U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of GARY L. HORN and DEPARTMENT OF THE ARMY,
PINE BLUFF ARSENAL FIRE DEPARTMENT, Pine Bluff, AR

Docket No. 02-294; Submitted on the Record;
Issued September 19, 2002

DECISION and ORDER

Before COLLEEN DUFFY KIKO, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant is entitled to receive a schedule award for permanent impairment of the right upper extremity.

On June 10, 1999 appellant, then a 50-year-old firefighter/emergency medical technician, filed an occupational disease claim, alleging that factors of employment caused right elbow pain. He did not stop work. By letter dated September 14, 1999, the Office of Workers' Compensation Programs accepted that appellant sustained employment-related lateral epicondylitis of the right elbow[1] and on August 9, 2000 he filed a schedule award claim. The Office continued to develop the claim and in a September 27, 2001 decision, found that appellant was not entitled to a schedule award for the right upper extremity. The instant appeal follows.

The Board finds that appellant has a 1.5 percent impairment of the right upper extremity.

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulations,[3] schedule awards are payable for permanent impairment of specified body members, functions or organs. However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for all claimants, good administrative practice necessitates the use of a single set of Tables so that there may be uniform standards applicable to all claimants. The American Medical Association, *Guides to the Evaluation of Permanent*

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[1] The record indicates that the Office has also accepted that appellant sustained an employment-related herniated cervical disc and left knee strain. By decision dated August 24, 1993, the Office granted him a schedule award for a 20 percent permanent impairment for loss of use of the left lower extremity for a total of 57.60 weeks of compensation, to run from February 3, 1993 to March 13, 1994.

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

Impairment[4] (hereinafter A.M.A., *Guides*) has been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5]

The relevant medical evidence includes a May 2, 2000 report, in which Dr. Kevin J. Collins, a Board-certified physiatrist, finds decreased range of motion of bilateral upper extremities, decreased sensation of the right fourth and fifth digits and decreased reflexes in the right triceps. Dr. Collins diagnosed a large C6-7 right herniated disc with evidence of radiculopathy and recommended electromyography (EMG). A May 10, 2000, EMG was interpreted by Dr. John D. Schwankhaus, a Board-certified neurologist, as an abnormal study showing chronic reinnervative changes in the muscles, primarily of the C7-8 distribution with minimal changes at the C6 level, consistent with cervical radiculopathy. In a May 14, 2000 report, Dr. Collins noted the EMG findings and concluded that appellant had an "impairment rating of eight percent" based on the A.M.A., *Guides*.

In an August 22, 2000 report, Dr. Collins further explained that he evaluated appellant under Table 15, Page 54, of the 4th edition of the A.M.A., *Guides* and found that he had C7 involvement, primarily of the ulnar nerves with a 7 percent sensory deficit and a 34 percent motor deficit involving the flexor digitorum profundus and extensor carpi ulnaris muscles. Dr. Collins further advised that appellant had an 8 percent impairment rating, secondary to a herniated disc or a cervical category 3 with radiculopathy, which would equal a 15 percent whole person impairment rating.

By report dated January 9, 2001, an Office medical adviser advised that Dr. Collins' August 22, 2000 report, did not meet the Office requirements for evaluating entitlement to a schedule award, noting that the spine is not a scheduled member and that Dr. Collins did not provide clinical descriptions of the right upper extremity to support his findings in that regard. The Office medical adviser recommended referral for a second-opinion evaluation.

On June 22, 2001 the Office referred appellant to Dr. Barry D. Baskin, a Board-certified physiatrist, for further evaluation. In a report dated August 9, 2001, Dr. Baskin advised:

> "This gentleman does not have an impairment rating regarding his upper extremities. His upper extremity problem currently is from the cervical spine and he needs to be rated on the inner vertebral disc or other soft tissue lesion...."

In a supplementary report dated August 16, 2001, Dr. Baskin advised that appellant had C7 radiculopathy with subjective sensory loss. He advised that under the 5th edition of the A.M.A., *Guides*, Table 15-15, appellant's impairment was Grade III "with distorted superficial tactile sensibility, diminished light touch and two-point discrimination with abnormal sensations or slight pain that does interfere with some activities." Dr. Baskin concluded that under Table 15-15, appellant had a 30 percent sensory deficit which, under Table 15-17, represented a 5

[4] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB ___ (Docket No. 01-1361, issued February 4, 2002).

[5] *See James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

percent loss of function, which equaled a 1.5 percent impairment of the right upper extremity based on sensory loss. He concluded that appellant did not appear to have any motor loss.

In a report dated September 18, 2001, an Office medical adviser reviewed Dr. Baskin's August 9, 2001 report and advised that appellant reached maximum medical improvement on August 9, 2001 the date of Dr. Baskin's evaluation. The Office medical adviser further found that, based on the 5th edition of the A.M.A., *Guides*, appellant had no sensory or motor deficits of the upper extremities.

Initially the Board notes that, although the A.M.A., *Guides* include guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under the Act for injury to the spine.[6] In 1960, amendments to the Act 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. Therefore, as the schedule award provisions of the Act 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 originated in the spine.[7]

In the instant case, while in his initial report dated August 9, 2001, Dr. Baskin advised that appellant's impairment was better rated based on his herniated disc, he also advised that "his upper extremity problem currently is from his cervical spine." In an addendum report dated August 16, 2001, Dr. Baskin advised that appellant had diminished sensory perception in the right upper extremity, evaluated appellant's impairment utilizing the 5th edition of the A.M.A., *Guides* and concluded that appellant had a 1.5 percent impairment of the right upper extremity.

Section 15.12 of the 5th edition of the A.M.A., *Guides* describes the method to be used for evaluation of impairment due to sensory and motor loss of the extremities as follows. The nerves involved are to be first identified. Then, under Tables 15-15 and 15-16, the extent of any sensory and/or motor loss due to nerve impairment is to be determined, to be followed by determination of maximum impairment due to nerve dysfunction in Table 15-17 for the upper extremity and Table 15-18 for the lower extremity. The severity of the sensory or motor deficit is to be multiplied by the maximum value of the relevant nerve.[8]

The Board finds that, while the Office medical adviser properly concluded that maximum medical improvement was reached on the date of Dr. Baskin's initial evaluation, it does not appear that the Office medical adviser reviewed Dr. Baskin's supplementary report.[9] The Board has carefully reviewed Dr. Baskin's August 16, 2001 report and finds that he thoroughly

[6] *James E. Mills*, 43 ECAB 215 (1991).

[7] *See George E. Williams*, 44 ECAB 530 (1993).

[8] A.M.A., *Guides*, *supra* note 4 at 423.

[9] The Board further notes that in finding that Dr. Collins August 22, 2000 report, was insufficient to meet the Office standards, in his report dated January 9, 2001, the Office medical adviser did not review Dr. Collins previous reports dated May 2 and 14, 2000, in which he provided both findings on examination and EMG findings to support his conclusion that appellant had a permanent impairment of the right upper extremity.

explained how he reached his conclusion that appellant had a 1.5 percent impairment of the right upper extremity and, therefore, concludes that appellant is entitled to a schedule award for a 1.5 percent impairment of the right upper extremity.[10]

The September 27, 2001 decision of the Office of Workers' Compensation Programs is hereby reversed. The case is remanded to the Office for further proceedings consistent with this opinion.

Dated, Washington, DC
September 19, 2002

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

[10] The Board further notes that the record contains medical evidence indicating that appellant's right knee condition is worsening. A claimant may seek an increased schedule award if the evidence establishes that progression of an employment-related condition, without new exposure to employment factors, has resulted in a greater permanent impairment than previously calculated. *Linda T. Brown*, 51 ECAB ___ (Docket No. 98-498, issued October 1, 1999).