United States Department of Labor
Employees' Compensation Appeals Board

S.G., Appellant	)	
and	)	**Docket No. 19-1859**
	)	**Issued: August 20, 2020**
U.S. POSTAL SERVICE, BRANDON POST OFFICE, Brandon, FL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Deputy Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 10, 2019 appellant filed a timely appeal from an August 30, 2019 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 appellant has met her burden of proof to establish permanent impairment of a scheduled member or function of the body, warranting a schedule award.

FACTUAL HISTORY

On July 6, 2016 appellant, then a 44-year-old city carrier, filed a traumatic injury claim (Form CA-1) alleging that she injured her neck the day before when her vehicle was rear-ended when she was delivering mail while in the performance of duty. OWCP initially accepted her claim for cervical strain of muscle, fascia and tendon, and sprain of the ligaments of the thoracic

[1] 5 U.S.C. § 8101 *et seq.*

spine. It subsequently expanded acceptance of the claim to include aggravation of cervical spondylosis with radiculopathy. OWCP paid appellant wage-loss compensation on the supplemental rolls for intermittent periods of disability commencing June 5, 2017. On November 7, 2017 appellant underwent an OWCP-approved anterior cervical discectomy and fusion at C4-6 performed by Dr. Sheyan Armaghani, an orthopedic surgeon.

On January 8, 2019 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated January 14, 2019, OWCP requested that Dr. Armaghani provide a report addressing appellant's date of maximum medical improvement (MMI) and providing a rating of her permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[2] and *The Guides Newsletter,* Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*). It requested that Dr. Armaghani respond within 30 days.

In a report dated November 9, 2018, Dr. Armaghani examined appellant for complaints of neck and right arm pain. On physical examination of her upper extremities, he observed hand intrinsic strength of 4+/5 with otherwise normal findings, including normal reflexes and intact sensation to light touch at C4-T1 bilaterally. Dr. Armaghani diagnosed cervical spondylosis with myeloradiculopathy. He noted that appellant had reached MMI on October 26, 2018 and concluded that she had seven percent permanent impairment based on "1996 guidelines" for her cervical spine. In an addendum attached to the report dated February 6, 2019, Dr. Armaghani explained that this rating for her cervical spine represented dysfunction in her upper extremities as cervical spine nerves gave function to the upper extremities.

On March 13, 2019 Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), reviewed Dr. Armaghani's reports dated November 9, 2018 and February 6, 2019 and found that his permanent impairment evaluation could not be considered probative for schedule award purposes under FECA, because he had not utilized *The Guides Newsletter* in calculating appellant's percentage of permanent impairment of the upper extremities due to spinal nerve impairment. The DMA further noted that the reports lacked sufficient detail to permit assignment of an impairment rating. He recommended contacting Dr. Armaghani to obtain a supplemental report regarding appellant's percentage of permanent impairment or obtaining a second opinion evaluation from a Board-certified physician. The DMA noted that the date of MMI was presently undetermined.

In a letter dated April 2, 2019, OWCP requested a supplemental report from Dr. Armaghani in which he should provide an opinion as to permanent impairment consistent with the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter* and noted that ratings should be provided under both the diagnosis-based impairment (DBI) and range of motion (ROM) methodologies, if permitted. It enclosed the DMA's report of March 13, 2019 for his review and requested that he submit the supplemental report within 30 days.

On April 26, 2019 OWCP referred appellant to Dr. William Dinenberg, a Board-certified orthopedic surgeon, for a second opinion regarding appellant's permanent impairment. It noted

[2] A.M.A., *Guides* (6th ed. 2009).

the need to provide a discussion, with rationale, explaining whether the DBI or ROM methodology was utilized in calculating permanent impairment.

In a letter dated December 13, 2018, and received by OWCP on May 2, 2019, Dr. Armaghani noted his review of appellant's extensive history of medical treatment following her July 5, 2016 motor vehicle incident. He found that she had reached MMI, but he also noted that, due to her prior fusion procedure, she had a 25 percent likelihood of needing additional surgery above or below her current fusion within 10 years.

In a report dated May 23, 2019, Dr. Dinenberg noted his review of the medical record and a statement of accepted facts (SOAF). He reported physical examination findings which included: range of motion findings of cervical flexion and extension to 20 and 30 degrees respectively; rotation to the right of 50 degrees; rotation to the left of 60 degrees; 1+ biceps, triceps, and brachioradialis reflexes bilaterally; full strength of the biceps, triceps, deltoid, wrist flexion, extension, and finger abduction; 5-/5 grip strength on the right; 4+/5 grip strength on the left; forearm measurements of 23.5 centimeters (cm) on the left and 25 cm on the right; diminished sensation in the middle ring and small fingers on the left to light touch; normal sensation throughout the right upper extremity; nontenderness to palpation of the thoracic spine; and tenderness of the lower cervical spine to the left of the midline extending onto the left trapezius. Dr. Dinenberg diagnosed cervical spine strain, thoracic spine strain, and aggravation of spondylosis with radiculopathy of the cervical region, postanterior cervical discectomy at C4-5 and C5-6 with residual left upper extremity symptomology and cervical pain. He noted that appellant reached MMI on May 24, 2019, the date of his examination. Dr. Dinenberg requested an electromyography and nerve conduction velocity (EMG/NCV) study prior to assignment of an impairment rating.

An EMG/NCV study dated June 28, 2019 demonstrated normal results for the bilateral upper extremities with no electrodiagnostic evidence of nerve entrapment, generalized peripheral neuropathy, or cervical radiculopathy.

In an addendum report dated July 8, 2019, Dr. Dinenberg noted his review of the results of an EMG/NCV study completed on June 28, 2019 concluding that the study was normal for nerve conduction and electrodiagnostic results related to the bilateral upper extremities. He further noted that appellant's physical examination had demonstrated weakness of grip, left greater than right, and some atrophy of the left forearm compared to the right, with diminished sensation of the middle, ring, and small fingers on the left. Dr. Dinenberg explained that the diminished sensation of the left hand was most consistent with a C7-8 radicular symptomology, and that the loss of bilateral grip strength was more consistent with C8 radiculopathy or myelopathy. Noting that appellant's accepted cervical radiculopathy was related to the C4-5 and C5-6 discs, no residuals related to her accepted diagnosis were observed. Dr. Dinenberg also noted that, as such, no permanent impairment rating for her accepted conditions was appropriate, as her symptoms were related to conditions that had not been accepted as work related, such as myelopathy. He further noted that Dr. Armaghani had found appellant to be possibly myelopathic before her operative intervention and had noted preoperative weakness of grip.

In a report dated July 18, 2019, Dr. Katz, serving as a DMA, reviewed the medical record, including the second opinion report of Dr. Dinenberg dated July 8, 2019, and the SOAF. The DMA noted that Dr. Dinenberg had identified no objectively verifiable motor or dermatomal

sensory deficiencies in either upper extremity and reported normal electrodiagnostic studies for the accepted cervical disc levels, and that, as such, there was no ratable impairment of any spinal nerve and no ratable permanent impairment resulting from the accepted conditions. He noted that the key diagnostic factors utilized in determination of DBI for the accepted conditions of the claim were not eligible for an alternative range of motion impairment calculation based on the sixth edition of the A.M.A., *Guides*. The DMA found that appellant reached MMI on July 8, 2019 and concluded that she had zero percent permanent impairment of the right and left upper extremities based on the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter*.

By decision dated August 30, 2019, OWCP denied appellant's schedule award claim finding that she had not met her burden of proof to establish permanent impairment of a scheduled member or function of the body.

LEGAL PRECEDENT

The schedule award provisions of FECA,[3] and its implementing federal regulations,[4] 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.[5] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[6]

Neither FECA nor its regulations provide for a schedule award for impairment to the back/spine or to the body as a whole.[7] Furthermore, the back is specifically excluded from the definition of organ under FECA.[8] The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the upper or lower extremities. Recognizing that FECA allows ratings for the 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's procedures indicate that *The Guides Newsletter* is to be applied.[9] The Board has recognized the adoption of this methodology for rating extremity impairment, including the use of *The Guides Newsletter*, as proper in order to provide a uniform

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id*. at § 10.404(a).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Chapter 3.700.2 and Exhibit 1 (January 2010) *id*.

[7] *See L.L*., Docket No. 19-0214 (issued May 23, 2019); *N.D*., 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

[8] *See* 5 U.S.C. § 8101(19); *see also G.S*., Docket No. 18-0827 (issued May 1, 2019); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

[9] *Supra* note 6 at Chapter 3.700 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

standard applicable to each claimant for a schedule award for extremity impairment originating in the spine.[10]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish permanent impairment of a scheduled member or function of the body, warranting a schedule award.

In a report dated November 9, 2018, Dr. Armaghani indicated that appellant had reached MMI and assessed a permanent impairment rating of seven percent based on "1996 guidelines for [appellant's] cervical spine and bilateral upper extremities." In an addendum attached to February 6, 2019 report, he explained that this rating represented dysfunction in her upper extremities.

The DMA, Dr. Katz, properly explained that Dr. Armaghani's impairment evaluation could not be considered probative for schedule award purposes under FECA, because Dr. Armaghani had not utilized *The Guides Newsletter* in calculating appellant's percentage of permanent impairment of the upper extremities due to spinal nerve impairment.[11] The DMA further explained that Dr. Armaghani's reports dated November 9, 2018 and February 6, 2019 lacked sufficient detail to permit assignment of a permanent impairment rating.[12] The Board finds that the DMA properly explained that Dr. Armaghani's reports were insufficient to establish permanent impairment of a scheduled member or function of the body.

On May 23, 2019 Dr. Dinenberg, a second opinion physician, reviewed the medical record and conducted a physical examination. Pursuant to OWCP's request, he provided a permanent impairment evaluation based upon appellant's loss of ROM of the cervical spine. The Board notes initially that while OWCP requested that Dr. Dinenberg evaluate appellant's loss of ROM and he provided findings pertaining to appellant's loss of cervical spine ROM, neither FECA nor its regulations provide for a schedule award for permanent impairment of the spine. Therefore appellant's loss of cervical ROM was not a proper basis for assessment of permanent impairment.[13]

Dr. Dinenberg also observed that appellant had weakness of grip, left greater than right, and some atrophy of the left forearm compared to the right, with diminished sensation of the middle, ring, and small fingers on the left. After reviewing the June 28, 2019 EMG/NCV study, he explained in an addendum report dated July 8, 2019 that the diminished sensation of appellant's left hand found on physical examination was most consistent with a C7-8 radicular symptomology, and that the loss of bilateral grip strength was more consistent with C8 radiculopathy or myelopathy. Noting that appellant's accepted cervical radiculopathy was related to the C4-5 and

[10] *See E.D.*, Docket No. 13-2024 (issued April 24, 2014); *D.S.*, Docket No. 13-2011 (issued February 18, 2014).

[11] *Supra* note 9.

[12] This description must be in sufficient detail so that the claims examiner (CE) and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations. *K.F.*, Docket No. 18-1517 (issued October 9, 2019).

[13] *Supra* note 7.

C5-6 discs, no residuals related to those disc levels were observed. Dr. Dinenberg noted that, as such, no impairment rating for her accepted diagnoses was appropriate.

OWCP properly referred the evidence of record to the DMA. On July 18, 2019 the DMA noted that Dr. Dinenberg had identified no objectively verifiable motor or dermatomal sensory deficiencies in either upper extremity related to radiculopathy from the accepted cervical disc levels and had reported normal electrodiagnostic studies. He therefore found that appellant had no ratable permanent impairment pursuant to *The Guides Newsletter*.[14] The Board finds that the DMA in this case properly applied the standards of *The Guides Newsletter* to determine that appellant did not have permanent impairment of a scheduled member or function of the body as *The Guides Newsletter* rates permanent impairment from cervical radiculopathy based upon sensory or motor loss of the upper extremities.[15] It specifically explains that the ratings for the sensory component and the motor component are adjusted for functional history (Table 15-7)[16] and clinical studies (Table 15-9),[17] excluding physical examination (Table 15-8)[18] since neurologic examination defines the impairment values in Table 15-20.[19] The DMA explained that appellant had normal electrodiagnostic studies and had no objectively verifiable motor or dermatomal sensory deficiencies in either upper extremity related to radiculopathy from the accepted cervical disc conditions. The Board concludes that the DMA properly found that appellant's permanent impairment due to her accepted cervical radiculopathy could only be rated based upon her diagnoses and resulting motor and sensory losses of the upper extremities, under *The Guides Newsletter*. As appellant has no objectively verifiable motor or sensory losses from the accepted cervical disc conditions, the evidence of record did not establish that appellant had permanent impairment of a scheduled member due to her accepted cervical disc conditions.

The Board also notes that OWCP improperly suggested, by requesting that Dr. Dinenberg provide a permanent impairment rating based upon loss of ROM of appellant's upper extremities, that appellant's upper extremity impairment could be alternatively rated using ROM methodology. Under FECA Bulletin No. 17-06, "If the rating physician provided an assessment using the ROM method and the A.M.A., *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[20] The A.M.A., *Guides* however do not allow a permanent impairment rating due to loss of ROM if the diagnosis did not contain an asterisk in the DBI grid.[21] *The Guides Newsletter* explains that impairment for radiculopathy is reflected only as a DBI rating. *The Guides Newsletter* does not indicate by asterisk in the DBI grid that an alternate impairment

[14] *T.K.*, Docket No. 19-1222 (issued December 2, 2019).

[15] *See E.F.*, Docket No. 18-1723 (issued May 1, 2019).

[16] A.M.A., *Guides* 406.

[17] *Id.* at 410.

[18] *Id.* at 408; *supra* note 9.

[19] *See supra* note 9.

[20] FECA Bulletin No. 17-06 (May 8, 2017).

[21] *N.M.*, Docket No. 19-1925 (issued June 3, 2020).

rating due to loss of ROM can be made for a diagnosis of cervical radiculopathy from a spinal nerve impairment. Therefore, the DMA properly concluded that appellant's permanent impairment could only be rated under *The Guides Newsletter* for the accepted C4-5 and C5-6 radiculopathy diagnoses, and that appellant's permanent impairment could not be rated based upon loss of ROM.

Appellant has submitted no other medical evidence in conformance with *The Guides Newsletter*, establishing permanent impairment of a scheduled member or function of the body. The Board therefore finds that she has not met her burden of proof to establish her claim for a schedule award.

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 met her burden of proof to establish permanent impairment of a scheduled member or function of the body, warranting a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the August 30, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 20, 2020
Washington, DC

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

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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