United States Department of Labor
Employees' Compensation Appeals Board

J.R., Appellant	)	
and	)	**Docket No. 19-1324**
	)	**Issued: August 24, 2020**
U.S. POSTAL SERVICE, POST OFFICE, Baytown, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Deputy Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 28, 2019 appellant filed a timely appeal from a January 31, 2019 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.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 10 percent permanent impairment of the left upper extremity and 4 percent permanent impairment of the left lower extremity, for which he previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts and circumstances set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On August 7, 2007 appellant, then a 51-year-old rural carrier, injured his neck, shoulders, and back when his mail truck was struck from behind when stopped at a traffic light while in the performance of duty. OWCP initially accepted his traumatic injury claim for disorder of bursae and tendons in the left shoulder and later expanded the acceptance of his claim to include disorder of bursae and tendons in both shoulders, lumbar sprain, neck sprain, degeneration of cervical intervertebral disc, displacement of cervical intervertebral disc without myelopathy, displacement of lumbar intervertebral disc without myelopathy, displacement of lumbar or lumbosacral intervertebral disc, and acquired spondylolisthesis. Appellant stopped work on August 7, 2007 and OWCP paid him wage-loss compensation for disability from work on the supplemental rolls from October 2 through 27, 2007. OWCP placed him on the periodic rolls on October 28, 2007.

On July 19, 2011 appellant filed a claim for a schedule award (Form CA-7). He submitted an impairment evaluation by Dr. Lubor Jarolimek, a Board-certified orthopedic surgeon, who diagnosed bilateral rotator cuff syndrome, lumbar spine sprain/strain, cervical spine sprain/strain, cervical and lumbar disc degeneration, cervical and lumbar disc displacement, and acquired spondylolisthesis. Dr. Jarolimek opined that appellant sustained 8 percent impairment of the left upper extremity, 11 percent impairment of the right upper extremity, and 0 percent impairment of the bilateral lower extremities under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

By decision dated May 18, 2012, OWCP granted appellant a schedule award for 8 percent permanent impairment of the left upper extremity and 11 percent permanent impairment of the right upper extremity. The award ran for 59.28 weeks from April 8, 2012 through May 27, 2013. It noted that there was no permanent impairment of the lower extremities.

On March 6, 2015 Dr. Stephen Esses, a Board-certified orthopedic surgeon, performed OWCP-authorized back surgery, including discectomy at L4-5 and L5-S1, and decompression of the bilateral nerve roots.[4]

On December 10, 2015 appellant underwent an electromyogram and nerve conduction velocity (EMG/NCV) study of the upper and lower extremities which revealed findings consistent with right mild-to-moderate carpal tunnel syndrome with mild demyelination changes, left mild carpal tunnel syndrome, bilateral ulnar sensory neuropathy, bilateral peripheral sensory neuropathy affecting both lower extremities, right C7 nerve root irritation and left L5 radiculopathy.

[2] Docket No. 17-1523 (issued April 3, 2018).

[3] A.M.A., *Guides* (6th ed. 2009).

[4] On September 8, 2015 Dr. Robert C. Kratschmer, a Board-certified plastic surgeon, performed right carpal tunnel release and tenosynovectomy of the flexor digitorum superficialis and profundus tendons to the second, third, and fourth digits. It is unclear from the case record whether this surgery was authorized by OWCP.

In a December 18, 2015 report, Dr. Salvador P. Baylan, a Board-certified orthopedic surgeon, discussed appellant's history of injury and reported the findings of the physical examination he conducted on December 10, 2015. He diagnosed displacement of lumbar intervertebral disc without myelopathy, degenerative disc disease of the lumbar spine, degeneration of cervical intervertebral disc, and displacement of cervical intervertebral disc without myelopathy. Dr. Baylan noted that appellant reached maximum medical improvement (MMI) on December 10, 2015. He documented normal upper extremity strength, 4/5 strength in the left lower extremity, and decreased sensation in the left thigh and leg. Dr. Baylan referenced Proposed Table 2 of *The Guides Newsletter*, *Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (*The Guides Newsletter*) (July/August 2009). He determined that, under this table, appellant had nine percent permanent impairment of the left lower extremity due to mild sensory and motor deficits associated with the L5 nerve distribution and five percent permanent impairment of the left lower extremity due to mild sensory and motor deficits associated with the S1 nerve distribution.[5] Combining these values yielded a total permanent impairment of the left lower extremity of 14 percent. Dr. Baylan found no permanent impairment of the upper extremities due to the lack of objective evidence of cervical radiculopathy.

On March 23, 2016 OWCP referred appellant's case, along with a statement of accepted facts (SOAF) and the case record, to Dr. Taisha Williams, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA) for OWCP.[6] It requested that she provide an opinion on permanent impairment in accordance with the standards of the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter*.

In an April 28, 2016 report, the DMA utilized Proposed Table 2 of *The Guides Newsletter* to evaluate appellant's permanent impairment. She determined that appellant had four percent permanent impairment of the left lower extremity due to mild sensory and motor deficits associated with the L5 nerve distribution and one percent permanent impairment of the left lower extremity due to mild sensory and motor deficits associated with the S1 nerve distribution. Combining these values yielded a total of five percent permanent impairment of the left lower extremity. The DMA reviewed Dr. Baylan's December 18, 2015 report and indicated that she arrived at different values for the impairment rating because she disagreed with Dr. Baylan with respect to the calculation of grade modifiers.

Appellant submitted an October 3, 2016 EMG/NCV study of the upper and lower extremities which revealed right and left sensorimotor median neuropathy at the wrists consistent with carpal tunnel syndrome, bilateral ulnar sensory neuropathy, bilateral peripheral sensory neuropathy affecting the lower extremities, right C7 nerve root irritation, and left L5 radiculopathy. He underwent a right shoulder MRI scan on October 5, 2016 which revealed bursal surface partial

[5] In reaching his conclusions, Dr. Baylan calculated the grade modifier for functional history (GMFH) and the grade modifier for clinical studies (GMCS), and applied the net adjustment formula. *See infra* note 19.

[6] Shortly after the referral, the case record was supplemented to include a February 16, 2016 magnetic resonance imaging (MRI) scan of the lumbar spine which revealed spondylolisthesis at L5-S1, broad-based central disc herniation at L4-5. A cervical spine MRI scan of even date revealed central left disc herniations at C4-5, C5-6, and C6-7 with central stenosis and cord compression at C4-5, C5-6, and C6-7.

tear supraspinatus tendon, small insertional partial infraspinatus anchor, mild subdeltoid bursitis, and mild subacromial outlet narrowing.

OWCP referred appellant, along with a SOAF and the medical record, for a second opinion examination to be conducted by Dr. Donald Lazarz, a Board-certified orthopedic surgeon. It requested that he provide an opinion on permanent impairment in accordance with the standards of the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter.*

In an October 25, 2016 report, Dr. Lazarz detailed appellant's history of injury and reported the findings of his physical examination. He noted that appellant exhibited poor effort during examination testing. Dr. Lazarz specifically indicated that the examination showed significant neurological deficits in the upper and lower extremities which were inconsistent with the MRI scans and EMG/NCV studies, as well as with Dr. Baylan's documentation of physical findings. He noted that his examination revealed significantly decreased strength in the upper and lower extremities and decreased sensation in both lower extremities, but that Dr. Baylan documented normal upper extremity strength, 4/5 strength in the left lower extremity, and decreased sensation in the left thigh and leg. Dr. Lazarz opined that, due to these inconsistencies, the findings were considered invalid and appellant had zero percent permanent impairment of his upper and lower extremities due to the employment-related cervical and lumbar spine conditions. With regard to the bilateral shoulder sprain, he found one percent permanent impairment of each upper extremity pursuant to the diagnosis-based impairment (DBI) rating method.

On November 9, 2016 OWCP referred appellant's case, along with a SOAF and medical record, to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA. In his report dated November 14, 2016, the DMA concurred with Dr. Lazarz's impairment rating of one percent permanent impairment of the each upper extremity and zero percent permanent impairment of each lower extremity. He noted that MMI occurred on October 25, 2016.

On March 1, 2017 OWCP requested clarification of the DMA's November 14, 2016 report. It indicated that appellant had previously received a schedule award for 8 percent permanent impairment of the left upper extremity and 11 percent permanent impairment of the right upper extremity, and asked whether his impairment determination was in addition to the previously granted award. In a March 5, 2017 report, the DMA advised that his impairment determination was not in addition to appellant's previously granted award. He noted no increase in appellant's right and left upper extremity impairment.

OWCP declared a conflict in the medical opinion evidence regarding appellant's permanent impairment. The conflict was between the attending physician, Dr. Baylan, and the government physicians, Dr. Lazarz and DMA Dr. Harris.[7] In order to resolve this conflict, it referred appellant, along with a SOAF and the case record, for an impartial medical examination to be conducted by Dr. James Butler, Board-certified in physical medicine and rehabilitation.

[7] OWCP initially referred appellant for an impartial medical examination to Dr. James Hood, a Board-certified orthopedic surgeon. However, appellant was previously seen by Dr. Hood and he was therefore disqualified. OWCP then referred appellant to Dr. Larry Likover, a Board-certified orthopedic surgeon. However, Dr. Likover did not perform impairment ratings and was also disqualified.

OWCP requested that he provide an opinion on permanent impairment in accordance with the standards of the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter*.

In a November 1, 2018 report, Dr. Butler discussed appellant's history of injury and reviewed his medical records. He recounted that appellant still complained of aching and shooting pain in the shoulders, neck, and lower back radiating into the hands and legs with associated numbness, tingling, and weakness. Upon physical examination, Dr. Butler observed a well-healed surgical scar on the lumbar spine consistent with prior discectomy at L4-5, normal gait, decreased sensation and weakness in the left leg/foot in the L5 nerve distribution, normal sensation and strength in the upper extremities and right lower extremity, restricted range of motion (ROM) of the cervical and lumbar spine and bilateral shoulders, positive supine and sitting straight leg raises on the left, and negative foraminal compression test and Neer impingement test bilaterally. Dr. Butler reported that appellant reached MMI on November 1, 2018.

Dr. Butler indicated that permanent impairment related to appellant's accepted cervical spine conditions would be rated using Proposed Table 2 of *The Guides Newsletter*. He noted that appellant's sensation was intact and his motor strength was 5/5 throughout both upper extremities. Dr. Butler determined, therefore, that the rating would be zero percent permanent impairment of each upper extremity when considering the accepted cervical spine conditions. He also referenced Proposed Table 2 of *The Guides Newsletter* with regard to permanent impairment related to appellant's accepted lumbar spine conditions. Appellant had mildly decreased sensation and 4/5 weakness in the left lower extremity associated with the L5 nerve distribution, but the sensation and strength in the right lower extremity was intact. Dr. Butler noted that the mild sensory deficits of the L5 nerve, based upon EMG/NCV findings, equaled a default value of one percent permanent impairment. He noted that appellant's positive nerve conditions fell under a class of diagnosis (CDX) of 1 and calculated a GMFH of 1 and a GMCS of 0. Dr. Butler indicated application of the net adjustment formula required movement one space to the left of the default value, but still resulted in a finding of one percent impairment. He also indicated that, for the mild motor deficit in the L5 nerve distribution (no atrophy, minimal findings), appellant had a default value of five percent permanent impairment. However, application of the net adjustment formula required movement one space to the left of the default value, and resulted in a finding of three percent impairment. Combining these values yielded a total of four percent permanent impairment of the left lower extremity. In addition, Dr. Butler concluded that appellant had no permanent impairment of his right lower extremity because the sensory and motor findings were normal in that extremity.

Dr. Butler explained that, with regard to appellant's accepted condition of disorder of bursae and tendons in both shoulders, Table 15-5 of the sixth edition of the A.M.A., *Guides*, page 401, provided that the DBI rating method was not applicable because it required the presence of normal ROM.[8] Since there was evidence of right and left shoulder ROM loss and Table 15-5 contained an asterisk allowing for use of the ROM rating method for appellant's condition, the rating was assessed using Table 15-34 on page 475. For the left shoulder, loss of motion for flexion was 3 percent impairment, extension was 1 percent impairment, abduction was 3 percent impairment, adduction was 1 percent impairment internal rotation was 2 percent impairment and

[8] Dr. Butler referenced the portion of Table 15-5 for "sprain/strain" which indicated that the DBI rating method was to be used for this condition when there was no instability or loss of motion, but pain persisted at MMI.

external rotation was 0 percent impairment for 10 percent left upper extremity impairment. For the right shoulder, loss of motion for flexion was three percent impairment, extension was zero percent impairment, abduction was three percent impairment, adduction was one percent impairment internal rotation was two percent impairment and external rotation was zero percent impairment for nine percent right upper extremity impairment.[9] Therefore, Dr. Butler concluded that appellant had 10 percent permanent impairment of the left upper extremity, 9 percent permanent impairment of the right upper extremity, and 4 percent permanent impairment of the left lower extremity.

By decision dated January 31, 2019, OWCP granted appellant a schedule award for 4 percent permanent impairment of the left lower extremity and an additional 2 percent permanent impairment of the left upper extremity, (for a total of 10 percent permanent impairment of the left upper extremity). The award ran for 17.76 weeks from November 1, 2018 to March 5, 2019 and was based on the November 1, 2018 report of Dr. Butler.

LEGAL PRECEDENT

The schedule award provisions of FECA[10] and its implementing regulations[11] 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, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[12] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[13]

Neither FECA nor its implementing regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[14] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[15] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on

[9] Dr. Butler obtained three results for each type of ROM and used the maximum observed measurements. *See* A.M.A., *Guides* 464.

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] *Id. See also T.T.,* Docket No. 18-1622 (issued May 14, 2019).

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[14] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see A.G.,* Docket No. 18-0815 (issued January 24, 2019); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[15] *See supra* note 13 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5c(3) (March 2017).

evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the Federal (FECA) Procedure Manual.[16]

In addressing upper or lower extremity impairment due to peripheral or spinal nerve root involvement, the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter* require identifying the impairment CDX, which is then adjusted by the GMFH and the GMCS. The effective net adjustment formula is (GMFH-CDX) + (GMCS-CDX).[17]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the shoulder, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401.[18] Table 15-5 also provides that, if motion loss is present for a claimant with certain diagnosed conditions, permanent impairment may be assessed using section 15.7 (ROM impairment). Such a ROM rating stands alone and is not combined with a DBI rating.[19]

Section 8123(a) of FECA provides in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[20] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[21]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 10 percent permanent impairment of his left upper extremity and 4 percent permanent impairment of the left lower extremity, for which he previously received schedule award compensation.[22]

OWCP properly found a conflict in the medical opinion evidence regarding permanent impairment between appellant's attending physician, Dr. Baylan, and the government physicians, Dr. Lazarz, serving as an OWCP referral physician, and Dr. Harris, serving as a DMA. It properly referred appellant's case to Dr. Butler pursuant to 5 U.S.C. § 8123(a) for an impartial medical

[16] *Id.* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

[17] *See The Guides Newsletter*; A.M.A., *Guides* 430.

[18] *Id.* at 405-12.

[19] *Id.* at 401-05, 475-78.

[20] 5 U.S.C. § 8123(a).

[21] *D.M.*, Docket No. 18-0746 (issued November 26, 2018); *R.H.*, 59 ECAB 382 (2008); *James P. Roberts*, 31 ECAB 1010 (1980).

[22] *See B.M.*, Docket No. 19-1069 (issued November 21, 2019); *C.S.*, Docket No. 19-0851 (issued November 18, 2019).

examination in order to resolve the conflict in medical opinion evidence.[23] In his November 1, 2018 report, Dr. Butler opined, with regard to impairment stemming from the lumbar spine, that there was mildly decreased sensation and 4/5 weakness in the left lower extremity associated with the L5 nerve distribution. Utilizing *The Guides Newsletter*, he properly determined that mild sensory deficits of the L5 nerve distribution equaled one percent impairment and mild motor deficit of the L5 nerve distribution equaled three percent permanent impairment for a combined four percent permanent impairment of the left lower extremity.[24] In addition, Dr. Butler correctly found, with respect to the accepted cervical spine conditions, the sensory and motor findings was normal in in the left upper extremity for a rating of zero percent in that extremity. With regard to the accepted condition of disorder of bursae and tendons in both shoulders, Dr. Butler used the ROM method of Table 15-34 of the sixth edition of the A.M.A., *Guides* to calculate 10 percent permanent impairment of the left upper extremity.[25] Therefore, Dr. Butler properly concluded that appellant had 10 percent permanent impairment of the left upper extremity and 4 percent permanent impairment of the left lower extremity.

As noted above, when a case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[26] The Board finds that Dr. Butler's November 1, 2018 report is entitled to special weight and established that, at the time of the impartial medical examination, appellant only had 10 percent permanent impairment of the left upper extremity and 4 percent permanent impairment of the left lower extremity. Dr. Butler's opinion was based on a proper factual and medical history, and on the proper tables and procedures in the A.M.A., *Guides*. He correctly applied the A.M.A., *Guides* and *The Guides Newsletter*, and he provided medical rationale for his impairment rating.[27] As appellant has not provided a rationalized medical opinion to dispute Dr. Butler's impairment rating, the Board finds that he has not established more than 10 percent permanent impairment of the left upper extremity and 4 percent permanent impairment of the left lower extremity, for which he previously received schedule award compensation.[28]

[23] *See supra* note 20.

[24] *See supra* notes 16 and 17.

[25] *See* A.M.A., *Guides* 475. Dr. Butler properly noted that the DBI rating method was not available for appellant's accepted bilateral shoulder condition, disorder of bursae and tendons. He referenced the portion of Table 15-5 for "sprain/strain," the closest listed condition to appellant's accepted condition, which indicated that the DBI rating method was to be used for this condition when there was no instability or loss of motion, but pain persisted at MMI. *Id.* at 401.

[26] *See supra* note 21.

[27] *See D.B.*, Docket No. 17-0930 (issued July 11, 2018).

[28] The Board notes that as the January 31, 2019 schedule award does not address the issue of the extent and degree of permanent impairment of the right upper extremity as, upon further development of that issue, Dr. Butler did not find a basis for an increased permanent impairment greater than the prior schedule award. Therefore, that issue is not before the Board on this appeal. *See* 20 C.F.R. § 501.2(c).

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing a progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish greater than 10 percent permanent impairment of the left upper extremity and 4 percent permanent impairment of the left lower extremity for which he previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the January 31, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 24, 2020
Washington, DC

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

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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