worse in the left thumb. On examination, he found paraspinal spasm and tenderness throughout the spine, a bilaterally positive Spurling's test, and "diminished sweating and sensation in both hands with some thenar atrophy." Dr. Chmell diagnosed bilateral carpal tunnel syndrome and right radial styloid tenosynovitis under OWCP File No. xxxxxx055, and cervical disc displacement under OWCP File No. xxxxxx862. He opined that appellant had objective spinal abnormalities with "peripheral findings in the upper and lower extremities demonstrating neurologic impingement."

In a March 26, 2016 report, Dr. Chmell opined that appellant continued to have active residuals of accepted bilateral carpal tunnel syndrome, radial styloid tenosynovitis, cervical disc displacement, and a right rotator cuff rupture. He found her disabled from all work due to the accepted conditions.

Appellant submitted a June 17, 2016 lumbar magnetic resonance imaging (MRI) scan which showed degenerative changes from L3 through S1, with mild facet hypertrophy. A June 22, 2016 MRI scan of the cervical spine demonstrated the continued presence of a posterior disc osteophyte complex at C5-6 with mild effacement of the ventral thecal sac, without central or neural foraminal stenosis. A June 28, 2016 thoracic MRI scan showed stable anterior disc disease from T8 through T11 without significant spinal stenosis or neuroforaminal compromise.

[6] Docket No. 15-1286 (issued December 14, 2015).

In September 1, 2016 reports, Dr. Chmell requested that OWCP accept "traumatic aggravation of degenerative disc disease of the thoracic spine with facet joint arthritis." He diagnosed bilateral carpal tunnel syndrome and right radial styloid tenosynovitis.

By decision dated February 27, 2017, OWCP denied modification of its April 17, 2015 decision, as the medical reports, imaging studies, and correspondence appellant submitted in support of her request were insufficient to establish permanent impairment.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and its implementing regulations[8] 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.[9] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[10]

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).[11] In addressing impairment for the upper extremities, the sixth edition of the A.M.A., *Guides* requires identifying the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History GMFH, Physical Examination GMPE, and Clinical Studies GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13]

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 maximum medical improvement), describes the impairment in sufficient detail so that it can be visualized on review and computes

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

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

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

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

[12] *Id.* at 385-419; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[13] *Id.* at 411.

the percentage of impairment in accordance with the A.M.A., *Guides*.[14] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[15]

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.[16] In 1960, amendments to FECA modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[17]

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

ANALYSIS

The Board finds that appellant has not established permanent impairment of her bilateral upper extremities, warranting a schedule award.

On prior appeal, the Board affirmed OWCP's April 17, 2015 decision which denied appellant's schedule award claim based upon the report of Dr. Dzwinyk, the impartial medical examiner. The findings made in the Board's prior decision are *res judicata* absent any further review by OWCP under section 8128 of FECA.[20]

Appellant subsequently requested reconsideration of OWCP's April 17, 2015 decision denying her schedule award claim for bilateral upper extremity permanent impairment. She submitted letters alleging wrongdoing by OWCP and various government officials. These letters

[14] *Supra* note 7 at Chapter 2.808.5 (February 2013).

[15] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

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

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

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

[19] FECA Transmittal Docket No. 10-0004 (issued January 9, 2010); *supra* note 8 at Chapter 3.700, Exhibit 1, note 5 (January 2010); *The Guides Newsletter* is included as Exhibit 4.

[20] *See H.G.*, Docket No. 16-1191 (issued November 25, 2016).

are insufficient to meet appellant's burden of proof to establish permanent impairment as they are not medical evidence.[21]

In support of her request, appellant also submitted reports from Dr. Chmell, an attending Board-certified orthopedic surgeon, dated from December 3, 2015 to September 1, 2016. Dr. Chmell opined that the accepted bilateral carpal tunnel syndrome, right radial styloid tenosynovitis, and C5-6 disc herniation remained active and disabling. He, however, did not address the issue of permanent impairment in his reports. Dr. Chmell did not provide an assessment of appellant's upper extremities according to the applicable tables and grading schemes of the A.M.A., *Guides*. As previously noted to be of probative value the medical report must describe the impairment in sufficient detail so that it can be visualized on review and must compute the percentage of impairment in accordance with the A.M.A., *Guides*.[22] As Dr. Chmell did not provide an impairment rating in accordance with the A.M.A., *Guides*, his reports are of greatly diminished probative value in establishing whether appellant had a ratable permanent impairment due to her accepted upper extremities conditions.

The Board also finds that Dr. Chmell did not opine that the June 2016 MRI scans of appellant's cervical, thoracic, and lumbar spine established permanent impairment of her upper extremities. The sixth edition of the A.M.A., *Guides* does not provide for a schedule award for injury to the spine.[23] However, impairment of a scheduled member of the upper extremities is payable under FECA, if it originates from the spine.[24] The approach of rating impairment of the upper extremities caused by a spinal injury is provided in section 3.700 of OWCP procedures, which memorializes proposed tables as outlined in a July/August 2009, *The Guides Newsletter*.[25] The Board notes that Dr. Chmell did not reference or provide an evaluation in accordance with the July/August 2009, *The Guides Newsletter*. Dr. Chmell's rating is therefore insufficient to establish permanent impairment of appellant's upper extremities due to her accepted cervical conditions.[26]

On appeal, appellant contends that an accepted cervical spine condition caused a ratable permanent impairment of her upper extremities. As noted above, the medical evidence of record is insufficient to establish that the accepted C5-6 disc herniation caused permanent impairment of either upper extremity.

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.

[21] *Edward Matthew Diekemper,* 31 ECA 224-25 (1979).

[22] *Supra* note 11.

[23] *Supra* note 13.

[24] *Supra* note 14.

[25] *Supra* note 16.

[26] *E.D.*, Docket No. 10-0967 (issued January 7, 2011).

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish permanent impairment of her bilateral upper extremities, warranting a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the February 27, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 25, 2018
Washington, DC

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

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

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