United States Department of Labor
Employees' Compensation Appeals Board

C.W., Appellant	)	
and	)	**Docket No. 13-632**
	)	**Issued: June 14, 2013**
DEPARTMENT OF AGRICULTURE, FOOD SAFETY & INSPECTION SERVICE, Minneapolis, MN, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 22, 2013 appellant filed a timely appeal from a November 5, 2012 decision of the Office of Workers' Compensation Programs (OWCP) regarding 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 this case.

ISSUE

The issue is whether appellant sustained a ratable impairment of the right arm due to an accepted cervical spine injury.

FACTUAL HISTORY

OWCP accepted that on February 1, 2010 appellant, then a 51-year-old poultry inspector, sustained a herniated C5-6 disc in a motor vehicle accident that occurred in the performance of

[1] 5 U.S.C. § 8101 *et seq.*

duty.[2] Appellant stopped work on February 1, 2010 and did not return. Dr. Edward W. Hellman, an attending Board-certified orthopedic surgeon, diagnosed cervical stenosis with radicular left arm pain on March 16, 2010. On April 8, 2010 he performed a C5-6 discectomy and fusion with cage placement and bone autograft. OWCP approved the procedure.

Appellant received compensation on the daily rolls beginning on March 20, 2010 and on the periodic rolls beginning on June 6, 2010. A February 17, 2011 cervical computerized tomography (CT) scan showed well-maintained alignment of the C5-6 fusion, stable cage placement and patent exit foramina. On March 2, 2011 Dr. Hellman diagnosed failed neck syndrome as appellant had continued neck pain although her cervical fusion remained solid. He referred appellant to Dr. Gary Baxter, a pain management specialist.[3] Dr. Hellman held appellant off work commencing in March 2011. He opined on June 7, 2011 that many of appellant's complaints seemed "nonphysiologic."

On August 7, 2011 OWCP obtained a second opinion from Dr. Raju Vanapalli, a Board-certified orthopedic surgeon, who reviewed the medical record and statement of accepted facts. On examination, Dr. Vanapalli found subjectively restricted cervical motion due to pain, tingling and numbness along the ulnar border of the left elbow and forearm in the C8-T1 dermatome, equal reflexes in both arms and good grip strength bilaterally. He found that appellant had attained maximum medical improvement, stating that the accepted injury had resolved without objective residuals. Dr. Vanapalli noted that appellant's subjective complaints outweighed any objective findings.

In a September 27, 2011 report, Dr. Hellman noted that a repeat CT scan showed a solid cervical fusion with solid bone through the cage. He noted that a nerve conduction velocity (NCV) study showed cubital tunnel syndrome that could explain some of appellant's upper extremity symptoms. Dr. Hellman released appellant to restricted duty as of November 1, 2011, noting that she had scheduled a cubital tunnel and ulnar nerve transposition procedure.[4] He agreed with Dr. Vanapalli's opinion that appellant had no objective residuals of the accepted disc herniation.

Appellant elected to receive retirement benefits through the Office of Personnel Management (OPM) in lieu of FECA compensation benefits effective November 20, 2011.

On April 6, 2012 appellant claimed a schedule award. She submitted a March 21, 2012 impairment rating from Dr. Hellman utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, the A.M.A., *Guides*). Dr. Hellman opined that, according to page 564 of the A.M.A., *Guides*,[5] appellant had

[2] Cervical spine x-rays obtained on February 1, 2010 were normal. A February 24, 2010 magnetic resonance imaging scan showed a C5-6 disc bulge with stenosis and left-sided cord compression.

[3] Dr. Baxter provided periodic reports from May to November 2011 diagnosing cervical radiculitis and chronic neck pain.

[4] An October 17, 2011 functional capacity evaluation demonstrated that appellant could perform full-time sedentary work. The examiner noted that appellant showed inconsistent effort during testing.

[5] Page 564 of the sixth edition of the A.M.A., *Guides* is Table 17-2, entitled "Cervical Spine Regional Grid."

a class 1 impairment of the cervical spine, as her postoperative studies showed an entirely stable cervical fusion with no evidence of nerve root impingement.

In an April 6, 2012 letter, OWCP advised appellant of the additional evidence needed to establish her schedule award claim, including a physician's opinion confirming a ratable impairment of a scheduled member of the body based on the appropriate portions of the A.M.A., *Guides*. Appellant was afforded 30 days to submit such evidence.

On May 21, 2012 an OWCP medical adviser reviewed the medical record and concurred with Dr. Hellman's finding that appellant attained maximum medical improvement as of March 21, 2012. He opined that, in the absence of any radiculopathy in the C6 dermatome or elsewhere, appellant had a zero percent impairment of either upper extremity. The medical adviser noted that Dr. Hellman did not properly utilize the A.M.A., *Guides*, as he did not refer to *The Guides Newsletter*, July/August 2009 that set forth the methodology for rating upper extremity impairments originating in the spine.

By decision dated May 31, 2012, OWCP denied appellant's schedule award claim finding that the medical evidence did not establish a ratable impairment of a scheduled member of the body. It found that in the absence of an upper extremity radiculopathy as described in *The Guides Newsletter*, July/August 2009, appellant had not established an impairment of a scheduled member.

In a September 14, 2012 letter, appellant requested reconsideration. She submitted a July 24, 2012 impairment rating from Dr. Hellman finding 11 percent impairment of the right upper extremity based on unspecified portions of *The Guides Newsletter*, July/August 2009. Appellant also provided an April 19, 2012 electromyography and NCV report from a physical therapist showing a mild focal mononeuropathy of the right ulnar nerve across the elbow. The physical therapist noted "isolated muscle membrane instability at the right (C5-6) paraspinals that may suggest a very mild radiculopathy involving the respective dorsal primary rami."[6]

On October 17, 2012 an OWCP medical adviser reviewed the medical record and again found that appellant had attained maximum medical improvement as of March 21, 2012. He explained that the paraspinal muscle instability noted on the April 19, 2012 electrodiagnostic study "cannot be accepted as evidence of a radiculopathy." The medical adviser found that in "the absence of objective evidence of spinal nerve root deficit," appellant had no permanent impairment of either upper extremity.

By decision dated November 5, 2012, OWCP denied modification of its May 31, 2012 decision, finding that the evidence submitted on reconsideration did not establish a ratable impairment of either upper extremity.

[6] Appellant also submitted a July 30, 2012 report from Dr. Baxter stating that she could participate in all activities of daily living.

LEGAL PRECEDENT

The schedule award provision of FECA[7] and its implementing regulations[8] 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 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 regulations as the appropriate standard for evaluating schedule losses.[9]

No schedule award is payable for a member, function, or organ of the body not specified in FECA or in the regulations.[10] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back,[11] no claimant is entitled to such an award.[12] However, in 1966, amendments to FECA modified the schedule award provision 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. As the schedule award provision of FECA includes 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.[13]

ANALYSIS

OWCP accepted that appellant sustained a herniated C5-6 disc necessitating surgical fusion with cage placement and bone autograft. Appellant remained under treatment for neck pain through March 2012. She claimed a schedule award on April 6, 2012. Appellant submitted a March 12, 2012 impairment rating from Dr. Hellman, an attending Board-certified orthopedic surgeon, finding an impairment of the cervical spine without nerve root impingement. OWCP denied the schedule award claim on May 31, 2012 as appellant had not demonstrated a permanent impairment to a scheduled member of the body. On reconsideration, appellant submitted a July 24, 2012 report from Dr. Hellman finding 11 percent impairment of the right upper extremity based on unspecified sections of *The Guides Newsletter* July/August 2009. She also provided April 19, 2012 electrodiagnostic studies noting muscle instability in the right C5-6 paraspinals possibly indicating a very mild radiculopathy. OWCP denied modification on

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id*.; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

[10] *Henry B. Floyd, III*, 52 ECAB 220 (2001).

[11] FECA specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

[12] *Thomas Martinez*, 54 ECAB 623 (2003).

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

November 5, 2012 as the medical evidence did not support a nerve root impairment affecting either arm.

Appellant asserted that the accepted C5-6 disc herniation caused a permanent impairment of the right arm. Although FECA does not provide for a schedule award for the back or spine, impairment of the extremities due to a spinal injury may be compensable,[14] but appellant did not submit sufficient medical evidence to establish impairment. Dr. Hellman opined that appellant had 11 percent impairment of the right arm but did not describe the nature of this impairment or its pathophysiologic connection to the C5-6 disc herniation. He did not address how he applied *The Guides Newsletter* to take impairment. Dr. Hellman did not set forth the specific tables or grading schemes that he used to arrive at the 11 percent impairment. His opinion is therefore insufficient to meet appellant's burden of proof.[15]

Appellant also submitted April 19, 2012 electrodiagnostic studies performed and interpreted by a physical therapist, indicating a possible, very mild right C5-6 radiculopathy due to paraspinal instability. A physical therapist is not a physician as defined under FECA. As there is no evidence that a physician, signed or reviewed this report, it cannot be considered as probative medical evidence in this case.[16]

As appellant did not submit sufficient medical evidence demonstrating that the accepted C5-6 disc herniation caused a permanent impairment of a scheduled member, OWCP properly denied her schedule award claim. She 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 a ratable permanent impairment of the right upper extremity causally related to an accepted cervical spine injury.

[14] *See Thomas J. Engelhart, supra* note 13.

[15] *Renee M. Straubinger*, 51 ECAB 667 (2000) (where the Board found that before the A.M.A., *Guides* can be utilized, a description of the claimant's impairment must be obtained from his or her physician with the description 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).

[16] A medical report may not be considered as probative medical evidence if there is no indication that the person completing the report qualifies as a physician as defined in 5 U.S.C. § 8101(2). Section 8101(2) of FECA provides as follows: (2) physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. *J.T.*, Docket No. 12-1903 (issued February 15, 2013). *See Merton J. Sills*, 39 ECAB 572, 575 (1988).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 5, 2012 is affirmed.

Issued: June 14, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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