United States Department of Labor
Employees' Compensation Appeals Board

PETER C. BELKIND, Appellant	)	
and	)	**Docket No. 05-655**
	)	**Issued: June 16, 2005**
U.S. POSTAL SERIVCE, GENERAL MAIL FACILITY, Brooklyn, NY, Employer	)	

Appearances:
Paul Kalker, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On January 24, 2005 appellant, through his attorney, filed a timely appeal of the Office of Workers' Compensation Programs' merit decisions dated February 19 and November 4, 2004 finding that he was not entitled to a schedule award due to his accepted employment injury. Pursuant to 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 a permanent impairment resulting from his November 4, 2000 employment injury entitling him to a schedule award.

FACTUAL HISTORY

On November 4, 2000 appellant, then a 52-year-old letter carrier filed a traumatic injury claim alleging that he experienced pain in his neck, left shoulder and left arm while moving bags in the performance of duty on November 3, 2000. The Office accepted his claim for left shoulder sprain, left hand sprain, cervical radiculopathy and cervical sprain on January 31, 2001.

Appellant underwent a magnetic resonance imaging (MRI) scan on February 16, 2001 which revealed herniated discs at C3-4, C4-5, C5-6 and C6-7. On May 16, 2001 Dr. R.C. Krishna, a Board-certified neurologist, examined appellant and described his history of injury. He diagnosed multilevel cervical disc herniations resulting in a left C5-6 radiculopathy and a chronic neuropathic pain syndrome. Dr. Krishna found that appellant had four out of five weakness of the left deltoid, supraspinatus muscle and biceps muscle with tenderness. He also found atrophy of the left mid-arm circumference which was one inch smaller on the left than the right. Dr. Krishna stated that appellant reached maximum medical improvement on May 15, 2001, but that he required continued treatment and follow-up with a pain management anesthesiologist for possible epidural steroid injections and possibly spine surgical consultation to abate pain. He stated that appellant's left upper extremity exhibited 75 percent loss of use.

Appellant requested a schedule award on August 20, 2001.

Dr. Andrew M.G. Davy, a Board-certified anesthesiologist, examined appellant at Dr. Krishna's request on May 23, 2001 and submitted a report dated October 21, 2002. He noted appellant's employment injury and stated that appellant was left hand dominant. Dr. Davy performed a physical examination and diagnosed neck pain secondary to cervical disc disease, multilevel facet joint arthritis and multiple myofascial trigger points. He recommended cervical epidural steroid injections, facet joint injections and trigger point injections. Dr. Davy stated, "It is clear in my mind from my experience that[,] because of the sensory and motor deficits, which pain management will not reverse, that the patient does have a permanent disability as indicated in his other evaluations." He indicated that further treatment was to decrease appellant's pain and that appellant might eventually be a candidate for spinal cord stimulation.

On September 19, 2001 Dr. Sanford R. Wert, an orthopedic surgeon, stated that appellant had 51.4 percent disability of the cervical spine. He stated that in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[1] appellant had 30 degrees of abduction, one inch atrophy of his left upper extremity as well as subjective complaints of pain, weakness and tingling of the upper extremity. Dr. Wert stated that appellant had 2 percent impairment of his left upper extremity due to loss of abduction, 18 percent impairment of the left upper extremity due to carpal tunnel syndrome resulting in sensory deficit of the radial and ulnar digit branches of the median nerve. He concluded that combined with the 51 percent impairment of the cervical spine, appellant had 71.4 percent impairment of the whole person.

On April 1, 2002 Dr. Davy stated that appellant was experiencing greater difficulties with pain radiating down his left shoulder and his hand "feeling like rubber." Dr. Davy again requested authorization for cervical epidural steroid injections. In a November 27, 2002 report, he stated that the delay in treatment had resulted in chronic arthritic changes which further restricted appellant's work activities.

By letter dated January 16, 2003, the Office referred appellant for a second opinion evaluation. Dr. Kenneth A. Falvo, a Board-certified orthopedic surgeon, examined appellant on March 6, 2003. He described appellant's employment injury and performed a physical

[1] A.M.A., *Guides* (5th ed. 2001).

examination finding full range of motion of the shoulders, weaker grip strength on the left and loss of pinprick sensation in the left hand in a nonanatomic distribution with no interosseous wasting, but that the left forearm circumference was one centimeter less than the right. Dr. Falvo diagnosed left cervical radiculitis and noted that appellant's symptoms were ongoing. He stated that cervical epidural injections would not be of benefit. Dr. Falvo stated that the symptoms into appellant's left upper extremity were radicular in nature.

The Office medical adviser reviewed Dr. Falvo's report on August 22, 2003 and noted that he was unable to identify the nerve roots responsible for appellant's radicular upper extremity pain based on the report. He stated that Dr. Falvo provided no real objective findings and based the impairment on subjective complaints. The Office medical adviser stated that Dr. Falvo did not state that maximum medical improvement had been reached or that a permanent impairment of the left upper extremity existed. He did not provide an assessment of maximum medical improvement.

Dr. Davy completed a report on November 2, 2003 and found that appellant was totally disabled. He included a functional capacity evaluation and diagnosed neck pain secondary to cervical disc disease, multilevel myofascial trigger points and multilevel facet syndrome.

By decision dated February 19, 2004, the Office denied appellant's request for a schedule award on the basis that the medical evidence did not establish that he had reached maximum medical improvement.[2]

Appellant requested reconsideration on October 12, 2004 and submitted a report from Dr. Krishna dated April 14, 2004. Dr. Krishna provided a history of injury and history of medical treatment. He stated that appellant had reached maximum medical improvement on May 15, 2001 "from a noninterventional pain management plan…." Dr. Krishna stated that any treatments by Dr. Davy would only help to assist in controlling pain and would not improve the underlying condition. He provided his findings on physical examination including four of five weakness in the deltoid, supraspinatus, biceps, EHL, TA and GM muscles on the left side. He further noted that appellant's maximum mid arm circumference was one inch smaller on the left arm than the right. Dr. Krishna listed appellant's shoulder range of motion as abduction 50 degrees, adduction 30 degrees, forward flexion 70 degrees, and extension 25 degrees, internal rotation 15 degrees and external rotation 36 degrees. He also found that appellant had decreased sensation on the outer aspect of the left arm to pinprick. Dr. Krishna found that appellant's left biceps jerk deep tendon reflex was only one plus. He again concluded that appellant had reached maximum medical improvement on May 15, 2001 and stated, "Given the persistent sensory and motor deficits, pain management will not reverse these findings and therefore is palliative." Dr. Krishna stated that appellant had 75 percent impairment rating to his left upper extremity based on a total body impairment rating of the A.M.A., *Guides*.[3]

[2] Appellant filed a notice of recurrence of disability on September 22, 2004. The Office entered appellant on the periodic rolls on October 6, 2004.

[3] A.M.A., *Guides* at 499, Table 16-18.

By decision dated November 4, 2004, the Office denied modification of its prior decision and found that Dr. Krishna's April 14, 2004 report was not sufficient to "establish impairment percentages for a work-related impairment."[4]

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulation[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, the Act 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. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses. Effective February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[7]

Before the A.M.A., *Guides* can be utilized, a description of appellant's impairment must be obtained from appellant's physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[8]

Proceedings under the Act are not adversarial in nature nor is the Office a disinterested arbiter. While appellant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[9] Once the Office has begun an investigation of a claim, it must pursue the evidence as far as reasonably possible.[10] The Office has an obligation to see that justice is done.[11] The Board has stated that when the Office selects a

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[4] Following the Office's November 4, 2004 decision, the record contains additional new evidence. As the Office did not consider this evidence in reaching a final decision, the Board will not review it for the first time on appeal. 5 C.F.R. § 501.2(c).

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (2004).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims,* Chapter 2.808.6(a) (August 2002).

[8] *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

[9] *John J. Carlone*, 41 ECAB 354, 359-60 (1989).

[10] *Edward Schoening*, 41 ECAB 277, 282 (1989).

[11] *Lourdes Davila*, 45 ECAB 139, 143 (1993).

physician for an opinion on causal relationship, it has an obligation to secure, if necessary, clarification of the physician's report and to have a proper evaluation made.[12] Where the Office referred appellant for a second opinion physician and the report did not adequately address the relevant issues, the Office should secure a report on the relevant issues.[13]

It is a well-settled rule that maximum medical improvement arises at the point at which the injury has stabilized and will not improve further. This determination is factual in nature and depends primarily on the medical evidence.[14]

ANALYSIS

Dr. Krishna, a Board-certified neurologist, found that appellant had reached maximum medical improvement on May 15, 2001 and also provided physical findings relating to the impairment of appellant's left upper extremity. The Office undertook further development of the medical evidence and referred appellant for a second opinion evaluation by Dr. Falvo, a Board-certified orthopedic surgeon. He found that appellant had a loss of grip strength in his dominant left hand, that he had a smaller left forearm circumference and loss of pinprick sensation in the left hand. He noted that the symptoms into appellant's left upper extremity were radicular in nature.

In reviewing the March 6, 2003 report from Dr. Falvo, the Office medical adviser stated that the physician had not identified the individual nerve roots responsible for appellant's upper extremity impairment or provided an opinion on the date of maximum medical improvement. Due to these deficiencies in Dr. Falvo's report, the Office medical adviser did not offer an opinion as to whether appellant had reached maximum medical improvement and whether appellant had any permanent impairment of his upper extremity due to his accepted employment injuries and any preexisting injuries.[15]

As the Office undertook development of the medical evidence by referring appellant for a second opinion physician, it should secure a report adequately addressing the relevant issues of whether appellant reached maximum medical improvement and the extent of any permanent impairment to his left upper extremity as a result of the accepted condition of cervical radiculopathy and any preexisting injuries. The Office selected Dr. Falvo to provide an opinion regarding whether appellant was entitled to a schedule award and it has an obligation to secure clarification of his report and to have a proper evaluation made.

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[12] *Steven P. Anderson*, 51 ECAB 525, 534 (2000).

[13] *Robert Kirby*, 51 ECAB 474, 476 (2000).

[14] *Charles J. Cortese (Anthony L. Cortese),* 35 ECAB 1017, 1023 (1984).

[15] It is well established that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included. *Michael C. Milner*, 53 ECAB 446, 450 (2002).

CONCLUSION

The Board finds that the opinion of the Office's second opinion physician, Dr. Falvo, is not clear on whether appellant has reached maximum medical improvement or whether he has any permanent impairment due to his accepted employment injuries. On remand, the Office should obtain clarification of Dr. Falvo's report regarding appellant's permanent impairment rating. After this and such other development as the Office deems necessary, the Office should issue an appropriate decision.

ORDER

IT IS HEREBY ORDERED THAT the November 4 and February 19, 2004 decisions of the Office of Workers' Compensation Programs are set aside and remanded for further development consistent with this decision of the Board.

Issued: June 16, 2005
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member