United States Department of Labor
Employees' Compensation Appeals Board

P.P., Appellant	)	
and	)	**Docket No. 16-0831**
	)	**Issued: August 16, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 16, 2016 appellant, through counsel, filed a timely appeal of a November 13, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

ISSUE

The issue is whether appellant has more than nine percent permanent impairment of her right upper extremity for which she received a schedule award.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

On appeal counsel contends that there is an unresolved conflict of medical opinion evidence between appellant's attending physician, Dr. Nicholas Diamond, an osteopath, and OWCP's medical adviser regarding the extent of her permanent impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009).[3]

FACTUAL HISTORY

On June 26, 2009 appellant, then a 54-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that on June 22, 2009 she injured her right arm in the performance of duty. She attributed her condition to picking up eight tires out of postal vehicle. OWCP accepted appellant's claim on August 10, 2009 for the conditions of sprain of the right lateral elbow and forearm as well as lateral epicondylitis on the right. Appellant's physician, Dr. Stephen Huish, an osteopath and Board-certified physiatrist, found that appellant was totally disabled. OWCP entered her on the periodic rolls on December 29, 2009.

A magnetic resonance imaging (MRI) scan of the right elbow dated September 4, 2009 demonstrated mild low-level synovitis as well as lateral epicondylitis with no discrete tendon tear. Appellant underwent an electromyogram and nerve conduction velocity studies on September 8, 2009 which were considered normal. Her MRI scan of the right elbow on February 4, 2010 demonstrated subcutaneous edema posterior to the tricipital tendon insertion into the olecranon.

Appellant underwent an authorized surgical lateral release of the right elbow with epicondylectomy and repair of the common extensor tendon on March 16, 2010.

OWCP referred appellant for a second opinion evaluation with Dr. Wayne J. Altman, a Board-certified orthopedic surgeon. In a report dated May 25, 2010, Dr. Altman opined that she was capable of returning to her regular work duties as a mail handler. He found that appellant had full range of motion in the right elbow with no weakness to the wrist and thumb extensors and no sensory loss in the right upper extremity. Dr. Altman reported tenderness over the operative scar and mild tenderness over the distal triceps. He noted no swelling in the elbow, wrist, or digits and found that impingement sign was negative.

OWCP proposed to terminate appellant's compensation payments for wage-loss and medical benefits in a letter dated June 22, 2010 based on Dr. Altman's report. It provided her with an opportunity to submit additional evidence. However, appellant did not respond within the time allotted.

By decision dated July 28, 2010, OWCP terminated appellant's compensation payments for wage-loss and medical benefits effective July 31, 2010. Counsel requested an oral hearing

[3] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *id.*, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

from OWCP's Branch of Hearings and Review and by decision dated October 19, 2010, OWCP's hearing representative vacated the July 28, 2010 termination.

OWCP referred appellant for an additional second opinion evaluation with Dr. Sean Lager, a Board-certified orthopedic surgeon. In a November 24, 2010 report, Dr. Lager found that she had reached maximum medical improvement (MMI) and was capable of returning to full duty. He recommended work hardening and a functional capacity evaluation.

Dr. David B. Basch, a Board-certified orthopedic surgeon, completed a report on May 12, 2011 noting that appellant reported right elbow pain and stiffness. Appellant underwent a cervical spine MRI scan, which revealed posterior disc osteophyte complexes at C3-4, C4-5, C5-6, and C6-7 compressing upon the thecal sac with neuroforaminal stenosis and grade 1 retrolisthesis of C4 on C5 as well as C5 upon C6. Dr. Basch found contracture with weakness of her right biceps as well as the dorsiflexors. He reported weakness of right grip strength with no atrophy. Dr. Basch found mild soft tissue swelling and effusion over the right elbow. He diagnosed moderate-to-severe lateral epicondylitis of the right elbow and development of flexion contracture of the right elbow.

Appellant accepted a light-duty position at the employing establishment on May 18, 2011. She stopped work on June 16, 2011 due to increased pain in the right side of her neck, right shoulder, right elbow, and wrist, and radiating to her right hand. Appellant also reported chest wall pain with nausea and vomiting. Dr. Huish examined her on June 28, 2011 and diagnosed cervical sprain/strain, right shoulder strain, exacerbation of right elbow strain, and right wrist/hand strain. He opined that appellant had an exacerbation of right elbow and forearm pain after the work incident on June 16, 2011 which caused new injuries to her neck, right shoulder, and right hand and wrist. Dr. Huish found increased swelling over the lateral aspect of the right elbow with markedly restricted range of motion. He also found right-sided cervical dorsal paravertebral spasm. Dr. Huish diagnosed cervical sprain/strain, right shoulder strain, exacerbation of right elbow strain, and right wrist/hand strain.

Appellant filed a recurrence of disability (Form CA-2a) on July 19, 2011 alleging pain in her neck area, right side, and her shoulder down to her right hand occurring on June 25, 2011.

Dr. Basch examined appellant on July 11, 2011 and diagnosed chronic cervical strain with multilevel internal disc disruption and right-sided radiculopathy. He noted that she was experiencing sharp severe pain from her cervical region into her right arm. On August 22, 2011 Dr. Basch found diminished sensation in the C5, C6, C7, and C8 dermatomal distributions. He diagnosed chronic cervical strain with multilevel internal disc disruption, disc ridge complex at C3-4, C4-5, C5-6, and C6-7 with compression on the thecal sac and neuroforaminal stenosis with retrolisthesis of C4 upon C5 and C5 upon C6 with right-sided radiculopathy. Dr. Basch recommended referral to a pain management specialist due to multilevel disc involvement and a question of whether appellant was a surgical candidate.

OWCP expanded appellant's claim on August 18, 2011 to including sprain of the neck, sprain of the shoulder and upper arm, and sprain of the right wrist.

Dr. Basch completed a treatment note on October 17, 2011 and recommended an anterior cervical discectomy and fusion surgery as well as interventional pain management for appellant's cervical spine. He repeated these recommendations on January 23, 2012. In a treatment note dated April 23, 2012, Dr. Basch reported that appellant could no longer tolerate her neck pain and was referred to a pain management specialist for possible nerve root or facet joint injections.

In a May 16, 2012 report, Dr. Diamond, an osteopath, evaluated appellant's permanent impairment for schedule award purposes. He described her accepted injuries and reviewed appellant's medical records. Dr. Diamond reported that appellant's *Quick*DASH score was 72 percent for the right elbow. He noted that she had a moderate pain disability on the Pain Disability Questionnaire. On examination Dr. Diamond found paravertebral muscular spasm and cervical spine tenderness with limited range of motion. Appellant's sensory examination revealed a perceived sensory deficit over the C5 and C6 dermatomes involving the right arm. Dr. Diamond also found a diminished sensibility *via* Semmes-Weinstein Monofilament testing in the right hand to eight millimeters. For the right shoulder, appellant had anterior cuff tenderness, 0 to 160 degrees of abduction, 0 to 65 degrees of adduction and 0 to 70 degrees of internal rotation. There was right elbow effusion, as well as tenderness of the olecranon and lateral epicondyle. Appellant's right elbow pronation and supination were 0 to 70 degrees. Dr. Diamond diagnosed post-traumatic right elbow lateral epicondylitis with common extensor tendon tendinopathy, right shoulder strain and sprain, right wrist strain and sprain, and cervical spine strain and sprain with right C5-6 radiculitis.

Dr. Diamond applied the A.M.A., *Guides* and concluded that appellant's diagnosis-based estimate was for class 1 right elbow lateral epicondylitis with surgical release,[4] 5 percent impairment. He listed her grade modifiers as functional history, 3 based on the *Quick*DASH score,[5] physical examination 2,[6] clinical studies 1,[7] and found when applying the formula appellant had net adjustment of 3 for 7 percent impairment of the right upper extremity. Dr. Diamond also reported a class 1 right shoulder sprain/strain, one percent impairment.[8] He applied the formula and found a net adjustment of negative one.[9] Dr. Diamond also found class 1 mild sensory deficit of the right C5 and C6 nerve roots which he concluded was an additional one[10] percent impairment of the right arm after applying the applicable formula. He concluded that appellant had reached MMI and that she had nine percent permanent impairment of her right upper extremity due to her accepted conditions. Appellant completed a claim for compensation (Form CA-7) on August 8, 2012 and requested a schedule award (Form CA-7).

[4] A.M.A., *Guides* 399, Table 15-4.

[5] *Id*. at 406, Table 15-7.

[6] *Id*. at 408, Table 15-8.

[7] *Id*. at 410, Table 15-9.

[8] *Id*. at 401, Table 15-5.

[9] *Id.*

[10] *Id*. at 436, Table 15-21.

In a report dated February 25, 2013, Dr. Basch recommended that appellant receive an additional MRI scan of her cervical spine. He further recommended that she consider further treatment options including anterior cervical discectomy and fusion surgery.

By decision dated June 27, 2014, OWCP denied appellant's claim for a schedule award finding that her accepted conditions had not reached MMI such that she was not currently entitled to a schedule award.

Counsel requested an oral hearing from OWCP's Branch of Hearings and Review on July 3, 2014. In a letter dated November 19, 2014, he forwarded information from appellant that she was not interested in surgery.

Appellant underwent a cervical spine MRI scan on April 18, 2011 which diagnosed posterior disc osteophyte complexes at C3-4, C4-5, C5-6, and C6-7 causing neuroforaminal narrowing as well as straightening of the normal lordosis. She underwent x-rays of the right elbow on April 11, 2011 which demonstrated no acute fracture or dislocation.

Dr. Diamond completed a report on December 11, 2014 updating his May 16, 2012 report. He did not reexamine appellant or make changes to his findings on physical examination. Dr. Diamond's impairment ratings remained the same except for the C5 and C6 nerve roots. He found that appellant had class 1 mild sensory deficit of the right C5 nerve root or one percent impairment as well as the same impairment of the right C6 nerve root. Dr. Diamond applied the formula and tables in Chapter 17, The Spine and Pelvis of the A.M.A., *Guides*. He determined that appellant had 2 percent impairment of each of the nerve roots or 11 percent impairment of the right upper extremity. Dr. Diamond altered the clinical studies grade modifier 2 based on appellant's MRI scan for both cervical nerve roots.[11]

By decision dated January 13, 2015, OWCP's hearing representative vacated OWCP's June 27, 2014 decision and remanded the case for further action on appellant's schedule award claim.

OWCP referred Dr. Diamond's reports to its medical adviser on January 15, 2015. The medical adviser reviewed the findings and conclusion and agreed with Dr. Diamond's initial impairment rating of seven percent for right epicondylitis as well as one percent impairment for right shoulder strain. In regard to appellant's impairment due to sensory deficit, he provided, "[Dr. Diamond] used [m]ild [s]ensory [d]eficit of the right C5-6 roots (axillary nerve). He got a class 1. (Default Value) equals 1. His Net Modifier Adjustment was +2. The (default value), however, stayed at 1 percent for the right upper extremity." OWCP's medical adviser found that appellant had one percent impairment of the axillary nerve for nine percent impairment of the upper extremity. He concluded, "This is the same as he got on May 16, 2012. I would accept this."

By decision dated March 9, 2015, OWCP granted appellant a schedule award for nine percent permanent impairment of the right arm. Counsel requested an oral hearing from OWCP's Branch of Hearings and Review on March 12, 2015. At the oral hearing on August 27,

[11] *Id*. at 581, Table 17-9.

2015, he argued that OWCP's medical adviser was not entitled to the weight of the medical evidence as Dr. Diamond properly applied the A.M.A., *Guides* and as the medical adviser failed to apply the appropriate provisions to appellant's accepted cervical impairments.

By decision dated November 13, 2015, OWCP's hearing representative found that appellant had no more than nine percent permanent impairment of her right arm. She found that OWCP's medical adviser properly applied the A.M.A., *Guides* to Dr. Diamond's findings.

LEGAL PRECEDENT

The schedule award provision of FECA[12] and its implementing regulations[13] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of use of scheduled members or functions 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 determination is a matter which rests in the 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[14]

FECA does not authorize the payment of schedule awards for the permanent impairment of the whole person.[15] Payment is authorized only for the permanent impairment of specified members, organs, or functions of the body.

No schedule award is payable for a member, function, or organ of the body not specified in FECA or in the regulations.[16] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back or spine,[17] no claimant is entitled to such an award.[18]

Amendments to FECA, however, modified the schedule award provisions 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 provisions of FECA include the extremities, a claimant may be entitled to a

[12] 5 U.S.C. § 8107.

[13] 20 C.F.R. § 10.404.

[14] *Supra* note 3.

[15] *W.D.*, Docket No. 10-274 (issued September 3, 2010); *Ernest P. Govednick*, 27 ECAB 77 (1975).

[16] *W.D., id.*; *William Edwin Muir*, 27 ECAB 579 (1976).

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

[18] *W.D., supra* note 15. *Timothy J. McGuire*, 34 ECAB 189 (1982).

schedule award for permanent impairment to a limb even though the cause of the impairment originated in the spine.[19]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. Recognizing that certain jurisdictions, such as federal claims under FECA, mandate ratings for extremities and preclude ratings for the spine, the A.M.A., *Guides* has offered an approach to rating spinal nerve impairments consistent with sixth edition methodology.[20] OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures.[21] Specifically, it will address upper extremity impairment originating in the spine through Table 15-14.[22]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment class for the diagnosed condition Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[23]

ANALYSIS

The Board finds that appellant has no more than nine percent permanent impairment of her right upper extremity for which she received a schedule award.

OWCP accepted appellant's claim for sprain of the neck, shoulder, and upper arm, right wrist, right lateral elbow, and forearm as well as lateral epicondylitis on the right. Appellant underwent surgical lateral release of the right elbow with epicondylectomy and repair of the common extensor tendon. She filed a claim for a schedule award and submitted a May 16, 2012 report from Dr. Diamond addressing her permanent impairment for schedule award purposes.[24] Dr. Diamond found that appellant had seven percent impairment due to epicondylitis with a surgical repair. He further found that she had an additional one percent impairment of the right upper extremity due to her accepted right shoulder strain.[25] OWCP's medical adviser concurred

[19] *W.D., supra* note 15. *Rozella L. Skinner*, 37 ECAB 398 (1986).

[20] *Supra* note 3 at, Chapter 2.808.5c(3) (February 2013); *supra* note 3 at, Chapter 3.700 Exhibit 4 (January 2010).

[21] *Id*., at, Chapter 3.700 (Exhibits 1, 4) (January 2010).

[22] A.M.A., *Guides* 425, Table 15-14.

[23] *Id*. at 411.

[24] Dr. Diamond's December 11, 2014 report updated his May 16, 2012 report. He did not examine appellant again. The Board has held that that an impairment rating that is not based on reasonably current examination findings is of little probative value. *See P.S*., Docket No. 12-649 (issued February 14, 2013) (the Board found that a physician's January 2010 impairment rating was of reduced probative value because the physician relied on October 2007 findings as the basis for this updated impairment rating).

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

with these ratings and the Board notes that Dr. Diamond complied with the requirements of the A.M.A., *Guides* in reaching these ratings.

Dr. Diamond, on December 11, 2014, then determined that appellant had sensory deficits in his right upper extremity due to radiculitis as a result of his accepted cervical strain. He mentioned the appropriate provisions of the procedure manual in addressing appellant's claim for impairment of the arm as a result of the accepted cervical condition, but did not refer to the appropriate tables in either of his reports. Dr. Diamond should have considered tables in Chapter 15 of the A.M.A., *Guides*, relating to the upper extremities rather than referencing Chapter 17, which addresses the Spine and Pelvis. Dr. Diamond also did not base this rating on reasonably current findings.[26] For these reasons, Dr. Diamond did not properly apply the A.M.A., *Guides* to determine any additional impairment rating due to sensory deficit from appellant's cervical condition.

OWCP's medical adviser reviewed Dr. Diamond's report and found that appellant had a class 1, mild sensory impairment of the axillary nerve. He found that appellant was entitled to an additional one percent impairment due to this condition. The Board finds that the weight of the medical evidence establishes that appellant has no more than nine percent permanent impairment of her right upper extremity for which she received a schedule award.

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 no more than nine percent permanent impairment of her right upper extremity for which she received a schedule award.

[26] *Id*. at 399, Table 15-4.

ORDER

IT IS HEREBY ORDERED THAT November 13, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 16, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board