United States Department of Labor
Employees' Compensation Appeals Board

L.A., Appellant	)	
and	)	**Docket No. 22-0839**
	)	**Issued: April 21, 2023**
U.S. POSTAL SERVICE, POST OFFICE, Lake Mary, FL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 2, 2022 appellant filed a timely appeal from an April 5, 2022 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.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the April 5, 2022 decision, appellant submitted additional evidence to OWCP. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than 15 percent permanent impairment of the bilateral upper extremities for which she previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board on a different issue.[3] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On April 8, 2013 appellant, then a 55-year-old clerk, filed a traumatic injury claim (Form CA-1) alleging that, on that date, she sustained a head injury with visual disturbance when a metal container door unlatched and struck the left side of her head while in the performance of duty. OWCP accepted her claim for post-concussion syndrome, post-traumatic headache, and cervicocranial syndrome and subsequently expanded acceptance of her claim to include intervertebral disc disorder with myelopathy, and herniated discs at C3-4, C4-5, C5-6, and C6-7.

In a March 11, 2016 report, Dr. Robert R. Reppy, an osteopathic physician specializing in family practice, recounted that physical therapy had reduced appellant's chronic headaches and cervical spine pain. He diagnosed herniated discs with multilevel radiculopathy, cervical stenosis, and cephalgia secondary to cervical disc pathology.

On May 12, 2016 appellant filed a claim for compensation (Form CA-7) for a schedule award.[4]

In an August 25, 2017 report, Dr. Reppy reviewed medical records and opined that appellant had attained maximum medical improvement (MMI) on September 30, 2016, when her condition plateaued without subsequent improvement. He provided an impairment rating applying the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] and *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*). Dr. Reppy performed monofilament testing to determine sensory deficits. Strength testing demonstrated 4/5 upper extremity strength against gravity with some resistance. Dr. Reppy noted that *The Guides Newsletter* did not allow for impairment ratings at the C3-4 level. Using the diagnosis-based impairment (DBI) method, he referred to *The Guides Newsletter* to find 2 percent impairment for moderate sensory deficit at the C5 nerve roots, 2 percent impairment for moderate sensory impairment at C7, and 9 percent impairment for moderate motor impairment at C7. Dr. Reppy

[3] Docket No. 16-1420 (issued December 15, 2016).

[4] An October 5, 2016 magnetic resonance imaging (MRI) scan of the cervical spine demonstrated a loss of cervical lordotic curvature, increased disc herniations at C3-4, and disc herniations at C4-5, C5-6, and C6-7. A February 8, 2017 electromyography/nerve conduction velocity (EMG/NCV) study suggested left cubital entrapment syndrome and a possible right T1 anomaly.

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

found no permanent impairment at the C6 level. He assigned a grade modifier for functional history (GMFH) of 3 according to Table 15-7 (Functional History Adjustment: Upper Extremities) of the A.M.A., *Guides*, based on a *Quick*DASH score of 75 for pain symptoms with less than normal activity, limited cervical spine motion in all axes, and 2+ spasm of the paracervical musculature bilaterally. Dr. Reppy assigned a grade modifier for clinical studies (GMCS) of 2 according to Table 15-9 (Clinical Studies Adjustment: Upper Extremities) based on demonstrated moderate pathology. He assigned to the Class of diagnosis (CDX) of a class 1. Dr. Reppy utilized the net adjustment formula, (GMFH - CDX) + (GMCS - CDX), or (3-1) + (2-1), to calculate a net adjustment of 3, which moved the default percentages of impairment two places to the right for each affected spinal level. He, therefore, found three percent impairment for C5 sensory loss, no impairment for C5 motor loss, three percent impairment for C7 sensory loss, and nine percent impairment for C7 motor loss. Using the Combined Values Chart on page 604 of the A.M.A., *Guides*, Dr. Reppy combined the 3 percent impairment at C5 and 12 percent impairment at C7 to determine a final rating of 15 percent permanent impairment of each upper extremity.

On October 23, 2017 OWCP referred appellant's case, including a statement of accepted facts (SOAF), to Dr. Michael M. Katz, a Board-certified orthopedic surgeon and district medical adviser (DMA), to obtain an impairment rating. In an October 24, 2017 report, Dr. Katz noted that he reviewed the medical record and found that the range of motion (ROM) impairment method was inappropriate and concurred with Dr. Reppy's use of the DBI method. Dr. Katz noted that while a 4/5 motor deficit was classified as a mild deficit, and not a moderate deficit as Dr. Reppy had found, this discrepancy did not alter the final percentage of impairment as the adjusted impairment for both mild and moderate C7 motor deficits was nine percent. He therefore concurred with Dr. Reppy's assessment of 15 percent permanent impairment of each upper extremity.

By decision dated November 1, 2017, OWCP granted appellant a schedule award for 15 percent permanent impairment of the left upper extremity and 15 percent permanent impairment of the right upper extremity. The award ran for a 93.6-week period from August 25, 2017 through June 11, 2019.

In a July 20, 2021 report, Dr. Reppy diagnosed cervical disc disease with myelopathy and post-concussion syndrome. He opined that appellant had attained MMI as of July 16, 2021. Dr. Reppy noted that MRI scans had demonstrated disc herniations from C3 through C7,[6] and that a December 11, 2019 NCV study[7] established the presence of radiculopathy according to Proposed Table 1 of *The Guides Newsletter*. He determined a Class 1 impairment for the CDX of moderate degenerative disc disease based on imaging studies and appellant's persistent symptoms during normal activity. Dr. Reppy noted a range of one to three percent impairment for moderate C5 sensory deficit, eight to nine percent impairment for C5 motor deficit, two to five percent for C6

[6] In a November 6, 2018 report of an MRI scan of the cervical spine, Dr. W. Joseph Wall, a Board-certified radiologist, opined that the study demonstrated mild bilateral facet arthropathy at C2-3 and C3-4, a mild disc bulge at C4-5, severe left and mild right neuroforaminal narrowing at C5-6 with moderate central canal narrowing, and osteophyte formation creating mild central canal narrowing at C6-7. He also opined that the degenerative facet arthropathy had progressed at C5-6 and C6-7 compared to an October 5, 2016 MRI scan.

[7] A December 11, 2019 EMG/NCV study demonstrated right median motor mononeuritis. A May 5, 2021 EMG/NCV study demonstrated right radial entrapment neuropathy and a possible right C7 radiculopathy.

sensory deficit, nine percent for C6 motor deficit, one to three percent for C7 sensory deficit, and nine percent for C7 motor deficit. He assigned a GMFH of 2 for pain with normal activity, and a GMCS of 2 for a moderate problem. Dr. Reppy noted that there was no applicable grade modifier for physical examination findings (GMPE). He applied the net adjustment formula, (GMFH - CDX) + (GMCS - CDX), or (2-1) + (2-1), to calculate a net adjustment of 2, moving the default Grade C upward to Grade D. Referring to Table 1 of *The Guides Newsletter*, Dr. Reppy found three percent impairment for C5 sensory deficit, nine percent impairment for C5 motor deficit, four percent impairment for C6 sensory deficit, nine percent impairment for C6 motor deficit, three percent impairment for C7 sensory deficit, and nine percent impairment for C7 motor deficit. He added these percentages to equal 37 percent permanent impairment of each upper extremity.

On September 8, 2021 appellant filed a Form CA-7 claim for an increased schedule award.

On September 21, 2021 OWCP referred appellant's case, including a SOAF, to Dr. Katz to obtain an impairment rating. In a September 27, 2021 report, Dr. Katz reviewed the medical record and SOAF. He opined that Dr. Reppy had not provided a sufficient description of the objective findings on which he based his July 20, 2021 impairment rating, and that Table 1 of *The Guides Newsletter* capped cervical spinal impairment at 37 percent for unilateral radiculopathy or 56 for multilevel or bilateral radiculopathy. Dr. Katz recommended that OWCP refer appellant for a second opinion evaluation to obtain an impairment rating.

On November 2, 2021 OWCP referred appellant to Dr. Omar David Hussamy, a Board-certified orthopedic surgeon, for a second opinion evaluation. A copy of the case record, a SOAF, and a series of questions were provided for his review.

In a February 11, 2022 report, Dr. Hussamy reviewed the medical record and SOAF. On examination, he noted limited cervical range of motion in all axes, motor strength at 5/5 throughout both upper extremities, and decreased sensation to light touch and pinprick in the C5, C6, and C7 dermatomes bilaterally. Dr. Hussamy indicated that appellant had attained MMI as of that day. He referenced the A.M.A., *Guides* to find a Class 1 impairment for the CDX of herniated discs, a GMFH of 2, and a GMCS of 2. Dr. Hussamy utilized the impairment rating methodology set forth in *The Guides Newsletter*. Beginning at the C5 level, he applied the net adjustment formula, (GMFH - CDX) + (GMCS - CDX), (2-1) + (2-1), resulting in a net adjustment of 2, which raised the default CDX class C upward to E, which resulted in three percent permanent impairment of the bilateral upper extremities for moderate motor deficit at C5. Utilizing the same formula, Dr. Hussamy found bilateral upper extremity impairment of three percent for moderate sensory deficit at C5, five percent for moderate sensory deficit at C6, and three percent for moderate sensory deficit at C7. He added the impairment ratings to find a total of 11 percent permanent impairment of the left upper extremity and 11 percent permanent impairment of the right upper extremity.

On March 21, 2022 OWCP referred appellant's case, including a SOAF, to Dr. Katz for another supplemental opinion. In a March 21, 2022 report, Dr. Katz concurred with Dr. Hussamy's February 11, 2022 rating of 11 percent permanent impairment of the right upper extremity and 11 percent permanent impairment of the left upper extremity. He noted that, as appellant had previously been granted a schedule award for 15 percent permanent impairment of

each upper extremity, she had not established a greater percentage of impairment than that previously awarded.

By decision dated April 5, 2022, OWCP denied appellant's claim for an increased schedule award.

LEGAL PRECEDENT

The schedule award provisions 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.[8] 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. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[9] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[10] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[11]

No schedule award is payable for a member, function, or organ of the body that is not specified in FECA or the implementing regulations.[12] The list of scheduled members includes the eye, arm, hand, fingers, leg, foot, and toes.[13] Additionally, FECA specifically provides for compensation for loss of hearing and loss of vision.[14] Neither FECA nor its implementing regulations provide for a schedule award for impairment to the back or to the body as a whole.[15] Furthermore, the back is specifically excluded from the definition of organ under FECA.[16] The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that, FECA allows ratings for extremities

[8] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[9] *Id.* at § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[10] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.* at Chapter 2.808.5a (March 2017).

[11] *R.C.*, Docket No. 21-1332 (issued July 1, 2022); *J.C.*, Docket No. 20-1071 (issued January 4, 2021); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[12] *D.L.*, Docket No. 20-0059 (issued July 8, 2020); *W.C.*, 59 ECAB 374 (2008); *Anna V. Burke*, 57 ECAB 521 (2006).

[13] 5 U.S.C. § 8107(c).

[14] *Id*.

[15] *K.Y.*, Docket No. 18-0730 (issued August 21, 2019); *L.L.*, Docket No. 19-0214 (issued May 23, 2019); *N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

[16] *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).

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.[17] 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 standard applicable to each claimant for a schedule award for extremity impairment originating in the spine.[18]

The claimant has the burden of proof to establish that the condition for which a schedule award is sought is causally related to his or her employment.[19]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[20]

Section 8123(a) of FECA provides that, if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[21] This is called an impartial medical examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[22] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[23]

ANALYSIS

The Board finds that this case is not in posture for decision.

In support of her schedule award claim, appellant submitted a July 20, 2021 report from her treating physician, Dr. Reppy, who determined that, under *The Guides Newsletter*, appellant had a default value of one percent moderate sensory deficit at C5, eight percent motor deficit at

[17] *Supra* note 10 at Chapter 3.700 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[18] *R.C.*, *supra* note 13; *J.C.*, *supra* note 13; *E.D.*, Docket No. 13-2024 (issued April 24, 2014); *D.S.*, Docket No. 13-2011 (issued February 18, 2014).

[19] *See G.S.*, Docket No. 18-0827 (issued May 1, 2019).

[20] *Supra* note 10 at Chapter 2.808.6(f)(March 2017).

[21] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[22] 20 C.F.R. § 10.321.

[23] *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

C5, two percent sensory deficit at C6, nine percent motor deficit at C6, one percent sensory deficit at C7, and nine percent motor deficit at C7. Dr. Reppy assigned a GMFH of 2 for pain with normal activity, and assigned a GMCS of 2 for a moderate problem. He applied the net adjustment formula to find a net grade modifier of 2, resulting in three percent C5 sensory deficit, nine percent C5 motor deficit, four percent C6 sensory deficit, nine percent C6 motor deficit, three percent C7 sensory deficit, and nine percent C7 motor deficit. Dr. Reppy concluded that appellant had a final impairment rating of 27 percent permanent impairment of each upper extremity.

In a February 11, 2022 report, Dr. Hussamy, an OWCP second opinion physician, also assigned a GMFH of 2 and GMCS of 2. He applied the net adjustment formula to find three percent moderate C5 motor deficit, three percent moderate C5 sensory deficit, six percent moderate C6 sensory deficit, and three percent moderate sensory deficit at C7. Dr. Hussamy added these percentages to determine a final 11 percent permanent impairment of each upper extremity.

As Dr. Reppy, appellant's attending physician, and Dr. Hussamy, a second opinion physician, disagree regarding the nature and extent of appellant's bilateral upper extremity permanent impairment, the Board finds that a conflict in medical opinion exists.[24] While both physicians properly utilized the A.M.A., *Guides* and *The Guides Newsletter*, they differed on the severity of motor deficit at C5 and the presence of motor deficits at C6 and C7. As noted above, if there is a disagreement between the employee's physician and an OWCP physician, OWCP shall appoint a third physician, known as a referee physician or impartial medical specialist, who shall make an examination.[25] Because the reports of Dr. Reppy and Dr. Hussamy are of equal weight, appellant must be referred to an impartial medical specialist to resolve the existing conflict in the medical opinion evidence regarding the nature and extent of the permanent impairment of the bilateral upper extremities.[26]

On remand, OWCP shall refer appellant, along with the case record and SOAF, to a specialist in the appropriate field of medicine for an impartial medical evaluation to resolve the conflict in the medical opinion evidence. After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision.

[24] *V.S.*, Docket No. 21-1300 (issued April 25, 2022); *see L.E.*, Docket No. 20-1505 (issued June 7, 2021); *see also C.B.*, Docket No. 20-0258 (issued November 2, 2020).

[25] *Supra* note 21.

[26] *C.P.*, Docket No. 21-1363 (issued May 3, 2022); *V.S.*, *supra* note 24; *D.W.*, Docket No. 21-840 (issued November 30, 2021); *M.M.*, Docket No. 18-0235 (issued September 10, 2019).

ORDER

IT IS HEREBY ORDERED THAT the April 5, 2022 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: April 21, 2023
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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