United States Department of Labor
Employees' Compensation Appeals Board

O.N., Appellant	)	
and	)	**Docket No. 14-1744**
	)	**Issued: July 13, 2015**
DEPARTMENT OF THE AIR FORCE, AIR NATIONAL GUARD, NEW YORK NATIONAL GUARD, Latham, NY, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 12, 2014 appellant filed a timely appeal from a June 26, 2014 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 this case.

ISSUES

The issues are: (1) whether OWCP properly determined the date of maximum medical improvement for the start of appellant's schedule award; and (2) whether appellant sustained greater than two percent impairment of the right arm for which he received a schedule award.

On appeal appellant contends that the report of the second opinion physician was based on an examination not performed when he was at maximum medical improvement. He requests a further examination to determine his actual impairment.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On January 6, 2009 appellant, then a 44-year-old fuel distribution worker, filed a traumatic injury claim. On January 5, 2009 he was completing fuel operations in a pit and while disconnecting the hose he lost his footing. He hit a locking mechanism on the pit lid and felt pain in his right shoulder and arm. On February 26, 2009 OWCP accepted appellant's claim for right-sided bicipital tenosynovitis and later, on October 19, 2009, it expanded his claim to include cervical disc herniation and right cervical radiculopathy.

Appellant received treatment from Dr. Thomas A. Piserchia, an orthopedic surgeon,[2] who submitted reports dated January 19, 2009 through May 28, 2014. Dr. Piserchia initially noted persistent symptoms in appellant's right arm, and diagnosed tendinitis, a possible stretch on the brachial plexus, and cervical radiculopathy. He removed appellant from work following the injury and treated him with injections, physical therapy, and medication. Dr. Piserchia noted that appellant initially appeared to be responding to conservative treatment.

Dr. Piserchia's referred, appellant for treatment by Dr. G. Alexander Jones, a neurosurgeon.[3] Appellant had appointments with Dr. Jones from February 6, 2009 to May 28, 2014. On February 6, 2009 Dr. Jones reviewed a magnetic resonance imaging scan and conducted a neurologic examination. He concluded that appellant had a right-sided paracentral disc herniation with compression of the C7 root, and a left C4-5 herniation.

On June 5, 2009 OWCP referred appellant to Dr. David Sundstrom, a Board-certified neurosurgeon, for a second opinion. In a June 30, 2009 report, Dr. Sundstrom diagnosed appellant with cervical disc herniation. He noted that appellant's herniated cervical disc at C6-7 was the result of his injury at work on January 5, 2009. Dr. Sundstrom also noted a herniation on the left at C4-5, but determined that this did not contribute to appellant's symptoms. He stated that appellant was unable to return to his usual job as a fuel distribution system worker. Dr. Sundstrom noted it was unlikely that appellant would find good relief from continued nonsurgical management. He found appellant to be a candidate for a C6-7 discectomy. Because appellant had both axial neck and radicular pain, Dr. Sundstrom recommended an anterior cervical discectomy, interbody fusion, and stabilization. He noted that appellant should return to full duty within three to six months of the surgery.

In a July 24, 2009 report, Dr. Jones noted that appellant's symptoms had improved slightly, and indicated that appellant could return to work to try to perform his job duties. He indicated that there was a significant chance that appellant's strength in the right triceps would significantly improve following a cervical discectomy and fusion operation. Dr. Jones anticipated that appellant could return to work, without restrictions, three months postoperatively.

On February 19, 2010 Dr. Jones responded to OWCP questions, and noted that he was treating appellant for cervical disc herniation and right cervical radiculopathy, and that neither condition had resolved. He noted that without surgical intervention appellant would experience

[2] The Board is unable to confirm that Dr. Piserchia is Board-certified.

[3] The Board is unable to confirm whether Dr. Jones is Board-certified.

no further improvement in his right arm because the chance of spontaneous improvement decreases after the first year following the injury. Dr. Jones recommended that, if appellant did not have surgery, physical therapy could continue to strengthen the affected muscle groups in the right arm. He opined that, once appellant was two years post injury, the chance of further improvement without surgery approaches zero. Dr. Jones noted that with the proposed surgery there was a strong likelihood that appellant's motor strength and radicular pain, would improve. He noted that appellant had not made a final decision regarding the surgery.

In a February 18, 2011 report, Dr. Jones noted that appellant's surgery had been approved. He diagnosed appellant's weakness as the result of the C6-7 disc herniation. Dr. Jones repeated that a C6-7 anterior cervical discectomy and fusion with plating was reasonably indicated, but might not improve the strength in his right arm. Appellant finally decided against surgery.

Appellant also continued treatment with Dr. Piserchia, and in a March 8, 2010 report, Dr. Piserchia stated that surgery would not benefits appellant at that time. Dr. Piserchia continued to recommend light-duty work status. He also noted that appellant had enjoyed benefits from physical therapy and recommended that it be continued. In an April 20, 2010 note, Dr. Piserchia noted that appellant had been treated with conservative management over an extensive period of time, and may be a candidate for surgical intervention on the cervical spine. He opined that appellant could not return to his preinjury job of refueling planes, but that he might function in other nonstrenuous positions at the employing establishment. In a June 29, 2010 report, Dr. Piserchia advised appellant to increase his activities as tolerated, with the goal of return to normal duties.

Dr. Piserchia again referred appellant to a neurosurgeon, Dr. Steven K. Jacobs.[4] In an April 26, 2011 report, Dr. Jacobs listed impressions of traumatic cervical disc herniation at C6-7 which caused impingement on the right neuroforamen and traumatic right-sided cervical radiculopathy at that level. He opined that appellant's employment-related accident of January 5, 2009 was the competent producing cause of appellant's current condition. Dr. Jacobs recommended continuing physical therapy and chiropractic treatment. In a May 3, 2011 report, he noted that appellant did not wish to consider surgery. Dr. Jacobs reported that appellant believed he was managing his weakness and the pain had been reduced by physical therapy.

On September 22, 2011 appellant filed a claim for a schedule award.

In an April 12, 2012 report, Dr. Piserchia took appellant off work, noting persistent symptoms that appeared to be unchanged from his initial presentation.

On May 22, 2013 OWCP referred the case to its medical adviser to determine the impairment of appellant's arms and the date of maximum medical improvement under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). It asked the medical adviser to review the attached medical records, as well as the second opinion medical report of Dr. Sundstrom.

[4] The Board is unable to confirm that Dr. Jacobs is Board-certified.

In a May 22, 2013 report, the medical adviser discussed the objective tests and the June 30, 2009 second opinion of Dr. Sundstrom. Based on the objective studies, he determined:

> "Utilizing the [A.M.A., *Guides*], the *Guides Newsletter; July to August 2009*, page 4, Proposed Table 1, Spinal Nerve Impairment, Upper Extremity Impairments, C7 nerve root, [c]lass 1, moderate sensory pain deficit, default value [g]rade C, 2 [percent] impairment of the right upper extremity. Grade adjustments and modifiers do not change this value. There is no motor deficit according to the medical records.
>
> "In summary, this claimant has a schedule award of two [percent] for the right upper extremity, with the date of maximum medical improvement the date of Dr. Sundstrom's evaluation, [January 5, 2009]."

On August 7, 2013 OWCP issued a schedule award for a two percent impairment of the right upper extremity.[5] The date of maximum medical improvement was June 29, 2009. The schedule award was 6.4 weeks, between June 29 and August 10, 2009.

On March 25, 2014 appellant requested reconsideration, stating that he was willing to undergo another OWCP-authorized examination. He resubmitted reports by Drs. Piserchia, Jones and Sundstrom and reports of a physical therapist based on referral from Dr. Piserchia. Additionally, Dr. Piserchia reported on January 19, 2014 that appellant had limited range of motion of the cervical spine in rotating and tilting. He recorded limited range of motion findings for the right upper extremity of 150 degrees abduction and forward flexion of 160 degrees. In a progress report dated May 28, 2014, Dr. Piserchia diagnosed cervical spondylosis and right-sided radiculopathy and advised appellant to engage in activities progressively.

In a decision dated June 26, 2014, OWCP found that the evidence was not sufficient to modify the August 7, 2013 schedule award decision. In reaching this conclusion, the senior claims examiner noted that on August 17, 2013 OWCP had granted appellant a schedule award for a seven percent impairment to the "right upper extremity" as a result of the work injury.

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing regulations[7] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for 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 insure equal justice under the law to all claimants, good administrative practice necessitates the use of 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

[5] The Board notes that the August 7, 2014 schedule award contained an error. It referred to a schedule award for "lower right extremity" impairment even though all accepted conditions involved the right upper extremity.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

appropriate standard for evaluating schedule losses.[8] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[9]

To support a schedule award, the file must contain competent medical evidence that establishes that appellant had reached maximum medical improvement and evidence that describes the impairment in sufficient detail for the claims examiner to visualize the character and degree of disability and give a percentage based on a specific diagnosis.[10] The attending physician should perform the evaluation whenever possible, however, the claimant may submit an examination from another physician if the regular attending physician does not wish to or cannot provide an impairment rating.[11] If the claimant does not provide an impairment evaluation from his physician when requested, and there is an indication of permanent impairment in the medical evidence of file, the claims examiner should refer the claimant for a second opinion evaluation. The claims examiner may also refer the cases to the medical adviser prior to scheduling a second opinion examination to determine if the evidence in the file is sufficient for the medical adviser to provide an impairment rating.[12] After obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage of impairment.[13]

Before a schedule award can be awarded, it must be medically determined that no further improvement can be anticipated and the impairment must reach a fixed and permanent state, which is known as maximum medical improvement.[14] Maximum medical improvement means that the physical condition of the injured member of the body has stabilized and will not improve further.[15] The determination of the date of maximum medical improvement is factual in nature and depends primarily on the medical evidence.[16] The date of maximum medical improvement is usually considered to be the date of the evaluation accepted as definitive by OWCP.[17] While additional medical treatment such as surgery may be recommended in order to improve the claimant's condition, the claimant is not required to undergo such treatment.[18] Under the

[8] *Id.*

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

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.5(b) (February 2013).

[11] *Id.* at 2.808.6.

[12] *Id.*

[13] *Id.*

[14] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3a(1) (January 2010); *see also P.L.*, Docket No. 13-1340 (issued October 28, 2013).

[15] *Adela Hernandez-Piris*, 35 ECAB 839 (1984).

[16] *J.B., Docket No.* 11-1469 (issued February 14, 2012); *Franklin L. Armfield*, 28 ECAB 445 (1977).

[17] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a(1)(c) (January 2010); *see also Richard Larry Enders*, 48 ECAB 184 (1996) (the date of maximum medical improvement was the date of the audiologic examination used as the basis of the schedule award).

[18] *Id.* at Chapter 3.700.3a(1)(a).

circumstances, OWCP must calculate the percentage of a schedule award as if no further improvement were possible if the claimant declined such intervention.[19]

ANALYSIS

The Board finds this case not in posture for decision.

OWCP accepted that as a result of appellant's January 5, 2009 employment-related injury, appellant sustained right-sided bicipital tenosynovitis, cervical disc herniation, and right cervical radiculopathy. He filed a claim for a schedule award on September 22, 2011. On August 7, 2013 OWCP issued a schedule award for a two percent permanent impairment of the right lower extremity. In a June 26, 2014 decision on reconsideration, it denied modification of this decision.[20]

In the instant case, OWCP based its decision on the opinion of the second opinion physician, Dr. Sundstrom, and the medical adviser. This was an error. Dr. Sundstrom's narrative report does not comment on whether appellant had reached MMI and it appears from the referral that he was not asked to offer an opinion on that question. However, in addition to his narrative report, he also completed and signed an OWCP-CA5 Work Capacity Evaluation. That form includes the question of whether the employee had reached MMI and allows the evaluating doctor to check a box to indicate an affirmative or negative answer. Dr. Sundstrom checked the box to indicate that appellant had not reached MMI as of June 29, 2009. In light of the Form OWCP-CA5, OWCP incorrectly cited the opinion of Dr. Sundstrom to support its June 26, 2014 decision which affirmed that appellant had, in fact, reached MMI on June 29, 2009. Dr. Sundstrom found the opposite.

The Board further notes that OWCP's decision on appeal is incorrect on its face. The decision before the Board states that the prior decision (dated August 7, 2013) found an impairment of seven percent to the right arm and explicitly denies modification of that result. In fact, the August 7, 2013 decision found an impairment of two percent to the right leg. It is reasonably clear from the rest of OWCP's August 7, 2013 decision that the award was intended to be right arm.[21] The June 26, 2014 OWCP decision was a merit review of appellant's claim and should have corrected the error in the August 2013 decision and should also have correctly stated the schedule award in purported to affirm. As the record stands, neither decision clearly explains that appellant has been awarded two percent of the right arm. Both decisions inaccurately state the opinion of Dr. Sundstrom which was that, on June 29, 2009, appellant was not at MMI. OWCP must give appellant a decision which clearly and consistently states the

[19] *Id.*

[20] OWCP's decisions are not clear with regard to the amount of the impairment and the affected body part. In the August 7, 2013 decision, it erroneously issued a schedule award for a two percent impairment of the lower right extremity. However, as is evident from all of the medical evidence and from the accepted conditions, the award should have been issued for appellant's upper right extremity. In its June 26, 2014 decision on reconsideration, OWCP noted the correct body part, *i.e.*, the right upper extremity. However, it erroneously indicated that the April 7, 2013 schedule award was for seven percent impairment.

[21] *Supra* notes 5 and 20. In addition, the reports of Dr. Sundstrom and OWCP medical adviser both evaluate the right arm.

schedule award in his case and which accurately reports the medical opinion relied upon to support that award.[22]

On remand, OWCP should develop the medical evidence to determine appellant's impairment under the A.M.A., *Guides*. It shall ask his treating physician for an impairment rating, and the proceed to further develop the medical evidence. Following this and any other further necessary development, OWCP should issue a *de novo* decision regarding any employment-related permanent impairment.[23]

CONCLUSION

The Board finds that this case is not in posture for decision as the medical evidence must be further developed in order to determine appellant's impairment.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 26, 2014 is set aside, and the case is remanded for further action consistent with this decision.

Issued: July 13, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[22] 20 C.F.R. § 10.126.

[23] In light of the disposition of the first issue, the second issue is moot.