U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CAROL A. JACKSON and U.S. POSTAL SERVICE, POST OFFICE, Houston, Tex.

Docket No. 96-1210; Submitted on the Record;
Issued March 27, 1998

DECISION and ORDER

Before MICHAEL J. WALSH, WILLIE T.C. THOMAS, MICHAEL E. GROOM

The issue is whether appellant has greater than a five percent permanent impairment of her right arm and two a percent permanent impairment of her left arm.

The Board has duly reviewed the record and finds that appellant has not established that she has more than a five percent permanent impairment of her right arm and a two percent permanent impairment of her left arm.

The schedule award provisions of the Federal Employees' Compensation Act[1] and its implementing federal regulations[2] set forth the number of weeks of compensation to be paid for permanent loss of the member, functions, and organs of the body listed in the schedule. No schedule award is payable for a member, function or organ of the body not specified in the Act or in the regulations.[3] As neither the Act nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back or cervical spine, or for the whole person,[4] no claimant is entitled to such an award.[5] However, amendments to the Act in 1960 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 originates in a scheduled or nonscheduled member. As the schedule award provisions of the Act

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[1] 5 U.S.C. §§ 8101-8193.

[2] 20 C.F.R. § 10.304.

[3] *William Edwin Muir*, 27 ECAB 579 (1976) (this principle applies equally to body members that are not enumerated in the schedule provision as it read before the 1974 amendment, and to organs that are not enumerated in the regulations promulgated pursuant to the 1974 amendment); *see also Ted W. Dietderich*, 40 ECAB 963 (1989); *Thomas E. Stubbs*, 40 ECAB 647 (1989); *Thomas E. Montgomery*, 28 ECAB 294 (1977).

[4] *Gary L. Loser*, 38 ECAB 673 (1987).

[5] *E.g., Timothy J. McGuire*, 34 ECAB 189 (1982).

include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originates in the spine, if the medical evidence establishes impairment as a result of the employment injury.[6] The Act does not specify the manner in which the percentage of loss of a member shall be determined and the method for making such a determination rests in the sound discretion of the Office of Workers' Compensation Programs.[7] The Office has adopted, and the Board has approved, the use of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[8]

Appellant, a 37-year-old window clerk, injured her right neck and shoulder from lifting a heavy package at the same time she twisted her body. Based on initial medical reports, the Office accepted appellant's claim for a cervical strain. Subsequent testing performed by Dr. Hans O. Wendenburg, a neurosurgeon and family practitioner, revealed a herniated disc at the C5-6 level. The Office amended the acceptance of appellant's claim to include a C5-6 herniation, and authorized surgery performed by Dr. Wendenburg. Appellant returned to part-time work in mid-May 1989 and full-time work with restrictions the following month. She continued to have symptoms with complaints focused on right-sided pain and discomfort in her left thumb. Dr. E. Floyd Robinson, a Board-certified neurosurgeon, interpreted subsequent diagnostic tests as showing a herniation at the C4-5 level and he estimated a 15 percent impairment due to the prior C5-6 herniation with the prior surgery.

An Office medical adviser who reviewed Dr. Robinson's report in April 1991, identified C6 as the nerve root involved and rated the percent of impairment of that nerve under the applicable tables of the A.M.A., *Guides*.[9] The Office medical adviser multiplied 8 by 60 percent to arrive at 4.8 which he rounded to a 5 percent impairment of the right arm.[10] He proceeded to rate the discomfort on the left side in the same manner, but based on less discomfort of the thumb, he rated the degree of impairment lower, and multiplied 8 by 25 percent to arrive at 2 percent impairment of the left arm.

The Office granted appellant a schedule award for a five percent impairment of the right arm, a two percent impairment of the left arm due to the herniated disc and surgery at C5-6 level. The Office approved the recommendation for further surgery at the C4-5 level, which Dr. Wendenburg performed on June 27, 1991. Four months after surgery, Dr. Wendenburg reported persistent shoulder and neck muscle spasms and estimated a 25 percent impairment due

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[6] *Rozella L. Skinner*, 37 ECAB 398 (1986).

[7] *See Richard W. Robinson*, 39 ECAB 484 (1988).

[8] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th edition 1993) (hereinafter A.M.A., *Guides*).

[9] *Id*. (3d ed. 1988). The Board notes that the third edition was used by the Office for all decisions issued before September 1, 1991.

[10] *Id*. 40, 41 Tables 10, 12 (3d ed. 1988). The Office medical adviser noted that the maximum percent of impairment of the C6 nerve root was 8 percent for loss of function due to pain or discomfort, or sensory deficit, and with respect to the right arm, he graded the degree of pain at 60 percent, which was the maximum representing decreased sensation with or without pain which interferes with activity.

to the chronic cervical spasm. On January 14, 1992 the Office placed appellant on the periodic rolls for further wage-loss compensation.

Dr. Wendenburg referred appellant to Dr. Jose R. Tandoc, a Board-certified physiatrist, who prescribed physical therapy treatment. In April and May 1992 reports, Dr. Tandoc reported findings of swelling on the wrist and fingers and tingling of the right thumb. After administering a rheumatoid arthritis test, Dr. Tandoc attributed the symptoms to residual cervical pain from the prior neck surgeries and he diagnosed synovitis of the right wrist. Following a work hardening program, he released appellant to work on October 12, 1992 with lifting restrictions. Dr. Tandoc noted continued minimal discomfort around the right shoulder and a slightly weak grip, with a full range of motion of the neck and a lack of inflammation at that time. Appellant returned to work in mid-October 1992 with a lifting restriction and use of a straight-back chair. Following appellant's return to work, Dr. Tandoc decreased her lifting ability from 20 pounds to 10 pounds based on residual tenderness of the left-mid trapezius and some elements of muscle spasms.

On November 1, 1992 appellant filed a claim for an additional schedule award. She submitted a November 10, 1992 report by Dr. Tandoc, who reported occassional pain of the right forearm close to the elbow without further neck pains, and noted the need for a continued 10-pound lifting restriction. In a January 1993 report, Dr. Tandoc calculated between a 25 and 28 percent impairment due to the cervical condition. He indicated that the estimated percentage of impairment was based on 7 to 10 percent impairment for motor deficit of the hand and fingers, 5 percent impairment for the left upper extremity and hand, 9 percent impairment due to the cervical disc surgery with residual pain, 2 percent impairment based on the repeated surgery, and 2 percent impairment due to a 20 percent loss of the motion of the cervical spine.

An Office medical adviser recommended further a referral to a second opinion physician for a complete evaluation under the third edition, revised version of the A.M.A., *Guides*.[11] Dr. Ralph Mancini, a Board-certified physiatrist, evaluated appellant on June 22, 1993. Dr. Mancini acknowledged that appellant received a prior schedule award for impairment of her upper extremities, and he noted that his current calculations were based on impairment to the cervical spine under the appropriate tables of the A.M.A., *Guides*. He reported appellant's complaints of muscle spasms in the right arm, the anterior neck and swelling in both hands and bilateral shoulders, with general discomfort and no numbness in the upper extremities. He noted that electrodiagnostic studies showed minimal abnormalities in the C5-6 distribution seen in a single muscle, and that the study showed a borderline right median sensory latency. Dr. Mancini calculated a 25 percent impairment of the whole person due to a 7 percent impairment for each herniated disc, 5 or 6 percent impairment for loss of range of motion of the neck, and 3 percent impairment due to the residual myofascial pain syndrome which he felt accounted for most of appellant's pain.

Based on the lack of reported additional permanent impairment of the upper extremities, the Office denied appellant's claim for an additional schedule award in a decision dated April 4, 1994. Appellant requested an oral hearing or written review of the record and submitted

[11] The Board notes that under the third edition, revised, which was used by the Office for its decisions between September 1, 1991 and October 31, 1993, the percentages of impairment as calculated previously did not change.

an April 21, 1994 report from Dr. Tandoc, who calculated an additional three percent impairment of the right arm based on the involvement of the C5 nerve root. He noted that the maximum amount of impairment for the C5 nerve root was 5 percent, which when multiplied by 60 percent reflective of grade three level of interfering with activity equaled 1.5 percent. Dr. Tandoc indicated that the prior amount of impairment due to the C6 nerve root involvement was 6.4 percent, and noted that when added to 1.5, there was an 8 percent impairment of the right upper extremity.[12] Appellant also submitted a May 3, 1994 report from Dr. Janet Strickland, a Board-certified internist, who reported findings of diffuse tender points on the cervical spine, a loss of range of motion of the cervical spine, a decrease in sensation on the left lateral forearm and left middle finger. In addition, she noted with deep tendon reflexes in the upper extremities, a decrease in the biceps on the right, a decrease in the triceps bilaterally, and a decrease in the brachioradial on the right. In a May 11, 1994 report, Dr. Strickland reported that the electrodiagnostic studies in November 1988 showed evidence of a chronic right C5-6 and C6-7 radiculopathy. She estimated a 15 percent impairment to the whole person based on the cervical discectomies and fusion, with 6 percent impairment to the whole person based on decreased range of motion of the cervical spine.

By decision dated June 2, 1994, an Office hearing representative remanded the case for an impartial medical specialist to examine appellant, in order to resolve a conflict in medical opinion between the findings of Dr. Mancini and Tandoc on the degree of impairment to the right upper extremity.

The Office referred appellant, together with the medical evidence, to Dr. Brian Alpert, a Board-certified orthopedic surgeon, to serve as the impartial medical specialist with respect to the degree of impairment of the right upper extremity. Dr. Alpert examined appellant on August 19, 1994 and indicated that he reviewed the medical reports of record. He reported appellant's complaints of intermittent radiating symptoms of pain down the right arm with weakness at times in the right arm, as well occasional left shoulder symptoms. Dr. Alpert reported that the pain in the right arm sometimes wakes her from her sleep and she notices associated stiffness at times. He provided findings on the examination, including tenderness and a decreased range of motion of the cervical spine. Dr. Alpert identified the nerve root at the C6 nerve root distribution along the lateral forearm and hand. He noted that appellant's muscle strength was at grade five out of five bilaterally. Dr. Alpert stated that her deep tendon reflexes were positive one bilaterally in the right brachioradialis and the triceps reflexes bilaterally with the deep tendon reflexes at positive two bilaterally. He noted a lack of significant muscle atrophy. Dr. Alpert noted the degree of impairment of the right arm previously calculated, based on impairment of the C6 nerve root, as

[12] The Board notes that the prior Office medical adviser had correlated a 5 percent impairment, as opposed to the reported 6.4 percent impairment, due to nerve root involvement of the C6 nerve.

demonstrated by the electrodiagnostic studies.[13] He noted appellant's prior surgery at the C4-5 level, but did not provide any findings on impairment to any other nerve root other than the C6 nerve root. Nor did he provide findings with respect to impairment to the left shoulder. Instead, he noted that appellant had a 14 percent whole person impairment rating for loss of range of motion of the cervical spine and changes of ankylosis from the fusion at C4-6, as demonstrated by x-ray.[14]

The Office referred the medical evidence to a second Office medical adviser, who calculated that appellant had no more than a 5 percent impairment of the right arm, based on the report of Dr. Alpert.[15]

By decision dated September 19, 1994 the Office denied appellant's request for an additional schedule award. Appellant requested a written review of the medical records, and submitted test results from electrodiagnostic testing on October 12, 1994 which revealed mild or early left C6 radiculopathy. She also submitted a January 21, 1995 report by Dr. Wendenburg, who reported appellant's continued complaints of left shoulder pain down to her hand with tingling. Appellant also submitted the results from a magnetic resonance imaging (MRI) scan performed on February 6, 1995, which showed cervical spondylotic changes with foraminal encroachment primarily on the left at both C3-4 and C6-7, as well as a mild concentric disc bulging at C7-T1.

By decision dated February 13, 1995, an Office hearing representative affirmed the September 19, 1994 decision. Appellant requested reconsideration and submitted a May 17, 1995 report from Dr. Strickland, who noted her prior findings from the disability evaluation on May 11, 1994. Dr. Strickland indicated that appellant sustained a 15 percent impairment based on sensory and strength deficits and 6 percent impairment based on a decreased range of motion of the cervical spine. Appellant also submitted updated reports from Dr. Wendenburg, who reported that the MRI was ordered to determine the cause of appellant's persistent left arm pain and tingling sensations. She also submitted reports by Dr. Tandoc, who reported appellant's statement that the MRI showed a herniated disc at the C6-7 level with spondylosis. Dr. Tandoc noted appellant's complaints of persistent tightness and pain along the left arm and shoulder, and stated that while her range of motion of the neck was restricted, she had no loss of strength of the left arm.

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[13] The record indicates that Dr. Albert noted a 50 percent instead of 60 percent impairment, according to Table 11, the grading scheme for loss of strength, instead of using Table 10, the grading scheme for pain, discomfort, or loss of sensation. Accordingly, he calculated a 4 percent impairment of the right arm, instead of a 5 percent impairment previously awarded. *Id*. 48, 51, Tables 11, 12, and 13 (4th ed. 1993).

[14] A schedule award is not payable for a member, function or organ of the body not specified under the Act or implementing federal regulations. Neither the Act or implementing regulations provide for a schedule award for impairment to the spine or to the body as a whole; *see James E. Mills*, 43 ECAB 215 (1991).

[15] The Office medical adviser multiplied the maximum amount of impairment of the C6 nerve root, which was eight percent, with the amount of impairment under grade three, the level of pain which interfered with activity. However, the Office medical adviser applied the minimum amount of impairment at the grade three level, which was 26 percent, and multiplied 8 percent by 26 percent to arrive at 2.8 percent, rounded up to a 3 percent impairment of the right arm.

Following a review by an Office medical adviser of Dr. Strickland's report, the Office, by decision dated January 30, 1996 reviewed the merits of appellant's claim and denied modification of the prior decisions.

The Board notes that while appellant has submitted medical evidence in support of her claim for an amended schedule award for permanent impairment to both the right and left arms, she has not submitted sufficient objective evidence of a greater impairment. With respect to the right arm condition, the Board notes that the electrodiagnostic studies show a C6 nerve radiculopathy, for which she was fully compensated by the prior award for a five percent impairment based on the maximum amount of impairment to the C6 nerve root, rated at the level of pain interfering with activity. While Dr. Tandoc, a Board-certified physiatrist, identified the C5 nerve root as an affected nerve root from the C4-5 herniated disc and surgery, the electrodiagnostic studies did not evidence nerve root radiculopathy other than at C6. Neither did the report from Dr. Alpert, a Board-certified orthopedic surgeon and impartial medical specialist, establish neurologic deficit of the C5 nerve root to establish a further basis of impairment of the right arm.[16] Where there exists a conflict of medical opinion and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist is entitled to special weight if sufficiently well rationalized and based upon a proper factual review of the case.[17] Based on the lack of objective findings from the electrodiagnostic examination and the lack of identifiable impairment of a nerve root other than the C6 nerve root by Dr. Alpert, the Board finds that appellant has not established additional impairment to the right arm as a result of her cervical injury and herniated disc.

With respect to the award for impairment to the left arm, the Board notes that the Office based its initial award on the rating of impairment at the second grade level, pain which is forgotten during activity, multiplied by the maximum amount of impairment of the C6 nerve root. While appellant submitted reports from her physicians to indicate that she continued to be symptomatic in the left arm due to her cervical injury and surgery, she did not submit any medical evidence to show an impairment greater than a two percent impairment of the left arm due to her cervical condition. As stated previously, appellant's entitlement to a schedule award for permanent impairment due to a spinal injury is limited to the impairment in the extremities. Thus, the reports she submitted by Dr. Strickland, an internist, are not sufficient to establish entitlement to a greater schedule award, based on the basis of a cervical spine impairment provided by Dr. Strickland. Accordingly, appellant has not established entitlement to a greater schedule award than previously awarded.

The decision of the Office of Workers' Compensation Programs dated January 30, 1996 is hereby affirmed.

[16] Section 8123(a) of the Federal Employees' Compensation Act provides in part: "If there is a 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. 5 U.S.C. § 8123(a). Based on the conflict in medical opinion between the findings of Dr. Mancini, a Board-certified physiatrist, and Dr. Tandoc, the Office referred appellant to Dr. Alpert for resolution of the conflict in medical opinion.

[17] *Glenn C. Chasteen*, 42 ECAB 493 (1991).

Dated, Washington, D.C.
March 27, 1998

Michael J. Walsh
Chairman

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member