United States Department of Labor
Employees' Compensation Appeals Board

A.L., Appellant	)	
and	)	**Docket No. 13-701**
	)	**Issued: November 13, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Hartford, CT, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 5, 2013 appellant, through his attorney, filed a timely appeal from a January 14, 2013 decision of the Office of Workers' Compensation Programs (OWCP) that denied his claim for a schedule award. 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 decision.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has a permanent impairment due to the accepted conditions.

On appeal, appellant's attorney asserts that the January 14, 2013 decision is contrary to fact and law.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On March 2, 2003 appellant, then a 44-year-old mail handler, filed a traumatic injury claim alleging that he injured his back when a chair he was sitting in at work collapsed. He stopped work that day.[2] OWCP accepted that appellant sustained back and neck strains, a back contusion, post-traumatic headaches, an intervertebral disc disorder and displacement of a cervical disc. Appellant received continuation of pay and compensation for disability.[3]

A March 3, 2004 electromyogram and nerve conduction velocity (EMG/NCV) study was normal. Appellant came under the care of Dr. Stephan C. Lange, a Board-certified neurosurgeon. On August 25, 2006 Dr. Stephen F. Calderon, a Board-certified neurosurgeon and an associate of Dr. Lange, performed a cervical fusion at C5-6 and anterior arthrodesis at C4-5. Appellant returned to a modified processing clerk position on January 22, 2007.

On July 21, 2010 appellant filed a schedule award claim. In a March 4, 2010 report, Dr. Lange noted appellant's report of continued right-sided neck pain that radiated into the right arm with weakness and numbness. Physical examination demonstrated limited neck range of motion, 4/5 weakness in right grip versus the left and 5/5 strength in all other muscle groups. Sensory examination demonstrated diminished pain over the dorsum of the right hand. Dr. Lange indicated that he would rate appellant at 15 percent disability.

By letter dated November 4, 2010, OWCP informed appellant of the medical evidence needed to support his claim for a schedule award. It requested a report by his physician in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] Appellant was provided impairment worksheets for the upper and lower extremities, to provide his physician for an impairment rating.

In a November 11, 2010 report, Dr. Lange noted that appellant was concerned about right arm atrophy. On evaluation and measurement, the circumference of the right arm was about one-quarter inch less than the left. Dr. Lange recommended an upper extremity EMG/NCV study that was obtained on December 3, 2010 and reported as normal. On December 11, 2010 he completed an impairment evaluation. Dr. Lange advised that, under Table 17-2, Cervical Spine Regional Grid, appellant had a class 3 impairment. He found a grade modifier of 2 for functional history and no modifiers for physical examination and clinical studies. Dr. Lange then applied the net adjustment formula and concluded that appellant had eight percent whole person impairment based on the cervical spine.

In a March 31, 2011 report, Dr. Christopher R. Brigham, Board-certified in family and occupational medicine and an OWCP medical adviser, reviewed the medical record. He found that maximum medical improvement was reached on November 18, 2008, 84 months postinjury,

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[2] Appellant had a previous case before the Board, adjudicated by OWCP under file number xxxxxx207. In Docket No. 98-154 (issued January 7, 2000), the Board remanded appellant's case to OWCP for further development as to whether he sustained an employment-related emotional condition in the performance of duty causally related to an accepted employment factor.

[3] In a September 21, 2006 decision, OWCP denied compensation for the dates June 15 to November 8, 2003. On February 16, 2007 an OWCP hearing representative affirmed the September 21, 2006 decision.

[4] A.M.A., *Guides* (6th ed. 2008).

when appellant last had active physical therapy treatment. Dr. Brigham noted that Dr. Lange did not provide an impairment rating in accordance with OWCP regulations because he rated whole person impairment and did not rate appellant's extremities. He noted that OWCP had adopted proposed tables outlined in the July/August 2009 *The Guides Newsletter* for rating impairment of the upper or lower extremities caused by a spinal injury. To have a ratable impairment, there must be sensory and/or motor deficits of the upper extremities. Dr. Brigham reviewed the physical findings of Dr. Lange's March 4, 2010 report. He stated that grip strength was not a measure of strength associated with a cervical nerve root and Dr. Lange found 5/5 strength of all other muscle groups. Therefore, appellant had no ratable impairment for motor loss. Regarding Dr. Lange's finding of diminished sensation over the dorsum of the right hand, it was innervated by the C6, C7 and C8 nerve roots. As these nerves had not been operated on, the reliability of appellant's subjective complaint of sensory loss in the right hand was questionable, especially in light of the normal EMG/NCV studies of March 3, 2004 and December 3, 2010. Dr. Brigham concluded that appellant had no ratable upper extremity impairment due to the accepted cervical condition.

By decision dated April 27, 2011, OWCP denied appellant's claim for a schedule award. It found that the medical evidence did not establish that he sustained any permanent impairment to a scheduled member.

Appellant, through his attorney, timely requested a hearing, that was held on July 26, 2011. At the hearing, he testified that he continued to have headaches, numbness and weakness throughout his right arm and hand and had diminished right upper extremity strength. The record was left open for 30 days. Nothing further was submitted.

In a September 6, 2011 decision, an OWCP hearing representative affirmed the April 27, 2011 decision.

On August 20, 2012 appellant requested reconsideration. He submitted an August 31, 2011 report from Dr. Karen M. Garvey, Board-certified in internal and occupational medicine, who provided examination findings and an impairment evaluation. Dr. Garvey agreed that maximum medical improvement was on November 18, 2008. On examination shoulder and elbow strength were 4+/5 on the right and 5/5 on the left with right hand opposition of thumb and index finger 4/5 and right thumb and third finger 4/5. All other hand opposition strength was 5/5. Dr. Garvey found decreased sensation to pain (pinwheel) and light touch in the distribution of C4, C5 and C6 on right and normal sensation to pain and light touch in the C7-Tl distribution of the right arm. The left arm had normal sensation to pain and light touch in corresponding dermatomes. Dr. Garvey found that the mid-upper arm measured 13.5 inches on the right and 14 inches on the left and that the mid-forearm measured 8 inches on the right and 9 on the left.

In a November 1, 2011 report, Dr. Garvey advised that, following the tables outlined in the July/August 2009 *The Guides Newsletter*, using Table 15-19, the nerves involved were branches of the brachial plexus, including the axillary nerve at C5-6 with motor and sensory involvement of the deltoid muscle and the musculocutaneous nerve at C5, C6 and C7 involving motor and sensory involvement of the muscles of the upper arm and forearm. She found that under Table 15-14, appellant had a rating of severity 1 mild sensory deficit due to distorted superficial tactile sensibility and a severity 1 motor deficit based on strength measurements of 4/5. Dr. Garvey advised that appellant had a grade modifier of 1 for functional history because pain symptoms occurred with strenuous and vigorous activity which required medications to

control. Because appellant's sensory and motor involvement was limited to the C5 and C6 distribution with symptoms involving the shoulder, upper and lower arm, Table 15-20, brachial plexus impairment, was appropriate. This had a default value for sensory impairment of three percent and a nine percent default value for motor impairment. Dr. Garvey applied the net adjustment formula and found that appellant had two percent sensory impairment and five percent motor impairment which combined for six percent upper extremity impairment.

Dr. Morley Slutsky, an OWCP medical adviser Board-certified in occupational medicine, provided a January 2, 2013 report. He advised that maximum medical improvement was reached on August 31, 2011, the date of Dr. Garvey's examination. Dr. Slutsky noted that Dr. Garvey reported sensory and motor loss in the C4, C5 and C6 distribution but that Dr. Lange found sensory loss in the C6, C7 and C8 distribution. The medical adviser stated that appellant's findings were variable, nonphysiologic and not supported by the objective, diagnostic testing which included multiple upper extremity EMG/NCV tests which revealed no pathology coming from the spine. Dr. Slutsky stated that appellant was found to have normal manual muscle testing and nonphysiologic sensory findings, although immediately postsurgery his sensation was intact. Using the July/August 2009 *The Guides Newsletter* and the sixth edition of the A.M.A., *Guides*, as there were no valid, reliable or objective findings upon which to rate an upper extremity impairment. Dr. Slutsky concluded that, if further controversy existed, appellant could be referred for a second opinion evaluation with an orthopedic surgeon or neurologist but that any clinical findings would have to be supported by diagnostic testing before a rating would be applied.

In a merit decision dated January 14, 2013, OWCP denied modification of the prior decisions. Based on Dr. Slutsky's opinion, if found no valid, reliable or objective basis to rate an upper extremity impairment.

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] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* was used to calculate schedule awards.[8] For decisions issued after May 1, 2009, the sixth edition is to be used.[9]

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*. at § 10.404(a).

[8] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

[9] FECA Bulletin No. 09-03 (issued March 15, 2009).

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.[10] 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.[11]

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.[12] 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*.[13] Specifically, it will address lower extremity impairments originating in the spine through Table 16-11 and upper extremity impairment originating in the spine through Table 15-14.[14]

ANALYSIS

The Board finds this case is not in posture for decision. The accepted conditions in this case include intervertebral disc disorder and displacement of cervical disc. Appellant had surgery on August 25, 2006. In a merit decision dated January 14, 2013, OWCP found that the weight of the medical evidence rested with the opinion of Dr. Slutsky, the medical adviser and denied appellant's schedule award claim.

In a November 1, 2011 report, Dr. Garvey, an attending physician, advised that she followed the tables outlined in the July/August 2009 *The Guides Newsletter* to conclude that appellant had a total six percent upper extremity impairment due to motor and sensory loss. She rated impairment of the cervical spine in terms of motor or sensory loss but did not address the absence of electrodiagnostic support. Dr. Slutsky noted that EMG/NCS studies of June 18, 2003, May 13, 2008 and December 3, 2010 were all reported as normal. Section 15.4f of the A.M.A., *Guides* provides that "if either motor weakness or sensory loss is present on examination … both must be present on nerve conduction testing."[15] Dr. Garvey's report is therefore of diminished probative value and insufficient to establish entitlement to a schedule award.

Dr. Slutsky advised that there were no reliable physical findings upon which to base an upper extremity rating. He also indicated, however, that it would be appropriate to refer appellant for a second opinion evaluation with an orthopedic surgeon or neurologist. The Board

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

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

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

[13] FECA Transmittal No. 10-04 (issued January 9, 2010); Federal (FECA) Procedure Manual, *supra* note 8.

[14] A.M.A., *Guides, supra* note 4 at 533 and 425 respectively.

[15] *Id*. at 445.

will set aside the January 14, 2013 decision and remand the case for OWCP to refer appellant for an appropriate second opinion evaluation, as recommended by Dr. Slutsky.[16] After such further development as it deems necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds this case is not in posture for decision regarding the degree of appellant's right upper extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the January 14, 2013 decision of the Office of Workers' Compensation Programs is vacated and the case remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: November 13, 2013
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[16] *See Peter C. Belkind*, 56 ECAB 580 (2005) (proceedings under FECA are not adversarial in nature nor is OWCP a disinterested arbiter; while a claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence).