United States Department of Labor
Employees' Compensation Appeals Board

S.K., Appellant	)	
and	)	**Docket No. 10-2151**
U.S. POSTAL SERVICE, POST OFFICE, Carol Stream IL, Employer	)	**Issued: July 8, 2011**

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 25, 2010 appellant filed a timely appeal from a July 27, 2010 decision of the Office of Workers' Compensation Programs (OWCP) regarding a schedule award. Pursuant to the Federal Employees' Compensation Act (FECA)[1] 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 established that she sustained more than a 23 percent permanent impairment of the right upper extremity and a 31 percent impairment of the left upper extremity, for which she received a schedule award.

On appeal, appellant contends that OWCP should have accorded her attending physician the weight of the medical evidence.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on December 27, 2004 appellant, then a 44-year-old clerk, sustained adhesive capsulitis of the left shoulder, tenosynovitis of the left wrist and aggravation of herniated C5-6 and C6-7 discs while lifting trays of mail.[2] Appellant stopped work on December 28, 2004 and did not return. She received compensation on the supplemental rolls beginning on February 8, 2005 and on the periodic rolls beginning on May 13, 2007.

In reports from March 9 to May 19, 2005, Dr. Daniel Harrison, an attending Board-certified neurosurgeon, noted weakness in the left triceps and left wrist extensors with an absent left triceps deep tendon reflex. He diagnosed cervical spondylosis and cervical spinal stenosis.

Dr. Samuel J. Chmell, an attending Board-certified orthopedic surgeon, followed appellant beginning on April 9, 2005. In reports through March 26, 2007, he observed restricted cervical and left shoulder motion, cervical radicular symptoms into the left shoulder girdle and arm, left hand weakness, diminished biceps and radial brachialis reflexes on the left and diminished sensation in the left forearm and thumb. Dr. Chmell diagnosed adhesive capsulitis of the left shoulder, left shoulder derangement, multiple tendinitis of the left wrist and herniated C5-6 and C6-7 discs with nerve root impingement and left-sided radiculopathy, lumbar disc derangement and lumbar radiculopathy.[3] He submitted periodic reports from August 30, 2007 to July 2, 2009 finding appellant totally disabled for work due to left-sided cervical and lumbar radiculopathy.[4]

On February 3, 2009 appellant claimed a schedule award. She submitted a March 19, 2009 letter from Dr. Chmell opining that she had reached maximum medical improvement regarding the cervical spine and upper extremities.

In an August 26, 2009 report, Dr. Chmell performed a schedule award assessment referring to the sixth edition of the American Medical Associations, *Guides to the Evaluation of Permanent Impairment* (hereinafter, "A.M.A., *Guides*"). Regarding the left upper extremity, he assessed a 12 percent impairment of the shoulder according to Table 15-34[5]: three percent for flexion limited to 120 degrees; one percent for extension at 30 degrees; three percent for abduction at 120 degrees; one percent for abduction at 20 degrees; two percent for internal

[2] A February 11, 2005 cervical magnetic resonance imaging (MRI) scan showed C5-6 and C6-7 left paramedian disc herniations with possible nerve root impingement.

[3] On May 26, 2006 OWCP doubled File No. xxxxxx307 master with File No. xxxxxx241, accepted for an aggravation of degenerated L4-5 and L5-S1 discs.

[4] On May 9, 2007 OWCP obtained a second opinion from Dr. Richard H. Sidell, a Board-certified orthopedic surgeon, who opined that appellant could perform full-time limited duty. Dr. Sidell diagnosed left-sided C5-6 and C6-7 radiculopathy. OWCP found a conflict between Dr. Chmell and Dr. Sidell regarding appellant's work capacity and obtained an impartial medical opinion from Dr. Edward J. Goldberg, a Board-certified orthopedic surgeon. In an August 1, 2007 report, Dr. Goldberg found weakness in the left triceps and diminished sensation in the left C6-7 distribution. He opined that appellant could return to full-time limited duty. OWCP did not issue a decision pursuant to Dr. Goldberg's opinion.

[5] Table 15-34, page 475 of the sixth edition of the A.M.A., *Guides* is entitled "Shoulder Range of Motion."

rotation at 60 degrees; and two percent for external rotation at 40 degrees. Dr. Chmell found a 12 percent impairment of the left wrist according to Table 15-32[6]: three percent for flexion limited to 45 degrees; three percent for extension at 45 degrees; two percent for radial deviation at 10 degrees; and four percent for ulnar deviation at 10 degrees.

Regarding the right upper extremity, Dr. Chmell assessed a 12 percent impairment of the right shoulder according to Table 15-34, as follows: three percent for flexion limited to 110 degrees; one percent for extension at 25 degrees; three percent for abduction at 100 degrees; one percent for abduction at 30 degrees; two percent for internal rotation at 50 degrees; and two percent for external rotation at 45 degrees. He found a 12 percent impairment of the right wrist according to Table 15-32: three percent for flexion limited to 40 degrees; three percent for extension at 40 degrees; two percent for radial deviation at 10 degrees; and four percent for ulnar deviation at 5 degrees. Dr. Chmell totaled the wrist and shoulder impairments to equal a 24 percent impairment of each upper extremity.[7] He then added a 40 percent impairment to each upper extremity according to Table 17-7[8] and Table 17-8[9] for C5-6 and C6-7 radiculopathy with bilateral wrist weakness, diminished sensation and reflexes. Dr. Chmell totaled these impairments to equal a 64 percent impairment of each upper extremity.

On September 4, 2009 OWCP referred the medical record to its medical adviser for calculation of a schedule award.[10] In a report received on September 14, 2009, OWCP's medical adviser concurred with Dr. Chmell's assessment of a 12 percent impairment of each upper extremity for limited motion of the wrist and an additional 12 percent for limited motion of the shoulder. The medical adviser found that according to Table 15-20, page 434 of the A.M.A., *Guides*,[11] left-sided "C5-7 radicular symptoms with sensory deficits correspond[ed] to a class 1 rating" of an 11 percent permanent impairment. Using the Combined Values Chart on page 604, OWCP's medical adviser calculated a 31 percent impairment of the left upper extremity by combining the two 12 percent impairment for range of motion to equal 23 percent, then combining the 11 percent neurologic deficit to equal 31 percent. The medical adviser found a 23 percent impairment of the right upper extremity by combining the two 12 percent impairments for range of motion.

By decision dated September 18, 2009, OWCP granted appellant a schedule award for a 23 percent impairment of the right upper extremity and a 31 percent impairment of the left upper

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[6] Table 15-32, page 473 of the sixth edition of the A.M.A., *Guides* is entitled "Wrist Range of Motion."

[7] Dr. Chmell categorized the wrist and shoulder impairments bilaterally as class 1, with unspecified grade modifiers for Physical Examination (GMPE).

[8] Table 17-7, page 576 of the sixth edition of the A.M.A., *Guides* is entitled "Physical Examination Adjustment: Spine."

[9] Table 17-8, page 578 of the sixth edition of the A.M.A., *Guides* is entitled "Common Radicular Syndromes."

[10] OWCP first obtained a September 8, 2009 report from OWCP medical adviser, who did not include range of motion impairments in his assessment. It therefore referred the medical record to a second OWCP medical adviser.

[11] Table 15-20, page 434 of the A.M.A., *Guides* is entitled "Brachial Plexus Impairment: Upper Extremity Impairments."

extremity. The award, equivalent to 168.48 weeks of compensation, ran from August 30, 2009 to November 12, 2012.

In a November 25, 2009 letter, appellant requested a telephonic oral hearing. At the hearing, held January 12, 2010, she asserted that the schedule award deprived her of retirement benefits and adversely affected her employment status. Appellant submitted progress notes from Dr. Chmell dated from October 8, 2009 to March 2010 and a March 9, 2010 physical therapy evaluation.

By decision dated and finalized March 26, 2010, OWCP's hearing representative affirmed the September 18, 2009 schedule award, finding that the schedule award did not adversely affect appellant's employment status or rights to retirement benefits.[12]

In an April 22, 2010 letter, appellant requested reconsideration. She submitted new reports from Dr. Chmell and physical therapy notes dated from April 15 to July 14, 2010. In an April 19, 2010 report, Dr. Chmell contended that OWCP's medical adviser ignored appellant's right wrist weakness and diminished upper extremity reflexes. He reiterated that appellant had a 64 percent permanent impairment of each upper extremity. In April 29, June 3 and July 10, 2010 chart notes, Dr. Chmell noted continuing neck and low back pain.

On July 14, 2010 OWCP requested that its medical adviser review the new medical evidence and indicate if the September 18, 2009 schedule award should be modified.

In a July 19, 2010 report, OWCP's medical adviser reviewed Dr. Chmell's assessment of a 64 percent permanent impairment of each upper extremity. The medical adviser noted that Dr. Chmell found a 24 percent impairment of each upper extremity due to restricted shoulder and wrist motion. OWCP's medical adviser opined that the 40 percent he assessed for cervical radiculopathy according to Table 17-7 and Table 17-8 was inappropriate as appellant's cervical pathology was isolated to the left side, with no right upper extremity complaints. Also, Table 17-7 and Table 17-8 were not directly related to assigning upper extremity impairments due to spinal conditions. Table 17-7 was an adjustment scale and Table 17-8 was an educational listing of nerve roots. OWCP's medical adviser concluded that the evidence appellant submitted accompanying her request for reconsideration was insufficient to warrant modification of the September 18, 2009 schedule award.

By decision dated July 27, 2010, OWCP denied modification on the grounds that the additional evidence submitted was insufficient to warrant modification. It found that Dr. Chmell did not refer to the appropriate sections of the A.M.A., *Guides.* OWCP further found that the physical therapy notes were not probative medical evidence as they were not signed or reviewed by a physician.

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[12] On June 8, 2010 OWCP approved appellant's request to pay the remainder of the schedule award as a lump sum.

LEGAL PRECEDENT

The schedule award provisions of FECA[13] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a mater 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 American Medical Associations, *Guides to the Evaluation of Permanent Impairment* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[14] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2008.[15]

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).[16] Under the sixth edition, the evaluator identifies the impairment class for the Diagnosed Condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), GMPE and Clinical Studies (GMCS).[17] The net adjustment formula is GMFH-CDX + GMPE - CDX + GMCS- CDX.

ANALYSIS

OWCP accepted that appellant sustained adhesive capsulitis of the left shoulder, tenosynovitis of the left wrist and aggravation of herniated C6-7 discs. Appellant claimed a schedule award on February 3, 2009. Dr. Chmell, an attending Board-certified orthopedic surgeon provided an August 26, 2009 impairment rating finding a 12 percent impairment of each upper extremity for restricted shoulder motion and an additional 12 percent impairment for restricted wrist motion. He added a 40 percent impairment of each upper extremity due to cervical radiculopathy, resulting in a 64 percent impairment of each upper extremity.

In a September 14, 2009 report, OWCP's medical adviser concurred with Dr. Chmell's findings of restricted shoulder and wrist motion. The medical adviser assessed an additional 11 percent on the left for radicular symptoms, noting that there were no documented radicular signs on the right and that Dr. Chmell used inappropriate tables to assess a 40 percent upper extremity impairment due to neurologic deficits. OWCP's medical adviser then utilized the Combined Values Chart to calculate a 31 a percent impairment of the left arm and a 23 percent impairment

[13] 5 U.S.C. §§ 8101-8193.

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

[15] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[16] A.M.A., *Guides* (6th ed. 2008), page 3, Section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[17] A.M.A., *Guides* (6th ed. 2008), pp. 494-531.

of the right arm. OWCP based the September 18, 2009 schedule award on these percentages. On reconsideration, appellant submitted an April 19, 2010 report from Dr. Chmell reiterating that appellant had a 64 percent permanent impairment of each upper extremity. OWCP's medical adviser explained that Dr. Chmell again misapplied the A.M.A., *Guides*. OWCP denied modification by July 27, 2010 decision.

The Board finds that OWCP's medical adviser properly applied the appropriate tables and grading schemes of the sixth edition of the A.M.A., *Guides* to Dr. Chmell's clinical findings. OWCP's medical adviser concurred with Dr. Chmell's ratings for restricted motion but explained that the neurologic impairments were calculated incorrectly. The medical adviser provided the correct assessment method and calculation for cervical radiculopathy affecting the left upper extremity. Appellant did not submit probative medical evidence establishing a greater percentage of impairment.

On appeal, appellant contends that OWCP should have accorded Dr. Chmell the weight of the medical evidence and found a 64 percent impairment of each upper extremity. As stated, Dr. Chmell's opinion could not be accorded the weight of the medical evidence as he did not properly apply the A.M.A., *Guides*.

Appellant may request a schedule award or increased schedule award 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 established that she sustained more than a 23 percent permanent impairment of the right upper extremity and a 31 percent impairment of the left upper extremity, for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 27, 2010 is affirmed.

Issued: July 8, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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