United States Department of Labor
Employees' Compensation Appeals Board

M.K., Appellant	)	
and	)	**Docket No. 13-542**
	)	**Issued: September 17, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Conway, AK, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 7, 2013 appellant filed a timely appeal from a July 10, 2012 merit 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 the case.

ISSUE

The issue is whether appellant has more than one percent permanent impairment of his left upper extremity for which he received a schedule award.

FACTUAL HISTORY

On October 15, 2003 appellant, then a 53-year-old maintenance mechanic, injured his head and neck in an automobile accident at work. OWCP accepted the claim for concussion, neck sprain and cervicalgia, postconcussion syndrome. Appellant stopped work on October 15,

[1] 5 U.S.C. §§ 8101-8193.

2003 and returned to work part-time limited duty on June 14, 2005 and full-time light duty on April 7, 2007. He retired on September 30, 2010.

An October 15, 2003 computerized tomography scan of the cervical spine revealed no acute traumatic changes in the cervical spine and some degenerative changes at C5-6 and C6-7. An electromyogram (EMG) dated November 19, 2003 revealed bilateral carpal tunnel syndrome. A June 11, 2009 magnetic resonance imaging (MRI) scan of the cervical spine revealed multilevel disc degenerative disease at C3-4 and C6-7 and multilevel neural foraminal narrowing at C4-5 and C6-7. Appellant was treated by Dr. M. Carl Covey, a Board-certified orthopedist, on September 27, 2010, for chronic neck pain of seven years duration. Dr. Covey noted findings of cervical pain with radiation to the bilateral upper extremities. He diagnosed spondylosis, cervical, radiculitis of the upper extremities and neck pain.

On December 13, 2010 appellant filed a claim for a schedule award. He submitted an October 11, 2010 impairment report from Dr. John W. Ellis, Board-certified in family medicine, who noted a history of appellant's work injury. Dr. Ellis diagnosed contusion to the head with scalp tenderness, muscle tendon strain of the neck with occipital headaches, deranged discs of the neck at C6, C7 and C8, spinal nerve root impingement, strain of the left shoulder joint with internal derangement and probable tear, strain of the left elbow with medial epicondylitis and ulnar nerve impingement with cubital tunnel syndrome, left wrist sprain with carpal tunnel syndrome and Guyon's canal syndrome and direct injury to the nerves with double crush syndrome due to the cervical spinal nerves in the neck with innervation into the left hand. He noted that appellant reached maximum medical improvement on July 16, 2010. Dr. Ellis opined that appellant had a 29 percent impairment of the left arm due to his work injury. Under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[2] using the diagnosis-based impairment, appellant had two percent impairment for a strain of the shoulder, pursuant to Table 15-5, page 401, two percent impairment for medial epicondylitis, pursuant to Table 15-4, page 399 and two percent impairment for wrist strain, Table 15-3, page 395, for six percent combined diagnosis-based impairment. For entrapment neuropathy, under Table 15-23, page 449 of the A.M.A., *Guides,* he had six percent impairment for carpal tunnel syndrome and three percent impairment for cubital tunnel syndrome for nine percent total combined impairment for entrapment neuropathy. For the cervical spine nerve roots, under Table 15-20, page 434, appellant had three percent impairment for C6 spinal nerve, six percent impairment for C7 spinal nerve impairment and 10 percent for C8 spinal nerve impairment for a total combined cervical spinal nerve root impairment of 17 percent. Dr. Ellis concluded that appellant had 6 percent impairment under the diagnosed-based impairment method (2 percent for strain of the shoulder, 2 percent for medial epicondylitis and 2 percent for wrist strain) and 24 percent impairment for peripheral nerve impairment (9 percent for entrapment neuropathy, 17 percent for cervical spinal nerve impairment) for 29 percent combined left arm impairment. He advised that appellant would need future treatment, including possible neck, left shoulder and left elbow surgery.

[2] A.MA., *Guides* (6th ed. 2008).

Appellant submitted reports from Dr. Covey dated November 23, 2010 and January 25, 2011, who treated appellant for head, neck and left shoulder pain. Dr. Covey diagnosed cervical spondylosis, radiculitis of the upper extremities and neck pain.

In developing the claim, OWCP referred appellant to a second opinion physician and also to an impartial medical examiner to determine his diagnosed conditions and whether he had residuals of the accepted conditions. The referee physician, Dr. Harold Chakales, a Board-certified orthopedist, in a February 2, 2011 report, diagnosed residuals of cervical spine injury with degenerative disc disease, residuals of left shoulder injury and postconcussion syndrome. He recommended additional diagnostic studies. On February 28, 2011 appellant underwent an EMG, which revealed mild carpal tunnel syndrome bilaterally, remote and mild C5-6 motor nerve root irritation on the left side with no evidence of motor nerve root irritation on the right side, ulnar nerve compression bilaterally, peripheral neuropathy or myopathic process. A February 28, 2011 left shoulder MRI scan showed no abnormalities. A February 28, 2011 cervical spine MRI scan revealed multilevel mild degenerative changes with evidence of mild central canal stenosis and bilateral mild to moderate foraminal narrowing at C4-5 and C5-6, mild degenerative changes and no evidence of fracture or subluxation. In a March 18, 2011 supplemental report, Dr. Chakales reviewed the findings of the diagnostic studies. He diagnosed mild cerebral concussion with no apparent residuals except some headaches; strain to the left shoulder with no evidence of abnormality with a normal MRI scan; cervical spondylosis, primarily at C4-5, with some permanent aggravation at C4-5 and C5-6. Dr. Chakales noted that appellant had preexisting cervical spondylosis, which was aggravated by his injury but was currently quiescent. He opined that appellant reached maximum medical improvement. Dr. Chakales stated that appellant had a long-term sequelae of cervical spine injury with a permanent aggravation of cervical spondylosis, which appellant claimed to be symptomatic and a cerebral concussion but there was no evidence that it was active. He further noted that appellant had a left shoulder sprain which was resolved. Dr. Chakales opined that appellant reached maximum medical improvement and did not need active medical treatment.[3]

On March 30, 2011 OWCP expanded the claim to include aggravation of cervical spondylosis without myelopathy.

In a May 6, 2011 report, OWCP's medical adviser reviewed the medical evidence and Dr. Ellis' report and opined that none of the ratings for the several cervical levels cited by the physician were supported by signs and symptoms affecting either upper extremity reported by Dr. Ellis to be radicular. The medical adviser noted that the ratings Dr. Ellis provided under Table 15-20 for nerve root residuals affecting the arms were not calculated correctly as he did not use grade modifiers as required by the A.M.A., *Guides*. He further noted that all of the sensory symptoms in the upper extremities noted by Dr. Ellis as being a consequence of peripheral nerve conditions could not be processed for schedule awards as OWCP did not accept the upper extremity diagnoses. The medical adviser questioned whether the upper extremity diagnoses not accepted by OWCP were at maximum medical improvement as Dr. Ellis recommended further studies or surgery. He further noted that Dr. Ellis' report contained no

[3] Dr. Chakales recommended a functional capacity evaluation (FCE) to determine appellant's ability to work. An FCE was performed on April 18, 2011.

radicular signs or symptoms to support that there was a radicular aspect to the relevant diagnosis accepted by OWCP, aggravation of cervical spondylosis. The medical adviser indicated that based on the signs and symptoms in Dr. Ellis' report the impairment ratings for the right and left upper extremities as a consequence of the accepted diagnoses of aggravation of cervical spondylosis was zero. He noted that the other diagnoses at the cervical level would not cause radicular symptoms and cervical spondylosis would not cause upper extremity radicular signs or symptoms.

In a decision dated May 10, 2011, OWCP denied appellant's claim for a schedule award.

On June 14, 2011 appellant requested reconsideration. He submitted May 26 and July 25, 2011 reports from Dr. Covey, who treated him for headaches, neck and left arm pain. Dr. Covey noted findings of cervical pain with radiation into the left shoulder and arm. He diagnosed cervical spondylosis, upper extremity radiculitis and neck pain.

On June 28, 2011 OWCP expanded appellant's claim to include sprain of the left shoulder and upper arm that resolved by March 18, 2011.

In an August 8, 2011 report, the medical adviser reviewed the medical evidence and opined that appellant reached maximum medical improvement on April 18, 2011. He noted that OWCP now accepted a left shoulder strain that resolved by March 18, 2011. Under the A.M.A., *Guides*, Table 15-5, Shoulder Regional Grid: Upper Extremity Impairments, muscle/tendon, sprain/strain with no residual instability or loss of motion but persisting pain at maximum medical improvement, would be a class 1 with a history of painful injury, residual symptoms without objective findings (this impairment can be given only once in an individual's lifetime) can range from zero to two percent with the default value of one percent. The medical adviser noted that in this case he used class 1 for the strain/sprain because the February 28, 2011 MRI scan of the left shoulder revealed no abnormalities. He noted that to determine which rating from class 1 was appropriate you must consider the impact of the grade modifiers tables. Using Table 15-7, functional history adjustment, the grade modifier was one in that "pain symptoms with strenuous/vigorous activity, medication to control symptoms and the ability to perform self-care activities independently." The medical adviser noted that no specific examination about the left shoulder, over the acromioclavicular joint, supraspinatus nerve, bicipital tendon or glenohumeral has been reported in medical records by any provider in the last two years. Using Table 15-8, physical examination adjustment for the upper extremities the grade modifier would be one, giving appellant the benefit of the doubt based on the range of motion figures reported in the April 18, 2011 FCE for the left and right shoulder, which were both equally limited. Using Table 15-9, clinical studies adjustment of the upper extremities, the grade modifier was zero as the MRI scan of the right shoulder dated February 28, 2011 revealed no abnormalities. Using the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), (1-1) + (1-1) + (0-1), the total adjustment was -1. This resulted in a grade B and one percent impairment of the left upper extremity.

In an August 30, 2011 decision, OWCP granted appellant a schedule award for one percent impairment of the left arm. The period of the award was from April 18 to May 9, 2011.

Appellant requested an oral hearing which was held on January 9, 2012. In August 25, 2011 to February 8, 2012 reports from Dr. Covey noted a cervical medial branch nerve radiofrequency lesioning procedure on August 25, 2011. In October 7, 2011 to February 12, 2012 reports, he noted appellant's status and diagnosed cervical spondylosis, upper radiculitis and left shoulder and neck pain.

In a March 28, 2012 decision, a hearing representative set aside the August 30, 2011 decision and remanded the case for further medical development. The hearing representative directed that OWCP's medical adviser review the medical reports to determine if appellant had arm impairment from the accepted cervical spine conditions.

OWCP requested that its medical adviser address whether cervical degenerative disc disease and cervical spondylosis were the same condition and what were the appropriate diagnoses for appellant's work-related condition. It also requested that the medical adviser address whether appellant had arm impairment due to the spine condition.

In an April 11, 2012 report, the medical adviser stated that OWCP had accepted cervical spondylosis without myelopathy. He noted the definition of spondylosis was degenerative joint disease affecting the cervical vertebrae, intervertebral discs and surrounding ligaments and connective tissue, sometimes with pain or paresthesia radiating down the arms as a result of pressure on the nerve roots. The medical adviser indicated that this definition of spondylosis includes cervical degenerative disc disease. He advised that based on the March 18, 2011 report from Dr. Chakales appellant did not have radicular pain, sensory change or weakness affecting either upper extremity. The medical adviser stated that Dr. Chakales noted appellant's complaint of numbness and tingling in the hands and, considering the EMG results, it was medically reasonable to conclude that appellant's symptoms were due to peripheral nerve entrapment and not due to radicular component of cervical spondylosis. He advised that there was no medical documentation in the recent history to show that appellant had radicular signs or symptoms due to cervical spondylosis without myelopathy.

Appellant submitted an April 9, 2012 report from Dr. Covey, who treated appellant for neck and left arm pain and diagnosed neck pain and radiculitis of the upper limbs.

Appellant submitted reports from Dr. Covey dated May 9 and June 7, 2012, who treated appellant for persistent neck pain radiating to the left arm and diagnosed neck pain and cervical spondylosis. Dr. Covey performed a cervical medial branch nerve radiofrequency lesioning procedure on June 7, 2012.

In a July 10, 2012 decision, OWCP found that appellant had no more than one percent impairment of his left arm and that he had no left arm impairment due to cervical spondylosis.[4]

[4] This decision corrected a previously issued April 19, 2012 decision.

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 issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[8]

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).[9] Under the sixth edition of the A.M.A., *Guides*, for upper extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

No schedule award is payable for a member, function or organ of the body not specified in FECA or in the implementing regulations.[12] FECA and the implementing regulations do not provide for the payment of a schedule award for the permanent loss of use of the back or the body as a whole.[13] The Board notes that section 8101(19) specifically excludes the back from the definition of organ.[14] However, a claimant may be entitled to a schedule award for permanent impairment to an upper or lower extremity even though the cause of the impairment originated in the neck, shoulders or spine.[15]

---

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

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

[9] A.M.A., *Guides*, *supra* note 2 at 3, section 1.3, ICF: A Contemporary Model of Disablement.

[10] *Id.* at 385-419.

[11] *Id.* at 411.

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

[13] *See Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[14] 5 U.S.C. § 8101(19).

[15] *Thomas J. Engelhart*, *supra* note 12.

ANALYSIS

Appellant contends that he is entitled to a schedule award greater than one percent permanent impairment of the left upper extremity. OWCP accepted the claim for concussion, cervical strain, cervicalgia, postconcussion syndrome, aggravation of cervical spondylosis without myelopathy and a left shoulder/upper arm sprain that resolved by March 18, 2011.

In an October 11, 2010 report, Dr. Ellis opined that appellant had 29 percent impairment of the left arm. The Board has carefully reviewed Dr. Ellis' October 11, 2010 report and notes that it is not clear how he came to his impairment conclusion in accordance with the relevant standards of the A.M.A., *Guides.*[16] Dr. Ellis' report failed to provide an adequate description of appellant's physical condition so that an impairment rating could be determined by an OWCP medical adviser. For instance, Dr. Ellis noted that appellant had two percent impairment for a strain of the shoulder, two percent impairment for medical epicondylitis, two percent impairment for wrist strain, six percent impairment for carpal tunnel syndrome and three percent impairment for cubital tunnel syndrome and with regard to the cervical spine nerve roots appellant had three percent impairment for C6 spinal nerve, six percent impairment for C7 spinal nerve impairment and 10 percent for C8 spinal nerve impairment. However, he did not explain how he applied grade modifiers in arriving at his calculations as contemplated by the A.M.A., *Guides.*[17] Further, Dr. Ellis provided impairment ratings for carpal tunnel syndrome, cubital tunnel syndrome, epicondylitis, wrist strain; however, none of these conditions were accepted as work related.[18]

According to OWCP's procedures, an attending physician's impairment rating report must include a detailed description of the impairment and a rationalized opinion as to the percentage of permanent impairment under the A.M.A., *Guides*.[19] When the attending physician fails to provide a rating that conforms to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment.[20] As Dr. Ellis did not adequately describe appellant's condition or correlate his findings with the A.M.A., *Guides*, his report is insufficient to establish the extent of appellant's permanent impairment.

The medical adviser reviewed the medical record and in an August 8, 2011 report utilized the Shoulder Regional Grid, Table 15-5, A.M.A., *Guides*, page 401 and identified a class 1

[16] *Lela M. Shaw*, 51 ECAB 372 (2000) (where the Board found that a physician's opinion which does not explicitly define impairment in terms of the A.M.A., *Guides*, *i.e.*, whether it be based on findings of pain, loss of range of motion or loss of strength, is insufficient to establish that appellant sustained any permanent impairment due to her accepted employment injury).

[17] *See supra* note 10. Dr. Ellis provided calculation worksheets but he did not clearly explain the reasons why particular grade modifiers were determined for particular diagnoses.

[18] *See Alice J. Tysinger*, 51 ECAB 638 (2000) (for conditions not accepted by OWCP as being employment related, it is the employee's burden to provide rationalized medical evidence sufficient to establish causal relation, not OWCP's burden to disprove such relationship).

[19] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6(c) (January 2010).

[20] *Linda Beale*, 57 ECAB 429, 434 (2006). *See also James Kennedy, Jr.*, 40 ECAB 620, 627 (1989).

impairment based on sprain/strain with no residual instability or loss of motion but persisting pain, which had a default value, C, of one percent upper extremity impairment.[21] The medical adviser noted class 1 was appropriate for the strain/sprain because the February 28, 2011 MRI scan of the left shoulder revealed no abnormalities. He noted that, for functional history, appellant was assigned a grade modifier one for pain symptoms with strenuous vigorous activity and medications to control symptoms and his ability to perform self-care activities independently.[22] The medical adviser assigned a grade modifier of one for the physical examination adjustment, based on the range of motion figures in the FCE of April 18 2011.[23] For clinical studies, appellant was assigned a grade modifier of zero as the February 28, 2011 MRI scan of the left shoulder revealed no abnormalities. Applying the net adjustment formula resulted in a modifier of -1, which resulted in a grade adjustment from C to B. The corresponding upper extremity impairment for a class 1, grade B sprain/strain was one percent.[24]

In an April 11, 2012 report, the medical adviser noted that, with regard to cervical spondylosis, appellant had reported numbness and tingling in the hands and, considering the EMG results, it was medically reasonable to conclude that appellant's symptoms were due to peripheral nerve entrapment and not due to radicular component of cervical spondylosis. He further noted that there was no medical documentation in the recent history to show radicular signs or symptoms due to cervical spondylosis without myelopathy which would warrant an impairment finding.

The Board finds that the medical adviser properly applied the A.M.A., *Guides,* to rate impairment to appellant's left upper extremity. There is no medical evidence of greater impairment under the A.M.A., *Guides*.

On appeal, appellant asserts that the medical adviser did not adequately consider Dr. Ellis' report. As noted above, Dr. Ellis failed to properly explain his impairment calculations pursuant to 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 one percent impairment of the left upper extremity, for which he received a schedule award.

[21] A.M.A., *Guides* 401, Table 15-5.

[22] A.M.A., *Guides* 406, Table 15-7.

[23] A.M.A., *Guides* 408, Table 15-8.

[24] *Supra* note 21.

ORDER

IT IS HEREBY ORDERED THAT the July 10, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 17, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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